**Lancashire Health and Wellbeing Board**
**Tuesday, 18 July 2023, 2.00 pm,**
**Pavilion Cafe, Avenham Park, Preston, PR1 8JT**

# AGENDA

**Part I (Open to Press and Public)**

| Agenda Item | Item for | Intended Outcome | Lead | Papers | Time |
|---|---|---|---|---|---|
| **1. Appointment of Chair and Deputy Chair** | Information | The Board is asked to note the appointment by Full Council on 25 May 2023 of County Councillor Michael Green, Cabinet Member for Health and Wellbeing as Chair and James Fleet, Integrated Care Board, NHS as Deputy Chair of the Committee for the municipal year 2023/24. | Chair | | 2.00pm |
| **2. Welcome, introductions and apologies** | Action | To welcome all to the meeting, introduction and receive apologies. | Chair | | 2.05pm |

Sam Gorton: sam.gorton@lancashire.gov.uk 01772 534271

| Agenda Item | Item for | Intended Outcome | Lead | Papers | Time |
|---|---|---|---|---|---|
| **3. Disclosure of Pecuniary and Non-Pecuniary Interests** | Action | Members of the Board are asked to consider any Pecuniary and Non-Pecuniary Interests they may have to disclose to the meeting in relation to matters under consideration on the Agenda. | Chair | | 2.10pm |
| **4. Minutes of the Last Meeting held on 9 May 2023** | Action | To agree the minutes of the previous meeting. | Chair | (Pages 1 - 8) | 2.15pm |
| **5. Constitution, Membership and Terms of Reference of the Committee** | Action | The Board is asked to review the Terms of Reference and Membership. | Chair | (Pages 9 - 14) | 2.20pm |
| **6. Voice of the Community** | Discussion/ Action | To receive a presentation from the River Ribble Trust and discuss how the Health and Wellbeing Board can support/change ways of working. | Harvey Hamilton-Thorpe | | 2.25pm |
| **7. Lancashire Better Care Fund Plan 2023 to 2025** | Discussion/ Action | To receive an overview of the Lancashire Better Care Fund (BCF) plan 2023 to 2025. | Sue Lott | (Pages 15 - 42) | 2.40pm |
| **8. Lancashire and South Cumbria Integrated Care Board Update** | Discussion/ Action | To receive an update on the work to date and future plans in respect of the:<br>• Integrated Care Board Annual Report 2022/23<br>• Integrated Care System Capital Resource Plan 2022/23 and 2023/24<br>• Integrated Care System Joint Forward Plan 2023 onwards | James Fleet | (Pages 43 - 270) | 3.10pm |

| Agenda Item | Item for | Intended Outcome | Lead | Papers | Time |
|---|---|---|---|---|---|
| **9. Place Integration Deal** | Discussion/ Action | To receive an update on the recent decision of the Integrated Care Board to delegate responsibility for some NHS services to all four Places in the Lancashire and South Cumbria Integrated Care System including Lancashire Place. | Louise Taylor | (Pages 271 - 290) | 3.55pm |
| **10. Urgent Business** | Action | An item of Urgent Business may only be considered under this heading, where, by reason of special circumstances to be recorded in the minutes, the Chair of the meeting is of the opinion that the item should be considered at the meeting as a matter of urgency. Wherever possible, the Chief Executive should be given advance warning of any Members' intention to raise a matter under this heading. | Chair | | 4.10pm |
| **11. Date of Next Meeting** | Action | The next scheduled meeting of the Board will be held at 2pm on Tuesday, 5 September 2023. The possible area will be Hyndburn, East Lancashire. | Chair | | 4.15pm |

H MacAndrew
Director of Law and Governance

County Hall
Preston

**Lancashire County Council**

**Lancashire Health and Wellbeing Board**

**Minutes of the Meeting held on Tuesday, 9 May, 2023 at 2.00pm in YMCA Lofthouse Building, London St, Fleetwood FY7 6JL**

**Present:**

**Chair**

County Councillor Michael Green, Lancashire County Council

**Committee Members**

James Fleet, NHS Lancashire and South Cumbria Integrated Care Board
County Councillor Shaun Turner, Lancashire County Council
Dr Sakthi Karunanithi, Public Health, Lancashire County Council
Dave Carr, Director of Policy, Commissioning and Children's Health
Louise Taylor, Adult Services and Health and Wellbeing, Lancashire County Council
David Blacklock, Healthwatch
Clare Platt, Health Equity, Welfare and Partnerships, Lancashire County Council
Sam Gorton, Democratic Services, Lancashire County Council

**Apologies**

County Councillor Phillippa Williamson, Lancashire County Council
Chris Sinnott, Lancashire Chief Executive Group
Councillor Barbara Ashworth, East Lancashire, Lancashire Leaders Group
Councillor Viv Willder, Fylde Coast, Lancashire Leaders Group
Councillor Matthew Brown, Central, Lancashire Leaders Group

## 1. Welcome, introductions and apologies

The Deputy Chair, James Fleet commenced the meeting on behalf of the Chair who was delayed.

The Deputy Chair welcomed all to the meeting and thanked the staff at YMCA Lofthouse Buildings, Fleetwood.

Apologies were noted as above.

Replacements were noted as follows:

County Councillor Shaun Turner was attending of behalf of County Councillor Sue Whittam, Lancashire County Council.

Dave Carr, Director of Policy, Commissioning and Children's Health was attending on behalf of Jacqui Old, Executive Director for Education and Children's Services, Lancashire County Council.

Mo Girach, Lancashire Teaching Hospitals Trust also attended the meeting as an Observer.

Colin Hutchinson, YMCA Fleetwood, gave a brief overview of how the YMCA supports residents in Fleetwood and surrounding areas, particularly in relation to substance abuse and housing. Fielding House provides housing and support to vulnerable young adults (16 to 22 years). The Lofthouse Building similarly provides housing and support for older adults. Brookfield School supports children who may have been excluded from mainstream education. There is also YMCA leisure provision and 'warm spaces' have also been provided utilising the funding from Lancashire County Council.

The Chair joined the meeting during the presentation.

Following the overview from Colin Hutchinson, the Chair, thanked him for his passionate and informative overview and was thanked for everything he and the staff did for the locality.

## 2. Disclosure of Pecuniary and Non-Pecuniary Interests

There were no disclosures of interest in relation to items appearing on the agenda.

## 3. Minutes of the Last Meeting held on 7 March 2023 and Matters Arising

**Resolved:** That the Board agreed the minutes of the meeting held on 7 March 2023.

There were no matters arising from the minutes.

## 4. Voice of the Community

The Chair welcomed Lucy MacNeill who provided the Board with an overview of the activity in Fleetwood, and that of Future Fleetwood, supporting access to food and initiatives for children and young people locally.

Through the pandemic Lucy started working closely with partners across the town working with the NHS and Future Fleetwood. It was noted that post pandemic the food banks continued and are now run by different local groups. Lucy also runs youth activities and works in very close partnership with organisations in the town, such as Lancashire County Council, Wyre Borough Council and the NHS as well as the voluntary sector organisations.

A key area of focus is to raise aspirations for the young people, which can then effect change throughout the generations going forward. Throughout the pandemic, the young people helped with food banks, supporting every age group, they made phone calls for the elderly and toy donations at Christmas. Subsequently there has been

an increase in mental health issues with people finding it difficult to access timely support.

A Youth Hub has been funded by the Department for Work and Pensions (DWP) and is working with school leavers who are distanced from the employment market and dealing with mental health issues and improving basic skills.

The discussion highlighted the need to work in partnership (Lancashire County Council, Wyre Borough Council, NHS, Schools and voluntary organisations) to address the local needs. There is a need to build on what is available, working in partnership and utilising space/buildings that are available such as Milton Street and working with Early Help services.

The discussion highlighted a need for both universal and targeted services to support young people, raising aspirations and effective partnership working.

**Resolved:** That the Board noted the update and look to support work with children and young people by improving partnership working.

**5. Place Based Partnership**

Louise Taylor, Executive Director for Health and Wellbeing, Lancashire County Council and Director of Health and Care Integration, Lancashire and South Cumbria, NHS provided the Board with a progress report on the actions taken to develop the Lancashire Place-Based Partnership. The report covers the period March-May 2023 following the last update to the Board in March 2023 and intends to ensure that the Health and Wellbeing Board are fully sighted on the progress during the development stage.

The report provides further information:

- Developing the Lancashire Place – Workshops
- Developing ways of working in the three localities
- Developing ways of working – the governance options appraisal
- Developing a Health and Care Integration Deal

Appendix 'A' – Workshop Summary Report
Appendix 'B' – Locality Arrangements

Following the presentation, the following issues were discussed:

- The challenge is to effectively engage communities and effective partnership working
- The starting point is to understand what is working well and to be much better at evaluating what is being done and understand the money that is being spent on schemes which are currently having the greatest impact from a population health perspective, in order to start to be able to scales things better.
- Need to look at more effective partnership
- Identify the added value of what different sectors can bring to the table.

- Listen to local concerns and then use evidence with data to address issues.
- There are common features in communities across Lancashire and there needs to be a sustainable approach.
- Need to recognise the important role of the Voluntary, Community and Faith Sector (VCFSE) where often the money tends to go further with a greater degree of flexibility and a more creative way of delivery.

**Resolved:** That the Health and Wellbeing Board considered and commented as appropriate on the progress report on the development of the Lancashire Place-Based Partnership.

**6. Family Hubs Networks**

Dave Carr, Policy, Commissioning and Children's Health, Lancashire County Council provided an update on the Family Hubs Networks.

The Board were informed that the development of the Family Hubs Networks continues to progress, with local project teams established in six districts across Lancashire. These teams have identified local assets which could form part of the network and have undertaken user research which is informing the development of networks. Alongside this, work is underway to capture and share information on services and to strengthen the communication of the service offer to parents, carers, young people and practitioners.

Many of the core services that are expected to be delivered through the Family Hubs Networks are in place across Lancashire, either fully or partially, but need to be better connected, so that more families, children and young people can get the right support at the right time.

The work to develop networks at that local level is underpinned with a digital programme which will help families to connect to services without having to retell their stories, and a digitally enabled community of practice to strengthen links between practitioners.

Further details can be found in the report.

Dave Carr and Marc Hodges, Programme Office, Lancashire County Council gave a presentation (Appendix 'A' attached to the agenda) which contained further information on:

- Lancashire Hubs Networks
- Components for District Family Hubs Network – Not Just a Building
- Who is involved with Family Hubs Network Implementation
- The Importance of District Crews
- Lancashire Family Hubs Networks Approach
- Working with Districts
- Annex F – Updated April 2023
- RAG System
- Digital Products

- Family Hubs Information Sharing Service
- Connecting to Families to Support
- Milestones and Insights
- Insights from User Research and Crews

Following the presentation to the Board, the following issues were discussed:

- Best Start in Life is one of the Health and Wellbeing Boards strategic priorities
- Family hubs are a good example of partnership working with Public Health, Children's Services, NHS and the voluntary, community and faith sector.
- The service and provision will just grow over time and colleagues are linking in with National and Regional Family Hubs Groups.

**Resolved:** That the Health and Wellbeing Board considered and commented as appropriate on the progress report on the development of Family Hubs Networks in Lancashire.

**7. Better Care Fund**

Sue Lott, Adult Social Care, Lancashire County Council and Paul Robinson, Midlands and Lancashire Commissioning Support Unit updated the Board on the Lancashire Better Care Fund Reset work.

The Board noted that the Better Care Fund End of Year (2022/23) is being completed.

The Adult Social Care Discharge Fund has been confirmed for 2023-25, with planning in progress. The monies will be fully pooled into the Better Care Fund.

The Better Care Fund Plan is a two-year plan, with the ability to review and amend at the end of 2023/24. Planning is in progress, with the multi-agency steering group leading the work together on populating the plan and bringing the narrative together. The engagement with the Health and Wellbeing Board at this meeting is part of the information gathering and ambition setting for the Lancashire Plan.

Further details can be found within the report and in Appendix 'A'.

The Board also received a presentation which is appended to these minutes which provides further information on:

Lancashire Better Care Fund Update
- Lancashire Better Care Fund Reset
- Metrics and Performance
- Adult Social Care Discharge Fund
- Better Care Fund 2022/23 End of Year Reporting

Health and Wellbeing Board guidance and support
  Lancashire Better Care Fund Planning 2023 and beyond
  - Stakeholders …engagement and involvement

- The approach to embedding integrated, person-centred health, social care and housing
- How will we enable people to stay well, safe and independent at home for longer?
- How will we provide the right care in the right place at the right time?
- How do we best support unpaid carers using the Better Care Fund?
- How do we make the most of Disabled Facilities Grants (DFG) and wider housing support to achieve the above?
- How do we use the Better Care Fund to address and reduce health inequalities for the local population?

Following the presentation, the following issues were discussed:

- Generally the severity of illness being presented may mean that targets in Lancashire may not be met.
- Citizen engagement is really promising, however need to ensure that there is no fatigue and look at joining engagement up.
- From a citizen engagement approach, it was noted that the providers will be brought together for a day to ask them what they are currently dealing with and joining up the feedback with the people making decisions.
- There were also two areas which needed deep dive sessions around unpaid carers and housing.
- Look at joining up the funding for housing that comes into local areas.
- The Board noted that there was report going to Lancashire County Council's Cabinet on 8 June 2023 on Lancashire Accommodation with Support Plan, identifying the need for joined up working with services.
- The Board requested that an informal meeting be arranged to continue discussions further around Lancashire Better Care Fund Planning 2023.

**Resolved:** That the Health and Wellbeing Board:

i) Considered and commented as appropriate on the progress in the “reset” of the Lancashire Better Care Fund and next steps.
ii) Received further updates on Lancashire Better Care Fund reset activity and the Discharge Support Fund use and impact at future Board meetings.
iii) Considered and commented as appropriate on the approach to using the Adult Social Care Discharge Fund as set out in the plan.
iv) Contributed ideas and expectations for the 2023-25 Lancashire Better Care Fund Lancashire Plan.
v) Requested that Sam Gorton, Democratic Services, Lancashire County Council arrange an informal workshop for the Board to discuss Better Care Fund Planning 2023 and beyond, key questions including housing and unpaid carers.

## 8. Urgent Business

**Integrated Care Board (ICB) Joint Resource Capital Plans 2022/2023**

The Board were asked to note that the Integrated Care Board (ICB) Joint Resource Capital Plans 2022/2023 had been produced and there was a requirement for the Health and Wellbeing Board to receive them. It was also noted that the 2023/2024 plans would also need to come to the Board.

**Resolved:** That the Health and Wellbeing Board would receive both the Integrated Care Board Joint Resource Capital Plans 2022/2023 and 2023/2024 at its next meeting in July 2023.

## 9. Date of Next Meeting

The next scheduled meeting of the Board will be held at 2.00pm on 18 July 2023, venue to be confirmed.

The informal meeting to discuss the Lancashire Better Fund Planning 2023 and beyond key questions including housing and unpaid carers, will be arranged as soon as possible, and details confirmed with members.

H MacAndrew
Director of Law and Governance

County Hall
Preston

**Lancashire Health and Wellbeing Board**
Meeting to be held on Tuesday, 18 July 2023

| **Corporate Priorities:** |
|---|
| N/A |

**Constitution, Membership and Terms of Reference of the Committee**
(Appendix 'A' refers)

Contact for further information:
Sam Gorton, 01772 532471, Democratic Services Officer
Sam.gorton@lancashire.gov.uk

**Brief Summary**

The Constitution, Membership and Terms of Reference of the Lancashire Health and Wellbeing Board.

**Recommendation/s**

The Health and Wellbeing Board is asked to note the Constitution, Membership and Terms of Reference.

**Detail**

The County Council at its meeting on the 25 May 2023 approved the constitution and membership of the Lancashire Health and Wellbeing Board.

The Committee's Terms of Reference are set out at Appendix 'A'.

**Appendices**

Appendix 'A' is attached to this report. For clarification it is summarised below and referenced at relevant points within this report.

| Appendix | Title |
|---|---|
| Appendix 'A' | Terms of Reference |

**List of background papers**

None

Reason for inclusion in Part II, if appropriate

N/A

Appendix A

## Lancashire Health and Wellbeing Board Terms of Reference

### 1. Purpose

To achieve the best possible health and wellbeing outcomes and reduce health inequalities in Lancashire.

### 2. Functions

To achieve the purpose outlined above, the Health and Wellbeing Board will deliver the following key functions:

**Enable shared understanding** - to lead the development of a Joint Strategic Needs Assessment and ensure that it is informing the development of plans and priorities of the Board and its partners.

**Develop a Health and Wellbeing Strategy** – to agree a Health and Wellbeing Strategy and work in partnership with our system partners to support the delivery of this Strategy.

**Provide System Leadership** – to lead and direct the health and wellbeing system to ensure we continuously improve our services and make the best use of resources that deliver better outcomes for people.

**Seek Assurance** through monitoring and evaluation of the health and wellbeing strategy and where necessary provide appropriate and effective challenge.

**Accountability** – to be able to demonstrate and evidence that the decisions of the Board, and their subsequent outcomes, are clearly focused on improving the health and wellbeing and reducing health inequalities in Lancashire.

**Commissioning** - to enable collaboration between commissioners, joint commissioning and pooled budgets, where this provides better integrated service delivery and outcomes.

**Engagement** – listen to and understand the needs of local people; to ensure there is effective dialogue and engagement with our communities, and joint working between the county council, our district councils, local NHS and with other key strategic partnerships via. Safeguarding Boards, Local Economic Partnership, Children and Young People Partnership, Community Safety Partnership etc.

**Integration** – to promote integration and partnership working between the NHS, local government and wider public, private, voluntary, community and faith sector.

**(Approved and last updated by Full Council, 23 February 2023**
**Owner - Democratic Services)**

## 3. Principles

The Health and Wellbeing Board members recognise shared values as the foundation of a strong partnership and through trust, openness, equality and fairness will ensure a strong and sustainable partnership that delivers improved health and wellbeing outcomes and reduce health inequalities in Lancashire.

**Trust** – to have confidence in the integrity and ability of all partner organisations working collaboratively through the Health and Wellbeing Board.

**Openness** – demonstrating transparency and openness between partners in how decisions are made and in sharing activities, plans and ambitions.

**Equality** – each partner organisation/sector has an equal standing within the Health and Wellbeing Board.

**Fairness** – commitment throughout the Health and Wellbeing Board that the behaviour and actions of partners is equitable, impartial and objective.

## 4. Membership

The membership of the Lancashire Health and Wellbeing Board is comprised of the following:

- The Cabinet Member for Health & Wellbeing (Chair)
- The Leader of the Council*
- The Lead Member for Health
- Executive Director of Adult Services and Health & Wellbeing*
- Executive Director of Education and Children's Services*
- Director of Public Health*
- 1 member (Chair, CEO or Executive Director) to be nominated by NHS Lancashire and South Cumbria Integrated Care Board*
- Three District Councillors (one from each of the sub areas of Lancashire, to be nominated by the Lancashire Leaders Group)
- One District Council Chief Executive (to be nominated by the Lancashire Chief Executives Group)
- The Chair of Healthwatch*

*Members marked with an asterisk are statutory members who must be on the Board to meet the requirements of the Health and Social Care Act 2012.

All Board members to have one vote each.

The Board may invite any other representatives to meetings of the Board as it deems appropriate. Such representatives will not be formal members of the Board and they shall not have a vote but may participate in the debate with the consent of the Chair.

**(Approved and last updated by Full Council, 23 February 2023**
**Owner - Democratic Services)**

## 5. Meeting Arrangements

The Health and Wellbeing Board is a committee of the County Council and unless specified below, meeting arrangements are subject to the County Council's procedural Standing Orders:

- The Board will appoint the Deputy Chair annually from amongst the voting membership.
- The Board will meet at least four times a year. Additional meetings may be arranged by resolution of the Board or with the agreement of the Chair.
- Meetings will be at County Hall, Preston, unless otherwise agreed by the Board.
- Decisions will be made by consensus where possible, or when appropriate by a majority vote.
- In the event of a tied vote, the Chair has a second or casting vote.
- The quorum at a meeting of the Board shall be a quarter of the whole number of voting members of the Board with at least one Cabinet Member being present.
- Substitutes for Board members are permitted with written notification being given to the Clerk by the relevant nominating body in advance of the meeting.
- The Board may invite any other representatives to meetings of the Board as it deems appropriate. Such representatives will not be formal members of the Board and they shall not have a vote but may participate in the debate with the consent of the Chair.
- Meetings of the Board are open to the public, but they may be excluded where information of an exempt or confidential nature is being discussed – see Access to Information Rules set out at Appendix 'H' in the County Council's Constitution.
- The Board cannot discharge the functions of any of the Partners.

**(Approved and last updated by Full Council, 23 February 2023**
**Owner - Democratic Services)**

**Lancashire Health and Wellbeing Board**
Meeting to be held on Tuesday, 18 July 2023

| **Corporate Priorities:** Delivering better services; |
|---|

**Lancashire Better Care Fund Plan 2023 to 2025**
(Appendix 'A' refers)

Contact for further information:
Sue Lott, Head of Adult Social Care, Lancashire County Council, sue.lott@lancashire.gov.uk
Paul Robinson, Head of Service Redesign, Midlands and Lancashire Commissioning Support Unit, paul.robinson27@nhs.net

**Brief Summary**

This report provides an overview of the Lancashire Better Care Fund (BCF) plan 2023 to 2025. Having received approval by both Lancashire County Council and Lancashire and South Cumbria Integrated Care Board this final draft plan was signed off by the Health and Wellbeing Board deputy Chair and submitted to the national Better Care Fund team for the required assurance.

National planning timetables precluded the plan being brought before the Board in a timelier manner. It is anticipated that the plan will receive national approval.

There are two elements required for submission: a planning template (this has been circulated separately to the agenda, to members of the Health and Wellbeing Board) and a narrative plan (Appendix 'A'). Their content and purpose are described below.

The requirement for a two-year plan allows for stability across service planning and delivery in 2023/24 while enabling the flexibility for the shaping and implementation of the necessary changes that are being identified through the Lancashire Better Care Fund reset process for 2024/25.

There will be a requirement for quarterly reporting on Better Care Fund activity and progress. The Board will be engaged and informed as part of that process.

**Recommendations**

The Health and Wellbeing Board is asked to:

i) Confirm the sign off the Lancashire Better Care Fund Plan 2023 to 2025.
ii) Receive quarterly reports that set out Better Care Fund progress alongside the development of the reset Lancashire Better Care Fund.

**Detail**

Lancashire Better Care Fund 2023 to 2025 is an NHS and Lancashire County Council pooled fund of just over £202 million. It is a requirement that there is an agreed plan for the use of the fund each year. The Health and Wellbeing Board is the accountable body for the fund and oversight of the development and delivery of that plan.

Due to the timing of Better Care Fund planning requirements, it was necessary to seek the final draft Better Care Fund plan to be signed off by the deputy Health and Wellbeing Board Chair under their delegated powers.

This followed the sign off by both Angie Ridgwell, Chief Executive and Director of Resources, Lancashire County Council and Sam Proffitt, Chief Finance Officer, Lancashire and South Cumbria Integrated Care Board.

The Plan is currently in the regional and national assurance process and feedback should be received by the middle of July 2023.

This time, the Plan is for the two years 2023 to 2025 rather than the one-year plan required in previous years. Having a two-year plan enables more stability and longer-term planning to be undertaken. For Lancashire it will allow it to use 2023/24 as a planning year and 2024/25 as an implementation year based around the Better Care Fund reset programme outcomes. While it has been necessary to state plans including spending plans for 2024/25 it is allowed and expected that there will be flexibility and changes to plans for 2024/25.

The planning template (this has been circulated separately to the agenda, to members of the Health and Wellbeing Board) sets out the expenditure plan that fully commits the required spend. Included in this template are the allocations of the Adult Social Care Additional Discharge Fund. This is split as a grant directly to Lancashire County Council of £7.7 million and an allocation through the Integrated Care Board of £5.3 million to be pooled into the this has been circulated separately to the agenda, to members of the Health and Wellbeing Board.

All Better Care Funds are pooled under a section 75 agreement that will be confirmed and formally agreed across the partnership later in the year once national approval of the Better Care Fund Plan is achieved.

Within the template is the metrics section where the aspiration and plan to meet prescribed measures of success is set out. There have been further changes to these mandated metrics this year with an increased emphasis on hospital admission avoidance, hospital discharge and maintenance/restoration of independence. There is a new metric introduced for 2023/24 focusing on emergency hospital admissions due to falls sustained by people aged over 65. There will also be a further metric introduced in 2024/25 relating to hospital discharges, measuring the time between people being declared fit to leave hospital and the actual date they are discharged. Acute hospital trusts have been directed to ensure that the quality of relevant data collection is improved and that they are ready to meet the data requirements of the new metric.

Greater detail on the metrics and performance against them will be given to the Health and Wellbeing Board at future meetings as quarterly reporting is reinstated.

Included in the template for this plan is the required intermediate care capacity and demand analysis. Building a demand and capacity plan requires the system to fully understand what its residents need. This is not just about working out the capacity needed for the presenting demand but understanding where capacity could have supported those people better.

In such a large and varied system such an analysis is complex, and it is recognised that we will improve how we do this. This analysis will be subject to regional and national scrutiny along with an expectation that it will become more sophisticated and "live".

In shaping the Lancashire response to the metrics and setting challenging but realistic targets along with the development of capacity and demand analysis, it has been possible to call upon a small number of data experts from the NHS and social care, who have come together as a data group and will continue to work together to improve our data reporting. This is a substantial step in collaborative working that significantly enhances the input from commissioners and practitioners.

The narrative Plan (Appendix 'A') gives the wider overview behind the planned spend from the fund. It sets out the overall approach to integration and how the health and social care system meets and addresses the two key Better Care Fund policy objectives of:

- Enabling people to stay well, safe and independent at home for longer
- Providing the right care in the right place at the right time.

Support to unpaid carers is emphasised in the plan with £11.4 million being allocated specifically to this area of spend.

Increasing emphasis has also been required on the role that housing and a person's home plays in supporting the Better Care Fund policy objectives.

Priority areas identified in multi-agency and Health and Wellbeing Board workshops have been considered by the Lancashire Better Care Fund Board, with three key areas agreed for priority focus in 2023/24. These are:

1. The Lancashire Better Care Fund Reset work itself
2. Intermediate care/Discharge to Assess
3. Disabled Facilities Grant and a whole Lancashire approach

The agreed approach of focussing on a small number of priorities and making a difference will cover the wider impact of housing and improving carer support. Running through all of this will be the thread of greater citizen engagement and service user supported design and change.

**Appendix**

Appendix A is attached to this report. For clarification it is summarised below and referenced at relevant points within this report.

| **Appendix** | **Title** |
|---|---|
| Appendix 'A' | Narrative Plan |

**Lancashire Health and Wellbeing Board**

# Better Care Fund plan

**2023-2025**

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| Signed on behalf of<br><br>Lancashire Health and Wellbeing Board | |
|---|---|
| By | |
| Position | Chair, Lancashire Health and Wellbeing Board |
| Date | |

| Signed on behalf of<br><br>Lancashire County Council | |
|---|---|
| By | |
| Position | |
| Date | |

| Signed on behalf of<br><br>Lancashire and South Cumbria Integrated Commissioning Board | |
|---|---|
| By | |
| Position | |
| Date | |

| | |
|---|---|
| Health and Wellbeing Board | Lancashire |
| Local Authority | Lancashire County Council |
| Integrated Commissioning Board | Lancashire and South Cumbria |
| Boundaries | Lancashire County Council upper tier authority<br><br>12 District Councils<br><br>Burnley Borough Council<br>Chorley Borough Council<br>Fylde Borough Council<br>Hyndburn Borough Council<br>Lancaster City Council<br>Pendle Borough Council<br>Preston City Council<br>Ribble Valley Borough Council<br>Rossendale Borough Council<br>South Ribble Borough Council<br>West Lancashire Borough Council<br>Wyre Borough Council<br><br>Borders with 2 Unitary Authorities within the Lancashire footprint:<br><br>Blackburn with Darwen Council<br>Blackpool Council<br><br>Borders also with Westmorland South Cumbria within the ICB footprint<br><br>Borders with Sefton Council and shares an Acute Hospital, which sits within the Cheshire & Mersey ICB footprint. |

## Lancashire Health and Wellbeing board

Chair: County Councillor Michael Green

## Organisations involved in the preparation of this plan

Lancashire County Council

Lancashire and South Cumbria ICB

Lancashire District Councils

University Hospitals of Morecambe Bay NHS Foundation Trust

Blackpool Teaching Hospitals NHS Foundation Trust

Lancashire Teaching Hospitals NHS Foundation Trust

East Lancashire Hospitals NHS Trust

Southport and Ormskirk Hospital NHS Trust

Lancashire Healthwatch

Lancashire District Councils through representation

## Stakeholder involvement

The Lancashire Better Care Fund (BCF) continues to engage with stakeholders at several levels, and through evolving structures.

This has been particularly seen through the activity to deliver a "reset programme" for the BCF in Lancashire. A large workshop held in December 2022, supported by the BCF regional lead, brought together representatives from the County and District Councils, the Acute Trusts, NHS community services providers, the Mental Health NHS Trust, VCFSE groups, Foundations, and Healthwatch*.

It is recognised that involving service users, those with lived experience is not as strong as it should be and with this in mind work continues to progress regarding citizen engagement, with a workshop planned for late summer 2023 with health and care providers delivering services funded by the Better Care Fund. This is an important precursor to a citizen engagement workshop and will support us to understand how providers may already be engaging with the people they serve, and how they respond and innovate or improve following feedback.

At a county level there are residential and domiciliary care groups run by social care commissioners, a voluntary sector group and a District Council health focussed group alongside on all District Council DFG oversight group.

The development of Place and the appointment of Lancashire County Council's Executive Director, Adult Services and Health & Wellbeing to Director of Health & Care Integration (Lancashire) (ICB place lead) as a dual role is seen as a significant advantage in being able to maintain and develop those place based stakeholder relationships that are key to enabling ICB wide and local systems to deliver.

2022/23 has seen increasing collaboration across the four BCFs that sit within the ICB footprint. While this has not yet produced aligned plans it has enabled better coordination where a single Acute Trust services two local authority areas.

**Healthwatch Lancashire is delivered by People First Independent Advocacy, a local charity which supports people and communities to have a voice.*

## Governance

Governance is held by the Lancashire Health and Wellbeing Board and the BCF is a standing agenda item for its bi-monthly meetings. Board members are also separately kept informed and involved, as required, of developments and actions required.

Focused workshops have been held with the Board to support BCF related decision making and planning. In June 2023, the Board considered the overarching ambition for the BCF and integration and proposed identifying a small number of priority areas for the coming year.

The Lancashire Better Care Fund Board has recently been reconstituted and established. Overseeing the progress of the Plan, the reset work, and the spend through the pooled fund, it is co-chaired by Lancashire County Council and LSC ICB and is setting out its requirements for support, monitoring and reporting. Two major priorities are the strengthening of financial oversight and data management. To deliver these, two Teams have been created in collaboration with the ICB and other BCF areas.

Locally, the Place boundaries have been reshaped and now follow the Local Authority boundaries rather than the previous Place boundaries of the Acute Trust footprints. The Lancashire Place is in development, and options on future governance based on national guidance and good governance will be considered by the HWB Board in September 2023..

There is an ambition that the Lancashire Place Partnership Board and the Lancashire Health & Wellbeing Board will work in tandem, ensuring oversight of the integration agenda including the BCF, and delivery against key priorities and metrics and developing common aims and aspirations.

As a broader partnership, the ICB and Four upper tier local authorities within the LSC ICS have in place a finance partnership group that meets to address common challenges and future planning. Broad level discussions cover spend and commitments underpinning integrated working, including the BCF and the Additional Discharge Fund amongst other elements.

## Executive summary

The Lancashire BCF and delivery against the Plan already sees several successful teams and services, many jointly commissioned or jointly delivered, that meet the national objectives and priorities.

Together, Lancashire partners have agreed that the system needs to 'go further' and have a dynamic and progressive plan in place. To facilitate that, a BCF 'review and reset' programme of work has commenced, which will see every item of current spend measured against a set of principles and criteria and determine if it should remain in the fund. Alongside this, other areas of spend currently outside the BCF will be reviewed and where they meet the objectives and priorities of the BCF, consideration will be given to enhanced pooling into the fund. Discussions are also underway locally on delegation from the ICB to Place, with decisions due on the 5th July. One of the key priorities in the Place integration deal is the BCF and the ambition to quicken the pace on pooling of budgets to accelerate our collective ambitions to have strong sustainable community services.

As a Lancashire partnership, the Health and Wellbeing Board are keen that through the review and reset of the BCF, Lancashire is ambitious but realistic. The BCF is the only vehicle locally for pooling funds currently and offers significant opportunity to support the system to design and deliver integration, and services and supports that enable people to start, live, work, age, and die well in a place that they see as their home.

During 2023/25, the reset work will enable the partnership to better articulate and demonstrate the impact the BCF is having for Lancashire residents. It will be underpinned by a robust engagement plan that really supports and enables the voice and experience of people and their carers to be a core part of the BCF Plan, and in shaping the services that are funded through it.

To ensure that the system can deliver on key priorities, locally we aim to focus on a smaller number of things but do these well and 'stay the course'.

Demand and Capacity modelling has been undertaken to inform the plan. There is significant investment from the BCF already in intermediate care and related services and teams to support and maintain system flow, and the review and reset work will support the Lancashire system to identify additional opportunities to further improve this. Lancashire has sought the support of the national BCF support offer and DSOG to achieve its ambitions.

Whilst the Plan is a 2 year plan, the intention is to review and refresh at the end of 2023/24 given the Lancashire BCF reset work taking place which will inform 2024/25 focus areas.

Lancashire's BCF metrics, whilst not significantly distant from planned targets or England averages, are not where we want them to be, and the Health and Wellbeing Board is keen that the Lancashire system focusses on tangible integrated actions and delivery that will achieve what matters and realise improvements. We will review how we operate, improve our use of data and evidence, and look at best practice locally and from elsewhere to inform how we work, and how we work together.

## Better Care Fund Plan and Approach to Integration

The Better Care Fund supports our approach to integration as the primary joint funding mechanism for the Lancashire area.

Working in a strengths-based way and keeping the person at the centre of what we do is integral to our collective approach and ambitions in achieving quality outcomes for Lancashire residents. The Health and Wellbeing Board recently considered this point and are firm in their commitment that this must drive how and why we work together, that being person centred is visible and evidenced from strategy and commissioning through to front line interactions with Lancashire residents.

Across the partnership, there is engagement of Lancashire residents in a variety of forums and for many purposes. Lancashire intends to build on these foundations and agree and describe how we involve citizens and people with lived experience and keep this at the forefront of what we do. A well informed and robust engagement plan is critical to the Lancashire BCF, and in partnership with Healthwatch Lancashire plans are underway to undertake engagement sessions and agree actions and commitments based on feedback.

Lancashire has a collective ambition to improve the health, wellbeing, choices, and opportunities for its residents through true partnership and integrated working. This is further set out in several overarching plans and priorities across the partnership, including the Lancashire Health and Wellbeing Strategy, the developing Lancashire Place Plan and priorities , the Living Better Lives in Lancashire vision and the Integrated Care Strategy.

The Lancashire and South Cumbria ICB recognises the identified investment of £10m to address the potential historic benchmarking comparisons in the BCF in Lancashire. This has been subject to a review and confirmation however it is acknowledged that a further detailed analysis of the BCF is required to ensure best value going forward and this has already been commissioned by the Health and Wellbeing Board . This will involve creating a robust process to jointly ensure how 'best value' is described and monitored with a view to creating system savings which will mitigate associated financial pressures.

This will explore the options of the future risk share and the creation of a transformation pot from within the BCF to support the implementation of new and more effective ways of working.

The Lancashire & South Cumbria partnership carried out a full review of placed based partnerships from May to July 2022, which included extensive engagement across a wide range of organisations and individuals. The outcome saw the realignment of Places to become coterminous with the 4 Local Authority footprints, to enable deeper integration of health and social care and an opportunity for a real step change in tackling some of the biggest challenges in improving health and care services, joining up services and reducing health inequalities. It is recognised that the Lancashire footprint is large, and there will be three delivery units within it: East Lancashire, Central Lancashire (including West Lancashire) and North/Coastal Lancashire.

Significant work is underway to develop and define the Place vision and priorities plus set out how integration and integrated working practices will develop further, and once ICB to Place delegation parameters are agreed this will help shape the integration agenda and opportunities. There is also the potential for greater pooling of NHS and local government funding locally, with the Better Care Fund the potential vehicle to support this.

Across Lancashire, Health and Wellbeing partnerships are being developed and implemented in partnership with District Councils at a localised level. The partnerships will enhance integration, oversight, and the inclusion of local citizens voices into the overarching Health and Wellbeing Board and the Place Partnership Board.

Lancashire County Council and the ICB are improving their collaborative approach through integration of care navigation (brokerage), contract management, operational and commissioning leads, to ensure seamless services for people, better care market management, and achieve best value from the 'Lancashire pound'.

A strengths-based approach is a key element of the services which support people to remain independent for longer The ambitious County Council Living Better Lives in Lancashire programme (LBLiL) aims to embed strengths-based working throughout its Adult Social Care workforce and improve outcomes for people through practice led transformation. The vision for the programme sets out through a series of 'I' and 'We' statements what the transformation will mean for people, staff and partners. The transformation builds on the renowned '3 Conversations Model' and will be an important part of improving the personalisation and tailoring of support for people, using available community and natural assets before contemplating regulated formal support.

The County Council, District Councils and the NHS have committed to working together to develop good quality accommodation with support services to meet the needs of the growing population of older people and working age adults with health, care and support needs in Lancashire. The Lancashire Accommodation with Support Plan 2023-28 sets out the collective ambition over the next 10 to 15 years to develop housing that offers different care and support options, in a range of locations for both older people and working age adults with care and support needs. Alongside other

work such as the developing Digital Strategy, the plans give rise to new opportunities to support people to live as independently as possible in their own home and stay connected to their communities and networks.

The partnership is keen to go further in relation to housing and accommodation needs, articulating an ambition for 2023/24 to explore a more consistent and creative approach to innovation within the use of the Disabled Facilities Grant, under an overarching strategic plan that incorporates prevention as well as responding to people who already need care, support, and adaptations.

Across Lancashire, there are already good integration foundations in place with a wealth of integrated teams and integrated working practices. These include, amongst others, the jointly commissioned Falls Lifting Response Service, which is a high quality, responsive service for those people in need of assistance either using the pendant type devices or via the 999 NWAS route. Other integrated working operates around hospital discharge and admission avoidance with multi-agency teams operating from single bases and with integrated processes to best support people in a timely way. Integrated Mental Health discharge teams are in place via the BCF to support people to be discharged from hospital and from s136 suites. Intermediate Care teams work together as MDTs to support people through short term services to achieve their maximum independence, and Integrated Neighbourhood Teams are in place in parts of Lancashire, with further roll out across the Place linked to the implementation of the Fuller stocktake. Jointly commissioned community equipment services are in place, with trusted assessor arrangements in place across a range of organisations to enable people to get the support they need quickly and avoid unnecessary hand-offs.

**<u>Priorities:</u>**

1. Lancashire BCF 'Reset'

Lancashire has committed to undertaking a full review of the BCF, including spend, value for money, effectiveness and performance of teams/services funded through the BCF, evidence and reporting, engagement and co-production, and outcomes being achieved for people.

The partnership is robust in its aspiration that the BCF is a fundamental part of enabling and driving integration. The review and reset programme will ensure that the monies the partners pool and invest into the fund bring the BCF Plan to life and have the right impact in delivering it. There is a collective ambition to understand how we might shift investment from existing spend to other areas that may need a higher priority focus. As part of the reset programme, partners will also review other services currently funded outside of the BCF that could be included in it and agree how additional investments and monies could be pooled.

Currently, spend from the BCF on specific Mental Health support is not significant. Initial discussions have therefore commenced regarding Mental Health monies being pooled into the BCF, bringing greater parity across mental and physical health through integrated working and commissioning opportunities.

At present, there is no allocation for a 'transformation fund' within the Lancashire BCF, and partners have jointly signalled the intent to create this within 2023/24 to improve opportunities for joint tests of concept and projects which meet the BCF objectives and priorities.

The Lancashire partnership is committed to a greater focus on prevention, and as part of the BCF reset programme how the Fund could be used to further support preventative measures and improve health outcomes will be explored.

2. Enabling more people to receive the right care, at the right level and in the right place

(See later section)

3. Data

Lancashire has identified the need to improve data quality, analysis, and reporting. Data quality is a challenge within hospital discharge reporting. Not Meeting Criteria to Reside (NMC2R) data quality and interpretation varies across the Acute Trusts locally, and there are some concerns about local readiness for the new BCF metric later this year of 'ready for discharge'.

In the BCF reset programme, data, evidence, and regular reporting will be reviewed and improved. The partnership is keen to better demonstrate the impact the Fund is having, and to more accurately pinpoint areas to investigate.

Work is underway across the ICB to better align reporting with the new Place boundaries. This will also support Lancashire to oversee and analyse performance at a local level and where the BCF monies may need to target to support improvements.

The Lancashire Insights information will also help shape and inform planning and modelling as part of the overall suite of Lancashire data.

4. Identify a small number of joint priority areas and tangible actions that focus on achievable and timely gains rather than attempt to solve all system issues within unrealistic timescales. For 2023/24 these are:
    a. Intermediate Care including Discharge to Assess
    b. DFG

## Implementing the BCF Policy Objectives

### Enabling People To Stay Well, Safe And Independent At Home For Longer

The ambition of the BCF in Lancashire is to build and sustain the right supports to enable people to live as independently and healthily as possible, with the right level of care for the right amount of time and support for themselves and their carers when they need it. Commissioned care is high quality and offers choice and control and promote peoples' independence.

Lancashire mirrors the national and regional picture in relation to care market challenges, including recruitment and retention issues. It is critical to ensure the stability of the care market and not introduce commissioning that could destabilise it. Lancashire partners are working to sustainably manage the local care market provision and to deliver national priorities that support people to remain safe and well in their own home and that benefit from integrated practices such as virtual wards and 2 Hour Urgent Community Response.

At an ICS level, a high-level Falls Prevention Strategy is in development which outlines the system wide approach to falls prevention that will be taken within Lancashire and South Cumbria over the next five years (2023-28).The key stakeholders who make up the membership of the Strategic Falls Prevention Group, are committed to ensuring that all older people who live in Lancashire and South

Cumbria have access to high quality falls prevention technology and services, irrespective of their condition or where they live. The Lancashire BCF supports several services that contribute to achieving the aims and ambitions of the Falls Prevention Strategy and reducing emergency admissions to hospital following a fall including:

a. A high quality, responsive Technology Enabled Care Falls Lifting Response service for people in need of assistance either using the pendant type devices or via the 999 NWAS route. During 2023/24 we are exploring how to expand the integrated practices across the Falls Lifting Service and 2-hour Urgent Community Response.
b. Intermediate care services for people following a fall
c. Community equipment, adaptations and digital technology

The Council is working in partnership with Public Health and the ICB to develop an ICS wide Dementia Strategy which will shape and inform service provision and support for people with dementia and their carers to ensure they have the right care and support, in the right place which is joined up across all relevant partners. The ambitions of the strategy are:

a. Preventing avoidable cases of dementia
b. Improving people’s experience of being diagnosed and living with dementia
c. Championing innovation and participation in research

Through engagement with carers of people with dementia it was clear that a joint strategy is needed to deliver the quality and type of support and information, not just for people living with dementia, but also people who are carers of people who have dementia.

" *People with dementia need to have a care plan with the likely 'journey' set out as to what we can expect to have to deal with, what the process might be. I feel that other health conditions have much better support and a clearer treatment plan with scheduled follow-up appointments. It isn't like this with dementia. We are just get left to 'get on with it'* "

"*There isn't enough information around what we can expect from being a dementia carer, what services are available that we might need to access and how the dementia journey might look*."

The BCF currently funds several non-specialised services which also provide support to people living with Dementia and their carers, and account will be taken of the Dementia Strategy Review alongside the Lancashire BCF Reset work to understand where more specialised services may be required.

Discharge to Assess is funded through the BCF, iBCF and the Additional Discharge Fund, and it's recognised that there are improvement and efficiencies opportunities. During 23/24 we will specifically review bed based 'Discharge to Assess' fee rates, service delivery and brokerage to achieve a consistent service offer with reasonable fee rates that are harmonised across health and social care and aim for a single brokerage process.

Lancashire County Council is reprocuring Home based care provision, using a Pseudo-Dynamic Purchasing System (PDPS) which gives greater flexibility and opportunities for both the Local Authority and care providers. The ICB has signed up to being a partner to the PDPS, giving greater integrated commissioning opportunities. The new procurement, called 'Living Well at Home', covers all home-based care and support including Homecare, Intermediate Care, Extra Care and non-regulated care such as Hospital aftercare with VCFSE providers. The specification, informed through engagement with the care market, has been developed in partnership between LCC and the ICB,

who together will be looking at how to integrate commissioning teams and jointly commission against the specification.

The first stage, Homecare, commenced in November 2022, with the ambition to facilitate greater resilience in the geographical coverage across the County and enable people to get the assessed care they need at the right time.

LCC has reviewed and redesigned it's homebased 'intermediate care' services, using stakeholder consultation throughout including people with lived experience, to inform and sense check proposals. The new and innovative service, called 'Short Term Care at Home' will offer short-term home-based support of anything from a one-off urgent hour of care provision to several weeks of reabling support. Tailored to the person's needs, and under a 'home first' ethos for both step down and step up, the ambition is to enable more people to be safe, well and supported in their own home and maximise their level of independence. In doing so, this will positively contribute to reducing the number of people admitted to long term care home placements.

Alongside the procurement of the new Short Term Care at Home service, together with partners LCC is redesigning how it assesses for and supports people through intermediate care services. The multi-disciplinary teams working with people on the Short Term Care at Home service will ensure that:

a. The service is inclusive and strengths based
b. The focus is on enabling people to remain in, or return to, their own home with parity across step up and step down demand
c. Peoples' experience is a good one that supports them to maximise their independence and improve their wellbeing
d. Hand-offs are reduced and the person has a single point of contact throughout their time on the service
e. High quality appropriate outcomes are achieved for people

The ICS has a whole system intermediate care transformation programme about to commence, which has been reshaped under the new name of Enhanced Care at Home. The Lancashire redesign will align with the ICS transformation programme.

**Capacity and Demand…community**, The demand and capacity modelling shows us that we are largely on track with the level of intermediate care capacity in place currently to meet predicted community activity levels. However, the system is committed to focussing on supporting more people to remain in their own homes and increasing the use of intermediate care and other prevention services to enable that. We are mindful that we have data quality challenges in the system, and the intention is to build on the good foundations in bringing data together so far, and to undertake more intensive modelling during 2023/24 to inform 2024/25 capacity planning and that capacity is of the right type.

The Lancashire and South Cumbria Integrated Neighbourhood Care Delivery Framework describes how delivering the vision set out in the Fuller stocktake report and reorientating the health and care system to a local population health approach will transform how we work together to provide care for our populations.

As there are so many commonalities in aims, the BCF will work alongside this approach and support and enhance as opportunities are identified. The framework defines what good will look like.

“Our integrated neighbourhood team of teams’ approach will:

•Have a clear shared vision, purpose, and deliverables.

•Be made up of a blended generalist and specialist workforce which includes primary care, secondary care, community and mental health services, social care providers and the voluntary, community, faith, and social enterprise (VCFSE) sector

• Some teams may be collocated but there will be a space for the collective team of teams to come together and work together.

•Be supported by digital tools and knowledge that enable both population data analysis and person-based care information to be shared.

•Use population health data to proactively identify and target people who would benefit from a multi-disciplinary team (MDT) approach.  Promote personalised care.

• Co-design and offer joined-up accessible, preventative health, social and community care, making full use of the knowledge and skills of the team.

•Work effectively as an MDT, making the best use of team skills, sharing knowledge and experience, training and learning together.

•Have robust shared leadership and governance arrangements.

•Have a culture of continuous improvement, listening and responding to the people they support.”

## **Provide The Right Care In The Right Place At The Right Time**

Lancashire is focussed on providing the right support at the right time. Stability of the care market and sufficiency of the right support in the right place are critical elements of achieving the ambition, and a collaborative approach to market management and modelling is being developed. Joint work is underway to procure home based support, with fee rates that better support care providers to deliver high quality care and recruit and retain staff, help embed stability across the care market and delivers value for money for social care and health partners.

The Lancashire and South Cumbria Enhanced Care at Home transformation programme will deliver a set of standardisations and delivery principles across the ICS, aiming to improve the quality, consistency and availability of appropriate short term support through joint commissioning arrangements. Lancashire effectively uses existing intermediate care services to maximise people's independence and enable people to remain well for longer with the aim to reduce or delay the need for formal support, which in turn frees up capacity in commissioned care services for people who need them to access at the right time for them.

Lancashire has a well developed Single Handed Care ethos and has provided training for OTs and care providers. Single handed care equipment and training has been installed in the Council's residential rehabilitation units, enabling people with more complex needs to benefit from intermediate care where this can’t be delivered in their own home.

In terms of hospital discharge, Lancashire is complex, with teams supporting discharges for Lancashire residents from five local Acute Trusts as well as several 'out of area' hospitals that regularly take Lancashire citizens. For discharges from Mental Health hospitals, the picture is similarly complex, with the teams supporting people ready for discharge from five main sites, six section 136 suites and three main 'out of area' hospitals.

A discharge to assess model is in place for people being discharged from the general Acute hospitals, with the ambition to look in 2023/24 at extending the model to people being discharged from the Mental Health hospitals. An ICS Standard Operating Procedure, set of Principles and a local Pathway Definitions document are in place, helping frontline staff understand what scenarios and service options fit under each national pathway and to aid decision making. Discharge services including brokerage operate 7 days a week, as a minimum from 8am-6pm including Bank Holidays supporting patient flow.

There are a range of home and bed-based services funded through the BCF and iBCF, and the Additional Discharge Fund (ADF) to provide safe and timely support for people who need it and are ready for discharge, including a 'crisis plus' service which enables people to return home with 24/7 support for up to 7 days. A 'Take Home and Settle' service is commissioned via Age UK providing people with immediate low level social support on the day of discharge and for up to 3 days, and if they need it, extended support for up to 6 weeks. The ADF has been used to maintain the additional D2A capacity already in place and previously funded by the Discharge Support Fund.

Under a 'Home First' ethos, assessments take place outside of the hospital, with many people having access to an Occupational Therapist the same day they are discharged. For those people who return home, they have their assessment in their own familiar environment where they have greater control over the process. Where people are unable to return directly home, intermediate care beds are used wherever possible, plus several spot purchased care home beds.

Lancashire has 5 multi-agency hubs supporting people to be discharged from hospital, avoid admission and through intermediate care services. The system admission avoidance offer is still developing, including newer NHS services such as 2hr Urgent Community Response. Within the hubs, the teams include social care, NHS, Age UK, care providers, Carers Services and District Council reps. In addition to the hubs, integrated discharge teams are in place focussing exclusively on timely hospital discharge, including from the Mental Health Hospitals.

Several innovative schemes are in place funded through iBCF monies that have a positive impact on supporting more people to return home as quickly as possible or get the right type of support to maximise their independence. These include:

a. Health and Housing Coordinators: a new role being tested through LCC/District Council partnership, supporting people to return home from hospital or a care setting as quickly as possible where housing or accommodation issues are a barrier. The scheme provides quick access to a single point of contact to address housing or accommodation issues and enable the person to return home quickly. So far, the scheme has supported 55 people to return home, reducing their delays in hospital and/or avoiding an unnecessary short stay in a Care Home through interventions such as furniture moves enabling one-storey living and making properties safe to return to by fixing plumbing, electricity, and gas faults to ensure a person is returning to safe and warm environment.
b. Lancashire Hospital Discharge Home Recovery scheme: this removes barriers to unpaid carers being able to support relatives and friends on discharge through one-off Grants. Carers are connected to the Carers Service who support them with a plan, contingencies and extended support following discharge. The scheme also has a discretionary Grant element to purchase one-off goods that may be a barrier to hospital discharge.

"*The dryer has been a big help as I am not having to make multiple trips to the laundrette which has saved me a lot of time which allows me to have a short break, and this means that I can continue supporting my father and was able to bring him home from hospital*."

c. The Positive Ageing and Mental Health Wellbeing Scheme: an enhanced residential intermediate care service supporting people with mental health issues provides bespoke, enhanced support, that also includes introducing people to digital technology and coaching them in its use, enabling some people who were previously identified as needing long term bed-based care to return home. The scheme is seeing very positive outcomes for people, some of whom have not seen their own home for more than 12 months.

**Capacity and demand**

Within the demand and capacity modelling, the data shows that Lancashire is broadly on track with the level of capacity to meet predicted demand activity on discharge from hospital. The system is mindful that to maintain that capacity to support discharge, robust grip is required on moving people through intermediate care services in a timely way. This is being addressed in the Council's intermediate care redesign work, with the ambition to further reduce delays in hospital and support more people to return directly home.

The ambition is to reduce reliance on bed based services, and through both the intermediate care programmes and the BCF review, this transition is a key focus to achieve.

**Virtual wards**

The Virtual Ward programme across Lancashire & South Cumbria (L&SC) has a trajectory of 746 beds by March 2024, this is equivalent to 50 beds per 100k population which is the top end of the national ambition. In June 2023, there were 365 virtual ward beds operational for a range of conditions. L&SC are above the North West and England averages for both the capacity of beds available and the utilisation of these.

Initial modelling across L&SC has shown that once fully operational with 746 virtual beds, the potential impact on general and acute beds could be in the range of 87 to 277 beds, however, this impact is depending on demand remaining stable and we know that bed occupancy is typically over 95%.

L&SC are focusing on implementing a step-up model for virtual wards, seeking the bulk of referrals from community teams and in particular the 2 hour Urgent Community Response (UCR) provision where there is opportunity to avoid admissions to hospital. The UCR teams are currently operating at a high level of referrals when compared to peers, on average over 2100 per month for L&SC, this is increasing month on month and providers are meeting a consistent 94% of referrals within 2 hours, against the 70% target.

**Discharge to usual place of residence**

It is expected that as we continue to deliver and enhance the above services, we will see continued improvement in this metric and positive impact for individuals and their families in being able to return to the place they call home, wherever that is, in a timely and safe way with barriers removed whether organisational, environmental of support requirements.

Lancashire currently sits just under the England average for the percentage of people who return directly home from hospital, averaging 90% currently. Some further examples of interventions planned for 2023/24 that will positively impact on the metric are:

a. Recognition that a focus on improving discharge pathway 0 is needed in ward and other areas as part of implementing the discharge care bundle using QI methodology.
b. The procurement of the Short Term Care at Home services, and the redesign of the assessment and case management of people through intermediate care
c. Review of existing 'home first' arrangements across the Lancashire and South Cumbria hospitals including decision making and delivery arrangements
d. Optimisation of existing intermediate care bedded facilities through testing some changes to the specification, staffing models and strengthening of the wrap around support offer
e. Introduction of a standardised Lancashire specification and pricing structure for D2A bed-based services where these need to be spot purchased in addition to the existing intermediate care beds
f. Continuation of the piloting of the Positive Ageing and Mental Health Wellbeing intermediate care beds, and expansion of the criteria for intake. Learning from the pilot will also be used in developing the new bed based intermediate care offer, which will incorporate D2A.
g. Together with Lancashire Teaching Hospitals, explore the potential to use 'Finney House' (a 5-year leasing partnership between Lancashire Teaching Hospitals and a private company) within the intermediate care suite of options.
h. Meaningful engagement with people with lived experience and their carers, and the articulation from a place of experience of 'what a great discharge looks like'. This is to be used to shape and inform service and process improvements.
**i.** Improve the communications with, and information given to, people getting ready for discharge and their carers.

**High Impact Change Model (HICM) for Managing Transfers of Care**

Lancashire has several services, teams, and ways of working in place and funded or contributed to by the BCF and/or the Additional Discharge Fund, that embody many of the 9 key changes.

Lancashire's discharge to assess model, services and ethos in place support people to be discharged wherever possible in a safe and timely way with a focus on 'home' link to HICM 4. 'Home first' , crisis care hours and Reablement are already in place, and the new Short Term Support at Home procurement and revised D2A beds provision will further improve the offer. The ambition of Lancashire to extend the discharge to assess model and ways of working during 2023/24 to people being discharged from mental health wards will remove the current inequity, reduce delays, and improve outcomes.

The multi-agency hubs in place that support both hospital discharge and admission avoidance meet HICM 3. As detailed earlier, the hubs, which are hosted by LCC, have co-located staff working together in an integrated way to reduce hand-offs between organisations and delays in people getting the right support from the right professionals at the right time. The hubs also operate on a 7-day basis as a minimum from 8am-6pm to support flow throughout the week, meeting HICM 5.

Within the integrated working practices at each Acute Trust, regular patient flow meetings, length of stay meetings and MADE type events are held regularly to reduce delays, maintain capacity and smooth the discharge processes and any barriers.

In line with HICM 6 as part of the redesign of intermediate care services, a key component is an ambition to enable care providers to become Trusted Assessors. The current intermediate care providers and the other hub staff work closely together and have commenced some of this work with care providers able to make and implement decisions on when people no longer need intermediate care services, within agreed parameters. The ambition is to move this further along, to reduce delays for people receiving the services and increase integrated working.

Lancashire already has a successful Trusted Assessor model in place regarding a defined list of community equipment items, which Social Care Support Officers from Adult Social Care can assess for and prescribe. This contributes positively to people only needing to 'tell their story once', people receiving the right support without delays, reducing hand-offs and good integrated working practices. Some of the District Council Home Improvement Agency staff are also community equipment trusted assessors, again supporting people receiving the right support when they need it.

Aligned to HICM 7, focussing on ensuring people have meaningful choice is a key part of the strengths-based working in Lancashire, especially in relation to safe and timely transfers of care. Whilst choice may be more limited under short term 'discharge to assess' services and timescales, professionals ensure that people and their family and carers have the information they need to make informed choices and remain in control of what the next steps are for them.

In relation to HICM 9, in partnership with the District Councils, Lancashire County Council is testing a new role of 'Health and Housing Coordinator' aiming to have 1 in each of the multi-agency hubs and linked into the 5 main Acute Hospitals. The new role offers quick access to housing and accommodation expertise and support, reducing and removing barriers to discharge.

Lancashire has identified that there are opportunities for improvement in having and using systems that actively monitor patient flow with real time capacity data alongside. Early discharge planning does not always take place as consistently as it should, and this is also a key challenge for the system.

The national discharge oversight team has commenced a scoping conversation with Lancashire to explore the challenges, good practice and improvement opportunities, and together with the national BCF support offer will support the system to implement actions in response to the recommendations made.

It is already planned to carry out a full review and assessment against the HICM tool during 2023/24.

**Delivering Duties Under The Care Act**

Lancashire is focussed on providing services and supports that enable people to remain in their own homes for as long as possible, are high quality and offer choice and control and promote peoples' independence. Through Living Better Lives in Lancashire, 'I' statements set out what people should expect from the strengths based operating model and how the County Council will deliver:

- “I matter”
- “I will be listened to”
- “I will have care and support that is coordinated, and everyone works well together and with me”

- “I will have care and support that enables me to live as I want to, seeing me as a unique person with skills, strengths, and goals”
- “I will be supported close to where I live”
- “I will be asked about my experiences and my suggestions for improvement

The Care Act (2014) sets out a range of duties and responsibilities for Councils that aim to ensure the wellbeing of people in need of care and support services. It also sets out that services should be personalised, and the person must always be at the centre.

Within the Lancashire BCF, the fund contributes to the costs of the Lancashire Advocacy provision in place to support people who may need support in getting their voice heard or participating in their assessments or help getting the care and support they need.

Carers services are in place to enable objective and specialist support, information and advice, alongside a range of carer support services (see later section).

BCF funding also contributes to the County Council's discharge teams, who supported over 13,000 people in 2022/23 to be discharged from hospital. Assessments were undertaken in peoples' own homes or in more home-like environments, enabling people to have more choice, control and influence over the assessment process and outcomes. The funding also contributes to the services that support hospital discharge and admission avoidance, including crisis support, crisis plus, Reablement and Residential Rehabilitation.

Integrated working to support hospital discharge is well established across Lancashire, and the system aims to build on this and commence designing the blueprint for Care Transfer Hubs within its Intermediate Care transformation programme, setting out that they should be both step down and step up.

Assessments for, and provision of, equipment supports prevention of falls, delays or reduces the need for formal care and support, improves the independence, dignity and wellbeing of people and supports them to be able to better live their life in the way they want to. Joint community equipment services are in place across Lancashire with larger more complex items of equipment ordered and delivered from one Loans Store commissioned across the partnership, and a 'retail model' in operation for smaller items of equipment that are prescribed and can be collected from or delivered (including fitting if needed) by a range of mobility retailers and pharmacies.

Embracing and using digital technology is an important part of the prevention strategy. The Lancashire telecare strategy has been refreshed with the ambition to use the latest technology and most impactful items, with an eye to the digital switchover in 2025. Small low -cost items can really maximise peoples' independence, and use of 'just checking' technology for example for people with a Learning Disability has had positive impact locally. Similarly, funded by the BCF, the use of portable wearable technology has supported people to be discharged from hospital, where there are concerns about vulnerability and frailty.

The Council and the ICB are working together on the ICB Digital Strategy, ensuring innovation is proposed in both acute care and in the digital journey of regulated care providers.

Recent fee uplifts for care providers are supporting greater stability and sustainability in the care market, supported by the BCF. Care and support services that are of high quality and deliver a good experience for people who use them is a key priority. The use of digital technology in reducing or

delaying the need for care and support is also being explored, with a recent test of change proposal being considered for implementation in 2023/24.

## Supporting Unpaid Carers

In the 2021 Census data, there were an estimated 38,396 people in Lancashire over the age of 65 providing unpaid care to a partner, family member or other and by 2035 this number will have risen by 31% to an estimated 49,219.

The Census shows that an estimated 49,836 people of all-ages in Lancashire provide care to another person for 20 hours or more a week. Approximately 65% of this number provide unpaid care for 50 hours or more a week. The Census also shows that Lancashire has higher volumes of unpaid care hours being undertaken than the England average.

Work is underway to develop a new Carers Strategy for Lancashire County Council, the implementation of which will be supported by the BCF. The Strategy will prioritise key areas of work, shape local commissioning and joint commissioning intentions, identify policy recommendations and build on prior efforts by Councils and the NHS to create a more joined-up offer to unpaid carers. Input and guidance have also been sought from the NW ADASS Carers Leads groups.

In partnership with the Lancashire Carers Service (LCS), several engagement workshops have been held with carers across Lancashire via existing forums or through 'coffee and chat' events, to identify their issues and concerns and to develop services that work better for them. People were asked about their life as a carer, if there are things organisations such as the County Council can do better to support them in their caring role, and how the Council can improve. The high volume of feedback will inform and shape the Strategy and feedback to and from carers will continue throughout the development of the Strategy and beyond.

Feedback from carers demonstrates the challenge they face, and what the Strategy needs to address:

"*I couldn't leave my wife for even a minute, there was no rest at all. I was 'on-call' 24/7 dealing with such difficult behaviour*"

"*You just get passed from pillar to post, surely it can be more streamlined with less referrals to different clinics and professionals, it just adds to waiting to get the support that we desperately need"*

"*At the time of caring you don't really realise what you are doing, just to get by, it's only afterwards that you reflect on how tough it was and just how much strength and energy it took"*

The county council will share its findings with key stakeholders, including providers and the NHS, through the Lancashire and South Cumbria Carers Strategic Partnership. The ambition is to publish the new Strategy in the Autumn of 2023. The intention then is that the county council's strategy will lead into a joint, integrated ICS Carers Strategy and complement other current initiatives such as the new Lancashire Carers Service Carers Charter and the LCS Integrated Care Partnership Strategy.

The Lancashire BCF funds several services for carers currently, including carers assessments through the Carers Centres across Lancashire, respite services, information and advice plus support to carers of people with mental health issues. Following a bespoke assessment, a support plan is developed with the carer which may include a range of universal, informal, and commissioned support to enable the carer to take a break and have a meaningful contingency plan as well as feel supported

and able to maintain their caring role. The Carers services have recently been recommissioned to update the offer and ensure that it better reaches unpaid carers who are seldom heard. Significant engagement has taken place with unpaid carers in partnership with the Lancashire Carers Service to understand 'what good looks like' to them in relation to carers services.

As part of the BCF reset programme, the services will be reviewed alongside the new Carers Strategy once developed and check if they are meeting the aims and ambitions in both the Strategy and the BCF Plan. Informed by feedback and engagement from carers, joint commissioning opportunities will be explored and implemented as appropriate.

A pilot scheme was implemented recently using iBCF monies which saw carers services officers co-located in the hubs that oversee hospital discharge and intermediate care. Learning from that scheme showed that unpaid carers are not consistently identified in discharge planning and are not always as involved and informed as they should be. The learning from this pilot is being used to shape and inform an improved carers service offer, as well as the training and awareness that hospital staff need to be able to better identify unpaid carers.

As noted earlier, the Lancashire Hospital Discharge Home Recovery scheme is also in place to support unpaid carers to be able to care for people at the point of discharge, where there are barriers to them being able to do so.

## Disabled Facilities Grant (DFG) and wider services

As the upper tier Local Authority, LCC passports the DFG directly through to the 12 Lancashire District Councils with responsibility for housing. All Districts operate the DFG in line with the regulations, and where possible, using Regulatory Reform Orders (RRO), they use elements of the funding more flexibly.

Across Lancashire, the District Councils have widely used RROs to provide discretionary grants, that provide timely support to people who wish to stay in their own home and community, this has included the removal of means testing for lower value grants and increasing the statutory £30,000 maximum threshold for grants. These changes enable more people to benefit from adaptations, speed up the process, reduce number of people dropping out before or after means testing and reduce wasted assessment resources.

Discretionary grants, working alongside full DFGs, have enabled flexible and rapid support for vulnerable people, including people living with dementia, with interventions that enable them to live independently, making their homes accessible, safe, and warm. Where DFG budgets have been sufficient, this discretionary grant work has helped to fund Home Improvement Agencies (HIA) which provide a broad range of housing support services that can meet the high need for small scale preventative work, including minor adaptations, repairs, advice and support.

During Covid, a waiting list developed with the Occupational Therapy service which led to some delays. Through focussed work, the number of people waiting for assessment has reduced by approximately 45% since October 2022 , impacting positively on assessments for and provision of timely DFGs across Lancashire.

The announcement by the Government of an additional £102m nationally over 2 years was welcomed by the Lancashire Councils. Early discussions in the Health and Wellbeing Board have suggested that this additional short term funding, as well as supporting the core DFG work, could

support some test of change work that focuses on tangible prevention actions to improve the health and wellbeing of Lancashire residents.

During 2023/24 a scoping piece of work is proposed around DFG and further innovation opportunities with a consistent practice model across the Lancashire Place. Best practice from elsewhere and subject matter expertise will support the innovation work and look at how DFG could potentially support and connect with other agendas such as the Dementia Strategy, and the potential for joint roles and expansion of trusted assessors. A focus on 'early prevention' will form part of the discussions to understand if we're using DFG to our best advantage across the partnership and for the residents of Lancashire. Within the scoping work, a focus on what peoples' experience of DFG is and how we use that feedback to inform future collaboration and innovation in this area is key, with an offer from Healthwatch Lancashire to facilitate this.

## Equality and health inequalities

Lancashire is a larger county that has great diversity in geography, urban v rural, affluence v deprivation and population make up.

- Lancashire has only 2.9 working age people per older person, which is lower than England which has 3.7 working age 2,600 people to one older person
- The latest female life expectancy (LE) at birth in Lancashire (2018-20) was 82.0 years. This is 0.3 years lower than in 2017-19.
- The latest male life expectancy (LE) at birth in Lancashire (2018-20) was 78.3 years. This is 0.3 years lower than in 2017-19.
- Across Lancashire there is a wide variation in male and female life expectancy. The lowest is in Burnley and highest is in the Ribble Valley.
- The latest fuel poverty statistics indicated that 13.7% of households (71,822) were fuel poor in Lancashire (England = 13.4%). Six Lancashire areas were in the top third of the national fuel poverty rankings.
- Inequality in life expectancy at birth for both males and females is in the second worst quintile in England

The Lancashire and South Cumbria Integrated Care Partnerships' Integrated Care Strategy sets out the priority areas that it will focus on to improve the health and wellbeing of residents, and to make sure that our health and care services are more joined up and easier to access.

The strategy has been written by a partnership of several Lancashire and South Cumbria organisations including local government and Public Health, NHS, Healthwatch, organisations from local business and education, and VCFSE groups.

It highlights that there are many things that affect people's health and wellbeing including the way that health and care services are provided, the way that people are supported to live healthy lives or wider issues such as living in disadvantaged communities. All these things are present in Lancashire, meaning there are unfair differences in health and wellbeing and unequal life chances across our communities. Some people might live shorter lives, or they might not have as many healthy, disability-free years of their life.

Taking a population health approach, the Integrated Care Strategy aims to tackle the most complicated issues affecting people's health and wellbeing that can only be solved by different organisations working together with communities.

The strategy sets out its priorities that focus on five areas of people's lives:

- Starting Well: Give our children the best start in life, supporting them and their families with problems that affect their health and wellbeing, and getting them ready to start school
- Living Well: Reduce ill health and tackle inequalities across mental and physical health for people of all ages by understanding the cause of these unfair differences
- Working Well: Increase ambition, aspiration, and employment, with businesses supporting a healthy and stable workforce and employing people who live in the local area
- Ageing Well: Support people to stay well in their own home, with connections to their communities and more joined up care
- Dying Well: Encourage all our residents to feel comfortable in talking about planning for dying, and to be well-supported when a loved one dies

The themes that will help to deliver on these priorities are:

- 'One workforce' across health and care, helping services be more joined up for our residents
- Supporting unpaid carers with their own health and wellbeing as well as the people they are looking after
- Using digital resources and making better use of information about our population
- Using our buildings as collective resources across communities
- Committing to sustainability in health and care services to reduce our environmental impact

These and priority areas and themes fit well with the aims across the Lancashire BCF with the funded BCF schemes clearly addressing all. There is an aspiration that we tighten the links and better demonstrate the impact.

The ICB is to use the national toolkit, Equality Delivery System (EDS) to support providing better working practices and environments, free of discrimination

The ICB has placed a strong focus on developing its ICS Belonging Framework and Belonging Plan which has created the necessary forums and lines of accountability required to effectively work in partnership with ICS system partners to collaborate on EDS grading activities from 2023/24 onwards.

The ICB remains committed to using EDS frameworks to support consistent assessment of performance against EDS domains and promote involvement of our diverse population and workforce across all aspects of its work.

NHS Lancashire and South Cumbria Integrated Care Board will undertake its first formal EDS grading exercise in 2023/24 and will support its system partners with the transition to the EDS 2022 framework. It is anticipated that system partners will work together to:

- Identify relevant services for assessment and use relevant data to identify strengths and weaknesses in patient access and experience
- Collaborate to engage and involve relevant stakeholders from diverse backgrounds in EDS grading activities

- Work together to review our grading processes and outcomes to ensure consistency in our approach across the system
- Co-produce materials and processes required to effectively implement EDS 2022 across the system

The BCF can specifically shape its response to health inequalities through the use of better data that is available to us to shape services and expectations about service access and use.

For example, the data that shows the difference in Length of Stays in acute settings between younger and older patients and between those from white and ethnic minority backgrounds along with their discharge destinations. These patterns will guide us as we reset the BCF, and shift spend.

Our BCF plan has not changed significantly in its content over the last year. However, as services have rolled forward or been renewed, they have been and will continue to be subject to the scrutiny of such processes as Equality Impact Assessments and patient experience review.

Each partner in the Lancashire Better Care Fund is clear on expressing its desire to recognise and respond to protected characteristics in individuals and communities.

Lancashire BCF partners are committed to extending the Core20Plus5 approach to all of health and social care and will support targeted action when possible. This will be an aspect that will be factored in to the “reset” programme.

**Lancashire Health and Wellbeing Board**
Meeting to be held on Tuesday, 18 July 2023

**Corporate Priorities:**
Delivering better services;

**Lancashire and South Cumbria Integrated Care Board Update**
(Appendices 'A', 'B', 'C' and 'D' refer)

Contact for further information:
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**Brief Summary**

In line with discussions at previous meetings, the Lancashire and South Cumbria Integrated Care Board is keen to share with partners an update on its work to date and its future plans. Consequently, the following Integrated Care Board documents are being shared with the Lancashire Health and Wellbeing Board for review.

- **Integrated Care Board Annual Report 2022/23** – following establishment of the Lancashire and South Cumbria Integrated Care Board in July 2022, the first formal annual report of the organisation has been signed by the Integrated Care Board. A copy of the report is attached at Appendix 'A' for review by the Health and Wellbeing Board.
- **Integrated Care System Joint Capital Resource Plan 2022/23 and 2023/24** – the 2022/23 capital resource plan (Appendix 'B') was discussed at the May Health and Wellbeing Board meeting with the expectation that the 2022/23 plan and the full report on the 2023/24 plan (Appendix 'C') would come back in July for the Health and Wellbeing Board to review.
- **Integrated Care System Joint Forward Plan 2023 onwards** – the emerging themes of the developing Joint Forward Plan were discussed at the March Health and Wellbeing Board meeting. Following Integrated Care Board support for a draft plan – and subsequent engagement with partners and the public – a final version will be signed off at the 5 July 2023 Integrated Care Board meeting. This same version (Appendix 'D') is attached for Health and Wellbeing Board to review.

**Recommendations**

The Health and Wellbeing Board is asked to:

i) Review and comment on the Integrated Care Board annual report for 2022/23 (Appendix 'A').
ii) Review and comment on the Integrated Care System Joint Capital Resource Plan for 2023/24 (Appendix 'C') and to receive the plan for 2022/23 (Appendix 'B').
iii) Consider and comment on the Joint Forward Plan (Appendix 'D'), offering its reflections on the content and particularly on whether the Board feels that the plan takes proper account of the Lancashire health and wellbeing strategy.

**Detail**

**Work to date – Lancashire and South Cumbria Integrated Care Board Annual Report 2022/23 (Appendix 'A')**

The Lancashire and South Cumbria Integrated Care Board was established on 1 July 2022 under the Health and Care Act 2022. The eight Clinical Commissioning Groups in the area were disestablished and their powers transferred to the Integrated Care Board, along with the statutory requirement to publish a formal Annual Report at the end of each financial year.

Given the timing of the Integrated Care Board establishment, its Board will receive at the July meeting the part-year annual reports and accounts of each of the Clinical Commissioning Groups, alongside the first formal annual report of the Integrated Care Board, which summarises the performance of the organisation during the transition year.

The latter report is attached at Appendix 'D' for consideration of the Health and Wellbeing Board.

**Integrated Care System Joint Capital Resource Plan 2022/23 (Appendix 'B') and 2023/24 (Appendix 'C'**

At the May Health and Wellbeing Board meeting, the Board was asked to note that the Integrated Care Board Joint Resource Capital Plans 2022/2023 (Appendix 'B') had been produced and that there was a requirement for the Health and Wellbeing Board to receive them. It was also noted that the 2023/2024 plans (Appendix 'C') would also need to come to the Board when available.

It was resolved that the Board would receive the Integrated Care Board Joint Resource Capital Plans for both 2022/2023 and 2023/2024 at its meeting in July 2023.

Both plans are attached - as Appendix 'B' (2022/23 capital plan summary list) and Appendix 'C' (2023/24 Joint Resource Capital Plans with supporting narrative).

**Future plans – Lancashire and South Cumbria Integrated Care System Joint Forward Plan 2023 onwards (Appendix 'D')**

**Background**

The Health and Care Act 2022 established new NHS bodies in the form of Integrated Care Boards, that take on functions previously delivered by Clinical Commissioning Groups and required the creation of Integrated Care Partnerships in each local system area, with a view to empower local health and care leaders to join up planning and provision of services, both within the NHS and with local authorities, and help deliver more person-centred and preventative care.

Before the start of each financial year, the Integrated Care Board, with its partner NHS trusts and NHS foundation trusts, must prepare a 5-year Joint Forward Plan, to be refreshed each year. For this first year, however, NHS England has specified that the date for publishing and sharing the final plan with NHS England, their Integrated Care Partnerships and Health and Wellbeing Boards, is 30 June 2023 rather than 1 April.

The Act did not change the statutory duties of Health and Wellbeing Boards, as such - similar to the previous relationship with Clinical Commissioning Groups, the Integrated Care Board must involve the Health and Wellbeing Board in the exercising of its statutory functions as below:

- Joint Forward Plans must set out the steps that the Integrated Care Board proposes to take to implement the health and wellbeing strategy.
- The Health and Wellbeing Board must be involved in the preparation or revision of the Joint Forward Plan.
- In particular, the Health and Wellbeing Board must be provided with a draft of the Joint Forward Plan, and the Integrated Care Board must consult with the Health and Wellbeing Board on whether the draft takes proper account of the health and wellbeing strategy.

A draft Joint Forward Plan for Lancashire and South Cumbria Integrated Care System was received by the Integrated Care Board at the end of March 2023, following which there has been engagement with partners and the public. The final version shared with the Integrated Care Board on 5 July 2023 for sign off is attached at Appendix 'D' for consideration by the Health and Wellbeing Board.

## Key Points

The Joint Forward Plan sets out five strategic priorities:

| OUR LONG-TERM STRATEGIC PRIORITIES | | |
|---|---|---|
| STRENGTHEN OUR FOUNDATIONS | | |
| **Improve our long-term financial sustainability** and value for money, through transformation with providers. | | |
| IMPROVE PREVENTION | IMPROVE AND TRANSFORM CARE PROVISION | |
| **Prevent ill-health and reduce inequalities** by collaborating with partners. | **Integrate and strengthen primary and community care** with partners and providers. | **Improve quality and outcomes** through standardisation & networking with providers. |
| WORLD CLASS CARE | | |
| **Deliver world-class care** for priority disease areas, conditions, population groups and communities. | | |

The 'improving prevention' priority is where the key link to delivery of the Integrated Care Partnership Integrated Care Strategy – which in turn was built upon the health and wellbeing plans of the Health and Wellbeing Boards in Lancashire and South Cumbria – can be found, although there are clearly connections across all priorities:

Since the review of the draft Joint Forward Plan document by the Integrated Care Board in March 2023, there have been further amendments made to the contents – most notably, the alignment of the plan's narrative to the developing system recovery and transformation approach, aimed to deliver system financial balance over the next three years.

## Next Steps

The final version of this plan will be received by the Integrated Care Board at its meeting on 5 July 2023.

A detailed system delivery plan with measurable goals, annual milestones, targets, performance ambitions and trajectories for providers, places and neighbourhoods is under development, aligned with the System Recovery and Transformation plan.

The Integrated Care Board will work with partners to develop a more comprehensive updated plan for 2024/25 onwards with the opportunity for further engagement and collaboration across partners to be reflected in the plan.

**Appendices**

Appendices A, B, C and D are attached to this report. For clarification they are summarised below and referenced at relevant points within this report.

| Appendix | Title |
|---|---|
| A | Integrated Care Board Annual Report 2022/23 |
| B | Integrated Care System Joint Resource Capital Plans 2022/23 (summary list) |
| C | Integrated Care System Joint Resource Capital Plans 2023/24 (with supporting narrative) |
| D | Integrated Care System Joint Forward Plan 2023 onwards (final draft for Integrated Care Board) |

Appendix A

NHS
Lancashire and South Cumbria
Integrated Care Board

# LANCASHIRE AND SOUTH CUMBRIA INTEGRATED CARE BOARD

## Annual report

# 2022/23

1 JULY 2022 - 31 MARCH 2023

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# Welcome to the NHS Lancashire and South Cumbria Integrated Care Board Annual Report 2022/23

Welcome to the NHS Lancashire and South Cumbria Integrated Care Board (ICB) Annual Report, covering the period 1 July 2022 to 31 March 2023.

We came into existence on 1 July 2022. ICBs replaced clinical commissioning groups (CCGs) in the NHS in England from that date and are statutory bodies responsible for planning and funding most NHS services locally. In our case this is in all of Lancashire and in South Cumbria.

In 2022, a national extension of the timetable for the establishment of ICBs meant that CCGs continued with their statutory arrangements until 30 June 2022. Hence CCG Reports exist for the first quarter of the financial year 2022/23 and this Annual Report pertains to the remainder of that financial year.

At the time of writing, we have just published Turning Challenges into Opportunities[1], our State of the System report giving an overview of the health and care system in 2023. Turning Challenges into Opportunities focuses on the future, the challenges we face and our plans to succeed in meeting these.

In this Annual Report we share with you the important work we have undertaken in the first part of our existence, as the NHS approaches the 75th anniversary of its establishment.

The hard work began in earnest in 2022/23. We now have a clear strategy to tackle some of our key issues focusing on prevention and the integration of health and social care in place. We are working towards the NHS Long Term Plan 2023/24 will see the developments and delivery of local plans and budgets which will set us on the right path to achieve what we need to.

We will rise to challenges and overcome adversity. This is our opportunity to make a real difference to the provision of NHS services in Lancashire and South Cumbria and to the health and lives of the people who live here.

| Kevin Lavery | David Flory |
|---|---|
| **Chief Executive Officer** | **Chair** |

[1] https://www.healthierlsc.co.uk/application/files/7616/7950/3448/07a_-_State_of_the_System_Report.pdf

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## About this Annual Report

This annual report has been written with patients and the public in mind. Working within the requirements of the Department of Health's annual report and accounts guidance we have attempted to make this document:

**People-focused**

**Informative**

**Easy to read and understand**

**Visually appealing**

## Glossary

Some common terms used when describing the NHS in Lancashire and South Cumbria.

**Anchor institution**: This refers to large, public-sector organisations whose long-term sustainability is tied to the wellbeing of the populations they serve. Anchor institutions, who are rooted in their local communities, can positively contribute to their local area in many ways such as: widening access to quality work for local people; buying more from local businesses; reducing our environmental impact; using buildings and spaces to support communities; working more closely with local partners.

**Clinical commissioning groups**: Clinically led statutory NHS bodies which, under the Health and Care Act 2022 closed down on 30 June 2022 and their functions transferred to Integrated Care Boards.

**Fragile services**: Services which are at risk of being unsustainable because of lack of staff or other resources.

**Health and Care Act 2022:** A new law regarding health and social care provision which originated in the House of Commons in July 2021 and completed the Parliamentary process in April 2022. Amongst other things, the legislation aims to tackle health inequalities and create safer, more joined-up services that puts the health and care system on a more sustainable footing.

**Health inequalities:** The unfair and unacceptable differences in people's health that arise because of where we are born, grow, live, work and age.

**Integrated Care Board (ICB):** Under the Health and Care Act 2022, this is the NHS organisation that was established on 1 July 2022 - NHS Lancashire and South Cumbria Integrated Care Board[2]. CCGs closed down and their functions transferred to the new organisation, which is responsible for NHS spend and the day-to-day running of the NHS in Lancashire and South Cumbria.

**Integrated Care Partnership (ICP):** The broad alliance of organisations and representatives concerned with improving the care, health and wellbeing of the population, jointly convened by local authorities and the NHS.

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

[2] https://www.lancashireandsouthcumbria.icb.nhs.uk/

**Model of care:** This broadly defines the way health and care services are organised and delivered.

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

**Networked services:** This describes the way a clinical service works in a joined-up way across multiple sites or organisations. Often a clinical network will have one clinical lead who oversees the whole service.

**Place**: An area covered by a local authority – an area where partners can come together and take action to support local communities.

**Place-based director of health and care integration**: There are four directors of health and care integration responsible for improving health and wellbeing of residents within each of four place-based partnerships. They sit both on the ICB board and the board of the local authorities to create positive working links and shared priorities between both organisations. These roles have been put in place through collaboration with local authority partners. You can find out more about who they are on the ICB website.[3]

**Place-based partnerships:** Planners and providers working together across health, local authority and the wider community, to take collective responsibility for improving the health and wellbeing of residents within a place. For information on our place-based partnerships visit the web page.. [4]

**Population health management**: A way of improving the health of people in local communities by looking at which groups in the local population are most likely to become unwell and working out how to prevent and treat ill-health. This uses data and an understanding of local populations to identify those who are at risk to proactively plan and deliver care.

**Primary care:** Primary care is the first point of contact for healthcare for most people. It is mainly provided by GPs (general practitioners) but community pharmacists, opticians, dentists and other community services are also primary healthcare providers.

**Primary Care Networks (PCNs):** GP practices working together with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas in groups of practices. PCNs build on existing primary care services and enable greater provision of proactive, personalised, coordinated and more integrated health and social care for people close to home. Find out more on PCNs on the NHS England website.[5]

**Provider Collaborative:** Service providers will be collaborating at the various different levels of system, place and neighbourhood according to need. National guidance, Working together at scale: Guidance on Provider Collaboratives[6] has been published and a Provider Collaborative Board (PCB) has been established to enable partnership working of the acute, mental health and community providers across Lancashire and South Cumbria. Find out

[3] https://www.lancashireandsouthcumbria.icb.nhs.uk/news-and-media/latest-news/four-new-directors-health-and-care-integration-appointed-lancashire-and-south-cumbria
[4] https://www.healthierlsc.co.uk/integratedcare/developing-place-based-partnerships-lancashire-and-south-cumbria
[5] https://www.england.nhs.uk/primary-care/primary-care-networks/
[6] https://www.england.nhs.uk/publication/integrated-care-systems-guidance/

about the Provider Collaborative in Lancashire and South Cumbria. [7]The organisations that are involved as part of the collaborative are:

- Lancashire Teaching Hospitals NHS Foundation Trust
- Blackpool Teaching Hospital NHS Foundation Trust
- East Lancashire Hospitals NHS Trust
- University Hospitals of Morecambe Bay NHS Foundation Trust
- Lancashire and South Cumbria NHS Foundation Trust

**Secondary care**: Care that you receive in hospital, either as an inpatient or an outpatient. This may be planned or emergency care. It is more specialist than primary care.

**Social determinants of health**: The non-medical factors that influence health outcomes

**Social value:** This is about how we secure wider social, economic and environmental benefits for our population in addition to providing health and care. As anchor institutions we want to make the greatest positive impact possible on the lives of our communities to improve health and wellbeing, and reduce health inequalities.

**Specialised commissioning:** Planning and buying specialised services which support people with a range of rare and complex conditions, for example, rare cancers, genetic disorders or complex medical or surgical conditions.

**Triple Aim:** The triple aim is a legal duty on NHS bodies which requires them to consider the effects of their decisions on:

- the health and wellbeing of the people of England (including inequalities in that health and wellbeing)
- the quality of services provided or arranged by both themselves and other relevant bodies (including inequalities in benefits from those services)
- the sustainable and efficient use of resources by both themselves and other relevant bodies.

In pursuit of these aims, the Lancashire and South Cumbria ICB is part of a wider integrated care partnership (ICP), which is a partnership of all organisations that deal with improving care, health and wellbeing for the people of Lancashire and South Cumbria.

This partnership includes all the healthcare organisations and local authorities in the region.

**Wider determinants of health:** The diverse range of social, economic and environmental factors which influence people's mental and physical health. These include employment, housing, crime, education, air quality, access to green spaces and access to health and care services, among other things.

[7] https://lscprovidercollaborative.nhs.uk/

# PERFORMANCE REPORT

## Performance Overview

The full Annual Report and Accounts gives detail about the ICB, its purpose, the key risks it faces in striving to achieve its objectives and how it has performed in the period between 1 July 2022 and 31 March 2023.

The purpose of this performance overview is to provide the user a short summary with sufficient information to understand the ICB.

### Chief Officers Statement

The Lancashire and South Cumbria Integrated Care Board (ICB) was established on 1 July 2022 under the Government's Health and Care Act 2022. It is one of 42 ICBs in the country and replaced the eight clinical commissioning groups (or CCGs) that previously existed across the region. The ICB has since taken on responsibility for planning and buying NHS services for the 1.8million people living in Lancashire and South Cumbria.

Despite the challenges, these are exciting times for the NHS. I would like to thank everyone who has worked so diligently in the establishment of the ICB. It has been no small task and I do not underestimate the level of reserves that some people have called upon to get us where we are today. The people of Lancashire and South Cumbria, colleagues, partners, patients and the public are good humoured, with compassion and a 'can-do' attitude. This makes the area a great place to work and one which I have no doubt will respond to all the challenges faced in a constructive, collaborative and ultimately successful manner.

The ICB has made a step change in the openness of the NHS in its part formative year. It has gone to great lengths to encourage the public to understand and contribute to planning and developments.

It is important we involve people from all of the diverse communities across Lancashire and South Cumbria in our work. There are a number of key places where people can find out more and become involved in the future of the NHS. This is important because actively engaging people helps to reduce the differences in health and life expectancy and deliver services that meet the needs of our population.

At the time of writing we are also continuing to consult on the Integrated Care Strategy[8], which we plan to be approved early in the 2023/24 financial year. The strategy describes how partners will work together to improve the health, care and wellbeing of people in Lancashire and South Cumbria.

The ICB website[9] gives up-to-date information and news.

The State of our System report[10] describes ICB leadership ambitions.

The Public Involvement and Engagement Advisory Committee (PIE AC)[11] supports the ICB in ensuring the voice of local people and residents is actively embedded and valued in decision making.

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[8] https://www.healthierlsc.co.uk/application/files/8316/7950/3443/08a_-Appendix_A_-_Draft_Integrated_Care_Strategy.pdf
[9] https://www.lancashireandsouthcumbria.icb.nhs.uk/
[10] https://www.healthierlsc.co.uk/application/files/9416/8235/4122/State_of_our_system_report.pdf
[11] https://www.lancashireandsouthcumbria.icb.nhs.uk/get-involved/public-involvement-and-engagement-advisory-committee

There are many other ways to become involved from 'listening events'[12] to joining our Citizens Panel[13] or Volunteering.[14]

The time since 1 July 2023 has been very much formative.

Prominent amongst our successes in the short time since, we have, amongst other things:

- Improved the way our services work together and how we work as a part of the Health and Care Partnership. [15]
- Aligned new Place[16] based partnerships [17]with existing and newly formed local authority footprints.
- Prepared to take on new responsibilities for Dentistry, Ophthalmology and Community Pharmacy.
- Helped PCNs to respond to the Fuller Stocktake report - "Next steps for integrating primary care" - published in May 2022.
- Consulted with staff on putting in place a more efficient and effective staffing structure for the future.
- Facilitated digital and other innovations for patients and the public. Amongst these there is ChatBot, to help manage waiting lists, and Virtual wards to help manage the pressure on inpatient facilities and new ways to reduce the risk of Type 2 diabetes.
- Coordinated the system response to Industrial Action and Winter pressures.

The ICB is a key part of the wider partnership of all organisations that deal with improving care, health and wellbeing for the people of Lancashire and South Cumbria.

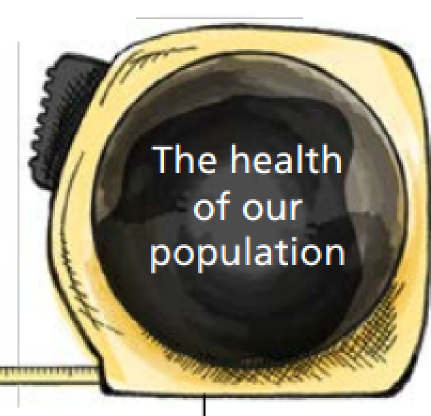
Together, this partnership will achieve a vision of longer and healthier lives for our population across Lancashire and South Cumbria.

I wish everyone well for the future.

Kevin Lavery
Chief Executive Officer
29th June 2023

[12] https://www.lancashireandsouthcumbria.icb.nhs.uk/get-involved/listening-events
[13] https://www.lancashireandsouthcumbria.icb.nhs.uk/get-involved/citizen-panel
[14] https://www.lancashireandsouthcumbria.icb.nhs.uk/get-involved/volunteering
[15] https://www.healthierlsc.co.uk/integratedcare
[16] https://www.healthierlsc.co.uk/application/files/8116/5900/9793/20220727_place_boundary_announcement_.pdf
[17] https://www.healthierlsc.co.uk/application/files/8116/5900/9793/20220727_place_boundary_announcement_.pdf

## Some facts and figures about Lancashire and South Cumbria




### 1.8million
people live in Lancashire and South Cumbria.

### 2.05million
expected population by 2033.

### Above
national average for people aged 50 and older.

### 85+
Expected dramatic increase over the next few years of people aged 85 and older.

### >90%
More than 90 per cent of people living in Lancashire and South Cumbria are white.

### 9%
Only nine per cent of our population are from ethnically diverse backgrounds.

### Heart disease
South Asian groups have the highest mortality from heart disease and also develop heart disease at a younger age. As with heart disease, stroke incidence and mortality are also higher in the South Asian population.

### 1/3
Almost a third of people live in some of the most deprived areas of England.

### 13%
live in fuel poverty and we know children growing up in adverse conditions in our communities can experience real challenges in their development.

### 38%
In some parts of Lancashire and South Cumbria, the number of children living in poverty is as high as 38 per cent.

### Lower
Life expectancy in Lancashire and South Cumbria is lower than the national average – by as much as almost a decade in some areas.

### Births
Babies born 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.

### Deaths
Rates of people dying earlier than they should is worse in Lancashire and South Cumbria than the England average.

### A&E
More emergency hospital admissions than in other areas of the country.

### 40%
of ill health is seen in people who smoke, do little physical activity, are obese or who abuse substances such as drugs and alcohol.

### Health
inequalities have got worse since COVID-19 pandemic.

### More
people from deprived communities admitted to hospital with the disease.

### Purpose and activities of the ICB

An integrated care board (or ICB) is a statutory NHS organisation which is responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in a geographical area.

Nationally, the expectation is that an ICB will:

- Improve outcomes in population health and healthcare
- Tackle inequalities in outcomes, experience and access
- Enhance productivity and value for money
- Help the NHS support broader social and economic development

The initial major priority themes that have been identified in Lancashire and South Cumbria are:

- Urgent and emergency care, discharge and elective care recovery
- Deliver a challenging budget for 2022/23
- Integration of community health and social care services
- Primary care development
- Improve quality and performance of our NHS trusts
- Prevention priorities
- Integrate health equity into our plans

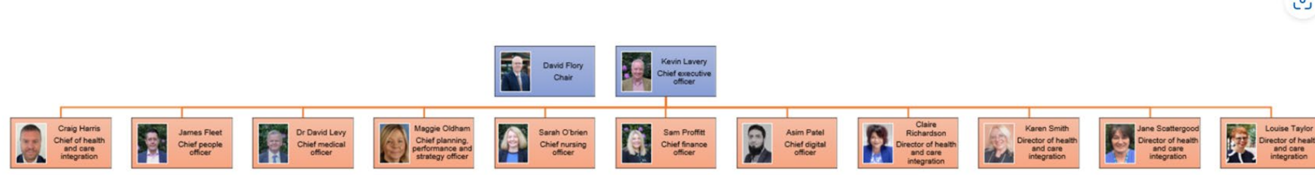
ICBs were legally established on 1 July 2022, replacing clinical commissioning groups (or CCGs), taking on the NHS planning functions previously held by CCGs (as well as absorbing some planning roles from NHS England).

Here in Lancashire and South Cumbria our ICB has replaced NHS Blackpool and NHS Fylde and Wyre CCGs (which were previously known as the Fylde Coast CCGs), NHS Morecambe Bay CCG, NHS West Lancashire CCG, NHS Chorley and South Ribble and NHS Greater Preston CCGs (previously known as Central Lancashire CCGs) and NHS Blackburn with Darwen CCG and NHS East Lancashire CCG.

ICBs have their own leadership teams, which include a chair and chief executive, executives and non-executive members, and also includes members from NHS trusts/foundation trusts, local authorities, general practice, and an individual with expertise and knowledge of mental illness.

As you would expect with bringing together eight organisations, there is a considerable programme of organisational development underway. This includes robust and transparent processes for working with staff to establish organisational structures appropriate for the strategic priorities of the ICB across Lancashire and South Cumbria.

The senior leadership team for the ICB has been confirmed as part of these processes and information is included in the structure charts below.



A full structure chart can be found on the ICB website.[18]

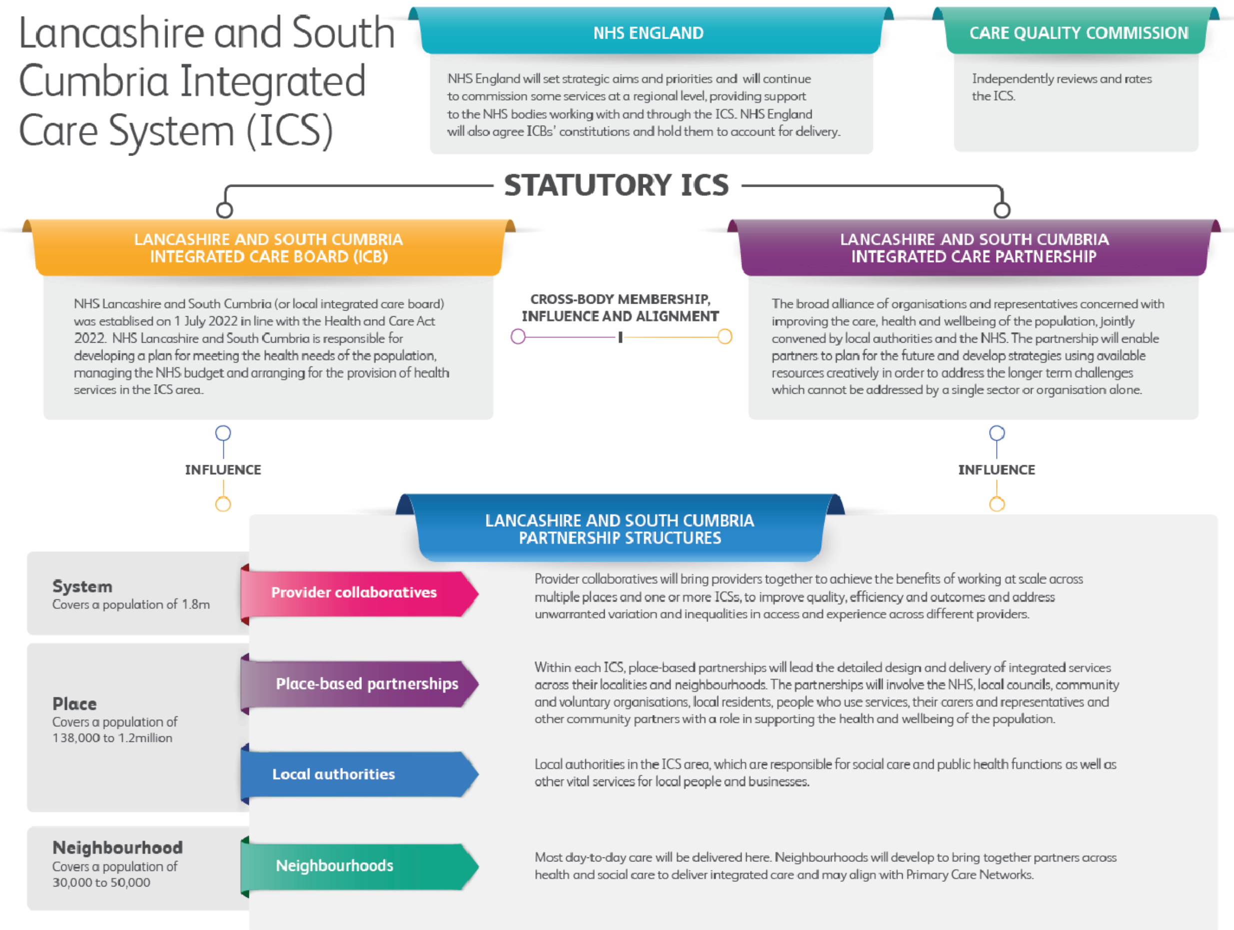
As an ICB, we need to look at ways in which we can use our resources more effectively. In November 2022, the ICB agreed a number of measures to tackle some our financial challenges. One of these measures was a mutually agreed resignation scheme (MARS) which was offered to all staff employed by the ICB prior to the end of December. Following a review of the response to the MARS, we are confident we have made positive steps on cost reductions. As this work has not concluded, full information on the structure cannot be provided but will be kept up to date on the ICB website in the coming months.

## Performance appraisal and progress towards delivering objectives.

The Performance analysis section of the annual report provides an overall explanation of how the ICB discharged its functions between 1 July 2022 and 31 March 2023. The performance analysis includes a Balanced Scorecard to show Key Performance Indicators and it highlights key achievements.

The performance analysis describes what the ICB has done to improve quality, manage risk and contribute to safeguarding. We do not capture everything we do in our annual report but the performance analysis describes the strides the ICB has taken to engage with people and communities, to strive to achieve 'net zero', reduce health inequalities and engage with local stakeholders. Should people want the detail on these matters, the performance analysis is a good place to start.

## Working with partners




[18] https://www.healthierlsc.co.uk/VCFSE

The ICB is a key part of the integrated care system which is a partnership of all organisations that deal with improving care, health and wellbeing for the people of Lancashire and South Cumbria. This includes all the healthcare organisations and local authorities in the region who work together as an Integrated Care Partnership.

The Integrated Care Partnership (or ICP) works together to address the health, social care and public health needs of their communities, always making sure the public's voice is at the heart of decision-making. An integrated care strategy (link to the website) has now been agreed following extensive engagement and involvement with partners, staff and the public throughout 2022/23.

Partners include local authorities, NHS organisations, businesses, education, Healthwatch and voluntary, community, faith and social enterprise (VCFSE) organisations[19]

As part of the Health and Social Care Act 2022, NHS Lancashire and South Cumbria Integrated Care Board (ICB)[20] and the unitary and upper tier local authorities have a statutory duty to coordinate Lancashire and South Cumbria ICP together.

The first formal Lancashire and South Cumbria ICP meeting took place on Friday 30 September 2022, and it started with an opportunity for the members to hear from our residents.

We are facing some very significant challenges. These include widening health inequalities, rising demand, pressure on quality and safety, staffing shortages, the wellbeing of our colleagues, and funding. These are well documented and have been exacerbated by the COVID-19 pandemic.

We must address these challenges with urgency. The State of our System report [21]gives more detail on the ICB's aim to turn challenge into opportunity.

We have seen that joining forces as equal partners can have huge benefits. Collaboration during the COVID-19 pandemic demonstrated what we can do together at scale to support our colleagues and patient care.

By working collaboratively, we will be much more likely to achieve our vision than if we work alone. This is because we will be able to better:

- agree joint priorities and how to best join forces to deliver them
- learn from and support each other
- share skills and best practice
- pool resources to support fragile services
- provide flexible career paths across organisational boundaries
- standardise our approach across Lancashire and South Cumbria to reduce variation and duplication
- support the local economy and the environment to add social value.

***The Lancashire and South Cumbria Provider Collaborative***

Our partnership brings together the five provider NHS trusts in Lancashire and South Cumbria to improve health and healthcare.

This is about working together to make sure patients, their families and communities benefit across the whole of the area.

[19] https://www.healthierlsc.co.uk/VCFSE
[20] https://www.lancashireandsouthcumbria.icb.nhs.uk/
[21] https://www.healthierlsc.co.uk/application/files/9416/8235/4122/State_of_our_system_report.pdf

The aim is to reduce health inequalities and improve services, outcomes and people's experiences of accessing healthcare. Our partnership also aims to ensure that Lancashire and South Cumbria is a great place to work.

The Provider Collaboration Board's vision, as agreed by the chairs and chief executives of the five trusts, is to ensure:

- The best health and wellbeing of our population
- High-quality services
- A happy and resilient workforce
- Financial sustainability

This is known as the 'quadruple aim'.

The Provider Collaboration Board has agreed seven priorities:

1. Develop a joint clinical vision
2. Develop a joint vision for central (non-clinical) services
3. Achieve parity of esteem between mental and physical health
4. Recover and restore elective care and other operational services
5. Improve the emergency and urgent care performance of the system
6. Develop our leadership and ensure a great place to work with a resilient workforce
7. Develop a clear financial strategy

There are many good examples of collaboration making a difference across Lancashire and South Cumbria, within both a clinical and non-clinical setting which you can read about LSC Provider Collaborative :: Collaboration in action[22]

### *Examples of system working*

Examples of how working with our partners has benefitted the health and wellbeing of our patients are included throughout the rest of this report but some others of note are:

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[22] https://lscprovidercollaborative.nhs.uk/collaboration-action

## 1. COVID-19

Our response to COVID-19 has outlined the huge benefits of collaborating – together we were able to make a massive difference to the lives of local people and their families.

The trusts supported each other to manage critical care capacity during time of huge pressure on NHS services, for example.

Pathology services also worked together to coordinate testing at scale. As one of 11 pilot sites for rapid saliva (LAMP) testing, by working collaboratively the service was set up in record time to enable mass testing of NHS staff.

## 2. Virtual outpatient appointments

At the beginning of the COVID-19 pandemic, it was necessary for our hospitals to deliver virtual clinics. The four acute trusts worked collaboratively to quickly put new digital systems in place.

The joined-up approach to using video consultations for scheduled clinic appointments received great feedback from staff and patients.

## 3. ChatBot - managing waiting lists

Chatbot is an automated call system, which guides patients through a series of questions designed by NHS consultants and healthcare experts. The pilot saw 2,282 waiting list patients in Morecambe Bay and Preston receive a call asking about their health condition. 75 per cent of patients responded to either the automated call, or a follow-up call from a member of staff.

The 2022/23 Chatbot programme has now been rolled out to other hospitals and medical specialties in Lancashire and South Cumbria and aims to contact 30,000 patients before the end of March 2023.

So far, out of 17,299 patients contacted this year, 13,583 have been validated at a response rate of 79 per cent with almost 1,200 patients indicating they could leave the waitlist.

Chatbot was Shortlisted as a finalist in the 2023 HSJ Awards.

## 4. Collaborative bank

The five trusts are developing a collaborative bank for nurses, midwives, health care assistants, allied health professionals and administrators. A collaborative bank is a Lancashire and South Cumbria-wide bank, with the trusts working together to boost our temporary workforce and improve patient care.

We want to make working at the bank attractive to increase our temporary workforce, meaning more colleagues supporting our departments and each other.

A collaborative bank will also mean fairer, more consistent bank rates, with colleagues able to work seamlessly across different trusts should they wish.

We also want to reduce our reliance on agency staff, so we have a more stable, consistent workforce who have all had the same training and understand our consistent processes to enhance patient care.

## Performance analysis

This section of the annual report provides an overall explanation of how the ICB discharged its functions between 1 July 2022 and 31 March 2023. It includes information on specific areas as required in reporting guidelines. The Performance analysis gives detail for users wanting to know more than is included in the earlier Performance Overview.

The Performance analysis starts with the sections required by reporting guidelines before moving on to further information which may be of benefit to the user.

The Accountability Report section of this report includes a **Governance Report** that details the accountability and decision-making framework that the ICB operates within, including details of its Unitary Board and Committees of the Board.

Detailed and comprehensive information about NHS Lancashire and South Cumbria Integrated Care Board can be found on the ICB website[23].

[23] https://www.lancashireandsouthcumbria.icb.nhs.uk/

## Performance Dashboard

The system has been subject to significant pressure throughout the year which has had an impact on performance across a range of areas. Not one part of the system operates in isolation, therefore pressures in one area are seen to directly affect another.

| DOMAIN | Metric | Actual (Latest) | Target |
|---|---|---|---|
| Elective Recovery | Total patients waiting more than 104 weeks to start consultant-led treatments | 6 Mar-23 | 0 |
| | Total patients waiting more than 78 weeks to start consultant-led treatments | 217 Mar-23 | 0 Mar-23 |
| | % Patients on incomplete pathway waiting less than 18 weeks | **60.3%** Mar-23 | 92% |
| Diagnostic Waiting Times | % Patients waiting less than six weeks for diagnostic test | **80.8%** Mar-23 | 95% Mar-24 |
| CYP / Maternity | Smoking at time of delivery | **11.9%** Dec-23 YTD | 6% |
| | Population vaccination coverage - MMR for 2 doses (5yrs old) | **89.4%** Oct-Dec22 | - |
| Cancer | 2 week wait referrals | **90.9%** Mar-23 | 93% |
| | 31 Day First Treatment | **88.3%** Mar-23 | 96% |
| | 62 Day referral to treatment | **59.4%** Mar-23 | 85% |
| | % meeting faster diagnosis standard | **75.4%** Mar-23 | 75% |
| Urgent and Emergency Care | A&E 4 Hour Standard (76% Recovery Target) | **76.9%** Mar-23 | 76% |
| | Average ambulance response time: Category 2 [NWAS] | **00:30:57** Mar-23 | 00:18:00 |
| Mental Health and Learning Disabilities | Inappropriate adult acute mental health Out of Area Placement (OAP) bed days | **540** Feb-23 | 0 |
| | Inappropriate adult acute mental health Out of Area Placement (OAP) bed days | **685** Jan-23 | 0 |

| | | | |
|---|---|---|---|
| | Estimated diagnosis rate for people with dementia | **68.3%** Mar-23 | 66.7% |
| | Access Rate for Improving Access to Psychological Therapy (IAPT) Services | **TBC** | |
| Primary Care | Number of general practice appointments per 10,000 weighted patients | 4561 Mar-23 | |
| | Seasonal influenza vaccine uptake amongst GP patients in England 2022 to 2023 - 65 Years + | **79.2%** Sep22-Feb23 | 85.0% |
| | Proportion of diabetes patients that have received all eight diabetes care processes | **43.5%** Jan-Dec22 | |

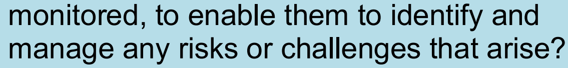
Note: The figures given are the latest available at the time of preparation of this Report. Data is collated by the Planning, Performance and strategy directorate.

### Key Lines of Enquiry (KLOEs)

Below details five characteristics of governance arrangements to support effective collaboration. It also sets out the key lines of enquiry used by NHS England.

| Governance arrangement | Description | Key lines of enquiry |
|---|---|---|
| **Developing and sustaining strong working relationships with partners:** | The manner of engagement must be consistently constructive and where appropriate proactive. | • Do providers consistently engage with partners in a meaningful, effective and constructive way?<br>• Are providers contributing to building a culture of transparency, honesty, and constructive challenge where collective responsibility is taken for problems and conflicts are resolved quickly?<br>• Do providers communicate system vision, values and strategic goals to their staff and other stakeholders? |
| **Ensuring decisions are taken at the right level** | Decisions should be taken at the most appropriate level (eg ICP, ICB, place-based partnership, provider collaborative, provider board). | • Do providers actively participate in all relevant and appropriate planning and decision-making forums? This may include system and place-based partnerships or provider collaboratives.<br>• Are decisions taken at the most appropriate level given the nature of the issue and are providers working with partners, including NHS bodies, local government and primary care, and engaging staff, patients and the wider public as necessary?<br>• Do providers engage with all relevant organisations and stakeholders on decisions that might affect them? |
| **Setting out clear and system-** | There should be clear consideration and articulation of why | • Are providers collaborating to develop the business case for any proposed system improvements, through a structured planning |

| minded rationale for decisions | decisions have been made, having regard to the triple aim duty of better health and wellbeing for everyone, better quality of health services for all, and sustainable use of NHS resources. | process, and working with patients, workforce and external partners?<br>• Do providers support an open and constructive dialogue regarding any risks or concerns?<br>• Has an equalities and health inequalities impact assessment been conducted where appropriate to inform decision-making?<br>• Have decisions been made with regard to the triple aim duty to support better health and wellbeing for everyone, better quality of health services for all and sustainable use of NHS resources, giving particular attention to reducing health inequalities between communities within the population?<br>• Are providers actively building business intelligence capacity to enable a single shared view of local challenges, performance and progress against delivery? |
|---|---|---|
| **Establishing clear lines of accountability for decisions** | There must be clear lines of accountability for decisions, taking into account providers' legal responsibilities and internal governance. | • Have providers established clear reporting lines and accountabilities, with timely and effective oversight of their involvement in system and place-based partnerships, and provider collaboratives?<br>• Do providers empower system, place-based and at scale provider decision-making by appropriately delegating responsibility?<br>• Are there appropriate governance mechanisms within the organisation and joint working arrangements with partners, such as dispute resolution or escalation mechanisms, in place and are they well understood and effective?<br>• Are providers' strategic plans integrated with the ICB's five-year joint plan and annual capital plan, and the plans of place-based partnerships and provider collaboratives?<br>• Are providers actively involved in co-producing and driving programmes and plans? |
| **Ensuring delivery of improvements and decisions** | There must be adequate systems and processes to ensure providers follow through on shared decisions so that system and place level improvements are delivered for the benefit of patients and the public. | • Are providers committed to enabling the successful delivery of plans, including a willingness to share any risks or benefits that arise from collaboration?<br>• Do providers proactively and openly share high-quality information as appropriate to support planning and/or implementation of improvements for the benefit of patients?<br>• Do providers commit adequate resources and staff to participate in system planning and delivery, such as taking up system leadership roles, embedding or seconding staff to partner organisations, or contributing to funding a joint project management office?<br>• Have providers put in place detailed delivery plans for their own organisations and agreed actions against which progress is regularly |

| | | |
|---|---|---|
| | |  monitored, to enable them to identify and manage any risks or challenges that arise? |

Some of the responses to the NHS England key lines of enquiry are included within the report as we highlight specific schemes and those not included can be found on the website. [24]

[24] https://www.healthierlsc.co.uk/download_file/7845/0

## Performance narrative

### Elective Recovery

The proposed refresh of the Elective Recovery Programme was presented to the Provider Collaborative Board (PCB) on the 16 February 2023 and approved.

The four acute Trusts have been working together to reduce waiting times for people requiring treatment.

#### *Eliminating long waits and reducing waiting times*

Due to the impact of the junior doctor industrial action in March 2023, Lancashire and South Cumbria was not able to fully eliminate 78 week waits by the end of March 2023 but the work done, particularly in recent months, to reduce long waiters has been immense and should be acknowledged. From a position on the 1 January 2023 of 4,498 patients within the 78 week cohort, this reduced to 160 by the 31 March 2023. 74 of the 160 patients were unable to be treated due to capacity, with the remaining 84 not treated due to being complex or patient choice.

Mirroring the national trend, the number of patients waiting over 52 weeks is also reducing; 7,670 as at 31 March 2023 compared with 10,646 on the 1 January 2023.

104-week waits were eliminated by the end of June 2022 in line with the national target.

We continue to work extremely hard to reduce waiting times and are working towards ensuring everyone is treated within 65 weeks by the end of March 2024, as per the national target. This is only possible because the trusts continue to focus great collective effort to improve access to care. For example, hospitals with shorter waiting times are offering appointments to patients whose nearest hospital has longer waits. As of April 2023, nearly 2,000 patients had chosen to travel further to have a quicker appointment.

Both theatre utilisation and day case rates within Lancashire and South Cumbria are within the top quartile within England at 81 per cent and 82.5 per cent respectively.

### Diagnostics

Although the performance for diagnostics is not meeting the target, it has been improving over the year. For Lancashire and South Cumbria, the latest reported figure is the lowest since diagnostics was first reported at ICB level in July 22. The most challenged area is endoscopy, although the ICB has an extensive plan to develop capacity in endoscopy and continues to develop the Community Diagnostic Centre capacity and capability, which is beginning to have a positive effect on waits for diagnostic tests.

**Diagnostic Imaging Network**

Patient waiting times for some diagnostic tests have improved because imaging services are being delivered as a collaborative network across the four hospital trusts in Lancashire and South Cumbria.

During the COVID-19 pandemic in April 2020, 47% of patients were waiting over six weeks for their CT and MRI scans. This has now reduced to below 6.6%.

Part of this involves offering patients whose nearest hospital has longer waits access to a scan more quickly at a hospital with a smaller waiting list. This means some patients are travelling further to be seen more quickly.

The Diagnostic Imaging Network made up of the four hospital trusts (Blackpool Teaching Hospitals NHS Foundation Trust, East Lancashire Hospitals NHS Trust, Lancashire Teaching Hospitals NHS Foundation Trust and University Hospitals of Morecambe Bay NHS Foundation Trust), provides the following imaging scans: CT, MRI, X-Ray, DEXA, radionuclide and non-obstetric ultrasound.

By working together, elective imaging activity across the Network has increased. As of 31 March 2023 our network is delivering 137% MRI and 150% CT scanning activity compared to pre-COVID levels in 2019/20.

### Children and Young People

The level of vaccination coverage of MMR for five years olds is above regional and national levels. There are ongoing workstreams to further increase coverage, including communications to parents and schools on the importance of vaccination for MMR

The level of smoking at the time of delivery is higher in the ICB than regionally or nationally. The key initiative is to implement support into maternity units to the four main providers to reduce tobacco dependency.

#### *National Priorities*

In relation to the voice of our children we have started to hear patient stories at the Children's Board and have ensured that our children help us to develop any new projects. We have undertaken training and will embed the Lundy model of participation within the ICB engagement strategy. This will ensure our children are involved in decision making and will be at the heart of everything we do.

The CYP team have been working to achieve the key clinical national priorities. Clinical Networks and Leads are in place for Asthma, Epilepsy, Palliative Care, and Diabetes.

#### *Palliative Care*

Palliative Care is now a statutory function of ICBs. The ICB has an active Palliative Care Clinical Network. This year we have implemented specialist Kentown Palliative Care Nurses to support children and young people with palliative care needs /life limiting conditions. We are working to recruit a Palliative Care Consultant to provide specialist clinical advice for children and young people in Lancashire and South Cumbria

In addition, we are working in partnership with Derian House Children's Hospice to implement a palliative care training programme for the children's workforce, which will upskill and improve the understanding of children's palliative care needs across all sectors.

#### *Asthma*

Lancashire and South Cumbria was successful in our bid to become a national pilot site to support the early support for children at high risk of an asthma attack. Our two specialist asthma nurses have been in post since early December and are working with our partners in Primary Care to identify our high-risk children and support the optimisation of their care and annual reviews.

Other projects we are progressing include the introduction of asthma-friendly schools, promotion of free accredited asthma training for the workforce, improvement work with our acute trusts in relation to treatment and discharge plans, ensuring children receive a personalised asthma action plan, working with our partners in the VCFSE to empower our children and families to manage their asthma, trialling an asthma app and working with our partners in housing to provide wrap around support for vulnerable families.

### *Diabetes*
The Diabetes Network is working to address inequalities in diabetes care (National Paediatric Diabetes Audit), reduce the incidence of Type 2 diabetes and improve access to technology for our deprived and ethnic minority populations

Data highlights poorer outcomes for children with Type 1 diabetes living in areas of social deprivation, children from ethnic minority backgrounds and young adults. In 2022-23 we have participated in 3 x pilot projects to increase access to technology (which has been shown to improve health outcomes) for these groups of young people. These pilots are currently showing excellent results with increased numbers of CYP now using technology.

We have undertaken partnership work the VCFSE to improve the care for children at risk of or diagnosed with type 2 diabetes. Using a culturally sensitive, targeted intervention we are hoping to improve the health outcomes for these children.

Lancashire and South Cumbria is expanding our pilot site for services for children with excess weight (who are at high risk of developing Type 2 diabetes). This will ensure that children receive support from both clinical and health coaching teams which will help to improve their health outcomes in the future.

### *Epilepsy*
The Epilepsy Network is working to address inequalities in epilepsy care, improve transition to adult services, improve access to mental health screening and access to specialist services. Expressions of interest have been submitted to the National team to support a senior Epilepsy Specialist Nurse who will work across LSC to drive forward these improvements. A further bid has been placed to pilot the implementation of a mental health screening tool with associated psychological care. National funding has been accessed to support the employment of an additional epilepsy specialist nurse at one Trust in LSC.

### *Elective care*
The children and young people (CYP) team is working with ICB, Regional and Trust colleagues in relation to elective recovery work, the emphasis is on restoring activity to pre pandemic levels. Work is ongoing with community dental colleagues and the ICB to address backlogs in activity (which is a Core 20 plus 5 priority). The team attends regional meetings working with NHSE and the children's hospitals, to identify appropriate models of recovery and prioritisation tools that are specific to children and young people.

Finally, the team is working in partnership with regional colleagues to identify priorities from the Getting it Right First-Time programme and to implement system wide improvements. This year's improvement guideline related to the management of abdominal pain in children.

Further plans are in place for the year ahead in relation to introducing youth workers who will empower children and young people to manage their long-term conditions', we will also appoint mental health champions on the children's inpatient wards to ensure joint working to meet the needs of these children.

### *Send*
Lancs and South Cumbria ICB continues to work in close partnership with Local Authorities across the system, as an example the ICB and North and South Cumbria Local Authority jointly participated in a successful Ofsted and CQC follow up inspection of our SEND services. The inspection clearly demonstrated collaborative working across the system and that we were and are clear where continued improvements need to be focussed.

As an ICB we are determined to continue to work hard to improve services for our children, young people and families with SEND, working in collaboration and promoting C0-production with Local Authorities, providers, the independent, voluntary sector, charities and CYP and families amongst others.

**Children and Young People Speech and Language Therapy**

Speech and Language Therapy have maintained significantly long waits for children and young people over the last couple of years due in part to the impact of COVID and the lack of workforce to deliver support with the increase in demand.

A redesign of the model for speech and language based on the Balanced system model which is seen as national best practice is underway, and testing of this model has shown significant reductions in waiting times alongside improved outcomes, as an example, Hyndburn now has no waits for speech and language therapy. Formal roll out of the new model is underway across the ICB and will commence during 23/24.

## Cancer

The ICB is not meeting some of its cancer waiting times targets and action plans; led by the Lancashire and South Cumbria Cancer Alliance, are in place to support improvement. There are challenges and increases in demand in various pathways which continue to be addressed. A robust programme of pathway improvement is in place which supports best practice pathway development, reduces unnecessary steps and the alignment of administrative and clinical processes in the interests of patient care.

### *Lancashire and South Cumbria Cancer Alliance*

Lancashire and South Cumbria Cancer Alliance [25]is a collaboration of all professionals and organisations involved in the delivery of cancer care for the people who live in our region.

The key ambitions in the Long Term Plan are:

**BY 2028**

55,000 more people each year will survive their cancer for five years or more

**BY 2028**

75% of people with cancer will be diagnosed at an early stage (stage one or two)

[25] https://www.lancashireandsouthcumbria.icb.nhs.uk/our-work/canceralliance

**Sponge on a string' boost for cancer services in Lancashire and South Cumbria**

An innovative 'sponge on a string' diagnostic test is set to improve cancer care and ease the pressure on health services in Lancashire and South Cumbria.

The potentially life-saving device, known as Cytosponge, will help identify people most at risk of oesophageal (gullet) cancer and be available close to people's homes. Cytosponge involves the patient swallowing a capsule attached to a 'string'. The capsule dissolves after a few minutes to release a sponge that gathers oesophagus cells for analysis after it is removed.

The test will be offered to people on endoscopy waiting lists who have conditions such as Barrett's oesophagus (when the normal cells lining the gullet have been replaced by abnormal cells, increasing the risk of developing oesophageal cancer). The test is minimally invasive and generally more comfortable, needs no sedation and can be delivered in a nurse-led clinic in about 15 minutes.

By contrast, an endoscopy requires a team of specialists in hospital and can take several hours of preparation.

The pandemic has increased the demand for endoscopy, a procedure in which a camera attached to a flexible tube is inserted into the patient's body, with Lancashire and South Cumbria having the fourth highest rate of upper gastrointestinal endoscopies in England.

The Lancashire and South Cumbria Cancer Alliance has worked with partners including the Innovation Agency to secure £500,000 from the SBRI Healthcare fund to spread Cytosponge from hospital services into the community.

## Urgent & Emergency Care

The new national target of 76 per cent of patients to be seen within four hours by the end of 2023-24 has been set. Accident and Emergency services were under significant pressure throughout 2022-23, with high numbers presenting for treatment. Performance levelled off across the first half of the year, but has deteriorated in the winter months, which is consistent to previous years. The number of attendances in February dropped significantly (almost 13,000 less attendances than December 2022). Performance across L&SC exceeds the national average.

Historically there were no reports of ambulance handover delays of over 60 minutes. During 2022-23 the number of delays reported was unprecedented, with December 2022 seeing the highest numbers of delays recorded. This impacts directly on the ability for ambulance crews to respond to calls and is reflected in the underperformance against the Category 2 response target. A reduction in delays has been since January 2023.

A robust programme of work is in place to support urgent and emergency care, and ahead of winter this year a number of initiatives and schemes were deployed to support the expected increase in demand on urgent care services across L&SC.

The ICB was allocated £12.95 million to support mobilisation of 27 demand and capacity schemes across L&SC in 2022-23. The schemes were robustly monitored through the Resilience and Surge Planning Group with monthly submissions to the regional and national teams.

The schemes were focussed on creating additional bed capacity both within hospital and in the community, in order for this to be achieved there was a range of schemes that supported timely discharges such as additional domiciliary care hours, patient transport, workforce and additional beds.

Funding for the demand and capacity schemes ended on 31 March 2023. However, due to the substantial and unrelenting pressures across our hospitals and some significant upcoming risks, the ICB's Resilience

and Surge Planning Group (RSPG) sought approval to extend a small number of schemes on short-term basis until 30 June 2023.

Additionally, examples of the other range of focus for the urgent and emergency care programme have been, optimising SDEC pathways, establishment of ambulance handover collaborative and associated projects, development of transfer of care hubs, maximising use of virtual wards for flow and discharge, expansion of 2-hour urgent community response, system control centre and place based tactical/silver command meetings.

**Winter pressures**

Winter always sees great pressure on the health system. The winter of 2022/23 has been one of the most pressured the NHS has ever seen. In Lancashire and South Cumbria, we have been able to manage the pressures within hospitals and in primary care reasonably well through a number of initiatives, such as the establishment of virtual wards and improvements to hospital discharge processes.

Our system control centre (SCC) manages demand and capacity and ensures adequate oversight of operational pressures at all times, ensuring rapid decisions are made to respond to any emerging challenges.

Bed occupancy in hospital remains high and delays in transfers from ambulance to hospital departments remain longer than they should be. In short, there are more people needing to get into hospital facing delays due to the time it takes to get people out of hospital.

A rise in flu cases over winter also placed extra pressure on services, with growing hospital admissions, along with the unanticipated increase in the number of cases of children with invasive group A strep.

## Mental Health

The rate for Improving Access to Psychological Therapies (IAPT) is below target for the ICB. There is an extensive plan ongoing to work with providers to ensure more people can access services when they need them

The access rate for Children and Young People to mental health services is well above target and continues to be one of the highest nationally.

The ICB has made significant progress in reducing the number of patients placed out of area for their mental health inpatient needs and work continues to reduce this even further with a target of zero out of area placements by the end of 2023-24.

The numberof people expected to receive a dementia diagnosis is above target for the ICB and continues to perform favourably against regional and national rates.

The ICB is required to disclose and explain the amount and proportion of expenditure incurred by the ICB in relation to mental health, referring to content covered in the accountability report.

| | 2022/23 |
|---|---|
| **Mental Health Spend** | £378,094 |
| **ICB Programme Allocation** | £3,017,236 |
| **Mental Health Spend as a proportion of ICB Programme Allocation** | 12.53% |

As the ICB is a new body comparative figures for previous years does not exist.

**Mental health urgent assessment centres**

The provider NHS Trusts worked together to develop five mental health urgent assessment centres (MHUACs) to improve care for people who are in crisis and who have attended their local Emergency Department seeking help.

Patients who attend Emergency Department in a crisis are quickly assessed by both hospital staff and the Mental Health Liaison Team. Where further mental health assessment is required and it is medically safe, they are invited to the MHUAC, which is located immediately next to Emergency Department.

The centres are transforming mental health emergency care by ensuring safe and effective assessment of both physical and mental health needs.

### Learning Disabilities

The number of learning disability patients over 14 years of age receiving an annual health check is below the level expected for the ICB and below the regional and national levels. There are several key initiatives ongoing to improve the performance working with primary care colleagues and listening to the experience of patients with a learning disability.

### Primary Care

Primary care covers a range of services for patients including GP practices, pharmacies, optometry and dentistry. On 01 July 2022 NHS Lancashire and South Cumbria Integrated Care board (ICB) became the accountable body, responsible for GP practices and pharmaceutical services in the area. During the reporting period for this annual report, optometry and dentistry remain the responsibility of NHS England.

In 2022-23 Lancashire and South Cumbria reported a greater number of general practice appointments per 10,000 population than the North West average with actual appointment volumes higher than originally planned and anticipated. However, despite this, the rate of appointments per 10,000 population is well below the national average. Plans are in place to improve patient communication, triage and signposting; however significant risk remains regarding GP demand and capacity and the ability to improve patient access.

Flu vaccination uptake in the over 65s in Lancashire and South Cumbria was 79.2per cent for the period between 1st September 2022 and 28th February 2023. Uptake was significantly reduced compared to 2021-22 season which appears to be a national trend.

At the end of 2021-22 Lancashire and South Cumbria reported a slightly higher proportion of patients receiving all eight care processes than the national average at 32.1 per cent. The most recent data covering Jan-Sep 2022 suggests that the position across Lancashire and South Cumbria is in line with national averages and higher than the North West position.

### *Restoration and recovery*

Colleagues working in primary care continue to work under very challenging circumstances with the impact of the COVID-19 pandemic still influencing patient demand on these services. There is evidence to show that patients seeking a consultation with a GP do so with significantly more complex needs than prior to the pandemic. This has resulted in additional time taken for consultations and management. Patient demand has also risen for episodic care. There are also significant workforce challenges across all of primary care including a reduction in the number of GPs. This is a national challenge and in

Lancashire and South Cumbia we have been working closely with our partners in NHS E both at regional and national level on a suite of interlocking GP recruitment and retention initiatives available to help and sustain the GP workforce in Lancashire and South Cumbria including:

- **New to Partnership Payment Scheme** which aims to grow the number of partners working in primary care, stabilising the partnership model and helping to increase clinicians participation levels
- **General Practice Fellowship Programme** supports all newly-qualified GPs working substantively in general practice in their transition from training to employment and guarantees a level of support and learning
- **Supporting Mentors Scheme** upskills experienced GPs and provides portfolio working opportunities
- **Primary Care Flexible Staffing Pools** increase the capacity in general practice and create a new offer for local GPs wanting to work flexibly.

GPs in Lancashire and South Cumbria also have access to the national GP Career Support Hub which provides a range of advice, guidance and career development tools for GPs.

Workforce planning and recruitment to primary care continues to be a key priority. The Additional Roles Reimbursement Scheme provides Primary Care Networks (PCNs) with the opportunity to increase their workforce and support places to increase the uptake and implementation of these roles.

Health and Wellbeing support is available to the whole primary care workforce in Lancashire and South Cumbria through the Lancashire and South Cumbria Primary Care Training Hub. Health and Wellbeing Champions have been recruited to provide and promote the available resources and initiatives to General Practice including access to wellbeing circles and financial wellbeing.

### *GP Access*

There have been increases in the number of appointments and consultations provided above the national average against a backdrop of a significant reduction in Full time equivalent (FTE) General Practitioners. This has resulted in an increase in GP workload intensity and a significant shift in the delivery of GP appointments across Lancashire and South Cumbria embodied by transition from a GP delivered model of care to a GP led model.

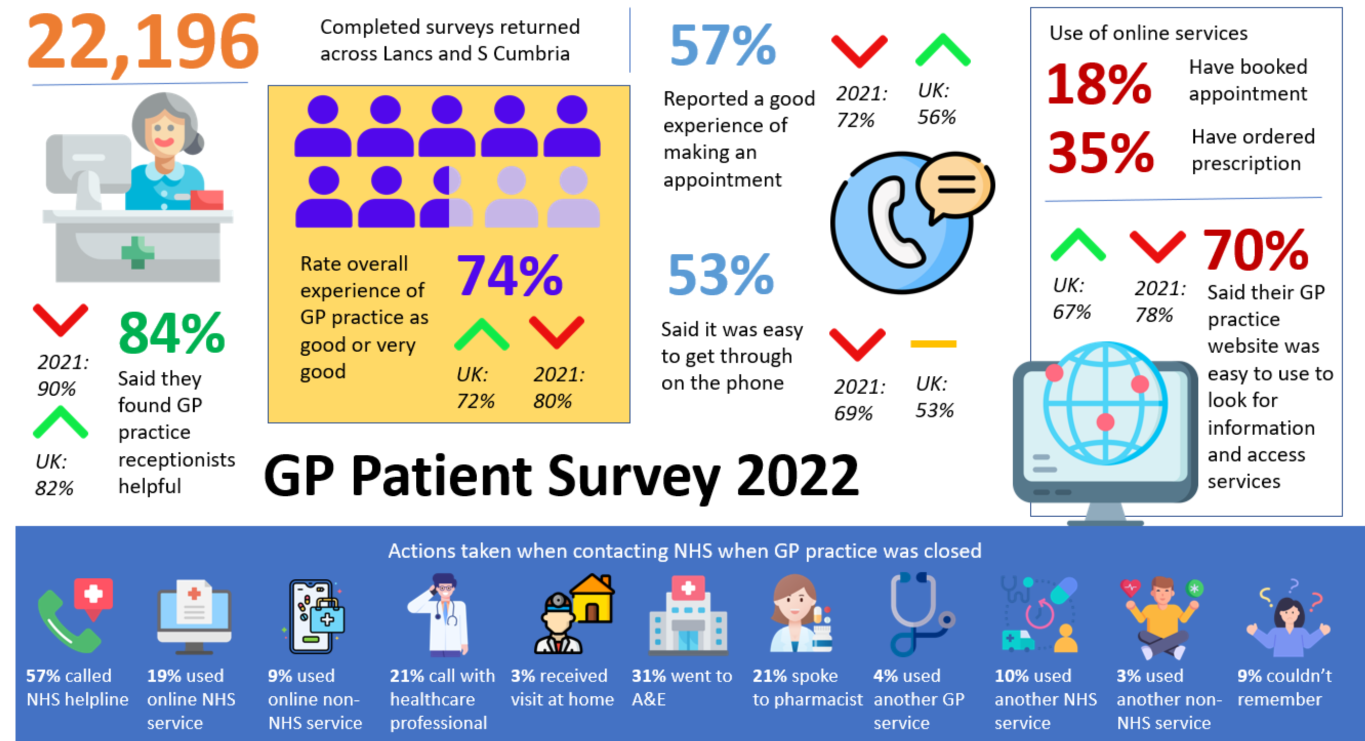
In September 2022 the Government published it plan:'Our Plan for Patients'[26] to ensure that everyone who needs an appointment with their practice within two weeks can get one and that patients with urgent needs are seen on the same day with additional appointments over winter. There was also an intention to publish data on how many appointments each GP practice delivers, and the length of waits for appointments, to enable patient choice. This data has been available from since November 2022 and NHS Lancashire and South Cumbria ICB reviews this regularly in order to provide support to those practices with the most acute access challenges to improve performance

NHS Digital[27], who publishes this data, acknowledges there are a number of changes required to make the data more robust. However, using that information we have continued to monitor and support best practice across our primary care GP providers to minimise variation in patient experience and will continue to build on this early work.

### *GP Patient Survey*

The GP Patient Survey 2022 was published in July 2022 and reflects on people's experience of healthcare services provided by GP surgeries.

[26] https://www.gov.uk/government/publications/our-plan-for-patients/our-plan-for-patients
[27] https://digital.nhs.uk/




## *Integrated Neighbourhood Care Development programme*

We continue to build on the work of our predecessor organisations, who for several years had been working as partners across Lancashire and South Cumbria to develop integrated neighbourhoods.

From a health and care perspective our focus has been on the development of integrated neighbourhood teams (INTs). These teams bring together teams and professionals to improve patient care for neighbourhood populations. Primary, community, secondary and social care, domiciliary and care staff and VCFSE partners form a team of teams, sharing information and resources to improve health and wellbeing and tackle health inequalities

We have made significant progress and have some great examples across the system of where INTs are well established and working well. For a range of reasons, including the impact of the pandemic, the pace of development has varied, and some areas have much further to go on their journey to integration.

The timely publication of the Fuller Stocktake report: "Next steps for integrating primary care", which was published in May 2022, provides a real opportunity for us to build on the excellent work to date and to move forwards with integrated neighbourhood care in all areas. The report, commissioned by NHS England, looked at what is working well, why it is working well and how the implementation of integrated primary care could be accelerated. It acknowledged that for generations primary care has been at the heart of our communities, with health visitors, community and district nurses, GPs, dentists, pharmacists, opticians, and social care workers being amongst the most recognisable of a multitude of dedicated staff delivering care around the clock in every neighbourhood in the country.

The report identified a 'moment of real opportunity' to streamline access to care and advice, provide more proactive, personalised care with support from a multi-disciplinary team of professionals to people with more complex needs and to help people stay well for longer as part of a more ambitious and joined-up approach to prevention.

To support this, we have developed the Lancashire and South Cumbria Integrated Neighbourhood Care Delivery Framework. Based on the Fuller stocktake report, the framework also draws on a range of other national and local documents. It builds on existing progress and good practice across the system

to create a framework to transform how we work together to provide care for our populations and to support the development of Neighbourhoods, across Lancashire and South Cumbria.

### *Further primary care contract delegation*

We have been preparing for the formal delegation of formally approved the delegation of all pharmaceutical, general ophthalmic and dental (POD) services to Integrated Care Boards from 1 April 2023. This includes the transfer of some NHS England regional staff who are supporting POD commissioning.

NHS England have formally approved the delegation of these services which will allow the ICB to integrate services and improve patient experience, quality and health outcomes. NHS E will also delegate responsibility for specialised services that have been identified as suitable and ready for further integration subject to system readiness from 01 April 2024 and work is already underway to ensure a smooth transition.

**Support and prevention of Type 2 diabetes**

More than 100,000 people aged 17 and above in Lancashire and South Cumbria have Type 2 diabetes and it's estimated that more than 75,000 people are at a high risk of developing the condition.

In Lancashire and South Cumbria people identified as being at risk are offered tailored support through the local Healthier You service. Healthier You is a nationally commissioned diabetes prevention programme aimed at reducing the risk of developing or delaying the onset of Type 2 diabetes. The programme can have a major impact on people's lives with participants who complete the programme achieving an average weight loss of 3.3kg.

In April, commissioners awarded a new contract to continue the national diabetes prevention programme (NDPP) service across the region. Reed Wellbeing took over from 1 August 2022. Due to the transition, and the issues this caused with transfer of information from the outgoing provider to the new one, referrals were paused throughout June and July. Since August, work has continued to assist practices target potentially at-risk patients.

In April 2022 Lancashire and South Cumbria was named as one of 11 additional areas to take part in a pilot of a low-calorie diet scheme. The aim of the diet is to help people with diabetes lose weight and potentially help them to achieve remission of their type 2 diabetes.

Eligible patients are referred by their GP and receive low-calorie meal replacement products for 12 weeks at no cost to themselves. Following this period regular food is re-introduced in a managed way to encourage healthy, nutritious eating habits. Participants then have regular one to one coaching sessions for the rest of the year to help them maintain their diet.

According to NHS England, early data from the programme showed participants lost 7.2kg on average after one month, and 13.4kg after three months. In Lancashire and South Cumbria referrals have been low but we are working with practices to help them better understand the scheme.

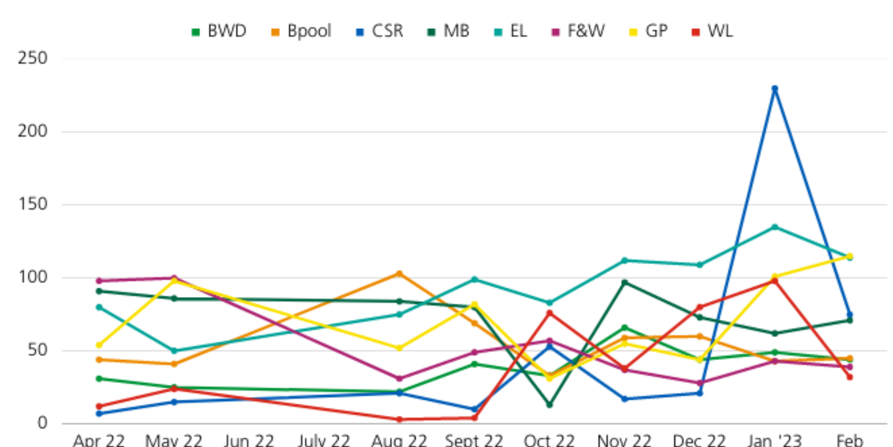
# Diabetes referrals at a glance

National Diabetes Prevention Programme and Low Calorie Diet referrals 2022/23

## NDPP referrals made
(by NHSE reporting former CCG area)

TOTAL
4,328*

*Does not include referrals made in June or July due to pause in reporting during transition to new provider




## Low Calorie Diet Programme referrals

169

### Digital

In 2018, Lancashire and South Cumbria published its '[Our Digital Future](https://www.healthierlsc.co.uk/download_file/force/1889/796)' [28]and set out the approach to partnership working across the local system.

It established the principles of:

- Creating digital solutions with the people who will be using them
- Judging progress against this digital strategy from the public's perspective
- Creating an environment that empowers the frontline
- Using data to prevent, predict and respond to ill-health
- Working together to reduce complexity in order to improve quality and safety

[28] https://www.healthierlsc.co.uk/download_file/force/1889/796

- Engaging with academia, industry and others to accelerate innovation

Much has happened since then and the NHS is a different place following the pandemic. A chief digital officer was appointed to the ICB in November 2022 and a new digital and data strategy is planned for Summer 2023. This is likely to focus on using data in a much more ambitious way to improve integration across our health services.

**A new approach to digital patient records begins**

Hospitals across Lancashire and South Cumbria are looking at setting up a new system to allow patient records to be shared effectively regardless of which health service a patient has visited.

The establishment of a single, seamless electronic patient records (EPR) system comes on the back of the introduction of a shared care record, which has already been supporting patients by bringing data together from all our different providers of care.

This innovative approach will transform how information is stored and utilised and provide the foundations to improve clinical and care pathways as well as allowing hospitals to work together far more effectively.

There are numerous methods of recording and accessing patient information across hospitals in Lancashire and South Cumbria. The aim is to capture best practice and reduce variation across hospitals to allow staff, patients and their families to dedicate more time to treatment and recovery, by streamlining the process of accessing and utilizing essential patient information.

The implementation of a single EPR system is considered a crucial milestone in advancing digital healthcare innovations and delivering integrated patient care throughout Lancashire and South Cumbria. By investing in a single system, we are making use of technology to offer the highest standard of care to patients, regardless of their location."

The EPR is the first of many ambitious steps in the Lancashire and South Cumbria Integrated Care Board's digital roadmap which promises more investment into technology and the rollout of more digital tools to improve care.

## Environmental matters

### *Sustainability*

On 1 July 2022, the NHS became the first health system in the world to embed net zero into legislation, through Health and Care Act 2022[29]. Net zero means cutting greenhouse gas emissions that cause global warming to as close to zero as possible, with any remaining emissions re-absorbed from the atmosphere by oceans and trees.

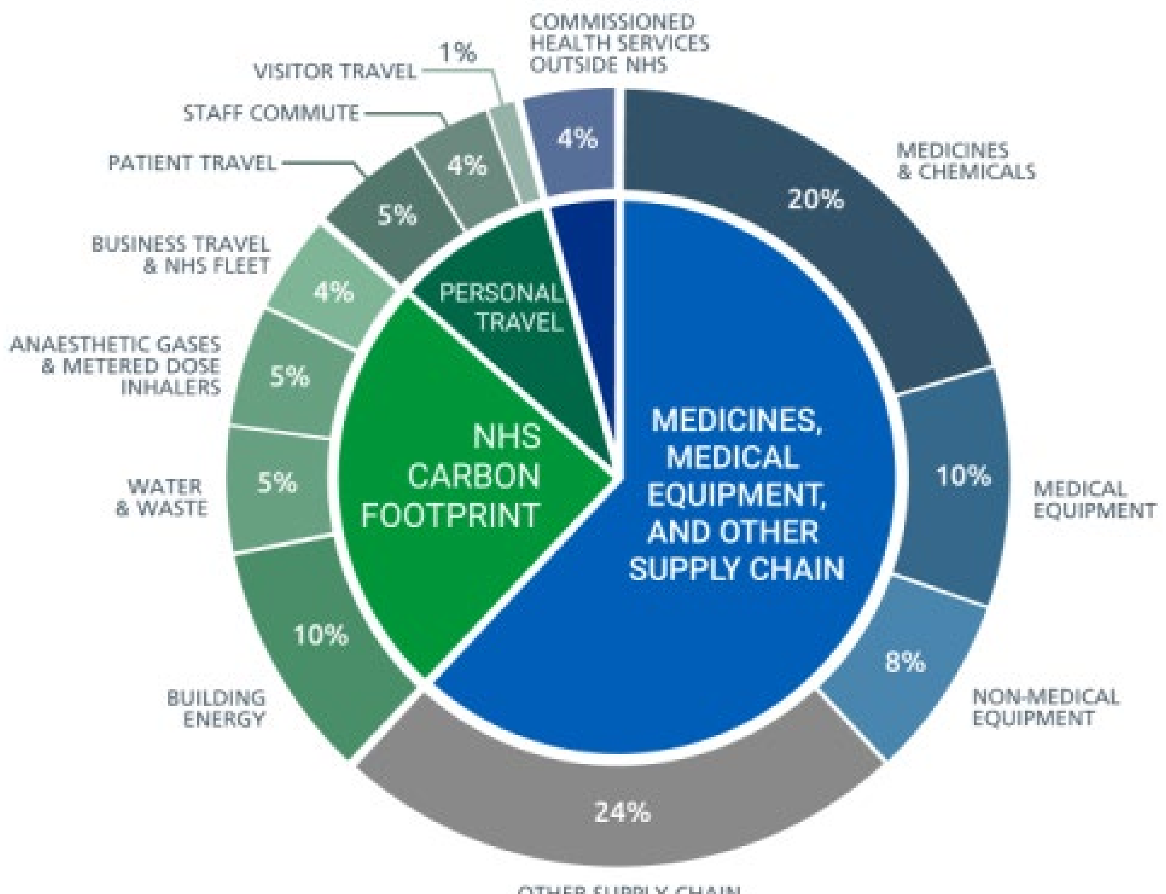
National NHS Goals:

- Emissions we control directly to be net zero by 2040, with ambition to reach an 80% reduction by 2028-2032.
- Emissions we can influence to be net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

By the year 2040, this trajectory would save an estimated 5,770 lives per year from reductions in air pollution alone. Delivering a 'Net Zero' National Health Service[30]

This diagram highlights the sources of carbon emissions by proportion of the NHS Carbon footprint plus. It shows where we need to focus our efforts.

[29] https://www.legislation.gov.uk/ukpga/2022/31/contents/enacted
[30] https://www.england.nhs.uk/greenernhs/a-net-zero-nhs/


COMMISSIONED
HEALTH SERVICES
OUTSIDE NHS
VISITOR TRAVEL
1%
STAFF COMMUTE
PATIENT TRAVEL
4%
4%
5%
MEDICINES
& CHEMICALS
20%
BUSINESS TRAVEL
& NHS FLEET
4%
PERSONAL
TRAVEL
ANAESTHETIC GASES
& METERED DOSE
INHALERS
5%
NHS
CARBON
FOOTPRINT
MEDICINES,
MEDICAL
EQUIPMENT,
AND OTHER
SUPPLY CHAIN
10%
MEDICAL
EQUIPMENT
WATER
& WASTE
5%
10%
8%
BUILDING
ENERGY
NON-MEDICAL
EQUIPMENT
24%
OTHER SUPPLY CHAIN

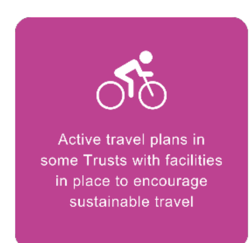
As an ICB, we play a key role in reducing emissions, influencing our providers, and building healthier communities. Our ICB Green Plan[31] was published in March 2023 and outlines how we will support NHS England and the UK government in fulfilling these emission goals.

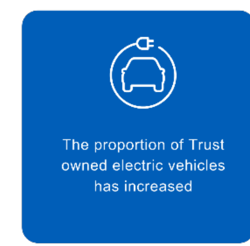
Our Green Plan is divided into the following nine areas of focus, each with clear goals & actions.

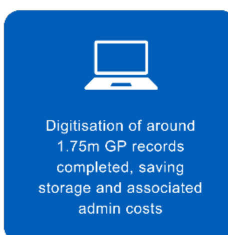
1. Workforce & Leadership- We must ensure everyone understands their role in reducing their carbon footprint.
2. Sustainable models of care- These models of care have less of an impact on our environment because they use less resources and cause less pollution, often focusing on preventative care.
3. Digital transformation- Technology can be used to reduce travel and paper while improving patient care. We must build on the progress that occurred during the pandemic.
4. Travel and transport -Staff and patients will be encouraged to use public transport and walk or cycle more. Car travel produces air pollution accounting for one in twenty deaths in the UK.
5. Estates and facilities -A range of interventions are planned for the next 5 to 10 years that will result in waste reduction, energy efficiency, expansion of green space and sustainable capital projects.
6. Medicines - We must avoid using those anaesthetic gases and gases in inhalers that are much worse for the environment than $CO_2$.
7. Supply chain and procurement - Our providers will be encouraged to focus on sustainability through changes to procurement and contract monitoring.
8. Food and nutrition - Healthy, locally sourced food will be promoted to our staff & patients.
9. Adaptation (adapting to environmental change) – Introducing Adaptation Plans will ensure our healthcare facilities can withstand the impacts of climate change such as floods and heatwaves.

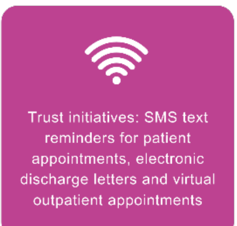
### *Achievements to date*

Over the last year we have already shown evidence of delivery across the ICB and seen progress in Trusts. Some of these achievements are highlighted below.



- A process is now in place to ensure all relevant new NHS procurements include net zero and social value.
- Anaesthetic gas use is below the National target of 5% across all Trusts.
- A decarbonisation review has been undertaken for all 17 hospital sites and plans produced that demonstrate how net zero can be achieved.

[31] https://www.lancashireandsouthcumbria.icb.nhs.uk/about-us/publications/strategies-and-plans/green-plan-2022-25

- Healthy/active travel plans in some Trusts with facilities and schemes in place to encourage sustainable travel.
- The proportion of Trust owned electric vehicles has increased.
- Digitisation of around 1.75m GP records completed saving storage and associated admin costs.
- Trust initiatives include SMS text reminders for patient appointments, electronic discharge letters & virtual outpatient appointments.
- Clinical pathway initiatives established across our Trusts include virtual wards, virtual outpatient appointments (BTH), a same day emergency care programme (ELHT), hospital home care service (LTH).
- ICB Exec level sustainability lead identified and a dedicated project manager.
- In primary care and Trusts, Green Champions have been trained and supported to encourage colleagues to adopt the principles of sustainability.

Actions in the coming year will build on these achievements. We will work much closely with other public services as well as voluntary and private sector providers to share learning and ensure we develop a joined-up approach to sustainability in Lancashire and South Cumbria.

### Lancashire and South Cumbria New Hospitals Programme

The Lancashire and South Cumbria New Hospitals Programme plans to develop cutting-edge facilities, offering the absolute best in modern healthcare and addressing significant problems with the current ageing Royal Preston Hospital and Royal Lancaster Infirmary hospital buildings.

Following on from the announcement of the shortlist of proposals for new hospital facilities in March 2022, the Lancashire and South Cumbria New Hospitals Programme team has carried out a detailed assessment of the shortlisted options. As a reminder, the published shortlist was as follows:

- A new Royal Preston Hospital on a new site, with partial rebuild / refurbishment of Royal Lancaster Infirmary.
- A new Royal Lancaster Infirmary on a new site, with partial rebuild / refurbishment of Royal Preston Hospital
- Investment at both Royal Preston Hospital and Royal Lancaster Infirmary, allowing partial rebuilding work on both existing sites
- Two new hospitals to replace Royal Preston Hospital and Royal Lancaster Infirmary (new sites).

Each shortlisted proposal has been comprehensively assessed for deliverability, affordability, value for money, and viability, considering feedback from patients, local people and staff.

This work has resulted in recommendations for preferred options and alternative options for both Royal Preston Hospital and Royal Lancaster Infirmary. In September 2022, the NHS in Lancashire and South Cumbria stated its preference for new hospitals on new sites for both Royal Preston Hospital and Royal Lancaster Infirmary as part of the New Hospitals Programme: newhospitals.info/update[32]

The detail behind each option will continue to be expanded and refined as further work on the shortlist progresses and the required business cases are developed. No final decisions have been made and the New Hospitals Programme team will continue to involve patients, local people, staff and wider stakeholders in the development of proposals.

The New Hospitals Programme team would like to say a huge thank you to everyone who has taken the time to share their views so far. Listening to the views of people living and working here is the only way we can fully understand what is required when shaping plans and proposals for new hospital facilities

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[32] https://newhospitals.info/update

Read more about what we've heard at newhospitals.info/YourHospitalsYourSay[33] or keep up to date on the latest news at newhospitals.info. [34]

## Improving Quality

### *About the Quality Committee*

The Quality Committee, which held its first formal meeting in September 2022, provides the ICB with assurance that it is delivering its functions in a way that secures continuous improvement in the quality of services. It does this against each of the dimensions of quality set out in the Shared Commitment to Quality and enshrined in the Health and Care Bill 2021. This includes reducing inequalities in the quality of care.

The Committee exists to scrutinise the robustness of, and provide assurance to, the ICB, that there is an effective system of quality governance and internal control. That system supports the ICB to effectively deliver its strategic objectives and provide sustainable, high-quality care.

The Quality Committee provides regular assurance updates to the ICB Board in relation to activities and items within its remit and more work about the work of the committee is included in the Corporate Governance Statement later in this report.

The Chief Nurse, Medical Director and Director of Nursing for Quality Assurance and Patient Safety are all members of the NHSE North West Regional Quality Group (RQG). The ICB provides a monthly update to the RQG regarding quality and patient safety and will escalate any areas of concern to this group and will also share any learning with this group.

The Quality Committee identifies risks and necessary escalations needed to mitigate the risks relating to patient safety, effectiveness and experience. Risks and Escalations considered include a report relating to the main providers across Lancashire and South Cumbria, focusing on primary care, medicines optimisation, community care, equality, diversity and inclusion, and urgent and emergency care.

The Quality Committee also receives Safeguarding updates covering the ICB's approach to delivering safeguarding statutory functions, changes in the NHS Safeguarding Accountability and Assurance Framework 2022 (SAF) and aspects of learning from safeguarding reviews and the ICB system response. The ICB accountabilities for safeguarding are noted by the committee which recognises the need for delivery and collaboration in the four Places.

### *System Quality Group*

In line with guidance from the National Quality Board the ICB has established a System Quality Group. Whereas the Quality Committee has a function to assure the ICB Board on the quality and safety of services the SQG is focusing on quality improvement and learning and replaces the Quality Surveillance Groups which had more of an assurance focus. The ICB held a development workshop with partners from across the system, to agree the TOR and remit of the SQG and to date meetings have focused on Urgent and Emergency Care, Diabetes and Cancer. The SQG reports into Quality Committee and any areas of significant concern would be escalated to Quality Committee

### *Improvement Hub and Development of a Lancashire and South Cumbria Quality Management System*

There is a strong commitment to improvement methodology and approaches in all the NHS providers in Lancashire and South Cumbria and ICB colleagues have been working with the improvement leads to establish a unified Lancashire and South Cumbria Quality Management System approach. In addition, the ICB will be establishing an Improvement Hub to be chaired by the Medical Director that will bring all the clinical networks together to share learning and outputs from clinical improvement work.

[33] https://newhospitals.info/your-hospitals-your-say
[34] https://newhospitals.info/

### *System Oversight Framework (SOF)*

The Quality team of the ICB work very closely with NHS Trusts in SOF 4 and SOF 3 and through System Improvement Boards (SIBs) we have seen some significant progress in 2022-23.

The ICB has established a clear process and system of support to drive quality improvement in the providers.

University Hospitals of Morecambe Bay Trust is in SOF 4 and, in line with the national framework, has an SIB that is chaired and led by NHS England North West and attended by the ICB. There is a clear improvement plan and exit criteria and the national team will review progress with a view to moving into SOF 3 this year.

Blackpool Teaching Hospitals is an SOF 3 Trust and has an SIB chaired and led by NHS England North West, who are planning to hand over the leadership to the ICB in the second quarter of 2023/24.

### *Safeguarding*

The ICB has statutory responsibility for safeguarding roles and functions in accordance with the NHS Accountability and Assurance Framework (2019), Children and Social Work Act (2017), Working Together to Safeguard Children (2018), Promoting the Health and Well-being of Children Looked After (2015) and the Care Act (2014). The responsibility for Safeguarding is held by the Chief Nursing Officer with a senior team in place and supporting governance and assurance structures.

It remains the responsibility of every NHS-funded organisation and each individual healthcare professional working in the NHS to ensure that the principles and duties of safeguarding adults and children are holistically, consistently and conscientiously applied, with the wellbeing of those adults and children at the heart of what is done.

NHSE requires the ICB to submit a response to the requirements of the Safeguarding Assurance & Accountability Framework (SAAF). The ICB has submitted an annual Safeguarding Self-Assessment to provide assurance of its arrangements to NHSE/I, as well as to the Adult Safeguarding Boards and Children's Safeguarding Partnership's. With the exception of training, full compliance has been declared this year; further detailed activity will be contained in the Annual Safeguarding Report due to be published in quarter 2 of this financial year. As part of the SAAF process the ICB must ensure that health services across the system have effective safeguarding arrangements in place which is further complemented by assurance visits and Section 11 Audit.

The Quality Committee also received Safeguarding updates covering the ICB's approach to delivering safeguarding statutory functions, changes in the NHS Safeguarding Accountability and Assurance Framework 2022 (SAAF) and aspects of learning from safeguarding reviews and the ICB system response. The ICB accountabilities for safeguarding are noted by the committee which recognises the need for delivery and collaboration in the four Places; furthermore, the Quality Committee is sighted on any emerging themes and the required actions to improve and strengthen arrangements. Risks and escalations include Children In Care Health Assessments, Liberty Protection Safeguards and Court of Protection / Deprivation of Liberty Safeguards and workforce.

The geographical footprint of the ICB is such that safeguarding partners are across and inclusive of both the Cumbria, Lancashire and North Yorkshire partnership arrangements for those adults, children and families requiring support and protection. Full representation has been maintained at Safeguarding Adults Board's, Safeguarding Children's Partnership and associated subgroup meetings, to fulfil and discharge both commissioning and statutory safeguarding responsibilities. This has enabled the ICB to work with its partners to ensure learning from local and national child death and safeguarding reviews has influenced and strengthened practice.

The published Partnership arrangements and reviews can be found below:

- Cumbria: Home page (cumbriasab.org.uk) https://cumbriasafeguardingchildren.co.uk/
- Lancashire: https://www.lancashiresafeguarding.org.uk/ Lancashire Safeguarding Adults Board - Lancashire Safeguarding Children

Board https://www.blackpoolsafeguarding.org.uk/safeguarding-adults-1 https://www.blackburn.gov.uk/adult-social-care/safeguarding-adults
- North Yorkshire https://safeguardingadults.co.uk/ https://www.safeguardingchildren.co.uk/

The ICB has engaged in several initiatives across Lancashire and Cumbria to influence safeguarding practice, and has been recognised for excellence in the provision of Sudden and Unexpected Death in Children Nurse led service; it being noted as an exemplar in a parliamentary debate (Jan 2023).[1]

Engagement with and listening to children and young people, families and adults remains a priority and this year the ICB has:

- Worked directly with and listened to feedback from Children in Care and Care Leavers and activity is in progress to develop an offer for apprenticeship/employment opportunities and access to Mental Health First Aid training.
- Worked with the Safeguarding Board to; assess how to Make Safeguarding Personal, to provide assurance around compliance and understand the improvements required to strengthen care packages and the quality monitoring processes.

Going forward the work plan includes actions to address newly acquired statutory responsibilities, including significant activity to address the ICB duty to co-operate in line with the Serious Violence Duty (2022) and Domestic Abuse Act (2021),and the development and finalisation the Safeguarding and Children In Care strategies which will demonstrate the ICB commitment to listening to children and families.

*It would be very easy to use this debate to set out all the things that went wrong and could have been done better, but I want to talk about something that went really well. Emily and Darren were given a SUDC nurse, Jo Birch, who has been a real support to the family through a year that has been, quite frankly, horrific. This is something that is in place in Lancashire, but not everywhere. I take this opportunity to thank Jo for her work and share with the House her role. Jo is part of a nurse-led SUDC service. It is the first nurse-led SUCD service in the country—most are paediatric-led. The service began in 2008 and covers the whole of Lancashire. It follows each case through until the final stage of the process, which is the child death overview panel. For the first 10 years, the service was just two nurses working Monday to Friday, but since 2018 it has become a seven-day service. I am pleased to learn that there are now a couple of other nurse-led teams, although Lancashire remains the only one like it in the north of England.*

**Cat Smith MP**

## Engaging with people and communities

Public involvement is an essential part of making sure that effective and efficient health and care services are delivered; by reaching, listening to, involving and empowering our people and communities, we can ensure that they are at the heart of decision making. The NHS in Lancashire and South Cumbria is committed to putting our population's needs at the heart of all we do.

The ICB has endorsed a strategy for working with people and communities which describes an ambition to develop robust and trusted relationships which empower our citizens and communities and enable a

[1] https://hansard.parliament.uk/commons/2023-01-17/debates/766901C8-5D94-4BE9-8530-7C5087ACB9E0/SuddenUnexplainedDeathInChildhood

change in culture and behaviours. The strategy is based on ten principles for public involvement and engagement. More information on the strategy is available here.

The ICB has established a Public Involvement and Engagement Advisory Committee [35](PIEAC) to support the ICB in ensuring the voice of local people and residents is actively embedded and valued in decision making of the ICB and at all levels of the system, particularly in relation to inequalities and those who are seldom heard. The Committee will support the ICB in ensuring the principles for working with people and communities are intrinsically in place across all parts of the organisation and wider integrated care system.

PIEAC first received a report about complaints received by the ICB at their initial meeting in October 2022 as part of a wider 'Insights Report'. The committee also received this information in subsequent meetings.

The content of this report has been reviewed and more detail included from the meeting in April 2023. This meeting was also provided with the number of complaints received from the inception of the ICB in July 2022 onwards. The report content will continue to be refined but will be based around the bullet point list submitted.

Both PIEAC and Quality Committee are sub-committees of the ICB Board. The Chair of PIEAC attends both committees and is an ICB Board member. They present a 'Chair's Report' at Quality Committee which includes this information, but Quality Committee does not currently receive the written report.

More information on the work of this committee can be found in the Corporate Governance Statement later in this report. Information about PIAEC, including a Terms of Reference, the schedule of meetings and agendas can be found on the PIEAC page of the ICB website. [36]

The ICB has a single point of contact for all new complaints including those received from Members of Parliament. All formal complaints are recorded on a case management system through the ICB's Patient Experience service. The ICB has an agreed and published policy, and all complaints and responses are reviewed by the Chief Nursing Officer. Each meeting of the bi-monthly PIEAC now receives a report which covers:

- The numbers of new contacts by type and comparisons to previous months.
- A summary of the type of complaints received and details of MP activity.
- Analysis of trends and themes emerging from the cases dealt with.
- Examples of learning.

Complaints are currently handled by a combination of ICB employees and Midlands and Lancashire Commissioning Support Unit (MLCSU).

***Engagement and involvement toolkit and guidance for ICB staff***

As part of our development of the communications and engagement team, along with a robust and resilient engagement infrastructure and process, the team have developed an engagement toolkit and guidance for use by ICB teams and to support wider partnership working across the ICS, including the Provider Collaboration Board and the wider workforce.

The toolkit aims to support teams to embed the ten principles for engagement and involvement in all areas of the organisation and partnership. Alongside this, the engagement team developed a workforce training programme that complements the toolkit and guidance The training along with learning and development training will be rolled out to the wider system throughout 2023/24 and we are considering an online option for the workforce and system partners.

[35] https://www.lancashireandsouthcumbria.icb.nhs.uk/about-us/sub-committees/public-involvement-and-engagement-advisory-committee
[36] https://www.lancashireandsouthcumbria.icb.nhs.uk/get-involved/public-involvement-and-engagement-advisory-committee

### *Citizen's Panel – database of public connected to ICB*

The ICB has developed a citizen's panel of members of the public who have agreed to participate in surveys, engagement and give their insights concerning health, wellbeing and health services in Lancashire and South Cumbria. The majority of these have been through a process of opting-in to be part of the panel from previous CCG databases. This model has been presented as good practice nationally and has been adopted by a number of ICBs. At the time of this report, the membership consists of about 1,400 members from across the region. Panel members receive a monthly bulletin with opportunities to engage with the work of the ICB, and information.

In response to demand from ICB colleagues, and interest from members of the citizen's panel, we have established a Readers' Group. The group has started to review documents, information, letters and leaflets and offers suggestions on how these can be more patient and public friendly. We currently have 62 members who have joined the group. Members of the readers group have contributed to the development of the ICB priorities and strategy, and our policy on volunteer expenses and is a good example of how policies and documents can be improved with public engagement and involvement. To support the panel, we have created pages on the ICB website, along with our strategy, and plans, and it also provides a link to join the citizen's panel which will be used as part of our proposed recruitment drive: https://www.healthierlsc.co.uk/get-involved/citizen-panel . A campaign has been developed to launch a recruitment drive to increase the membership of the panel. This has been actively promoted on social media and increased activity is planned for media and through the local engagement events.

### *Engagement at Place*

Work has begun to develop the approach to establish engagement networks with local communities in places. These build on existing networks and groups and provide an opportunity for the ICB to listen to community representatives, including existing patient voice groups, and GP practice patient participation groups. We have held listening events in Barrow, Blackburn, Blackpool, Burnley, and Preston and will continue to roll out these events throughout 2023/24. In addition to this, the engagement team structure includes provision for an engagement coordinator aligned to each place within Lancashire and South Cumbria and these rolls will actively support the development of engagement networks, specific local projects and the listening events as a key part of our engagement at place.

### *Clinical and care professional leadership*

A Lancashire and South Cumbria ICB ambition is to ensure that clinical and care professional leadership is a key part of everything it does. The ICB is committed to ensuring that clinicians and care professionals play an active role in the health and care system.

In September 2021, NHSE published implementation guidance on their Clinical and Care Professional Framework (CCPL)[37] to enable a multi-professional leadership to be created within ICBs.

The ICB is currently in the process of recruiting clinical and care professional lead roles across Places and the region. Information about the Clinical and Care Professional Framework can be found on the ICB website.[38]

[37] https://www.england.nhs.uk/wp-content/uploads/2021/06/B0664-ics-clinical-and-care-professional-leadership.pdf
[38] https://www.lancashireandsouthcumbria.icb.nhs.uk/about-us/clinical-and-care-professional-leadership

### Reducing health inequality

The establishment of the ICB in July 2022 provided a platform for the Lancashire and South Cumbria health and care system to develop its approach to population health management, preventing ill health and address health inequalities. During 2022/23 the ICB has worked with partners across Lancashire and South Cumbria to refocus its approach and re-build its structure. Taking action on prevention and improve population health is a priority for the whole ICB. The context for this work has been clearly laid out in reports and planning documents issued nationally and locally in the past year:

- The first meeting of ICB (July 2022) confirmed health inequalities as a major structural challenge - "requiring sustained focus on a multi-year basis"
- The ICB's core purposes are to improve outcomes in population health and healthcare, tackle inequalities in outcomes, experience and access, enhance productivity and value for money and help the NHS support broader social and economic development.
- Prior to the establishment of the ICB the health and care partners across Lancashire and Cumbria had commissioned the Institute of Health Equity to support a Lancashire and Cumbria Health Equity Commission, chaired by Professor Michael Marmot, with members from organisations from across the Lancashire and Cumbria Region including from local government, the NHS, the VCFSE sector and universities. The commission concluded its work during 22/23, culminating in the presentation of the report to leaders in October and November 2023. The final report A Hopeful Future: Equity and the social determinants of health in Lancashire and Cumbria - IHE (instituteofhealthequity.org)[39] sets out recommendations for system-wide approaches working with partners within and beyond the NHS to achieve long-term reductions in health inequalities through action on the wider determinants of health. The recommendations have helped to shape the ICB work programme and the ICP's proposed Integrated Care Strategy.

The ICB has a comprehensive approach to improving health and tackling health inequalities. The work to start building this approach commenced as one of the accelerator programmes in preparation for the establishment of the ICB. The programme of work has become embedded within the ICB through the establishment of the Population Health Directorate and through embedding the core duties across the organisation.

The ICB is focused on driving down the inequalities in access, outcomes and experience for people in our core20plus communities in relation to the clinical priorities set out in the national Core20plus5 guidance for adults and children and through working in place-based approaches with people and their communities. Key highlights of this work are detailed below.

The ICB has made significant progress in mobilising actions in 2022/23, in line with the 2022/23 planning guidance, including:

#### *Strengthening leadership and vision*

- The establishment of leadership posts within the ICB, including the Associate Medical Director for Population Health and the Director of Population Health, in addition to a team with capacity to support work across the system and within the four places.
- The establishment of the Population Health and Health Equity Academy to provide learning and development opportunities for clinical and other professionals. A first cohort of 45 clinical leaders from PCNs are nearing completion of their intensive 9 month programme co-designed and co-delivered with the King's Fund. The Academy has also provided a series of Best Practice sessions and a number of other training and development initiatives including supporting the establishment of a quality improvement programme in collaboration with the Provider Collaborative.
- Supported Trusts in developing their health inequalities strategies and plans, leading to a growth in health inequalities-focused activities now being underway across every Trust within LSC.

[39] https://www.instituteofhealthequity.org/resources-reports/a-hopeful-future-equity-and-the-social-determinants-of-health-in-lancashire-and-cumbria

- Established funded Health Inequalities Clinical Lead posts in every Primary Care Network to take a lead in understanding needs within their communities and working with communities and partners to address needs.
- Supported people across LSC to be champions and leaders for health inequalities including, for example place-based Clinical Leads, workstream leads, Core20plus5 Ambassadors and Public Health Fellows and trainees.
- Alignment of work with the Public Health Collaborative and work on shared priorities for example refreshing and strengthening work to address tobacco dependence.

### *Enabling infrastructure and support*

- Improving access to data, analysis & intelligence tools, skills & capacity.
- A health equity-based funding formula has been developed and tested and further work has begun to adapt it for use as an ICB funding formula to underpin our plans to improve health equity.
- A variety of bids have been successful, providing additional resource to work on specific projects, including for example the successful IHI bid with the provider collaborative to embed the use of quality improvement approaches to address health inequalities with a focus on cancer.
- Work has continued within Trusts and with partners at place to embed anchor approaches and further discussions are underway to share good practice and opportunities for joint work.
- The ICB received an allocation of new funding to address health inequalities in 2022/23. This funding was allocated against the Population Health and health inequalities work detailed in this report.
- Supporting Health Inequalities Clinical Leads in PCNs & place-based teams in approaches to community development and participation to ensure we hear the voices of those who have the worst access, experience and outcomes.
- Supporting the growth of community development and participation through spreading tools, techniques & approaches, for example training a cohort of people in Art of Hosting approaches which have subsequently been deployed to facilitate conversations with communities.
- Working across the system to enable ARRs roles to become embedded and key enablers in the building of integrated teams and working towards a continuum of delivery that includes development of a more psychosocial model of care that takes a more holistic approach to supporting the health and wellbeing of a community.
- A number of specific posts have already been established to take forward specific Core 20 plus 5 priorities, including a Learning and Disabilities and Autism Health Inequalities Lead role and a Cancer Health Inequalities Lead role.

### *Accelerating preventative programmes*

The ICB has increased access to preventative programmes for those facing the greatest health inequalities, for example through:-

- Population Health Management - Clinical and demographic data has supported planning, enabling targeted interventions to prevent ill health, improve care and address variation.
- Improving early diagnosis of cancer – for example by establishing targeted lung health checks in Blackburn with Darwen, Blackpool and East Lancashire; improved surveillance of people with conditions that predispose to liver cancer.
- L&SC COVID 19 Vaccination Programme – Targeted initiatives to drive vaccine uptake within groups and communities displaying hesitancy with a focus on ethnicity, vaccination in pregnancy, deprivation and isolation, transient, homeless and asylum seekers. The vaccination programme has worked in partnership with the Local Authorities, Public Health, Integrated Care Boards, Volunteer, Faith, and Social Enterprise sectors, including the Preston Windrush Initiative, the Caribbean and African Health Network (CAHN), Lancashire Council of Mosques, the IMO Charity, and One Voice.
- Screening - Pilots to increase cervical and breast screening for people with Learning Disabilities; review of the data flows for screening in prisons; cervical insight work in the areas with lowest uptake.

- CVD – Establishing a CVD Prevention Strategy and commencing delivery of a programme of CVD prevention programmes.

***Strengthening Population Health Management***

The ICB supported the 20 per cent most deprived population, identified by the Index of Multiple Deprivation through, and "PLUS" communities/inclusion groups, for example:

- A significant programme of work is underway within the Elective Recovery Programme to understand the health inequalities across the elective workstream. A Health Inequalities Elective Recovery Network has been established and has undertaken in-depth analysis of the data. Deprivation does not appear to have a significant impact in Lancashire and South Cumbria, whereas there are evident inequalities in terms of ethnicity and age. These are now being explored and action plans being developed.
- A health inequalities approach was taken to Long Term Conditions Recovery in Primary Care, targeting particular PCNs in the Core20plus areas.
- Work has been undertaken to address key "Plus" populations including delivering significant improvements in annual health checks for people with learning disabilities and with Serious Mental Illness. Both of these are described in detail elsewhere in this report. Ethnic minorities are another key "Plus" population in Lancashire and South Cumbria and have been the focus of a number of pieces of work detailed below. At a system level there has been a focus on improving the coding so that a Population Health Management approach can be used more effectively to address inequalities for our ethnic minority population.
- An Enhanced Health Check (EHC) programme, adopting an enhanced version of the standard NHS health targeting those from the 20 per cent most deprived population and aiming to increase access to public health, lifestyle and social prescribing services such as weight management and debt support. Through this work, Primary Care Networks are detecting a greater number of people with risk factors in the Core 20 plus communities in order to increase the uptake of screening, immunisation and other preventative and support services.
- Tabletop analysis of priority and exemplar wards provided by NHSE/Improvement Equity and Health Inequality Team together with Rightcare. VCFSE partners have been commissioned to undertake an exploratory phase of work in all priority wards to understand the higher than predicted levels of non-elective admissions and a similar piece of work in exemplar wards.
- Projects focused on Core20 communities [40]to provide support, information, and advice to young people and their families who have a diagnosis of pre-diabetes or Type 2 Diabetes and to reduce the rate of increase in the numbers of young people with obesity and at risk of becoming diabetic.
- Priority wards – a programme of deep listening, building towards collaborative working between health and care teams and the populations they serve to make lasting change. Whilst the 'core20' is the starting point for this work through hyper-local approaches we seek to build stronger relationships with the communities that live there, including GRT and BAME communities and those experiencing homelessness.
- An educational / self-empowerment project for communities based upon reducing emergency admissions for children living in Core20 areas.
- Delivered winter wellness programmes using risk stratification to focus on the Core20plus communities.
- Supported community-initiated and partnership-led approaches to address the cost of living and fuel crisis.
- Work in East Burnley with the Bengali community to redesign preventative and educational programmes to be more culturally appropriate.
- Increasing the numbers and quality of the annual health checks for people with serious mental illnesses with a particular focus on addressing health inequalities Improving ethnicity recording across all services and pathways. Work is continuing to improve ethnicity data capture and improvements are being demonstrated.

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[40] https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/

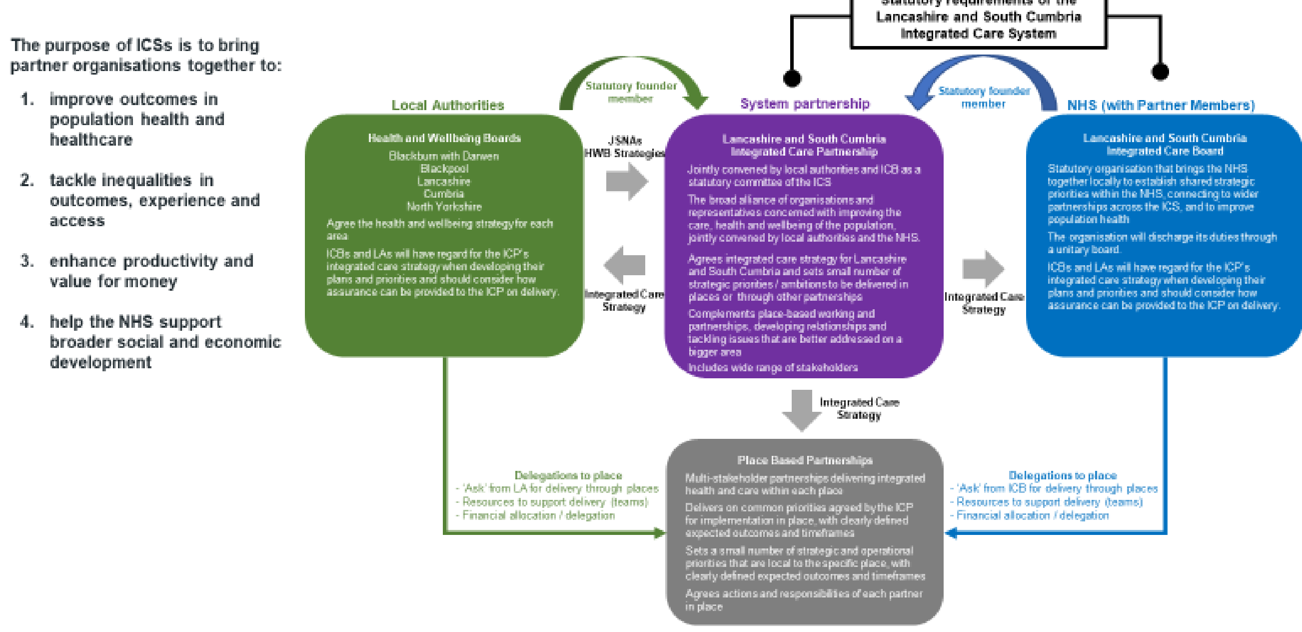
- Mitigation against digital exclusion - The ICB has worked with the VSFSE sector to support people to improve their digital maturity levels. Key areas of work include:-
- Supporting primary care services to become sustainable with digitally qualified workforce, supporting 2,317 people (2021-2022) from protected groups to improve their knowledge, skills and confidence and become lifestyle digitally included and providing case studies and videos to improve ICS workforce digital diversity. This programme is running again this year.
- Working alongside the elective care services within the acute trusts, supporting patients to improve their digital maturity and health and wellbeing (2022 -2023).

The ICB has supported a number of programmes of work to specifically enable each Primary Care Network, place or locality to better understand and work with the most vulnerable cohorts of our population to improve their access to, experience of, and ultimately outcomes of healthcare. Examples of specific areas of focus include:-

- Gypsy Roma Traveller Women in Lancaster – a significant early death rate from breast and cervical cancer was identified. Working with women from the community led to the practice redesigning screening services with GRT women, who are now working with them as community champions.
- HARRI (health, advice, recovery, resilience, information) health and wellbeing engagement vehicle, travels across Lancashire and South Cumbria to talk with the local communities and individuals, particularly targeting people in the Core20 and plus communities
- Fylde Coast:- dedicated Homeless Health Nursing Service and additional capacity to support harm reduction initiatives and assertive outreach. These services form part of a wider Homeless Health Hub. Successful bid for NHSE System Development Funding to support the development and implementation of a dedicated Homeless Mental Health Service. This is now operational. Chair the Fylde Coast Multiple Disadvantage Strategic Group. Fund 2 full time Homeless Link Workers who sit within the Hospital Discharge Team, links with above teams to facilitate timely discharge and ongoing care needs to support clients in remaining out of hospital.
- West Lancashire: PLUS groups have been identified by engaging with all the key stakeholders (GP's, WLBC, VCFS). Key PLUS groups are: asylum seekers / refugees; Farmers / growers / migrant workers; Boatees (canal boat people); Gypsy Romany Traveller; People with LD. The plan is to target these groups through a calendar of activity supported by health checking team and GP's from that PCN. Work commencing includes:- outreaching to boatees by the canalside and encouraging access to a health check using the HARRi Bus and local nearby health centres, working with Ecumencial centre and family forge to deliver drop ins for EHCs, children's health checks and women's health (cervical smears etc) for asylum seekers / refugees.
- In total 30 projects are underway, being undertaken by health Inequalities Clinical Leads in Primary Care Networks and supported by Action Learning Sets as part of the Population Health Academy.

## Health and wellbeing strategy

### A reminder of our statutory requirements and how the system works together




### *Health and Wellbeing Boards – what are they?*

Health and wellbeing boards are a formal committee of the local authority charged with promoting greater integration and partnership between bodies from the NHS, public health and local government. They have a statutory duty to, with others, produce a joint strategic needs assessment (JSNA) and a joint local health and wellbeing strategy (JLHWS) for their local population.

Local authorities covering the Lancashire and South Cumbria area have developed, and continue to update their Health and Wellbeing strategies. The ICB is involved in this through the key leads for each of the ICB's Places, through ICB executives being members of the Health and Wellbeing Boards and being involved with development sessions and workshops to review and update the Health and Wellbeing strategies.

### *Health and Wellbeing Boards in Lancashire and South Cumbria.*

There are 5 Health and Wellbeing Boards which are either entirely or partly within the Lancashire and South Cumbria ICB area:

- Blackpool Health and Wellbeing Board.[41]
- Lancashire Health and Wellbeing Board[42]
- Cumbria Health and Wellbeing Board[43]
- Blackburn with Darwen Health and Wellbeing Board[44]
- North Yorkshire Health and Wellbeing Board [45]

Reform of local authorities in Cumbria has seen the establishment of Cumberland Council and Westmorland and Furness Council. In Yorkshire, eight councils merge to become the unitary authority of North Yorkshire. These changes happened on 1 April 2023.

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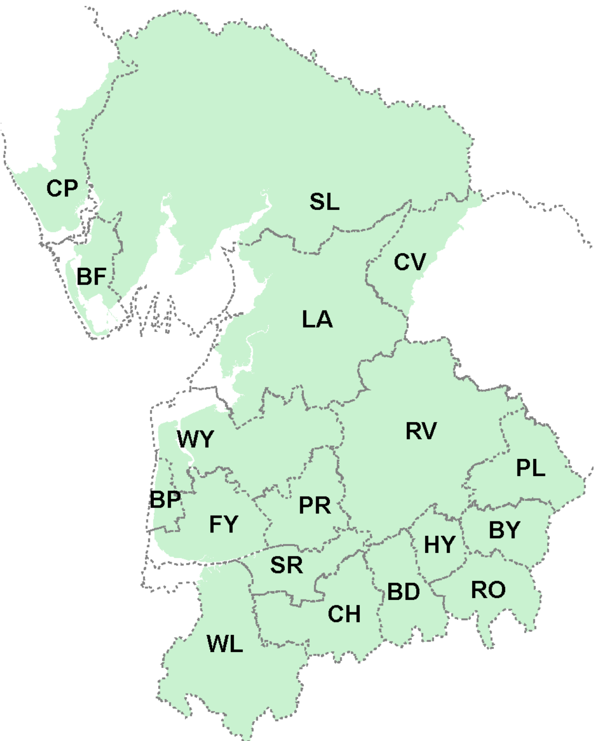
[41] https://democracy.blackpool.gov.uk/mgCommitteeDetails.aspx?ID=169
[42] https://www.lancashire.gov.uk/practitioners/health-and-social-care/health-and-wellbeing-board/
[43] https://councilportal.cumbria.gov.uk/mgChooseDocPack.aspx?ID=12148
[44] https://www.blackburn.gov.uk/health/health-strategy-and-reports/health-and-wellbeing-board
[45] https://www.nypartnerships.org.uk/hwbbstructure

Some residents of Lancashire and South Cumbria receive health services from, or in, North Yorkshire. It has been agreed that whilst there will be no member of Lancashire and South Cumbria ICB on North Yorkshire's Health and Wellbeing Board, there will be mutual engagement on matters of relevance.

Lancashire and South Cumbria ICB is represented on each Health and Wellbeing Board, except for North Yorkshire, by an ICB Director. During the year Councils have been refreshing the health and wellbeing strategies and Place leads have been involved in this work. Health and Wellbeing Boards have received updates on the establishment of the ICB and the development of its ways of working in Place and its Joint Forward Plan which is on track to be published by 30 June 2023. ICB representatives have been actively involved in shaping JLHWS. They have helped to ensure consistency and coherence across wider system strategies and to identify key areas requiring stronger focus, such as mental health and preventing homelessness.

## 5. Lancashire and South Cumbria Integrated Care System / ICB / ICP




Caption: Area encompassed by Lancashire and South Cumbria overlain by counties. Postcode area CV is in North Yorkshire.

### *Relationships*
Integrated Care Board and Integrated Care Partnership leaders, informed by the people in their local communities, need to have regard for and build on the work of Health and Wellbeing Boards to maximise the value of place-based collaboration and integration, and reduce the risk of duplication. They should ensure that actions are coordinated, add and are taken in the light of a common understanding of what is best for their population.

The Integrated Care Partnership (ICP) is a statutory joint committee of the ICB and each responsible local authority (upper tier and unitary) within the Lancashire and South Cumbria area. Membership of our ICP includes elected members from local authorities.

### *Developing plans*

The Health and Care Act 2022 requires ICPs to develop an Integrated Care Strategy which details how the assessed needs of the population, as identified in joint strategic needs assessments (JSNAs), will be met by the exercise of functions by the ICB, partner Local Authorities, and NHS England. This strategy is described in NHS England (NHSE) guidance as setting "the direction of the system … setting out how the NHS and local authorities, working with providers and other partners, can deliver more joined-up, preventative, and person-centred care for their whole population, across the course of their life".

A draft integrated care strategy was developed during the latter half of 2022/23, and the final version will be agreed by the ICP in April 2023/24. The JSNAs and existing Joint Health and Wellbeing Strategies were key to the creation of the integrated care strategy, ensuring that it was shaped around the needs of our residents.

The ICB must have regard to, and ensure alignment with, this integrated care strategy as it develops its own strategic and operational plans. Early in 2023, the ICB developed its Joint Forward Plan which starts to set out the ICBs response to agreements with Local Authority partners as set out in the integrated care strategy.

An example of collaboration and coordination can be seen in the sharing of population health intelligence by the ICB Population Health Team with the BwD JSNA Partnership Group to ensure that this informs the JSNA and vice versa.

For information, individual JSNAs can be found here:

- JSNA Cumbria[46]
- JSNA Lancashire[47]
- JSNA Blackpool[48]
- JSNA Blackburn with Darwen[49]
- JSNA North Yorkshire [50]

[46] https://www.cumbriaobservatory.org.uk/jsna/
[47] https://www.lancashire.gov.uk/lancashire-insight/jsna/
[48] https://www.blackpooljsna.org.uk/Home.aspx
[49] https://www.blackburn.gov.uk/health/health-strategy-and-reports/joint-strategic-needs-assessment
[50] https://www.datanorthyorkshire.org/JSNA/JSNA

## Financial review

### Performance Summary

Over the last year we have tracked the progress of our service providers (for example local hospitals, community services, primary care practices) against several national outcomes indicators and ensured that patient rights within the NHS Constitution were maintained. Additionally, we set local priorities against which provider progress was monitored. Performance reports were presented to and scrutinised the Finance and Performance Committee and a summary of key issues presented to the Governing Body.

### Financial Key Performance Indicators

The ICB's performance is measured against a number of financial key performance indicators as outlined below:

| Key performance indicator | Target | Actual | Result |
|---|---|---|---|
| **Revenue resource use does not exceed the amount specified in Directions** | Maintain expenditure within the allocated in-year resource of £3,043.2m | Total expenditure £3,043.2m | Achieved |
| **Maintain expenditure within cash funding received** | Net cash funding received<br>£3,054m | Cash Remaining at 31 March 2023<br>£0.58m | Achieved |
| **Revenue administration resource use does not exceed the amount specified in Directions** | Maintain administration (running costs) expenditure within the allocated resource of £26.5m | Total administration (running costs) expenditure £26.4m | Achieved |
| **QIPP savings targets identified and savings achieved** | Overall QIPP savings target £50.9m | Total QIPP savings £26.2m | Not achieved (shortfall covered by other mitigations - additional allocations and underspends in other areas) |
| **Capital resource does not exceed the amount specified in Directions** | Maintain expenditure within the allocated in-year resource of £3.5m | Total expenditure £3.4m | Achieved |
| **Comply with the Better Payment Practice Code (BPPC)** | Ensure 95% (by value and volume) of all valid invoices are paid by the due date or within 30 days of receipt of a valid invoice, whichever is later | NHS payables:<br>- 99.7% by value<br>- 99.3% by volume<br>Non-NHS payables:<br>- 97.2% by value<br>- 99.5% by value | Achieved |

## Financial review

As a result of the ICB only becoming a statutory body on 1 July 2022, this report only covers the 9-month period from July to March of the 2022/2023 financial year.

The first 3-month period from April to June was reported by the former eight Lancashire and South Cumbria CCGs. As CCGs had to report a breakeven position at 30 June 2022, NHS England made adjustments to individual CCG allocations in month 3 to cover any deficits and to ensure that overall allocation and expenditure were matched. To ensure financial balance across the whole financial year under this arrangement, NHS England made a compensating adjustment to the ICB allocation.

For the financial year 2022/23, the previous arrangement under which NHS providers were paid a nationally determined monthly 'block' contract payment was continued, to enable a measure of financial stability for all parties.

The following section provides a brief overview of the ICB's financial performance in the 9-month period of 2022/23. The financial accounts have been prepared under a Direction issued by NHSEI under the National Health Service Act 2006 (as amended). A full set of accounts, including associated certificates, is included later in this report.

## Allocation

As described above, the total in-year allocations to NHS Lancashire and South Cumbria ICB for 2022/23 relate to the 9-month period from July to March and were as follows:

- We received allocations totalling £2,719.5m for commissioning NHS services for the local community
- We received a further allocation of £236.7m for delegated commissioning of primary care medical services
- We received a further allocation of £34.5m for delegated commissioning of pharmacy services
- We received a further allocation of £26.5m from which we were expected to cover all our running costs

## 2022/23 financial duties

The ICB's performance against each of its financial duties, as reported in Note 2 to the Accounts, for the 9-month period from July to March 2022/23 financial year was as follows:

- The ICB remained within its cash limit.
- The ICB maintained its administration expenditure within its Running Costs Allowance.
- The ICB remained within its capital resource limit.

## Financial Performance

We have faced a number of financial pressures during the 9-month period from July to March 2022/23, including the inherited position from the former eight CCGs. The revised financial regime first introduced in 2020/21 to assist organisations in dealing with the Covid-19 pandemic, was largely replaced by a return to business-as-usual arrangements, with no additional funding for the Hospital Discharge Programme and the majority of other Covid-19 related expenditure being funded from within ICB allocations. The block contract arrangements in place with NHS providers for the previous two financial years have been maintained and adapted to cover payments to providers outside of the Integrated Care Board boundary, such that any contract values above £0.500m with individual providers are subject to a formal contract, with any below that value covered by Low Value Activity (LVA) arrangements, both of which are determined at an aggregated Integrated Care Board level.

As part of the planning process, the ICB was expected to make Quality, Improvement, Productivity and Prevention (QIPP) savings during the year, based on an ICS system agreed percentage of allocation. The ICB's overall target for the 9-month period was £50.9m but, due to the constraints imposed by the introduction of the block payments to providers as part of the revised financial regime, the only schemes able to deliver significant savings were in medicines management and continuing healthcare. Overall, the ICB's delivery against these efficiency plans realised savings of £26.2m, with the shortfall having

been covered by unplanned underspends in some areas and other mitigations to ensure a breakeven position could be reported, as described above.

### Analysis of Covid-19 expenditure

The CCG received no additional allocations to cover expenditure incurred as a result of the Covid-19 pandemic during the first quarter of the financial year.

### Analysis of EU exit related expenditure

The CCG has not incurred any additional costs in relation to the UK exit from the EU and has not been in receipt of any additional funding.

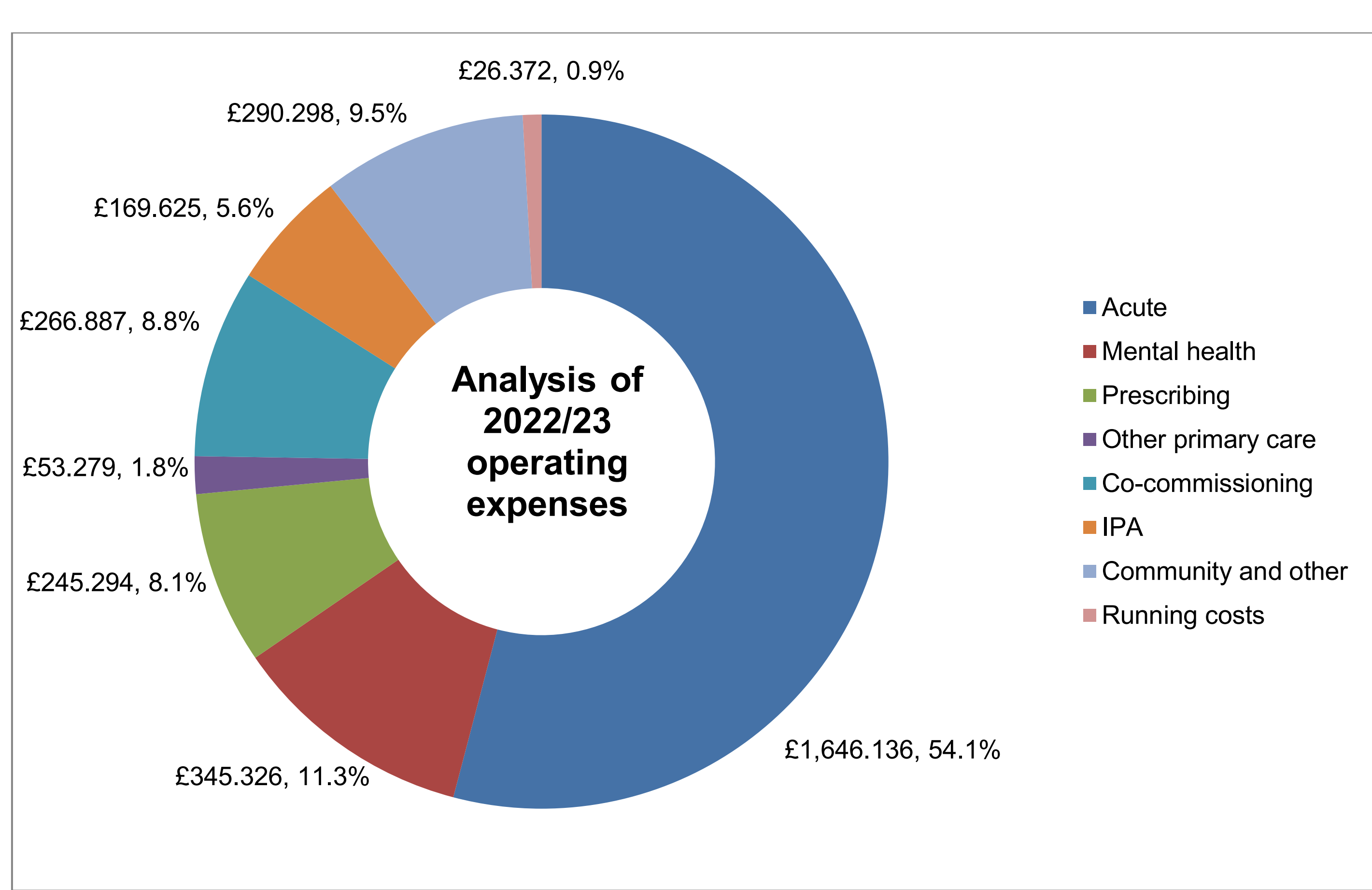
### Accounting policies

The ICB's accounting policies are shown in full in Note 1 to the Annual Accounts. Following the Health and Care Act receiving Royal Assent on 28 April 2022, which allowed for the establishment of Integrated Care Boards across England and the abolition of CCGs, the ICB took on the commissioning functions of the eight former CCGs as the successor body. As a result, the functions, assets and liabilities of the eight former CCGs transferred to the Lancashire and South Cumbria ICB on 1 July 2022. The accounting policies follow International Financial Reporting Standards (IFRS) to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury.

We have made no changes to accounting estimates during the 9-month period from July to March of the 2022/23 financial year, however, as described above, the ICB has continued to contract with NHS providers on a block basis and payments have therefore, in general, been fixed irrespective of levels of activity undertaken.

Further details of accounting estimates made are reported in Note 1.33 to the Accounts, "Critical accounting judgements and key sources of estimation uncertainty".

### Analysis of 2022/23 operating expenses



# ACCOUNTABILITY REPORT

**Kevin Lavery**

**Chief Executive Officer**

29th June 2023

# Accountability Report

The Accountability Report describes how we meet key accountability requirements and embody best practice to comply with corporate governance norms and regulations.

It comprises three sections:

The **Corporate Governance Report** sets out how we have governed the organisation during the period 1 July 2022 to 31 March 2023, including membership and organisation of our governance structures and how they supported the achievement of our objectives.

The **Remuneration and Staff Report** describes our remuneration polices for executive and non-executive directors, including salary and pension liability information. It also provides further information on our workforce, remuneration and staff policies.

The **Parliamentary Accountability and Audit Report** brings together key information to support accountability, including a summary of fees and charges, remote contingent liabilities, and an audit report and certificate.

## Corporate Governance Report

Lancashire and South Cumbria ICB was established on 1 July 2022. Prior to establishment there were eight Clinical Commissioning Groups (CCGs) within Lancashire and South Cumbria; these were abolished at midnight on 30 June 2022 at which stage all statutory functions, along with assets, liabilities and staff transferred to the ICB under a statutory transfer order. Due diligence was undertaken prior to the transfer, and CCG accountable officers provided written assurance of completed due diligence to NHS England.

This first financial period is one of transition and as such was a developmental period for the ICB. The complexity of reviewing and managing the eight CCGs systems, processes, operational policies, contracts, data, assets and liabilities into one operating model and governance framework has been an enormous undertaking, and there are still areas to align. The context in which the ICB is operating, given its size, demographics and in-year establishment has been challenging in our first nine months, and there are still areas for the ICB to improve and build on. The ICB inherited differing systems and processes from the predecessor CCGs such as three IT providers, eight financial ledgers, differing payroll providers and a varying model of commissioning support unit service level agreements across various functions transferred from CCGs.

Each predecessor CCG had differing risk management approaches and processes, and whilst the ICB agreed its strategic objectives and board assurance framework in December 2022, risk management is still to be fully embedded into the organisation and the board has still to agree its risk appetite statement. This will be a key priority in early 2023/24.

Understanding and mitigating risks within the ICB and the wider Integrated Care System across Lancashire and South Cumbria is a key factor to supporting the ICB in delivering its strategic objectives. Developing a level of openness, honesty, collaboration, and trust between system partners in risk management approaches is an important part of the system's maturity. This will be an area of focus for the ICB in 2023/24.

The ICB inherited a challenging aggregated financial position from the eight CCGs along with a reduction in allocations to reflect the convergence adjustment and reduced funding for Covid related costs incurred by providers. Despite this challenging starting position, the ICB has successfully managed a high level of risk to deliver a balanced year end position, with the Board and Finance and Performance Committee being routinely updated on progress against the mitigation plan.

The board and its committees were newly established on 1 July 2022, and recognising the need for development, various workshops have been held for each to build a common understanding of purpose and a cohesive approach to decision making for each, and to build relationships and trust within and across each membership group. The Board maintained direct oversight of the ICB's and system partner's financial position in the first four months of establishment, and as the organisation matured this was transferred in November to the Finance and Performance Committee.

A full staff consultation has been undertaken in our first financial year, to ensure our staff have a sense of belonging and to align our workforce to the priorities and delivery plans of the ICB. This has been a challenging and time-consuming exercise that has impacted on the progression of joined-up working across the ICB and the capacity to develop our new ways of working and embed our governance structures.

The ICB's operating model is still emerging and no delegations outside of the board, committees, or ICB executive officers have been progressed in the period of this annual report. An early review of Places in July 2022 led to a reconfiguration from five places to four to fully align to our local authorities, and whilst this slowed the development of our places, 2023/24 will see a devolvement strategy progressed at pace.

Our focus for the coming financial year will incorporate a full review of governance arrangements, including assessing where assurances can be strengthened to the board and across the committees, whilst accelerating the delegation of functions and resources to our four Places, underpinned by place-level governance arrangements.

## Members Report

The Board has established a number of committees and full details of the board and its committees can be found within the Governance Statement of this annual report.

### *Member practices*

There are currently 198 GP Practices across the ICB footprint. The list of Providers of Primary Medical Services is held in the Governance Handbook and can be accessed via the following link:

Appendix_F_Eligible_Providers_of_Primary_Medical_Services.pdf (healthierlsc.co.uk) [51]

### *Register of Interests*

The ICB holds a register of interests for the board, each committee and all individuals who are engaged by the ICB. Registers for the board, committees and those defined as decision making staff are published here: LSC Integrated Care Board :: Lists and registers (icb.nhs.uk) and are available on request at the ICB Headquarters.

### *Personal data related incidents*

There have been no Information Governance incidents in the period of this annual report that met the criteria for reporting through the Data Protection and Security Toolkit to the Information Commissioner's Office.

### *Modern Slavery Act*

NHS Lancashire and South Cumbria ICB fully supports the Government's objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking Statement for the period ending 31 March 2023 is published on our website at LSC Integrated Care Board :: Modern slavery statement (icb.nhs.uk)[52]

[51] Appendix_F_Eligible_Providers_of_Primary_Medical_Services.pdf (healthierlsc.co.uk)
[52] LSC Integrated Care Board :: Modern slavery statement (icb.nhs.uk)

## Statement of Accountable Officer's Responsibilities

Under the National Health Service Act 2006 (as amended), NHS England has directed each Integrated Care Board to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Lancashire and South Cumbria Integrated Care Board and of its income and expenditure, Statement of Financial Position and cash flows for the financial period.

In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts; and,
- Prepare the accounts on a going concern basis; and
- Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

The National Health Service Act 2006 (as amended) states that each Integrated Care Board shall have an Accountable Officer and that Officer shall be appointed by NHS England.

NHS England has appointed Kevin Lavery as the Chief Executive to be the Accountable Officer of Lancashire and South Cumbria Integrated Care Board. The responsibilities of an Accountable Officer, including responsibility for the propriety and regularity of the public finances for which the Accountable Officer is answerable, for keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Integrated Care Board and enable them to ensure that the accounts comply with the requirements of the Accounts Direction), and for safeguarding the Lancashire and South Cumbria Integrated Care Board's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities), are set out in the Accountable Officer Appointment Letter, the National Health Service Act 2006 (as amended), and Managing Public Money published by the Treasury.

As the Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that Lancashire and South Cumbria Integrated Care Board's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

Kevin Lavery
Chief executive officer
29 June 2023

## Governance Statement

### Introduction and context

NHS Lancashire and South Cumbria Integrated Care Board (ICB) is a body corporate established by NHS England on 1 July 2022 under the National Health Service Act 2006 (as amended).

The ICB's statutory functions are set out under the National Health Service Act 2006 (as amended).

The ICB's general function is arranging the provision of services for persons for the purposes of the health service in England. The ICB is required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its population.

Between 1 July 2022 and 31 March 2023, the Integrated Care Board was not subject to any directions from NHS England issued under Section 14Z61 of the of the National Health Service Act 2006 (as amended).

### Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Lancashire and South Cumbria ICB's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in the NHS Lancashire and South Cumbria ICB's Accountable Officer Appointment Letter.

I am responsible for ensuring that the NHS Lancashire and South Cumbria ICB is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within the ICB as set out in this governance statement.

### Governance arrangements and effectiveness

The main function of the Board is to ensure that the organisation has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically, and complies with such generally accepted principles of good governance as are relevant to it. The following sections provide details of how this has been achieved.

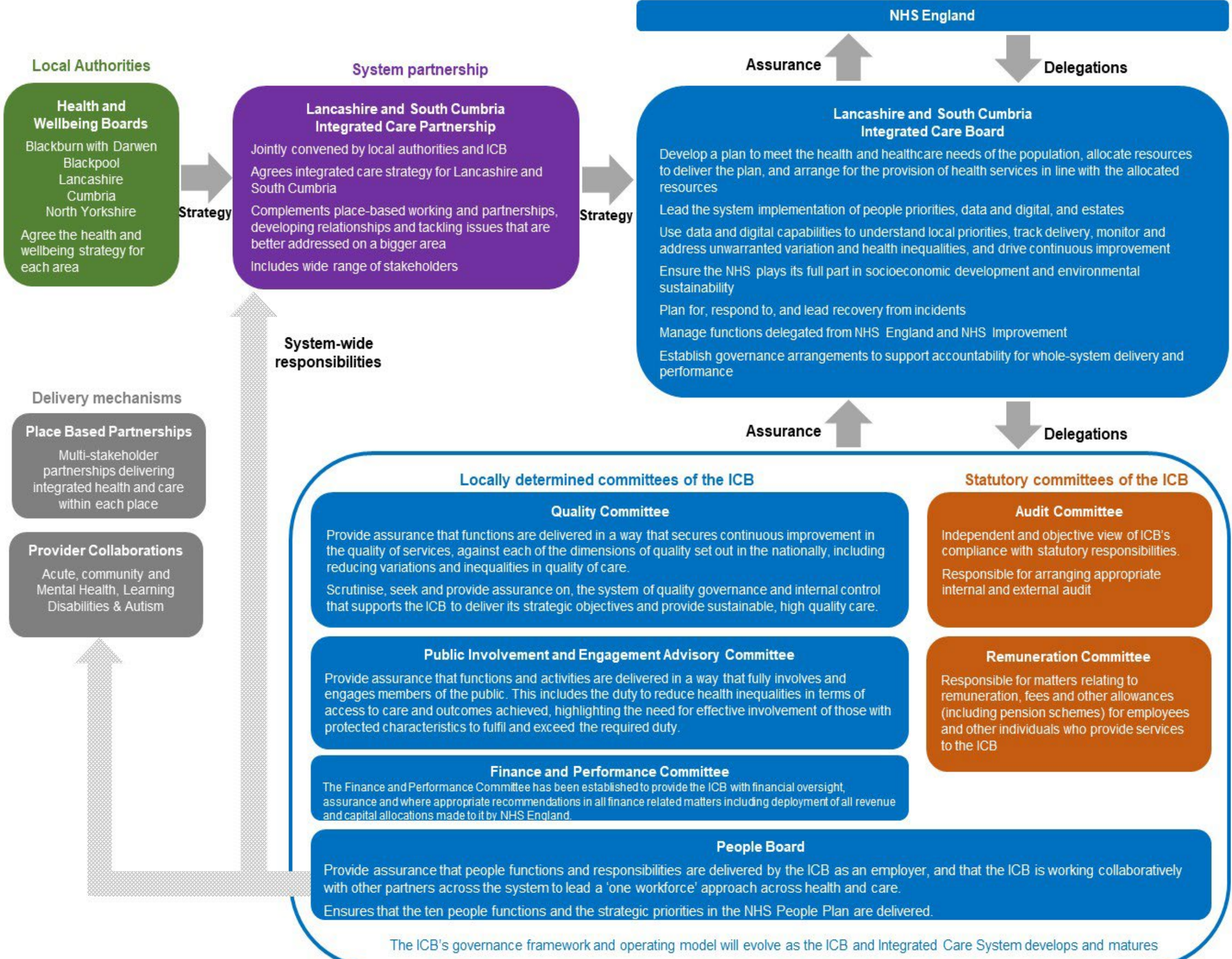
### Constitution and Governance Handbook

The ICB's Constitution describes how we organise ourselves together to provide the best health and care, ensuring that decisions are always taken in the interest of the patients and public we serve. The Constitution is underpinned by the duty that requires NHS bodies to consider the effects of their decisions on the health and wellbeing of the people of England, the quality of services and the sustainable and efficient use of resources.

The Constitution incorporates the ICB's Standing Orders, which form a central part of the ICB's governance framework.

The ICB's Governance Handbook brings together all the ICB's governance documents, and includes:

- A Scheme of Reservation and Delegation which sets out key functions reserved to the board of the ICB; functions delegated to committees and individuals; functions delegated jointly or outside of the ICB, and any functions delegated to the ICB
- Financial scheme of delegation
- Standing Financial Instructions – which set out the arrangements for managing the ICB's financial affairs
- Terms of Reference for all committees of the Board or joint committees of the ICB
- Delegation arrangements where ICB functions are delegated in accordance with section 65Z5 of the 2006 Act
- Key policy documents
- A Functions and Decisions Map, which is a high-level structural chart that sets out the committees of the ICB, and where decision making is taken by which part or parts of the Integrated Care System:




The ICB's constitution and governance handbook can be accessed via the following link:

Corporate Governance Handbook [53]

[53] https://www.lancashireandsouthcumbria.icb.nhs.uk/about-us/how-we-work/corporate-governance-handbook

The mechanisms described above have enabled the Board and its committees to take the effective decisions as described in the next section of this report.

### The Board

The Integrated Care Board is a unitary board, and its members are collectively accountable for the performance of the ICB's functions.  The board is responsible for:

- formulating a plan for the organisation
- holding the organisation to account for the delivery of the plan; by being accountable for ensuring the organisation operates effectively and with openness, transparency and candour and by seeking assurance that systems of control are robust and reliable
- shaping a healthy culture for the organisation and the system through its interaction with system partners.

The appointment process for board members varies according to the role they undertake and the appointment process specific to each role is specified in detail within section 3 of the ICB's constitution.  In accordance with paragraph 3 of Schedule 1B to the 2006 Act, membership of the Board must consist of at least a Chair; a Chief Executive and at least three Ordinary Members.  NHS England policy requires the ICB to appoint the following additional Ordinary Members:

- Three executive members, namely:
- Chief Finance Officer
- Medical Director
- Chief Nurse
- At least two Non-executive Members

The Ordinary Members must include at least three members who will bring knowledge and a perspective of their sectors.  These members are known as Partner members, who are jointly nominated by their respective organisations.

#### *Composition of the Lancashire and South Cumbria Integrate Care Board*

The Board is made up of 14 members:

| Board Member | Position |
|---|---|
| David Flory CBE | Chair |
| Kevin Lavery | Chief Executive |
| Professor Ebrahim Adia<br>(From 1 September 2022) | Non-Executive Member |
| Jim Birrell | Non-Executive Member |
| Sheena Cumiskey | Non-Executive Member |
| Roy Fisher | Non-Executive Member |
| Professor Jane O'Brien | Non-Executive Member |
| Dr David Levy | Medical Director |
| Professor Sarah O'Brien | Chief Nurse |
| Samantha Proffitt | Chief Finance Officer |
| Caroline Donovan<br>(From 1 July 2022 - 30 Sept 2022) | Partner Member, Mental Health Services |
| Chris Oliver<br>(From 1 October 2022 to date) | Partner Member, Mental Health Services |
| Dr Geoff Jolliffe | Partner Member, Primary Medical Services |
| Kevin McGee | Partner Member, NHS Trusts |
| Angie Ridgwell | Partner member, Local Authority |

The ICB is committed to tackling health inequalities and ensuring its board membership brings a balance of perspectives and the Board is made up from diverse individuals, backgrounds and perspectives to all the best decisions for its communities.

The Chair of the board keeps under review the skills, knowledge and experience considered necessary for members of the board to possess collectively in order for the board to carry out its functions effectively and take such steps to address or mitigate any shortfalls.

### *Regular Participants*

Participants are individuals who the board invite to make an informal contribution to their discussions on a regular basis. These individuals are invited to all meetings, receive copies of the papers and may take part in discussions. Because they are not a member, they cannot vote, and they have no accountability for decisions made by the board. Since establishment, the board has invited the following regular participant to board meetings:

| Regular Participant | Position |
|---|---|
| David Blacklock | Healthwatch Chief Executive |
| Debbie Corcoran | Non-Executive/Chair of Public Involvement and Engagement Advisory Committee |
| James Fleet | ICB Chief People Officer |
| Professor Craig Harris | ICB Chief of Health and Care Integration |
| Tracy Hopkins | Chief Executive Officer – Citizens Advice, Blackpool representing Voluntary, Community, Faith and Social Enterprise sector |
| Maggie Oldham | ICB Chief Planning, Performance and Strategy Officer/Deputy Chief Executive |
| Asim Patel | ICB Chief Digital Officer |
| Abdul Razaq | Director of Public Health |
| John Readman | Director of Adult and Social Care Services |

The board is quorate if nine members are present, including at least four independent members, either the Chief Executive or the Chief Finance Officer, two clinical members and one partner member.

The board has met in public on eight occasions between 1 July 2022 and 31 March 2023. All meetings were fully quorate, and all meetings held in public. Other than the first day board meeting on 1 July 2022 all meetings have been livestreamed.

Attendance at Board Meetings for the period 1 July 2022 to 31 March 2023:

| Member | 1 July 2022 | 27 July 2022 | 7 Sept 2022 | 12 Oct 2022 | 2 Nov 2022 | 7 Dec 2022 | 1 Feb 2023 | 29 March 2023 |
|---|---|---|---|---|---|---|---|---|
| David Flory CBE | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Kevin Lavery | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Professor Ebrahim Adia | - | - | x | ✓ | ✓ | ✓ | ✓ | x |
| Jim Birrell | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Sheena Cumiskey | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Roy Fisher | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Professor Jane O'Brien | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Dr David Levy | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Professor Sarah O'Brien | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Samantha Proffitt | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Caroline Donovan | ✓ | x | x | - | - | - | - | - |
| Chris Oliver | - | - | - | ✓ | ✓ | ✓ | ✓ | ✓ |
| Dr Geoff Jolliffe | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Kevin McGee | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Angie Ridgwell | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | x |

### *Board Performance*

In readiness for establishment on 1 July 2022, designate board appointments commenced in quarter four of 2021 and quarter one of 2022. As a new statutory body on 1 July 2022, the Chair of the Board approved the appointment of the Accountable officer. The Chair and Accountable Officer then approved the appointments of all other board members and the board met for its first meeting to agree and establish the core governance documents and arrangements and committees of the board.

Each meeting begins with a patient story, that sets the focus of the meeting and allows the board to reflect on where both learning and good practice can be shared.

To ensure the board had direct oversight of the ICB's and system partner's financial position as the ICB matured, the Chair and the Chief Executive Officer took a decision to not establish a Finance and Performance Committee for the first part of the year. Several private sessions have been held with the Board over this period, including Board to Board sessions with providers, to focus on the financial position, given the level of risk in terms of the ICB and the wider system position.

Each meeting held in public includes a report from the Chief Executive, a finance report, and a performance report.

Within its first nine months the Board has reviewed and approved significant areas of business including:

- System diagnostic: Inherited risks and issues, strategic aims, and early priorities for the Integrated Care Board
- Place-based Partnerships: Review of configuration from five to four to be conterminous with local authority boundaries
- Continuing Health Care: Transformation of Model of Delivery
- Establishment of the Lancashire and South Cumbria Health and Care Partnership and Development of our Integrated Care Strategy
- Emergency Preparedness, Resilience and Response Polices and Plans

- In lieu of Lancashire and South Cumbria Clinical Commissioning Group Annual General Meetings, the Annual Reports and Accounts for 2021/22 were collectively brought to the ICB Board to note and publish on the ICB's website
- Annual Review of Declarations of Interest Registers
- Risk Management Strategy and Policy, including the ICB's proposed Strategic Objectives and Board Assurance Framework
- Urgent and Emergency Care Board Assurance Framework and Winter Resilience Plans
- Transformation Programmes: Progress Update
- Operating Model for the ICB and Provider Collaborative Board
- State of Our System Annual Report
- Draft Lancashire and South Cumbria NHS Joint Forward Plan
- High-level budget for 2023/24
- Specialised Commissioning: Joint Working Arrangements
- ICB Green Plan and Sustainability Strategy
- 2022/23 financial plan

The board has also received updates on the following areas:

- Deep dives on Primary Care Access, Cancer, Urgent and Emergency Care, Learning Disability and Autism
- Reading the signals Maternity and Neonatal Services in East Kent – the Report of the Independent Investigation
- Quality of Mental Health, Learning Disability and Autism Inpatient Services – Response to National Director
- Patient Safety Incident Response Framework
- Cancer Recovery Plan
- Finance Monthly Position Reports

The board has met informally on five occasions, and development sessions took place over the period.

These focused specifically on development of the ICB, with an emphasis on:

- Board Seminar: Health Equity Commission
- Setting Our Strategic Objectives and Approach to Risk Management
- Non-Executive Session: Fraud, bribery and corruption, cyber fraud techniques and conflicts of interest / gifts and hospitality
- Board Seminar: Making Data Count and Information Governance
- Strategic Intent: Five Year Joint Forward Plan and Three Year Financial Strategy

The board has also held board to board sessions with University Hospitals Morecambe Bay NHS Foundation Trust, Blackpool Teaching Hospitals NHS Foundation Trust, and Lancashire Teaching Hospitals NHS Foundation Trust with the focus being specific to the position of each Trust

Agendas, papers and place and time for each meeting in public are published on the ICB website seven days in advance of the meeting, and members of the public are able to attend to observe the meeting and can submit public questions for items relating to the agenda. Further details can be accessed via the following link:

LSC Integrated Care Board :: Meetings and papers (icb.nhs.uk)

### *Committees of the Board*

To support the board in carrying out its duties effectively, a number of committees reporting to the board have been formally established. Each committee receives and considers regular reports, as outlined within their Terms of Reference. The minutes of the meetings are presented to the Board, and they also provide highlight reports to board in the form of 'Triple A' reports; Advise, Assure and Alert.

Given that each committee has been newly formed, preparatory sessions, workshops and informal meetings have been held at varying levels across each committee. All committees of the board are chaired by a non-executive board member and the non-executives meet regularly to discuss any areas of concern.

At its first day board meeting on 1 July 2022, the following committees were established:

Statutory committees

- Audit Committee
- Remuneration Committee

Non-statutory committees

- Remuneration Panel
- Quality Committee
- People Board
- Public Involvement and Engagement Advisory Committee (PIEAC)

Other decision making groups

- Primary Care Contracting Group

Since establishment a further committee was established on 28 November 2022:

- Finance and Performance Committee

Ratified committee minutes are formally recorded and submitted to the Board in its meeting in public, wherever possible as soon as practicable after the meetings have taken place.

As a final agenda item, the committees are asked to consider which matters should be presented to the board in the form of an Alert/Assure/Advise, (AAA), report. This allows for business to be rapidly escalated to the Board. The chair of each committee is also invited to provide verbal updates at each board meeting.

### *Audit Committee*

The Audit Committee is a statutory committee of the ICB in accordance with its Constitution. It is a non-executive chaired committee and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

The Audit Committee contributes to the overall delivery of the ICB objectives by providing oversight and assurance to the Board on the adequacy of governance, including quality governance, risk management and internal control processes within the ICB. The duties of the committee are driven by the organisation's objectives and the associated risks. The committee agrees an annual audit plan with sufficient flexibility to be able to respond to new and emerging priorities and risks.

The Audit Committee has no executive powers, other than those delegated in the Scheme of Reservation and Delegation and specified in its terms of reference. The Board approved the Terms of Reference for the Audit Committee, which includes its membership.

During 2022/23, there was a requirement for the Audit Committee to have responsibility and oversight of the Quarter 1 (April to June 2022) former CCG's Annual Reports and Accounts process for submission in June 2023. A co-opted independent lay member joined the Audit Committee to provide oversight and advice in this respect.

The Audit Committee agreed a workplan for 2022/23 which was regularly monitored and updated as required.

### Audit Committee Membership

| Member | Position |
|---|---|
| Jim Birrell | Non-Executive Member (Chair) |
| Sheena Cumiskey | Non-Executive Member |
| Roy Fisher | Non-Executive Member |
| Ian Cherry | Co-opted Independent Lay Member |

The chair of the committee is also the ICB's Conflicts of Interest Guardian.

The committee met four times over the 9-month period and all meetings were fully quorate. The quorum necessary for the transaction of business is two members.

### Attendance at Audit Committee meetings for the period 1 July 2022 to 31 March 2023:

| **Member** | 26 July 2022 | 29 September 2022 | 15 December 2022 | 16 March 2023 |
|---|---|---|---|---|
| Jim Birrell | ✓ | ✓ | ✓ | ✓ |
| Sheena Cumiskey | ✓ | ✓ | ✓ | ✓ |
| Roy Fisher | ✓ | ✓ | ✓ | ✓ |
| Ian Cherry | ✓ | ✓ | ✓ | ✓ |

### Audit Committee Performance

The Audit Committee has an annual workplan that incorporates the review of reports and positive assurances from Executives, managers, Internal Audit and External Audit on the overall arrangements for governance, risk management and internal control. Significant items that were considered during 2022/23 are shown below:

### Governance, risk management and internal control:

- Appointment of internal and external auditors
- ICB policies for risk management, managing conflicts of interest (including gift and hospitality), Freedom to Speak Up (policy and system approach) and core financial policies
- Board Assurance Framework and Corporate Risk Registers
- ICB registers of interests, gifts and hospitality and procurement decisions
- Single tender waivers
- Losses and special payments
- Standardisation of financial systems and controls
- ICB Q2-Q4 2022/23 Annual Report and Annual Governance Statement
- Predecessor CCG Q1 Annual Report assurance and 3 months accounts

- Information Governance Assurance Reports
- Review of Audit Committee Terms of Reference

Internal Audit (MIAA):

- Internal audit plan and progress reports
- Completion of checklist reviews against core controls including conflicts of interest, governance, quality governance, risk management, financial sustainability
- The Internal Audit Network Insight Reports
- Interim Head of Internal Audit Opinion for all 8 predecessor CCGs and the ICB
- Assurance reports to the committee and onward reporting to the Board

External Audit (KPMG):

- ICB Audit Plan and Strategy Overview for 9 months from 1 July 2022 to 31 March 2023
- ICB Audit Plan and Strategy Overview for 3 months ending 30 June 2022
- Health Technical Updates
- Assurance reports to the committee and onward reporting to the Board

External Audit CCG Q1 Accounts

Grant Thornton LLP undertook the audit work for 5 of the Lancashire and South Cumbria CCGs, namely

- NHS Blackburn with Darwen CCG
- NHS East Lancashire CCG
- NHS Chorley and South Ribble CCG
- NHS Greater Preston CCG
- NHS West Lancashire CCG

KPMG undertook the audit work for 3 of the Lancashire and South Cumbria CCGs, namely

- NHS Morecambe Bay CCG
- NHS Blackpool CCG
- NHS Fylde and Wyre CCG

Anti-fraud (MIAA):

- Annual work plan and progress reports
- ICB Anti-Fraud, Bribery and Corruption Policy and Response Plan

The terms of reference of the Audit Committee were reviewed upon establishment and can be accessed via the following link:

LSC Integrated Care Board :: Corporate Governance Handbook (icb.nhs.uk) [54]

[54] https://www.lancashireandsouthcumbria.icb.nhs.uk/about-us/how-we-work/corporate-governance-handbook

### *Remuneration Committee*

The Remuneration Committee is a statutory committee of the Board in accordance with its Constitution. It is a non-executive committee of the Board and its members are bound by the Standing Orders and other policies of the ICB.

The committee's main purpose is to exercise the functions of the ICB relating to paragraphs 18 to 20 of Schedule 1B to the NHS Act 2006. In summary:

- Confirm the ICB Pay Policy including adoption of any pay frameworks for all employees including senior managers/directors (including board members) but excluding the Chair and Non-Executive Members of the board.
- Where matters are discussed relating to Non-Executive Members of the ICB, a Remuneration Panel has been established and will be convened under its own Terms of Reference.
- The Board has also delegated the following functions to the Committee:
    - Elements of the nominations and appointments process for Board members
    - Oversight of executive directors' performance and appraisal

The committee meets in private at least twice a year and membership comprise three Non-Executive Board Members. During 2022/23 the committee met on eight occasions and was quorate for each meeting.

#### Remuneration Committee Membership

| Member | Position |
|---|---|
| Roy Fisher | Non-Executive Member (Chair) |
| Sheena Cumiskey | Non-Executive Member |
| Jane O'Brien | Non-Executive Member |

#### Remuneration Committee Performance

Within its first nine months the Remuneration Committee has reviewed and approved significant areas of business including:

- ICB Remuneration Policy fand Framework for Non-Agenda for Change Positions
- Remuneration Framework for Very Senior Managers
- Proposed Redundancies and a Mutually Agreed Resignation Scheme
- Clinical and Care Professionals Leadership model and remuneration

The terms of reference of the Remuneration Committee have been reviewing during its first year of establishment and can be accessed via the following link:

LSC Integrated Care Board:: Corporate Governance Handbook (icb.nhs.uk)

### *Quality Committee*

The Quality Committee is a formal committee of the board in accordance with its Constitution. It is a non-executive chaired committee, and its members are bound by the Standing Orders and other policies of the ICB.

The Quality Committee provides the board with assurance that the ICB is delivering its functions in a way that secures continuous improvement in the quality of services, against each of the dimensions of quality set out in the shared commitment to quality and enshrined in the Health and Care Act 2022. This includes reducing inequalities in the quality of care.

During 2022/23 the committee met on seven occasions including a preparatory session in August 2022 and a development session in October 2022.

### Quality Committee Membership

| Member | Position |
|---|---|
| Sheena Cumiskey | Non-Executive Member (Chair) |
| Roy Fisher | Non-Executive Member |
| Jane O'Brien | Non-Executive Member |
| David Eva (From 15 February 2023) | Independent Lay Member |
| David Levy | Medical Director |
| Sarah O'Brien | Chief Nursing Officer |
| Debbie Corcoran | Chair of Patient Involvement and Engagement Advisory Committee |
| Geoff Jolliffe | Primary Care Partner Member |
| Kathryn Lord | Director, Quality Assurance and Safety |
| Mark Warren | Local Authority Lead |

The chair of the committee is also the ICB's Senior Non Executive member.

### Quality Committee Performance

Each meeting begins with a patient story, that sets the focus of the meeting and allows the committee to reflect on where both learning and good practice can be shared.

Within its first five formal meetings the Quality Committee has reviewed and approved significant areas of business including:

- Continuing Health Care/Individual Patient Activity – Case for Change
- The Patient Safety Incident Response Framework.
- Quarterly quality and safety reports including lessons learnt and outcomes
- Emerging risks, escalations and 'never events'
- Children in care and deprivation of liberty safeguards
- Special Educational Needs and Disabilities (SEND)
- Update on Lancashire and South Cumbria Integrated Stroke and Neurodevelopment Network.
- Infection prevention and control
- Lancashire and South Cumbria Medicines Management
- Approval of key strategy and policy documents including:
  - Mental Health, Learning Disabilities and Autism Strategies
  - Policy on sponsorship and joint working with the pharmaceutical industry and other commercial organisations
  - Domestic Abuse and Workplace Policy
  - Mental Capacity Act Policy.

The committee also considered safeguarding concerns relating to children in care assessments, the profile of individuals referred to PREVENT and of Domestic Homicide reviews.

Other specific items the committee has considered include the Care Quality Commission (CQC) Inspection Report - Maternity Services, Blackpool Victoria Hospital (Blackpool Teaching Hospitals NHSFT) – which gave maternity services at Blackpool Victoria Hospital an overall rating as inadequate.  The committee received the report, noting that the Hospitals

Trust has a System Improvement Board (SIB) in place and that both the Trust and the SIB will have oversight of improvement.

### Committee Development

The Quality Committee takes steps to ensure its own continuous development with particular regard to the need to deliver ambitions which have impact for the whole system as well as for smaller units such as the Foxton Centre. The committee held a development session in October 2022 facilitated by Advancing Quality (AQuA).

Since establishment, one of the Quality Committee's aims has been whether it has made a difference and reflection and reviews of each meeting are undertaken. There have been threads and themes within reports presented at meetings, e.g., via patient stories. Collaborative working across the Lancashire and South Cumbria integrated care system continues.

### Links with other committees

The Quality Committee recognises the links it has with the Public Involvement and Advisory Engagement Committee (PIEAC) in respect of patient experience and involvement. The Quality Committee seeks to focus on effectiveness and safety whilst the PIAEC focuses on patient and public experience.

### System Quality Group

In line with guidance from the National Quality Board the ICB has established a System Quality Group, (SQG). Whereas the Quality Committee has a function to assure the Board on the quality and safety of services, the SQG is focusing on quality improvement and learning and replaces the Quality Surveillance Groups which had more of an assurance focus. The ICB held a development workshop with partners form across the system, to agree the TOR and remit of the SQG and to date meetings have focused on Urgent and Emergency Care, Diabetes and Cancer. The SQG reports into Quality Committee and any areas of significant concern would be escalated to Quality Committee.

Minutes and attendance at the Quality Committee meetings are published on the ICB's website via the Board meeting papers at: LSC Integrated Care Board :: Meetings and papers (icb.nhs.uk) [55]

The terms of reference of the Quality Committee have been regularly reviewing during its first year of establishment and the membership strengthened. They can be accessed via the following link: LSC Integrated Care Board :: Corporate Governance Handbook (icb.nhs.uk).[56]

## *Finance and Performance Committee*

The Finance and Performance Committee is a formal committee of the Board in accordance with its Constitution. It is a non-executive Chaired committee and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

The ICB did not establish a Finance and Performance Committee for the first part of the year, to ensure the board had direct oversight of the ICB's and system partner's financial position.

[55] https://www.lancashireandsouthcumbria.icb.nhs.uk/about-us/board/meetings-and-papers
[56] https://www.lancashireandsouthcumbria.icb.nhs.uk/about-us/how-we-work/corporate-governance-handbook

The committee oversees the performance of the ICB in delivering its statutory financial duties, national targets and objectives, ensuring the effective and efficient use of resources, whilst delivering financial balance.

The committee contributes to the overall oversight of the ICB objectives through the development and delivery of:

- A robust, viable and sustainable system financial plan. This includes financial performance of the ICB and financial performance of the NHS provider organisations within the ICB footprint.
- ICB performance monitoring and mitigation against mandated national and regional metrics as well as locally agreed indicators that ensure the ICB is meeting its defined objectives.

During 2022/23 the committee met on three occasions and held its inaugural meeting in November 2022.

### Finance and Performance Committee Membership

| Member | Position |
|---|---|
| Roy Fisher | Non-Executive Member (Chair) |
| Jim Birrell | Non-Executive Member |
| Debbie Corcoran | Non-Executive/Chair of Public Involvement and Engagement Advisory Committee |
| Maggie Oldham | Chief Planning, Performance and Strategy Officer |
| Asim Patel | Chief Digital Officer |
| Samantha Proffitt | Chief Finance Officer |
| Debra Atkinson | Company Secretary/Director of Corporate Governance |
| Katherine Disley | Director of Operational Finance |
| Stephen Downs | Director of Strategic Finance |
| Andrew Harrison | Director of Place and Programme Finance |
| Roger Parr | Director of Performance and Assurance |

### Finance and Performance Committee Performance

Monthly financial performance is scrutinised by the Finance and Performance Committee and reported to the Board. Significant items that were discussed and approved following the establishment of the committee in November 2022 are shown below:

- Financial Assurance Framework
- In-year financial performance of the ICB including QIPP delivery
- Financial performance of the NHS provider organisations within the ICB's footprint including CIP delivery
- Resource allocation (capital and revenue)
- ICB Recovery Plan
- 2023/24 Planning Update and Assumptions
- Continuing Health Care Business Case
- Establishing an effective system PMO – priority programmes for financial sustainability
- System Oversight Framework and performance monitoring and mitigation against mandated national and regional metrics, locally agreed performance indicators and review of progress against improvement
- Protocol for in-year changes to revenue financial forecast
- ICB Contracts Oversight
- Review of the Terms of Reference of the committee

Minutes and attendance at the Finance and Performance Committee meetings are published on the ICB's website via the Board meeting papers at: [LSC Integrated Care Board :: Meetings and papers (icb.nhs.uk)](https://www.lancashireandsouthcumbria.icb.nhs.uk/about-us/board/meetings-and-papers) [57]

The terms of reference of the Finance and Performance Committee have been reviewed during its first year of establishment and the membership strengthened. They can be accessed via the following link: [LSC Integrated Care Board :: Corporate Governance Handbook (icb.nhs.uk)](https://www.lancashireandsouthcumbria.icb.nhs.uk/about-us/how-we-work/corporate-governance-handbook) [58]

### *People Board*

The People Board is a formal committee of the ICB and is a non-executive chaired committee that provides the Board with assurance that it is delivering its functions and undertaking its responsibilities to deliver the workforce-related activities that are both carried out by the ICB as an employer, and collaboratively with other partners across the Integrated Care System.

The People Board acts as a system board to ensure system implementation of people priorities including delivery of the People Plan and People Promise by aligning partners across the Integrated Care System to develop and support 'one workforce', where it makes sense and is safe to do so, including through closer collaboration across the health and care sector, with local government, the voluntary and community sector and volunteers. The Board is also responsible for the oversight and assurance of Freedom to Speak Up, and the ICB's adherence to its statutory equality duty.

The people board ensures that the ten people functions are delivered and that the ICB and system partners are meeting the strategic workforce priorities in the NHS, as set out in the People Plan. These include improving people's experience of working within the NHS, enabling them to provide the best possible care and health outcomes for patients and citizens; transforming and growing the workforce to make use of the skills of staff and meet changing health needs; and developing a compassionate and inclusive culture that drives positive change for staff.

The board provides regular assurance updates to the Board and system partners, in relation to activities and items within its remit.

The People Board meets bi-monthly and during 2022/23 has met five times since the ICB was established. It is chaired by a non-executive of the Board and has 19 members.

People Board Membership

| Member | Position |
|---|---|
| Professor Ebrahim Adia | Non-Executive Member (Chair) |
| Professor Jane O'Brien | Non-Executive Member |
| James Fleet | Chief People Officer |
| David Levy | Medical Director |
| Sarah O'Brien | Chief Nursing Officer |
| Trish Armstrong-Child | Provider Collaborative CEO Lead |
| Samantha Baron | Local Authority Workforce/People Director |
| Catherine Whalley | Local Authority Workforce/People Director |

[57] https://www.lancashireandsouthcumbria.icb.nhs.uk/about-us/board/meetings-and-papers
[58] https://www.lancashireandsouthcumbria.icb.nhs.uk/about-us/how-we-work/corporate-governance-handbook

| | |
|---|---|
| Debbie Corcoran | Non Executive/Chair of Patient Involvement and Engagement Advisory Committee |
| Two from the following attended meetings:<br>Joe Hannett (Up to 31 March 2023), Angela Allen and Tracy Hopkins | Voluntary Sector Workforce Lead x 2 |
| Kevin Moynes | Provider Collaborative Workforce/People Director |
| Kate Smyth (From 22 March 2023) | Provider Non-Executive Director representing disability inclusion |
| Andrea Anderson | Director of Place and Programmes (Workforce) |
| Aisha Chaudhary | Director of Culture and Inclusion |
| Sonya Clarkson | People Director |
| Emma Davies | Director of Workforce Delivery |
| Peter Gregory | Primary Care Workforce Lead |
| Lee Radford | Director of Organisational Development and Education |

The chair of the committee is also the ICB's Deputy Chair of the Board, EDI Lead and Health and Wellbeing Guardian.

### People Board Performance

Since establishment, the People Board has made great strides in delivering its business bringing together representatives across the Lancashire and South Cumbria integrated care system.

Significant items discussed and approved during 2022/23 include:

- Lancashire and South Cumbria people and workforce analytics and insight reports
- Baseline activity reports against the People Plan and the 10 ICS People Functions
- Equality, Diversity and Inclusion Interim Strategy
- Freedom to Speak Up Policy
- "Belonging Framework" the culture and inclusion operating model
- Regional talent updates including inspiring leaders, leading systems change and organisational development programmes
- Workforce Race Equality and Workforce Disability Equality Standards – system reports
- North West ICS and ICB Staff Survey results
- System wide workforce priorities

A number of workforce priorities will be taken forward into 2023/24.

The terms of reference of the People Board have been reviewed during its first year of establishment and the membership strengthened. They can be accessed via the following link: LSC Integrated Care Board :: Corporate Governance Handbook (icb.nhs.uk) [59]

Minutes and attendance at the People Board meetings are published on the ICB's website via the Board meeting papers at: LSC Integrated Care Board :Meetings and papers [60]

[59] https://www.lancashireandsouthcumbria.icb.nhs.uk/about-us/how-we-work/corporate-governance-handbook
[60] https://www.lancashireandsouthcumbria.icb.nhs.uk/about-us/board/meetings-and-papers

### *Public Involvement and Engagement Advisory Committee*

The Public Involvement and Engagement Advisory Committee has been established to support the ICB in ensuring the voice of local people and residents is actively embedded and valued in decision making of the ICB and at all levels of the system, particularly in relation to inequalities and those who are seldom heard.

The committee provides regular assurance updates to the board in relation to activities and items within its remit.

The committee usually meets bi-monthly and during 2022/23 the committee met on five occasions including two development sessions in August and September 2022.

Public Involvement and Engagement Advisory Committee Membership

| Member | Position |
|---|---|
| Debbie Corcoran | Non-Executive (Chair) |
| Roy Fisher | Non-Executive Member |
| Professor Sarah O'Brien | Chief Nursing Officer |
| Dr Lindsey Dickinson | Representative from Primary Care |
| Neil Greaves | Director of Communications and Engagement |
| David Rogers | Head of Communication and Engagement |
| Sam Plum | Partner Member representing Local Authorities |
| Tricia Whiteside | Non-Executive Member with a role for patient experience or public engagement from an NHS provider |
| Sarah James | Representative from Place-based Partnership - Lancashire |
| Karen Kyle | Representative from Place-based Partnership – South Cumbria |
| Pauline Wigglesworth | Representative from Place-based Partnership - Blackpool |
| To be confirmed | Representative from Place-based Partnership – Blackburn with Darwen |

The committee supports the board in ensuring the principles for working with people and communities are intrinsically in place across all parts of the organisation and wider integrated care system. The committee defines best practice in terms of public engagement, involvement and communications and support other committees and parts of system in how the local voice is embedded and valued in all aspects of the ICB at different levels of the system including within place-based partnerships.

Public Involvement and Engagement Advisory Committee Performance

Significant items that were discussed and approved during 2022/23 are shown below:

- Strategy for working with people and communities
- A developing model for engagement, involvement and co-production for the ICB
- Engagement and involvement approaches for the New Hospitals Programme
- Engagement approaches for primary care transformation and existing insight
- Engagement and involvement approach and insight in the development of the integrated care strategy for Lancashire and South Cumbria
- Approaches and insights from capturing lived experience to support population health improvement through the example of three initiatives in Lancashire and South Cumbria

Since October 2022 the Public Involvement and Engagement Advisory Committee (PIEAC) has received summaries of public and community insights captured by the ICB, along with an engagement and involvement assurance report.

The ICB is aiming to increase the impact of engagements with the public through the use of a number of methods, including the website and social media – particularly in relation to mental health, suicide prevention and primary care. The majority of feedback suggests that the ICB's key messages are generally well received. More insight will be captured as the ICB engagement infrastructure is developed.

The Communication and Engagement team collates the outcomes and insights from completed engagement programmes and initiatives and reports these to PIEAC.

Specific insights are obtained from -

- Patient Experience
- Freedom of information (FoI) requests.
- MP and councillor interest
- Media interest and response
- Online and social engagement
- Survey responses
- Patient stories

Patient stories are sourced by the Communications and Engagement team to bring real life experience directly to the ICB Board and Quality Committee, as well as specific meetings focused on quality improvement.

The Public Involvement and Engagement Advisory Committee agreed a workplan for 2022/23 which was regularly monitored and updated as required and would be reviewed in the early part of Quarter 1 2023/24.

### Links with other committees

The PIEAC recognises the links it has with the Quality Committee in respect of patient experience and involvement. The PIAEC seeks to focus on patient and public experience, whilst the Quality Committee seeks to focus on effectiveness and safety.

Information on the committee members and attendees, terms of reference, upcoming meeting dates, agendas and papers and approved minutes can be accessed at: LSC Integrated Care Board :: Public Involvement and Engagement Advisory Committee (icb.nhs.uk) [61]

### *Primary Care Contracting Group*

At establishment of the ICB on 1 July 2022, in accordance with the powers under section 65Z5 of the NHS Act, NHS England (NHSE) delegated the exercise of commissioning of Primary Medical Services and Community Pharmaceutical Services functions to Lancashire and South Cumbria (LSC) Integrated Care Board (ICB).

The ICB, with agreement from NHSE, established a Primary Care Commissioning Group to act as an expert panel to ensure consistent decision making across the ICB with regards to delegated primary care services.

[61] https://www.lancashireandsouthcumbria.icb.nhs.uk/about-us/sub-committees/public-involvement-and-engagement-advisory-committee

Whilst not a committee of the board, the group reports to the executive management group, and to the board through a regular summary report of the groups business.

From April 2023 NHSE will also delegate the exercise of Primary Dental and Primary Ophthalmic services functions to the ICB and the ICB will hold over 1000 core primary care contracts, resulting in a significant number of contract related decisions needing to be made.

To ensure robust governance arrangements for all these functions, a review of primary care commissioning governance and decision-making arrangements and a full review of the Terms of Reference (ToR) of the Primary Care Commissioning Group (PCCG) has been undertaken. From April 2023 the group will become a formal committee of the Board, meeting in public where appropriate and with a revised membership to include further lay member involvement.

### *Special Lead Roles*

To support the ICB in discharging its statutory duties there are several special lead roles that required named individuals to undertake responsibility on behalf of the Board for the oversight of specific areas. Additionally, there are several roles for which it is considered best practice to have named individuals aligned to. From its commencement the ICB has the following appointment to these roles:

#### Senior Independent Risk Owner (SIRO)

The SIRO has overall responsibility for the organisation's information risk policy. They are accountable and responsible for information risk across the organisation, ensuring awareness across the organisation for the need for good judgment to be used to safeguard information and share it appropriately. All statutory NHS organisations are required to have a SIRO.

Chief Finance Officer, Sam Proffitt, undertook this role until the appointment of Asim Patel, Chief Digital Officer in November 2022 who is the ICB's named SIRO.

#### Caldicott Guardian

A Caldicott Guardian is the senior individual within the organisation with responsibility for protecting the confidentiality of people's health and care information and ensuring that information is used ethically and legally. All statutory NHS organisations are required to have a Caldicott Guardian.

David Levy, Medical Director, undertakes this role on behalf of the ICB.

#### Freedom to Speak up (FtSU) Lead

The role of the FtSU Guardian is to provide independent support and advice to staff who want to raise concerns, enabling NHS organisations to be more open and transparent and for employees to raise concerns without fearing the consequences. Whilst organisations will have multiple FtSU Guardians it is recommended that organisations have both an Executive and Non-Executive Lead Guardian.

James Fleet, Chief People Officer, and Professor Jane O'Brien, Non-Executive Member undertake these role on behalf of the ICB.

#### Equality, Diversity and Inclusion (EDI) Lead

It is important that the ICB ensure that its services and employment practices are fair, accessible, and inclusive for the diverse communities it serves and the workforce it employs.

In recognition of that need, it is best practice to have both and named Executive and Non-Executive Lead for EDI.

James Fleet, Chief People Officer, and Professor Ebrahim Adia, Non-Executive Member both undertake this role on behalf of the ICB.

### Conflicts of Interest Guardian

It is important that in discharging its duties the ICB has appropriate measures in places to manage circumstances that may arise whereby those with decision making powers is, or could be, influences or impaired in their decision making as a consequence of other interests they hold.

The role of the Conflicts of Interest Guardian is to strengthen the scrutiny and transparency of the organisation's decision-making processes.

It is commonly considered best practice for the Conflicts of Interest Guardian to be the Audit Chair, and Jim Birrell Audit Chair undertakes this role on behalf of the ICB.

### Senior Non-Executive Director

The role of the Senior Non-Executive Director is to be available to members of the ICB should they have concerns they wish to raise but for which contact through the usual channels via the ICB Chair or Chief Executive is either inappropriate or has failed to resolve the issue. Other aspects of this individual's role relate to the annual appraisal process for the ICB Chair.

Sheena Cumiskey, Non-Executive Member of the Board undertakes the role of Senior Non-Executive Director on behalf of the ICB.

### Health and Wellbeing Guardian

Ensuring the health and wellbeing of our workforce is a fundamental priority of the ICB. Creating a culture that enables colleagues to be happy and healthy at work this will contribute to improved patient and care and health and wellbeing in our population.

The role of the Health and Wellbeing Guardian is to support with oversight of the organisational culture to ensure that the health and wellbeing of the workforce is considered routinely across all organisational activities.

Professor Ebrahim Adia, Non-Executive Member of the Board undertakes the role of Health and Wellbeing Guardian on behalf of the ICB.

## *Other Population Groups and Functions*

The ICB must identify members of its board who have explicit responsibility for the following population groups and functions:

- Children and young people (aged 0 to 25)
- Children and young people with special educational needs and disabilities (SEND)
- Safeguarding (all-age), including looked after children
- Learning disability and autism (all-age).
- Down syndrome (all-age)

These roles ensure visible and effective board-level leadership for addressing issues faced by the groups outlined above, and to ensure that statutory duties related to safeguarding and SEND receive sufficient focus.

Professor Sarah O'Brien, Chief Nurse is the named board member with responsibility these areas.

The guidance also includes the requirement of at least one member of the board who has knowledge and experience in connection with services relating to the prevention, diagnosis, and treatment of mental illness.

Mental Health Lead board members for the ICB are David Levy Medical Director and Chris Oliver, Partner Member for Mental Health.

### *UK Corporate Governance Code*
NHS Bodies are not required to comply with the UK Code of Corporate Governance.

### *Discharge of Statutory Functions*
NHS Lancashire and South Cumbria ICB has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislation and regulations. As a result, I can confirm that the ICB is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

Responsibility for each duty and power has been clearly allocated to a lead Executive and they have assured that their structures provide the necessary capability and capacity to undertake all of the ICB's statutory duties.

### *Risk management arrangements and effectiveness*
At its first full business meeting on 27 July 2022, the Chief Executive presented a System Diagnostic Report to the board which identified a number of risks and issues inherited by the ICB upon its establishment. Throughout the transitional year, the board also received regular monthly update reports which highlighted key issues and opportunities around workforce, quality, performance, inequalities, financial sustainability, and strategic direction. Reports presented to board and its committees have informed the development of the Board Assurance Framework (BAF).

A development session took place with board members in October 2022 to agree the principal risks to the ICB meeting its strategic objectives. This informed the development of a BAF and strategic objectives, which was approved by the Board in December 2022, along with the risk management strategy.

Corporate risk registers (CCR) transferred from the eight CCGs continued to be in operation throughout the transitional period, and a comprehensive review was undertaken in Q4 of 2022/23 to fully amalgamate these into a single ICB CRR. The review considered legacy risks captured as part of the CCGs handover processes and enabled a rationalisation and review of transferred legacy risks, which were then aligned to the ICB's Strategic Objectives and assigned to the relevant executive director.

Further updates were provided to the audit committee in January 2023 and March 2023 to provide assurance of progress against the development and oversight of the BAF and Corporate Risk Register.

The ICB's Risk Management Strategy and Policy sets out the responsibilities of individuals, the ICB and its committees for managing risks associated with meeting its strategic objectives. It aims to create a framework to achieve a culture that encourages staff to:

- Identify and control risks which may adversely affect the operational ability of the ICB and the achievement of its strategic objectives.
- Score risks consistently using a grading matrix.

- Where possible, eliminate or transfer risks, or reduce them to an acceptable and cost-effective level (otherwise ensure the organisation openly accepts the remaining risk).
- Identify risks which are common across functions and explore the management of these collectively.

Risks are identified from a number of sources, including the Board, committees, staff of all levels, internal and external audit reports.

All identified strategic or corporate risks scored 9 and above are included on the corporate risk register or Board assurance framework. Directorates and/or functional areas oversee and manage operational risks assessed as 8 or below with Senior Responsible Officer oversight.

The ICB has made reasonable progress on the governance and oversight for strategic and operational risk management. Each predecessor CCG had differing risk management approaches and processes, and whilst the ICB agreed its strategic objectives and board assurance framework in December 2022, the embedding of a fully operational risk management framework will be a key priority for 2023/24.

A strengthened monthly cycle of risk management oversight and reporting has been developed towards the end of this part-year. This will support timely escalation and de-escalation of risks to the board, committees and Executives; moreover, it will enable an ongoing holistic approach to risk management and oversight across the organisation.

Given the BAF and strategic objectives were agreed in quarter three of 2022/23, during 2023/24 the board will review each of the strategic objectives to ensure alignment to the ICB's Five Year Joint Forward Plan, that will be approved in early July 2023. The board will also generate a risk appetite statement, to inform decision making in connection with risk. The board will also undertake an annual assessment of its risk appetite and will determine appropriate action to progress from its current position.

### *Capacity to Handle Risk*

The responsibility for risk management is clearly defined at all levels within the organisation. The ICB's Risk Management Strategy clearly outlines the roles and responsibilities of the Board, its committees, the Chief Executive Officer, the Chief Finance Officer and other staff within the ICB. Committee terms of reference include the review and monitor those risks on the BAF and Corporate Risk Register which relate to each committee.

The Audit Committee is responsible for reviewing the adequacy and effectiveness of the ICB's risk management arrangements and noted the ICBs Risk Management Strategy and Policy in September 2022 and received a full progress update on the development of risk management arrangements in December 2022 and March 2023.

The ICB uses a web-based application to record and monitor risks. This is available to risk owners to enable risk updates to be provided in a timely manner. Whilst this system is ready to operate, the risk management cycle of review is still to be fully embedded and from 2023/24 a monthly gateway cycle will include an at least monthly review of all risks held on the CRR and BAF, with exception reports to the Executive Leadership Team and live dashboards have also been established to support with functional oversight of risks specific to the strategic objectives of the ICB. There will be quarterly updates to the Board for those risks held on the BAF, with a particular focus on impact of risks that could affect the delivery of the strategic objectives and where there are opportunities to achieve delivery.

Support and training have been provided to the executives and their teams over this period and a series of engagement sessions have been held during January and February 2023 with lead executives and their senior responsible officers (SROs).

### *Risk Assessment*

Monitoring, evaluation and control of significant risks has continued to be developed throughout the transitional year.

To ensure appropriate assessment of risks, Individual sessions were held with SROs to undertake further review and triangulation of the open risks to determine which would remain open and held on the BAF (score of 15 or over) and those which would remain open and transfer to the ICB's corporate risk register (score of 9 or over).

The leadership team have also identified new risks and they have been supported to develop these for inclusion on the CRR or BAF as appropriate.

The ICB and wider system have navigated significant operational pressures throughout the winter including strike events, which have been managed both strategically and operationally with executive oversight. The risk profile of the ICB has changed throughout the transitional year. Initially the risk profile primarily reflected the adoption of the operational risks handed over by the CCGs; however, following the rationalisation of the legacy risks, the development and implementation of the risk management processes and strategic objectives, the risk profile now reflects the ICB's focus on its statutory duties and the success of its strategic objectives and vision.

Through the period of this annual report, the persistent risks related to:

- A balanced financial plan that delivers five per cent recurrent efficiencies for all providers and the ICB.
- Quality, financial and reputational risks of not meeting NHS Continuing Healthcare statutory responsibilities relating to assessment, eligibility, reviews, personal health budgets and commissioning and contracting.
- Improvement and sustainability of NHS trust performance when key measures (particularly urgent and emergency care, discharge and elective care recovery) are not achieved; constitutional targets may not be delivered in 22/23; national targets for 78 week waits and cancer 62 days are under pressure to be delivered.
- Primary care development, including the recommendations contained in the national Fuller Report.
- Delivery of strategic workforce transformation priorities as set out in the NHS People Plan.
- Estates infrastructure and facilities in some areas hinder the ability to deliver consistently high-quality care.

### *Other sources of assurance*

#### Internal Control Framework

The ICB has a system of internal control based upon the processes and procedures in place to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness.

Control mechanisms are embedded within all aspects of the ICBs governance, with the oversight of risk management within the organisation being one of them. There were no instances during the reporting period where the control environment was breached. The control mechanisms include:

- Suite of organisational policies ensuring that the ICB is compliant with national and legal standards such as Health and Safety Act, Standards of Business Conduct, Freedom to Speak Up, and Conflicts of Interest.
- The Constitution describe how we organise ourselves together to provide the best health and care, ensuring that decisions are always taken in the interest of the patients and populations we serve. The Constitution is underpinned by the duty that requires NHS bodies to consider the effects of their decisions on the health and wellbeing of the people of England, the quality of services and the sustainable and efficient use of resources.
- The ICB's Governance Handbook includes key documents that underpin our governance framework, including our Scheme of Reservation and Delegation (SoRD) and Scheme of Operational financial Delegation (SoFD). The SoRD sets out those decisions that are reserved to the board of the ICB and those decisions that have been delegated in accordance with the powers of the ICB and which must be agreed in accordance with and be consistent with the Constitution. The SoFD clearly sets out the financial delegated limited for individual officers and functions.
- There is a clear process for reporting, management, investigation and learning from incidents. The ICB has a Senior Information Risk Owner (SIRO) to support the arrangements for managing and controlling risks relating to information/ data security, who is also a member of the Audit Committee. The Chief Medical Officer is the Caldicott Guardian to ensure that patient confidentiality is protected. The sections of this report entitled 'governance arrangements and effectiveness' and 'delegation of functions' describe how the internal control arrangements operate in more detail.

### Annual audit of conflicts of interest management

The revised statutory guidance on managing conflicts of interest (published June 2016) requires commissioners to undertake an annual internal audit of conflicts of interest management. To support ICBs to undertake this task, NHS England has published a template audit framework.

For the 2022/23 reporting year, Mersey Internal Audit Agency (MIAA) has developed a checklist to support newly formed ICBs in establishing their conflicts of interest arrangements, specifically to ensure that they are in line with the national guidance issued by NHS England.

The checklist was undertaken in two phases and focused upon the establishment of core controls in relation to Conflicts of Interest. MIAA has completed the checklist for the Lancashire and South Cumbria ICB, and this has confirmed the position as follows:

Phase one of the checklist focused on implementation of core controls and was undertaken and reported in November 2022. The statement provided was as follows:

- The ICB has significantly progressed its development and implementation of core controls

Phase two of the checklist focused upon assessing the design and operation of the controls in place for conflicts of interest. MIAA have confirmed:

- The control framework for conflicts of interest has continued to significantly progress, both in design and operation of controls.

Overall, MIAA noted the controls in place to be well designed and mostly operating effectively. Key areas for further action were:

- Conflicts of Interest policy –the policy could be further improved through inclusion of roles and responsibilities of Corporate Governance team and line managers.
- Sample testing of 10 new starters found that for four, the declaration of interest form had not been completed within 28 days of their start date.
- The register for Gifts and Hospitality should be published on the ICB's website even if there have been no declarations.
- The Register of Procurement Decisions should be published on the ICB website following its presentation to Audit Committee.

All of these actions have been taken forward.

### Data Quality

Information is generated, and processed, for a broad variety of uses, and therefore the ICB employs varied techniques in assuring data quality across those different contexts. Where the ICB receives datasets from its service providers or external parties, a culture of routine data validation is promoted. The ICB and its data processors endeavour to both ensure that timescales for submission of information are adhered to, and that the quality & accuracy of such submissions is monitored and any issues fed back to relevant forums as appropriate.

The board receives a report on performance at each of its meetings and nationally published data is used to ensure accurate information is provided and offer a benchmarked position. In instances where data is provided to offer a more real-time position, a caveat is provided that the data is subject to validation.

The board acknowledges that these reports are still in development and the presentation of meaningful data and local narrative has been continually reviewed. The Finance and Performance Committee received these reports at every meeting and the committee has driven improvements to the quality of data presentation, with the intention that a fully integrated performance report will be accessible to the board and its committees in early 2023/24.

The board held a development session on 9 March 2023 which included a presentation on 'Making Data Count' from the NHS England team. Work is on-going to refine the data presentation utilised by the ICB to provide greater assurance to the board and that actions are underway to improve performance where necessary.

### Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit and the annual submission process provides assurances to the ICB, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

The Data Security and Protection Toolkit (DSPT) is the officially recognised self-assessment tool on data protection and cyber security. It was originally developed by NHS Digital for all

NHS organisations to measure compliance against the ten National Data Security Standards (DSSP), and in turn compliance with their statutory responsibilities and Data Protection legislation. Within the ten data standards there are mandatory assertions items to meet to ensure compliance with their statutory responsibilities.

The deadline for the completion and submission of the DSPT is 30 June 2023 with a baseline assessment submitted for the ICB on 28 February, and evidence is being collated to ensure the ICB completes a 'Standards Met' submission by the end of June 2023. The ICB Chief Digital Officer (and Senior Information Risk Officer) is responsible for ensuring information governance processes are fully embedded; to support this area of work, a new governance structure for the management and oversight of delivery of the information governance agenda has been developed. A monthly Information Governance (IG) Operational Group meeting has been established to support the operational delivery of the DSPT, policies and incidents. This Group feeds into a quarterly IG Oversight Group that is chaired by the Senior Information Risk Officer (SIRO) for the ICB. This Group provide assurance to the Audit Committee on progress of the IG Agenda to include cyber security.

The key objectives of these Groups are:

- To oversee the implementation and submission of the Data Security and Protection Toolkit across the organisation
- To develop, implement and monitor the organisations Information Governance framework
- To develop and maintain Information Governance policies
- To work with other member organisations groups and independent contractors to promote and advise on Information Governance issues
- To prepare the annual Information Governance assessment
- To work closely with the SIRO and Caldicott Guardian, offering support and seeking advice where appropriate
- To oversee incidents relating to information governance and cyber security and manage risk
- To monitor, control and advise on Information issues

Midlands and Lancashire Commissioning Support Unit (MLCSU) IG team provide the ICB with the Information Governance service delivery. The team support the ICB to collate, review and advise on all evidence required for the DSPT submission.

As at 31 March 2023 the ICB was confident that structures were in place in order for the organisation to be compliant with the DSPT requirements by the 30 June 2023 submission date. This is based on the number of assertions whereby evidence was firmly in place to signify the ICBs compliance with an individual mandatory assertion.

An internal DSPT delivery plan has been created, with internal timescales in place to ensure that evidence is firmly in place by the end of May 2023. This timeframe is to ensure that all evidence is firmly in place to ensure the ICBs compliance. Similarly, the timeframe allows sufficient time for the ICBs Quarterly IG Oversight Group to meet to review and gain assurance on the evidence collated.

In total there are 88 mandatory assertions whereby evidence is required from the ICBs three IT providers. Midlands and Lancashire commissioning support unit (MLCSU) Information Governance team are co-ordinating the collation of evidence from each provider. The team are required to review all responses and create one single response for the ICBs DSPT for submission.

There are DSPT requirements that relate to larger programmes of work where engagement from ICB staff is key when collating evidence required for the mandatory assertions. This includes areas such as, training needs analysis, asset registers systems and software and data flow mapping. Annual IG training and a new starter IG induction programme is in place to ensure that staff recognise the importance of protecting personal information and ensuring that data protection is embedded in the organisation in all processes, both by design and default.

Any recommendations received from MIAA as an outcome of their DSPT audit will be addressed prior to the final submission.

There are several processes undertaken and supported directly with by the MLCSU IG team, whereby evidence is directly collected and created by the team. Areas include, breach confidentiality reporting and investigation, IG induction programme, specialist IG training, Data Protection Impact Assessments (DPIAs) and data sharing/processing agreements and physical controls on site spot checks. Evidence is routinely refreshed throughout the year.

There are robust processes in place to ensure that all personal data breaches are reported and investigated by MLCSU IG team. Recommendations are presented to ensure that further breaches of the same nature are prevented.

To date, the ICB has had no reportable IG breaches to the Information Commissioners Office (ICO). All near miss incidents have been managed and investigated appropriately by undertaking low level root cause analysis and subsequent action plans to mitigate any further risk.

The IG Code of Conduct, the IG Data Security and Protection policies and the IG Handbook have been reviewed to reflect the requirements of the ICB. These documents are available on the ICB Intranet that detail the standards and expectations of the organisation and its staff in relation to information governance.

The Audit Committee also receives a quarterly update on progress against the DSPT and overall IG agenda, including data and security incidents.

### Business Critical Models

In line with best practice recommendations of the 2013 MacPherson review into the quality assurance of analytical models, I can confirm that a framework and environment is in place to provide assurance of business-critical models. In this transition year, further work is still to be done, and a programme of work will commence in April 2023 in relation to business continuity planning, which supports business impact analysis and resilience planning to ensure critical services are maintained. Planning is also underway to review digital resilience and to undertake a multi-professional exercise to test that resilience.

The ICBs Information Governance framework ensures that business critical systems are identified and managed effectively. As part of this framework and the programme of work commencing in April 2023, information asset owners will be appointed and trained to cover a range of business systems used by the ICB. Their responsibility in relation to business-critical systems will involve the maintenance of an information asset register relevant to their organisational remit, the maintenance of service continuity plans and the continuity of key skills to operate such systems.

There is still work to be done in this area in 2023/24, and once business critical services have been identified and continuity plans are in place, the Emergency Planning Resilience and Response team will undertake a quality assurance process to ensure that the plans are reviewed and strengthened.

### Third party assurances

The ICB currently contracts with a number of external organisations for the provision of back-office services and functions. Assurances on the effectiveness of the controls in place for these are received in part from an annual Service Auditor Report from the relevant service.

The organisations concerned are:

| Service | Provider | Assurances |
|---|---|---|
| Finance and Accounting Services | NHS Shared Business Services | Service Auditor Report |
| Payroll Management | Lancashire Teaching Hospitals | Service Auditor Report |
| IT Services | Blackpool Teaching Hospital | Service Auditor Report |
| IT Services | University Hospitals Morecambe Bay | Service Auditor Report |
| IT Services | MLCSU | Service Auditor Report |
| Various | MLCSU | Service Auditor Report |

In addition, Internal and external audit provide assurance to the ICB.

## *Control Issues*

The month 9 Governance Statement (December 2023) return reported control issues under six categories. Each of these issues could undermine the reputation of the ICB and wider NHS if not resolved and could put at risk delivery of the standards expected of the Chief Executive. These control issues have no bearing on fraud, material impact of the accounts or national security of data.

### Access to services/capacity

The ICB reported control issues under this category due to breaches in diagnostics and cancer. Plans are in place in each area of diagnostics affected to improve position.

### Regulators

The ICB reported control issues under this category due to never events and serious incidents reported. Each incident had a thorough investigation undertaken with lessons learnt identified and a mitigating action plan implemented.

### Mental Health and Dementia

The ICB reported control issues under this category due to issues with retaining workforce in mental health services and recovery plans being in place for Individual Placement Support and Improving Access to Psychological Therapies.

### Accident and Emergency

The ICB reported control issues under this category due to difficulties in meeting the 4 hour target. A range of strategies and approaches are being utilised to try to tackle the identified challenges with Urgent and Emergency Care access including:

- Access to urgent care advice through the NHS 111 online service
- NHS 111 clinical assessment can offer immediate advice or referred to the appropriate clinician for a face-to-face consultation
- Urgent treatment centres providing locally accessible and convenient diagnosis and treatment services diverting patients away from A&E
- Use of Same Day Emergency Care (SDEC) services allowing for the rapid assessment, diagnosis, and treatment of patients presenting with certain conditions, and discharge home same day if clinically appropriate

- Establishment of an Acute Frailty programme
- Working closely with primary and community care services
- Specific projects to deliver 2 Hour Urgent Community Response, Virtual Wards, Intermediate Care and Transfer of Care Hub

Referral to treatment

The ICB reported control issues under this category due to difficulties in meeting the referral to treatment targets. Actions that are being undertaken to improve this position include, Theatre transformation, Chatbot, Mutual aid, Outpatient transformation, Referral optimization, Clinical networks and Surgical hubs.

Ambulance services

The ICB reported control issues under this category due to daily average volumes for 30-60 min delays increasing throughout the year. In addition to increased acuity and increased call volume/ demand, NWAS have experienced significant challenges with staffing capacity (absences linked to covid, those self-isolating and non-covid).

The range of strategies and approaches being utilised to try to tackle the identified challenges are aligned to those detailed above within the Accident and Emergency section.

### *Review of economy, efficiency & effectiveness of the use of resources*

The ICB is charged with ensuring that it achieves economy, efficiency and effectiveness in its use of resources, and continues to develop and strengthen the system of internal controls. The Chief Finance Officer has worked with the Internal and External Auditors to ensure that the ICB receives assurance in relation to the use of resources and that this is reported to the Board.

The ICB has a strategic objective to 'meet financial targets and deliver improved productivity', and there is a risk on the Board Assurance Framework in this regard. Robust controls are in place such as; Standing Financial Instructions; Scheme of Reservation and Delegation; a financial budget for 2022-23 has been agreed; a single Lancashire and South Cumbria system plan has been submitted to NHSE detailing all commissioning and provider plans agreed by individual organisations within the system; additional financial controls have been implemented across the system (with peer review in place). The risk also has a mitigation plan to manage the gaps in assurance and control to mitigate the risk against this.

Monthly financial performance is scrutinised by the Finance and Performance Committee and reported to the Board. Internal and External Audit arrangements give a view to the Audit Committee on the delivery of the ICB's statutory financial responsibilities and the achievement of value for money. The ICB complies with the NHS Pension Scheme regulations. Performance reports are reviewed at the Board and Finance and Performance Committee.

The ICB has undertaken a Mutually Agreed Resignation Scheme (MARS) and a formal management of change process for an organisational restructure. This has enabled the organisation to remain within a reducing running cost allocation, in real terms, releasing recurrent efficiency savings from 1 April 2023.

The ICB has received its national NHS Staff Survey results and has established a multi-professional engagement group to analyse these and to design and implement a broad range of OD, leadership, engagement listening events and cultural initiatives to help improve our staff experience. The ICB is working with system partners to develop a bespoke systems

leadership programme in conjunction with the NHS NW Leadership Academy based upon the national NHS Leading for System Change programme.

The architecture for system delivery of efficiencies was established early in 2022/23 and is now fully embedded. Representatives of the ICB and provider partners contribute to each of the following groups:

- Delivery Boards to oversee the delivery of in year plans;
- Improvement Hubs to deliver on medium term projects; and
- A Transformation function overseeing longer term projects delivered over multiple years.

Going forward there is a clear focus on how these groups will deliver on programmes and projects underpinning the five priority savings programmes agreed by the ICB Board and System Delivery Board.

***Delegation of functions***

In line with NHSE policy, the ICB has not delegated any of its functions in its transitional year.

***Counter fraud arrangements***

The ICB Chief Finance Officer is responsible for ensuring appropriate arrangements are in place to comply with the Government Functional Standard 013: Counter Fraud within the NHS. An accredited Counter Fraud Specialist is contracted to undertake counter fraud work proportionate to identified risks via the contract the ICB holds with Mersey Internal Audit Agency.

The ICB Audit Committee receives a quarterly progress report against each of the Standards for Commissioners and a final one within an annual report. The Chief Finance Officer (CFO) provides executive support, and a proactive work plan is in place to address identified risks.

The CFO is proactively and demonstrably responsible for tackling fraud, bribery and corruption. Regular meetings are held with the Anti-Fraud Specialist and the CFO throughout the year.

Appropriate action is taken regarding any NHS Counter Fraud Authority quality assurance recommendations via alerts, Fraud Prevention Notices or Local Proactive Exercises, which are cascaded to the relevant departments within the ICB.

The Anti-Fraud Specialist has received four referral queries since July 2022. Two have been closed, as no fraud was identified after further checks conducted by the ICB. Two are still awaiting further information from the ICB to determine if there is any substance to the allegation. One of these referrals is regarding alleged abuse of annual leave by a member of staff and the second regarding a care provider receiving payments for care that has not been delivered. The ICB are undertaking further enquiries which will enable the AFS to determine if any fraud has occurred.

One fraud investigation (transferred from Chorley and South Ribble CCG) has been closed, as it couldn't be proven beyond all reasonable doubt (threshold for a criminal case) that an offence has been committed. £64,000 has been recovered by Civil recovery route.

'The ICB contracts an accredited counter fraud specialist to undertake counter fraud work. The counter fraud specialist has regular meetings with the Chief Finance Officer.

The anti-fraud work plan, which is approved by the Audit Committee, is risk based.

The Anti-Fraud Specialist provides regular updates on the progress of the anti-fraud plan to the Audit Committee via Progress Reports, which details the ongoing self-assessment against the 12 components of the Government Functional Standard 013 Counter Fraud'.

### *Freedom to Speak Up (FtSU)*

At its first meeting on 1 July 2022, the Board approved it's Freedom to Speak up Policy (whistleblowing/raising concerns) and appointed James Fleet, Chief People Officer to undertake the lead Executive FtSU role and Professor Jane O'Brien as the lead non-executive member on behalf of the ICB.

NHS England published an updated FtSU policy in June 2022, with the expectation that all NHS organisations have the updated policy in place by 31 January 2024. The ICB People Board approved the adoption of this policy in November 2022 and announced the ICB's ambition to establish a robust FtSU process to ensure everyone working within the organisation feels safe and confident to raise a concern. The aim is for speaking up to become business as usual and valued as an opportunity to engage, learn and improve.

The ICB's FtSU function has both an internal ICB role, as well as taking on a system wide FtSU co-ordinating responsibility. This includes sharing good practice and learning from across the system. The ICB FtSU function will report into the ICB People Board.

From January to March 2023, a freedom to speak up process was established which planned for the recruitment of several FtSU guardians, as well as a network of champions, in April 2023. This would allow the organisation to be more open and transparent and for staff to raise concerns without fearing any consequences.

There are several ways ICB staff can raise issues and concerns, including:

- Speaking to FtSU guardians or champions
- 1:1s with line managers
- A conversation with a health and wellbeing champion
- Listening rooms
- Coffee and chat sessions with executives
- Staff side representatives/trade unions
- Anonymously (or openly) at all staff briefings

The ICB is committed to listening to its staff, learning lessons and improving patient care and the services we commission. Over the reporting period of this annual report, no formal whistleblowing concerns have been raised.

## Head of Internal Audit Opinion

Following completion of the planned audit work for the period 1 July 2022 to 31 March 2023 for the ICB, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the ICB's system of risk management, governance and internal control. The Head of Internal Audit concluded that:

The overall opinion for the period 1 July 2022 to 31 March 2023 is:

| ***Limited Assurance: there is a compromised system of internal control as weaknesses in the design and/or inconsistent application of controls impacts on the overall system of internal control and puts the achievement of the organisation's objectives at risk.*** The opinion is not limited in scope but is provided in the context of the maturity of the organisation during the time of reporting. |
|---|

The complexity of the ICB, in terms of bringing together 8 CCGs to form the ICB, together with its maturity have been significant factors in determining the Head of Internal Audit Opinion. It is fully acknowledged that positive assurances have been provided for the core systems of finance and payroll and that progress continues regarding the development and embedding of the control framework. However, this opinion covers the period from establishment until the 31 March 2023 and for the majority of the core areas reviewed by internal audit, the outcomes have highlighted that whilst the development and embedding of the control framework has continued to progress, this hasn't been fully operational for the period under review.

Review coverage has been focused on:

- The organisation's Assurance Framework and strategic risk management arrangements;
- Core and mandated reviews, including follow up; and
- A range of individual risk-based assurance reviews focusing on priority assurance areas

### Assurance Framework (AF)

| | |
|---|---|
| Structure | The organisation's AF is structured to meet the NHS requirements. |
| Risk Appetite | The organisation has not agreed its risk appetite and as such, has not been used to inform the management of the AF. |
| Engagement | There could be greater visibility of the use of the AF by the Board. |
| Quality & Alignment | The AF generally reflects the risks discussed by the Board. |

During the period, Internal Audit issued the following:

| **Core & Risk-Based Reviews Issued** | |
|---|---|
| Risk Management Core Controls* | The control framework has **continued to progress**, both in design and implementation |
| Governance Core Controls* | The control framework has **continued to progress**, both in design and implementation |

| | |
|---|---|
| Conflicts of Interest Core Controls* | The control framework has **significantly progressed** its development and implementation of core controls. |
| Quality Governance Core Controls* | The control framework has **continued to progress**, both in design and implementation |
| Information Governance Core Controls* | The ICB has provided **reasonable evidence of progress** in establishing its IG and Digital governance frameworks and associated processes. At this point in time (March 2023) there are a number of core IG and IT controls to be further developed and implemented. |
| HfMA Improving NHS Financial Sustainability Checklist* | Self-assessment was not fully complete at the time of initial submission<br>Self-assessment was appropriately approved<br>Self-assessments against the 12 NHSE specified questions reviewed by internal audit were deemed to be reasonable |
| Financial Governance* | **Reasonable progress** in progressing actions (ref to above review on HfMA Improving Financial Sustainability Checklist) |
| Key Financial Systems*<br>General Ledger<br>Treasury Management<br>Accounts Payable<br>Accounts Receivable<br>Budgetary Control & Financial Reporting | **Substantial** |
| ESR HR / Payroll* | **Substantial Assurance** |
| Data Security & Protection Toolkit* | **N/A** *Feedback provided to support the submission to NHSD in line with their timescales (30 June 2023)* |
| NICHE Urology Assurance Review | **Substantial Assurance** |
| Pre-Delegation Assessments for Direct Commissioning Support | **Assurance that effective processes** have been established for the completion and monitoring of transition plans |

* *identified priority areas for in year delivery to the Head of Internal Audit Opinion for 2022/23*

**Follow Up**

During the course of the year, we have undertaken follow up reviews and can conclude that the organisation has made reasonable with regards to the implementation of recommendations. We will continue to track and follow up outstanding actions.

*Chris Harrop*
Managing Director, MIAA
March 2023

*Louise Cobain*
Assurance Director, MIAA
March 2023

## Review of the effectiveness of governance, risk management and internal control

The ICB was established on 1 July 2022 and this financial part year is one of transition. The complexity of establishing our organisation, whilst reviewing and managing the 8 predecessor CCGs systems, processes, operational policies, contracts, data, assets and liabilities into one operating model and governance framework has been an enormous undertaking. We inherited a challenging financial position, and we are still developing our operating model.

Within this context, my review of the effectiveness of the system of internal control is informed by the work of the internal auditors, and executive officers within the ICB who have responsibility for the development and maintenance of the internal control framework. I have drawn on the limited information available to me, and my review is also informed by comments made by the external auditors in their annual auditor report and other reports, and the work of the board and its committees.

Whilst the Board, its committees and the executive team have had good oversight of the principal risks and issues impacting on the ICB's ability to deliver and achieve its objectives, the board assurance framework was not established until December 2022, and other information available to me leads me to conclude there are limitations in the design and application of controls, which have impacted on the ICB's overall system of internal control and this will be subject to much more scrutiny in 2023/24.

Kevin Lavery
Chief Executive Officer
29th June 2023

## Remuneration and Staff Report

### Remuneration Committee

The makeup of the remuneration committee can be found earlier in this report.

### Percentage change in remuneration of highest paid director

Reporting bodies are required to disclose the percentage change from the previous financial year in respect of the highest paid member and the average percentage change from the previous financial year in respect of employees of the reporting body, taken as a whole:

| | **Salary and allowances** | **Performance pay and bonuses** |
|---|---|---|
| The percentage change from the previous financial year in respect of the highest paid director | N/A | N/A |
| The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole | N/A | N/A |

The ICB was formed on 1 July 2022 and therefore cannot provide a percentage change in remuneration from the previous financial year.

### Pay ratio information

Reporting bodies are required to disclose the relationship between the total remuneration of the highest-paid director / member in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration of the employee at the 25th percentile, median and 75th percentile is further broken down to disclose the salary component.

The banded remuneration of the highest paid director / member in NHS Lancashire and South Cumbria in the reporting period 1 July 2022 – 31st March 2023 was £255,000 - £260,000.

The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

| **2022/23** | 25th percentile | Median pay ratio | 75th percentile pay ratio |
|---|---|---|---|
| Total remuneration (£) | £39,523 | £50,847 | £72,921 |
| Salary component of total remuneration (£) | £37,633 | £50,847 | £69,855 |
| Pay ratio information | 6.84:1 | 5.06:1 | 3.53:1 |

During the reporting period 2022/23, no employees received remuneration in excess of the highest-paid director/member. Remuneration ranged from £20,000 - £25,000 to £255,000 - £260,000.

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

### Policy on the remuneration of senior managers

Remuneration of senior managers, up to and including Band 9, is undertaken in accordance with Agenda for Change, and guided and advised by the ICB's HR function.

### Remuneration of Very Senior Managers

We are obliged to review the remuneration of all our Senior Executives (non-agenda for change) on an annual basis and in accordance with NHS England's (NHSE) Guidance on ICB Executive Director pay.

NHSE has ranked all Integrated Care Systems in size order according to weighted population, with four categories, A,B,C and D, with A being the smallest and D the largest. This pay framework determines the pay range for the Chief Executive, and the proportionate minimum and operational maximum of statutory executive board roles and other board level executives. LSC ICB is ranked as band D, meaning that the Remuneration Committee can make decisions on board level executive pay, subject to this remaining under £170,000 per annum or the operational maximum, whichever is the lower. Pay proposals exceeding £170k or the operational maximum is subject to NHSE and Department of Health and Social Care approval.

The ICB has also adopted a local pay framework for other VSM roles, and all VSM pay is considered and agreed by the ICB's Remuneration Committee.

## Senior manager remuneration (including salary and pension entitlements)

| Name | Title | 1 July 2022 to 31 March 2023 | | | | | |
|---|---|---|---|---|---|---|---|
| | | (a) Salary (bands of £5,000) | (b) Expense payments (taxable) to nearest £100** | (c) Performance pay and bonuses (bands of £5,000) | (d) Long term performance pay and bonuses (bands of £5,000) | (e) All pension-related benefits (bands of £2,500) | (f) TOTAL (a to e) (bands of £5,000) |
| | | £000 | £ | £000 | £000 | £000 | £000 |
| Kevin Lavery | Chief Executive Officer | 190 - 195 | 1,300 | | | | 195 - 200 |
| Samantha Proffitt | Chief Finance Officer | 130 – 135 | | | | 117.5-120 | 245 - 250 |
| David Levy | Chief Medical Director | 105 – 110 | | | | | 105 – 110 |
| Sarah O'Brien | Chief Nursing Officer | 120 – 125 | | | | 85 – 87.5 | 205 - 210 |
| Maggie Oldham | Chief Planning, Performance and Strategy Officer – from 11/09/22 | 115 – 120 | | | | | 115 – 120 |
| James Fleet | Chief People Officer | 115 - 120 | 2,300 | | | 25 – 27.5 | 145 – 150 |
| Asim Patel | Chief Digital Officer – from 01/11/22 | 55 – 60 | 300 | | | 27.5 – 30 | 85 – 90 |
| Craig Harris | Chief of Health and Care Integration – from 01/11/22 | 60 – 65 | | | | 30 – 32.5 | 95 - 100 |
| Geoff Jolliffe | Partner Member - Primary Medical Services | 10 – 15 | | | | | 10 – 15 |
| David Flory | Chair | 55 – 60 | | | | | 55 – 60 |
| Ebrahim Adia | Non-Executive Member | 5 – 10 | | | | | 5 – 10 |
| Jim Birrell | Non-Executive Member | 10 – 15 | | | | | 10 – 15 |
| Sheena Cumiskey | Non-Executive Member | 10 – 15 | | | | | 10 – 15 |
| Roy Fisher | Non-Executive Member | 10 – 15 | | | | | 10 – 15 |
| Jane O'Brien | Non-Executive Member | 5 – 10 | | | | | 5 – 10 |

**Notes:**

1. All senior managers were in post from 1st July 2022 to 31st March 2023 unless specified above.
2. The full year equivalent salaries are as follows (bands of £5,000):

| | |
|---|---|
| Kevin Lavery | £255,000 - £260,000 |
| Samantha Proffitt | £175,000 - £180,000 |
| David Levy | £140,000 - £145,000 |
| Sarah O'Brien | £155,000 - £160,000 |
| Maggie Oldham | £200,000 - £205,000 |
| James Fleet | £155,000 - £160,000 |
| Asim Patel | £140,000 - £145,000 |
| Craig Harris | £150,000 - £155,000 |
| Geoff Jolliffe | £15,000 - £20,000 |
| David Flory | £75,000 - £80,000 |
| Ebrahim Adia | £15,000 - £20,000 |
| Jim Birrell | £15,000 - £20,000 |
| Sheena Cumiskey | £15,000 - £20,000 |
| Roy Fisher | £10,000 - £15,000 |
| Jane O'Brien | £10,000 - £15,000 |

3. Maggie Oldham is on secondment from Isle of Wight NHS Trust from 11th September 2022.
4. Expense payments (taxable) to the nearest £100 relate to the net taxable benefit of the use of lease cars.
5. The ICB does not have a performance-related pay scheme; the performance of staff is measured through the ICB's annual appraisal process. There is therefore no reference to performance-related bonuses.
6. Pension-related benefits are calculated as follows:

   ((20 x PE) + LSE) – ((20 x PB) + LSB) – Employee contribution

   Where:

   PE = the annual rate of unreduced pension that would be payable to the senior manager if they became entitled to it at the end of the financial year.

   LSE = the amount of unreduced lump sum that would be payable to the senior manager if they became entitled to it at the end of the financial year.

   PB = the annual rate of unreduced pension, adjusted for inflation, that would be payable to the senior manager if they became entitled to it at the beginning of the financial year.

   LSB = the amount of unreduced lump sum, adjusted for inflation, that would be payable to the senior manager if they became entitled to it at the beginning of the financial year.

   Ees cont = employee pension contributions for the financial year.

   To adjust PB and LSB for inflation the Consumer Prices Index (CPI) of 3.1% has been used.

## Pension benefits

| Name | Title | (a) Real increase in pension at pension age (bands of £2,500) | (b) Real increase in pension lump sum at pension age (bands of £2,500) | (c) Total accrued pension at pension age at 31 March 2023 (bands of £5,000) | (d) Lump sum at pension age related to accrued pension at 31 March 2023 (bands of £5,000) | (e) Cash Equivalent Transfer Value at 1 July 2022 | (f) Real Increase in Cash Equivalent Transfer Value | (g) Cash Equivalent Transfer Value at 31 March 2023 | (h) Employers Contribution to partnership pension |
|---|---|---|---|---|---|---|---|---|---|
| | | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| Samantha Proffitt | Chief Finance Officer | 5 – 7.5 | 10 – 12.5 | 65 – 70 | 130 – 135 | 1,075 | 1,244 | 109 | 0 |
| Sarah O'Brien | Chief Nursing Officer | 2.5 – 5 | 5 – 7.5 | 55 – 60 | 110 – 115 | 882 | 1,099 | 79 | 0 |
| James Fleet | Chief People Officer | 0 – 2.5 | 0 – 2.5 | 10 – 15 | 15 – 20 | 160 | 191 | 9 | 0 |
| Asim Patel | Chief Digital Officer | 0 – 2.5 | 0 – 2.5 | 40 – 45 | 70 – 75 | 557 | 625 | 21 | 0 |
| Craig Harris | Chief of Health and Care Integration | 0 – 2.5 | 0 – 2.5 | 40 – 45 | 70 – 75 | 564 | 634 | 21 | 0 |

**Notes:**

1. The payments made to the Lay Members do not include pension contributions. These persons have therefore been excluded from the above table.
2. Any Officers who are not members of the pension scheme have been excluded from the above table.
3. Ms Maggie Oldham is on secondment from Isle of Wight NHS Trust from 11 September 2023. Ms Maggie Oldham remains on the payroll of Isle of Wight NHS Trust.
4. For comparative purposes the CETV figures at 31 March 2022 have been inflated by 3.1%. The real increase in CETV is calculated as follows:

   {CETV at 31/03/2023 – (CETV at 31/03/2022 + 3.1%)} / 365 x 264 - 2022/2023 Employee superannuation contributions

   Where 264 represents the number of days between 1 June 2022 to 31 March 2023.
5. The Integrated Care Board was only able to obtain confirmation of the movement in the cash equivalent transfer values for the Directors' pension entitlements for the period from 1 April 2022 to 31 March 2023. As a result, the Integrated Care Board has apportioned the

movement on a straight line basis to estimate the cash equivalent transfer value at 31 March 2023 (as described in 4. above). This is considered to be a reasonable approximation of the movement in the value of the entitlements during the year.

### Cash equivalent transfer values

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

### Real increase in CETV

This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

CETV figures are calculated using the guidance on discount rates for calculating unfunded public service contribution rates that was extant on 31 March 2023; this guidance will be used in the calculation of 2023/24 CETV figures.

## Staff Report

### Number of senior managers

The following table details the breakdown of ICB staffing by pay band as at the 31st March 2023, including the number of senior managers (represented as 'very senior managers').

| Pay Band | Headcount |
|---|---|
| **Apprentice** | 0 |
| **Band 1** | 0 |
| **Band 2** | 0 |
| **Band 3** | 14 |
| **Band 4** | 38 |
| **Band 5** | 59 |
| **Band 6** | 52 |
| **Band 7** | 80 |
| **Band 8 - Range A** | 86 |
| **Band 8 - Range B** | 56 |
| **Band 8 - Range C** | 37 |
| **Band 8 - Range D** | 25 |
| **Band 9** | 29 |
| **Medical** | 34 |
| **Very Senior Managers** | 38 |
| **Grand Total** | **548** |

### Number of people (average whole time equivalent) employed by NHS Lancashire and South Cumbria ICB (subject to audit):

| | Total number | Permanently employed number | Other number | 2021/22 total number |
|---|---|---|---|---|
| **Total** | 492.74 | 446.27 | 46.47 | n/a |
| **Costs:** | **£'000** | **£'000** | **£'000** | **£'000** |
| **Salaries and wages** | 24,199 | 20,560 | 3,639 | n/a |
| **Social security cost** | 2,395 | 2,395 | 0 | n/a |
| **NHS pension cost** | 3,542 | 3,542 | 0 | n/a |
| **Other pension cost** | 0 | 0 | 0 | n/a |
| **Apprenticeship levy** | 31 | 31 | 0 | n/a |
| **Recoveries in respect of employee benefits** | 0 | 0 | 0 | n/a |
| **Total costs** | 32,866 | 29,226 | 3,639 | n/a |
| **Of the above, number of whole time equivalent people engaged on capital projects** | 0 | 0 | 0 | 0 |

## Staff composition

The following sections provide an overview of diversity within our existing ICB workforce as at 31 March 2023. Please note – we are unable to report on gender reassignment as this data is not routinely collected via the national NHS Electronic Staff Record.

As an ICB, we recognise the need for our workforce to be representative of our resident population. Furthermore, we recognise that we need to do far more to attract and retain a workforce that is representative of the communities we serve, retain the existing diversity within our workforce, and improve the experiences of our diverse staff. Within our existing workforce, there are significant issues with under-reporting of diversity monitoring data which means we need to work harder to encourage our employees to share this information with us so that we are able to understand their needs and the challenges they may face.

### *Gender*

The following table details the breakdown of total ICB staffing by gender as at the 31st March 2023:

| Gender | FTE | Headcount |
|---|---|---|
| **Female** | 372.79 | 420 |
| **Male** | 113.74 | 128 |
| **Grand Total** | 486.52 | 548 |

The following table details the gender split of the ICB Executive Director team (those who are directly employed by the ICB) as at the 31st March 2023:

| Gender | FTE | Headcount |
|---|---|---|
| **Female** | 2 | 2 |
| **Male** | 5 | 5 |
| **Grand Total** | 7 | 7 |

### *Disability*

Census 2021 data tells us that 19.7% of the total resident population of Lancashire and South Cumbria are disabled under the Equality Act, and 8.8% of those individuals, report that their disability limits their day-to-day activities a lot.

In total, 3.2 per cent of Lancashire and South Cumbria ICB's combined workforce has declared that they have a disability. However, 39.1 per cent of the workforce has not declared their disability status which means that the actual number of disabled staff is likely to be higher. This is further supported by the fact that there are a significantly higher number of staff members who have required reasonable adjustments to be made in the workplace due to a disability or long-term condition. Staff are also encouraged to discuss any needs or requests for reasonable adjustments as part of their health and wellbeing conversations with line managers.

### *Ethnicity*

The proportion of Lancashire and South Cumbria's resident population who are from an ethnically diverse background (i.e., non-White British) is currently 10.1 per cent. In comparison, 4.9 per cent of Lancashire and South Cumbria ICB's combined workforce self-reported as coming from ethnically diverse backgrounds. However, it should be noted that 13.6 per cent of the workforce has not stated their ethnicity so the actual proportion is likely to be slightly higher.

### *Religion and Belief*

The following table provides an overview of the most prevalent religions and beliefs within the ICB workforce compared to our resident populations in Lancashire and South Cumbria. Please note that it has not been possible to report on the religion of some of our people due to the risk of identifying individual members of staff.

| Religion and Belief | % ICB Workforce | % Population of Lancashire and South Cumbria |
|---|---|---|
| **Atheism** | 8.4% | 32% |
| **Christianity** | 38.8% | 52.8% |
| **Islam** | 3.2% | 8.3% |
| **Other** | 3.6% | 1.4% |
| **Not declared** | 45% | 5.4% |

### *Sexual Orientation*

The following table provides an overview of sexual orientation within our workforce compared to our resident populations in Lancashire and South Cumbria.

| Religion and Belief | % ICB Workforce | % Population of Lancashire and South Cumbria |
|---|---|---|
| **Gay or Lesbian** | 1.4% | 1.5% |
| **Heterosexual / Straight** | 57.7% | 90.2% |
| **Other** | 0.5% | 1.4% |
| **Not declared** | 40.4% | 6.9% |

### *Sickness absence data*

The following table details the monthly ICB sickness absence rate between 1st July 2022 (the formation of the ICB) and 31st March 2023, including a 12 month cumulative percentage:

| Month | Monthly % | 12 Month Cumulative % |
|---|---|---|
| **July-22** | 2.52 | 2.52 |
| **August-22** | 2.23 | 2.37 |
| **September-22** | 3.08 | 2.61 |
| **October-22** | 2.30 | 2.53 |
| **November-22** | 3.04 | 2.63 |
| **December-22** | 3.34 | 2.75 |
| **January-23** | 2.85 | 2.77 |
| **February-23** | 2.05 | 2.68 |
| **March-23** | 1.99 | 2.60 |

### *Staff turnover percentages*

The following table details the leavers by month and the staff turnover rate across the ICB between 1st July 2022 (the formation of the ICB) and 31st March 2023. March 2023 saw a significant increase in the number of leavers which was largely as a consequence of a time-limited Mutually Agreed Resignation Scheme operated by the ICB whereby 45 employees voluntarily left the organisation. There were also five Board level voluntary redundancies

(legacy CCG roles) and one additional redundancy scenario due to the ending of a fixed term contract in March 2023.

| Month | Leavers by Month | Overall Turnover Rate |
|---|---|---|
| **July-22** | 5.50 | 1.16 |
| **August-22** | 4.80 | 1.01 |
| **September-22** | 6.47 | 1.36 |
| **October-22** | 4.48 | 0.93 |
| **November-22** | 4.40 | 0.91 |
| **December-22** | 9.63 | 1.97 |
| **January-23** | 3.80 | 0.78 |
| **February-23** | 3.02 | 0.62 |
| **March-23** | 53.07 | 10.93 |
| **Grand Total** | 95.18 | 19.74 |

### *Staff engagement percentages*

Lancashire and South Cumbria ICB took part in its first national NHS staff survey in September 2022. The response rate to the survey was 84% against a 73% response rate benchmark across other similar organisations.

The organisation is currently running a 'Big Conversations' engagement programme to explore key themes from the survey and encourage staff to share more about their experiences, ideas, suggestions, and solutions. These sessions have been conducted at both are either by directorate or whole ICB levels, for the purpose of bringing for staff to come together to co-design interventions to improve the working lives of our staff across the organisation.

The ICB level Big Conversations have focused on specific areas/themes that emerged from analysis for the survey results, including: within their teams or alternatively organisation wide conversations are available for all staff with a focus on topic areas such as health and wellbeing, organisational leadership and culture.

### Staff policies

The ICB Board agreed to adopt the following corporate and staff policies upon the establishment of the ICB on the 1st July 2022:

- Complaints Policy
- Standards of Business & Conduct Policy
- Conflicts of Interest Policy
- Public Involvement & Engagement Policy
- Security Management
- Incident, Accident and 'Near Miss' Policy and Procedure
- Information Governance Staff Code of Conduct
- Information Governance & Data Security and Protection Policies
- Information Governance Handbook
- Bad debts
- Absence Management Policy
- Adoption Policy
- Annual Leave Policy
- Career Break Policy
- Disciplinary Policy
- Equality and Inclusion Policy

- Grievance Policy
- Harassment and Bullying at Work Policy
- Induction Policy
- Agenda for Change Job Evaluation and Re-banding Policy
- Managing Work Performance Policy
- Maternity Policy
- Appraisal objectives and performance review (including pay progression) policy
- Organisational Change Policy
- Parental Leave Policy
- Paternity Leave Policy
- Professional Registration Policy
- Recruiting Ex-Offenders Policy
- Recruitment and Selection Policy
- Retirement Policy
- Shared Parental Leave Policy
- Substance Misuse Policy
- Training and Development Policy
- Secondment Policy
- Temporary Promotion Policy
- Freedom to Speak up Policy (Whistleblowing / Raising Concerns)
- Human Rights Policy
- Lone Worker Policy and Procedure

The following list of policies have also been developed or reviewed throughout the reporting period by the ICB:

- Policy for the Development and Management of Policy and Procedural Documents (Policy for Policies)
- Social Media and Digital Content Policy
- Media Relations Policy
- Policy on Sponsorship and Joint Working with the Pharmaceutical Industry and other Commercial Organisations
- ICB Risk Management Strategy and Policy
- Business Continuity Policy
- Emergency Preparedness, Resilience and Response Policy
- Agile Working Guidance
- Anti-Fraud, Bribery and Corruption Policy & response Plan
- Section 106 Monies Community Infrastructure Levy Funding
- Mental Capacity Act
- Safeguarding Children and Adults
- Domestic Abuse and the Workplace Policy

### Trade Union Facility Time Reporting Requirements

The number of employees who were relevant Trade Union officials during the relevant period is 1.

Whilst the ICB does not currently have any formal agreed Trade Union Facility Time agreements in place, regular weekly staff side engagements are in place and facility time for accredited representatives is supported by the ICB.

## Off-payroll engagements

### *Table 1: length of all highly paid off-payroll engagements*

**For all off-payroll engagements as at 31 March 2023, for more than £245[1] per day:**

| | Number |
|---|---|
| **Number of existing engagements as of 31 March 2023** | **11** |
| **Of which, the number that have existed:** | |
| • **for less than one year at the time of reporting** | **11** |
| • **for between one and two years at the time of reporting** | **0** |
| • **for between two and three years at the time of reporting** | **0** |
| • **for between three and four years at the time of reporting** | **0** |
| • **for four or more years at the time of reporting** | **0** |

**Note:**

(1) The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

(2) All existing off-payroll engagements, outlined above, have at some point been subject to a risk based assessment as to whether assurance is required that the individual pays the right amount of Income Tax and National Insurance and, where necessary, that assurance has been sought.

(3) Of the eleven individuals outlined above, the individuals are employed by and on the payroll of an agency and therefore the off-payroll legislation does not apply.

### *Table 2: off-payroll workers engaged at any point during the financial year*

**For all off-payroll engagements between 1 July 2022 and 31 March 2023, for more than £245[1] per day:**

| | Number |
|---|---|
| **Number of temporary off-payroll workers engaged between 1 July 2022 and 31 March 2023** | 23 |
| **Of which:** | |
| **Number not subject to off-payroll legislation** | 0 |
| **Number subject to off-payroll legislation and determined as in-scope of IR35** | 0 |
| **Number subject to off-payroll legislation and determined as out of scope of IR35** | 23 |
| **Number of engagements reassessed for compliance or assurance purposes during the year** | 0 |
| **Of which: number of engagements that saw a change to IR35 status following review** | 0 |

**Note:**

1. The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.
2. A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Department must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes.

### *Table 3: off-payroll board member /senior official engagements*

For any off-payroll engagements of board members and / or senior officials with significant financial responsibility, between 1 July 2022 and 31 March 2023:

| | Number |
|---|---|
| **Number of off-payroll engagements of board members, and / or senior officers with significant financial responsibility, during the reporting period** | **0** |
| **Total number of individuals on payroll and off-payroll that have been deemed "board members and / or senior officials with significant financial responsibility" during the reporting period**<br>***see note 1 below** | **9** |

**Note:**

1: The total figure of 9 above includes Ms Maggie Oldham, who was on secondment from Isle of Wight NHS Trust in the post of Chief Planning, Performance and Strategy Officer.

## Exit packages, including special (non-contractual) payments

### *Table 1: Exit Packages*

| Exit package cost band (inc. any special payment element | Number of compulsory redundancies | Cost of compulsory redundancies | Number of other departures agreed | Cost of other departures agreed | Total number of exit packages | Total cost of exit packages | Number of departures where special payments have been made | Cost of special payment element included in exit packages |
|---|---|---|---|---|---|---|---|---|
| | WHOLE NUMBERS ONLY | £s | WHOLE NUMBERS ONLY | £s | WHOLE NUMBERS ONLY | £s | WHOLE NUMBERS ONLY | £s |
| **Less than £10,000** | **1** | 4,385 | **5** | 27,544 | **6** | 31,929 | **0** | **0** |
| **£10,000 - £25,000** | **2** | 33,740 | **10** | 168,978 | **12** | 202,717 | **0** | **0** |
| **£25,001 - £50,000** | **0** | **0** | **19** | 671,308 | **19** | 671,308 | **0** | **0** |
| **£50,001 - £100,000** | **0** | **0** | **18** | 1,152,448 | **18** | 1,152,448 | **0** | **0** |
| **£100,001 - £150,000** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** |
| **£150,001 – £200,000** | **4** | 640,000 | **0** | **0** | **4** | 640,000 | **0** | **0** |
| **>£200,000** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** |
| **TOTALS** | **7** | **678,125** | **52** | **2,020,277** | **59** | **2,698,401** | **0** | **0** |

Redundancy and other departure cost have been paid in accordance with the provisions of NHS Business Services Authority relevant pension scheme regulations and with due note to Agenda for Change Section 16. Exit costs in this note are accounted for in full in the year of departure.

*Table 2: Analysis of Other Departures*

| | Agreements | Total Value of agreements |
|---|---|---|
| | **Number** | **£000s** |
| Voluntary redundancies including early retirement contractual costs | **0** | **0** |
| Mutually agreed resignations (MARS) contractual costs | **46** | 1,830,423 |
| Early retirements in the efficiency of the service contractual costs | **0** | **0** |
| Contractual payments in lieu of notice* | **6** | 189,854 |
| Exit payments following Employment Tribunals or court orders | **0** | **0** |
| Non-contractual payments requiring HMT approval | **0** | **0** |
| **TOTAL** | **52** | **2,020,277** |

As a single exit package can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match the total numbers in Note 5.3 which will be the number of individuals.

*any non-contractual payments in lieu of notice are disclosed under "non-contracted payments requiring HMT approval" below.

The Remuneration Report includes disclosure of exit packages payable to individuals named in that Report.

### Compensation on early retirement or for loss of office (subject to audit)

The ICB made no payments for early retirement or for loss of office during the financial year.

### Payments to past Directors (subject to audit)

The ICB made no payments to past Directors during the financial year.

### Related party transactions

Information in respect of related party transactions is detailed in Note 19 to the Annual Accounts.

### Better Payment Practice Code (BPPC)

Information in respect of the Better Payment Practice Code (BPPC) is detailed in Note 7 to the Annual Accounts.

### Consultancy expenditure

During the financial period 1 July 2022 to 31 March 2023 we have spent £339k on external consultancy services.

Kevin Lavery
Chief Executive Officer
29th June 2023

## Parliamentary Accountability and Audit Report

NHS Lancashire and South Cumbria ICB is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements with this report. An audit certificate and report are also included in this Annual Report.

# INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE BOARD OF NHS LANCASHIRE AND SOUTH CUMBRIA INTEGRATED CARE BOARD

## REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

### Opinion

We have audited the financial statements of NHS Lancashire and South Cumbria Integrated Care Board ("the ICB") for the nine month period ended 31 March 2023 which comprise the Statement of Comprehensive Net Expenditure, Statement of Financial Position, Statement of Changes in Taxpayers Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the ICB's affairs as at 31 March 2023 and of its income and expenditure for the nine month period then ended; and
- have been properly prepared in accordance with the accounting policies directed by NHS England with the consent of the Secretary of State on 26 April 2023 as being relevant to ICBs in England and included in the Department of Health and Social Care Group Accounting Manual 2022/23; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006 (as amended).

### Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the ICB in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

### Going concern

The Accountable Officer of the ICB ("the Accountable Officer") has prepared the financial statements on the going concern basis, as they have not been informed by the relevant national body of the intention to either cease the ICB's services or dissolve the ICB without the transfer of its services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over its ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

In our evaluation of the Accountable Officer's conclusions, we considered the inherent risks associated with the continuity of services provided by the ICB over the going concern period.

Our conclusions based on this work:

- we consider that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and
- we have not identified, and concur with the Accountable Officer's assessment that there is not, a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the ICB's ability to continue as a going concern for the going concern period.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the above conclusions are not a guarantee that the ICB will continue in operation.

**Fraud and breaches of laws and regulations – ability to detect**

*Identifying and responding to risks of material misstatement due to fraud*

To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit Committee and internal audit as to the ICB's high-level policies and procedures to prevent and detect fraud, as well as whether they have knowledge of any actual, suspected or alleged fraud.
- Assessing the incentives for management to manipulate reported expenditure as a result of the need to achieve statutory targets delegated to the ICB by NHS England.
- Reading Board and Audit Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, we performed procedures to address the risk of management override of controls, in particular the risk that ICB management may be in a position to make inappropriate accounting entries.

On this audit we did not identify a fraud risk related to revenue recognition because of the nature of funding provided to the ICB, which is transferred from NHS England and recognised through the Statement of Changes in Taxpayers' Equity.

We also identified a fraud risk related to the completeness of accrued expenditure at period end, in response to the pressure on the ICB to achieve statutory targets delegated by NHS England.

In determining the audit procedures, we took into account the results of our evaluation of some of the ICB-wide fraud risk management controls.

We also performed procedures including:

- Identifying journal entries and other adjustments to test based on risk criteria and comparing the identified entries to supporting documentation. These included journals which reduced the reported expenditure close to the period end and those which reclassify expenditure from admin to programme.
- Assessing whether the judgements made in making accounting estimates are indicative of a potential bias.
- In response to the fraud risk related to the completeness of accrued expenditure, we performed procedures including a search for unrecorded liabilities and testing of purchase invoices recognised before and after the period end to identify any invoices recognised in the incorrect reporting period.

*Identifying and responding to risks of material misstatement related to compliance with laws and regulations*

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the Board and other management (as required by auditing standards), and discussed with the directors and other management the policies and procedures regarding compliance with laws and regulations.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

Firstly, the ICB is subject to laws and regulations that directly affect the financial statements including the financial reporting aspects of NHS legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

Secondly, the ICB is subject to many other laws and regulations where the consequences of non-compliance could have a material effect on amounts or disclosures in the financial statements, for instance through the imposition of fines or litigation. We identified the following areas as those most likely to have such an effect: health and safety, data protection laws, anti-bribery and employment law, recognising the regulated nature of the ICB's activities and its legal form. Auditing standards limit the required audit procedures to identify non-compliance with these laws and regulations to enquiry of the directors and other management and inspection of regulatory and legal correspondence, if any. Therefore if a breach of operational regulations is not disclosed to us or evident from relevant correspondence, an audit will not detect that breach.

*Context of the ability of the audit to detect fraud or breaches of law or regulation*

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as these may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

**Other information in the Annual Report**

The Accountable Officer is responsible for the other information, which comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information; and
- in our opinion the other information included in the Annual Report for the financial period is consistent with the financial statements.

***Annual Governance Statement***

We are required by the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the "Code of Audit Practice") to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2022/23. We have nothing to report in this respect.

***Remuneration and Staff Reports***

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared, in all material respects, in accordance with the Department of Health and Social Care Group Accounting Manual 2022/23.

**Accountable Officer's responsibilities**

As explained more fully in the statement set out on page 54, the Accountable Officer of the ICB is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the ICB's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to either cease the services provided by the ICB or dissolve the ICB without the transfer of its services to another public sector entity.

**Auditor's responsibilities**

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities.

**REPORT ON OTHER LEGAL AND REGULATORY MATTERS**

**Opinion on regularity**

We are required to report on the following matters under Section 21(4) and (5) of the Local Audit and Accountability Act 2014.

In our opinion, in all material respects, the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

**Report on the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources**

Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the ICB to secure economy, efficiency and effectiveness in its use of resources.

**Significant weaknesses**

The ICB faces a significant challenge in achieving its financial plan for 2023/24. The ICB must deliver Quality, Innovation, Productivity and Prevention Plans (QIPP) of c£170m, of which around 35% was at high risk at the end of the first quarter of the year. The ICB is responsible for ensuring that the Lancashire and South Cumbria system as a whole meets the forecast deficit of £80m, which is also subject to considerable financial risk in the form of high-risk identified Cost Improvement Programmes (CIPs) within the providers and a system stretch target. The ICB has only partial control over how the providers deliver on their CIPs, but there are system-wide interdependencies underpinning these plans that the ICB has a key role in enabling.

We have identified a significant weakness in relation to the financial sustainability of the ICB and the wider system. The significant weakness relates to the level and risk associated with the savings identified within the financial plan that could substantially threaten the delivery of the plan.

We recognise that the system is developing a recovery response that aims to restore financial balance to the system over a three-year period.

We have also identified a significant weakness in the ICB's arrangements in relation to key aspects of its governance arrangements The Board Assurance Framework (BAF), as well as the wider Risk Management Strategy and Policy, were not formally in place until December 2022 and were still not in effective operation at 31 March 2023. Further, the ICB's "Freedom to Speak Up" arrangements were not fully implemented until after March 2023, which is an important aspect of the overall system of internal control in respect of prevention and detection of fraud.

While formal governance features were absent, there is clear evidence from the Board papers and minutes that the matters considered during the year broadly align with the key risks identified through the 'stock take' of risks faced by the ICB, conducted in June 2022.

**Recommendations**

- We recommend that the ICB ensures that resource is allocated appropriately to ensure that each element of the financial plan gains momentum during Q2 of 2023/24 and begins to deliver on the required system-wide financial improvement.
- In relation to the Board Assurance Framework, management should address the concerns raised in relation to comprehensive identification and documentation of key risks, how these link to the ICB's strategic priorities and how the Audit Committee will gain assurance over the effective management of risks where appropriate controls are still to be identified. "Freedom to Speak Up" arrangements should be fully embedded as soon as possible.

***Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources***

As explained more fully in the statement set out on page 54, the Accountable Officer is responsible for ensuring that the ICB exercises its functions effectively, efficiently and economically. We are required under section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We planned our work and undertook our review in accordance with the Code of Audit Practice and related statutory guidance, having regard to whether the ICB had proper arrangements in place to ensure financial sustainability, proper governance and to use information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

**Statutory reporting matters**

We are required by Schedule 2 to the Code of Audit Practice to report to you if we refer a matter to the Secretary of State and NHS England under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the ICB, or an officer of the ICB, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in this respect.

## THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Members of the Board of NHS Lancashire and South Cumbria Integrated Care Board, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Members of the Board of the ICB, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Members of the Board of the ICB, as a body, for our audit work, for this report or for the opinions we have formed.

## CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of NHS Lancashire and South Cumbria ICB for the nine month period ended 31 March 2023 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Timothy Cutler
**for and on behalf of KPMG LLP**
*Chartered Accountants*
1 St Peter's Square
Manchester
M2 3AE

3 July 2023

Data entered below will be used throughout the workbook:

| | |
|---|---|
| Entity name: | NHS Lancashire and South Cumbria Integrated Care Board |
| This year | 2022-23 |
| Last year | 2021-22 |
| This year ended * | 31 March 2023 |
| This year commencing: | 01-July-2022 |

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**Statement of Comprehensive Net Expenditure for the period ended 31 March 2023**

| | Note | 2022-23 £'000 |
|---|---|---|
| Income from sale of goods and services | 3 | (21,053) |
| Other operating income | 3 | (6,881) |
| **Total operating income** | | **(27,934)** |
| | | |
| Staff costs | 5 | 32,865 |
| Purchase of goods and services | 6 | 3,038,204 |
| Depreciation and impairment charges | 6 | 193 |
| Provision expense | 6 | (1,754) |
| Other Operating Expenditure | 6 | 1,639 |
| **Total operating expenditure** | | **3,071,147** |
| | | |
| **Net Operating Expenditure** | | **3,043,213** |
| | | |
| Finance expense | | 4 |
| **Net expenditure for the period** | | **3,043,217** |
| | | |
| **Comprehensive Expenditure for the period** | | **3,043,217** |

**Statement of Financial Position as at 31 March 2023**

| | Note | 2022-23 £'000 |
|---|---|---|
| **Non-current assets:** | | |
| Right-of-use assets | 11 | 3,383 |
| Intangible assets | 12 | 0 |
| **Total non-current assets** | | **3,383** |
| **Current assets:** | | |
| Inventories | 13 | 6,292 |
| Trade and other receivables | 14 | 57,797 |
| Cash and cash equivalents | 15 | 580 |
| **Total current assets** | | **64,669** |
| **Total assets** | | **68,052** |
| **Current liabilities** | | |
| Trade and other payables | 16 | (209,947) |
| Lease liabilities | 11 | (353) |
| Provisions | 17 | 0 |
| **Total current liabilities** | | **(210,300)** |
| **Non-Current Assets plus/less Net Current Assets/Liabilities** | | **(142,248)** |
| **Non-current liabilities** | | |
| Lease liabilities | 11 | (3,034) |
| **Total non-current liabilities** | | **(3,034)** |
| **Assets less Liabilities** | | **(145,282)** |
| **Financed by Taxpayers' Equity** | | |
| General fund | | (145,282) |
| **Total taxpayers' equity:** | | **(145,282)** |

The notes on pages 5 to 31 form part of this statement

The financial statements on pages 1 to 4 have been approved in line with delegated authority granted by the Board on 21 June 2023 and signed on its behalf by:

Kevin Lavery
Chief Executive Officer

**Statement of Changes In Taxpayers Equity for the period ended 31 March 2023**

| | General fund £'000 | Total reserves £'000 |
|---|---|---|
| **Changes in NHS Integrated Care Board taxpayers' equity for 2022-23** | | |
| Net operating expenditure for the financial period | (3,043,217) | **(3,043,217)** |
| Transfers by absorption to (from) other bodies | (156,949) | (156,949) |
| **Net Recognised NHS Integrated Care Board Expenditure for the Financial period** | **(3,200,166)** | **(3,200,166)** |
| Net funding | 3,054,884 | **3,054,884** |
| **Balance at 31 March 2023** | **(145,282)** | **(145,282)** |

The notes on pages 5 to 31 form part of this statement

**Statement of Cash Flows for the period ended**
**31 March 2023**

| | Note | 2022-23 £'000 |
|---|---|---|
| **Cash Flows from Operating Activities** | | |
| Net operating expenditure for the financial period | | (3,043,217) |
| Depreciation and amortisation | 6 | 193 |
| Movement due to transfer by Modified Absorption | | (146,949) |
| Interest paid | | 4 |
| Other Gains & Losses | | (1) |
| (Increase)/decrease in inventories | | (6,292) |
| (Increase)/decrease in trade & other receivables | 14 | (57,797) |
| Increase/(decrease) in trade & other payables | 16 | 209,947 |
| Provisions utilised | 17 | (8,273) |
| Increase/(decrease) in provisions | 17 | (1,754) |
| **Net Cash Inflow (Outflow) from Operating Activities** | | **(3,054,139)** |
| | | |
| **Net Cash Inflow (Outflow) before Financing** | | **(3,054,139)** |
| | | |
| **Cash Flows from Financing Activities** | | |
| Drawdown Funding Received | | 3,054,884 |
| Repayment of lease liabilities | | (165) |
| **Net Cash Inflow (Outflow) from Financing Activities** | | **3,054,719** |
| | | |
| **Net Increase (Decrease) in Cash & Cash Equivalents** | 15 | **580** |
| | | |
| **Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Period** | | **580** |

The notes on pages 5 to 31 form part of this statement

**Notes to the financial statements**

## 1 Accounting Policies

NHS England has directed that the financial statements of Integrated Care Boards (ICBS) shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2022-23 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to Integrated Care Boards, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the ICB for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

### 1.1 Going Concern

These accounts have been prepared on a going concern basis**.**

The Health and Social Care Bill was introduced into the House of Commons on 6 July 2021. The Bill allowed for the establishment of Integrated Care Boards (ICB) across England and abolished Clinical Commissioning Groups (CCG). ICBs took on the commissioning functions of CCGs. CCG functions, assets and liabilities were transferred to ICBs on 1 July 2022.

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

When clinical commissioning group ceased to exist on 1 July 2022, the services continued to be provided by ICBs (using the same assets, by another public sector entity). The financial statements for ICBs are prepared on a Going Concern basis as they will continue to provide the services in the future.

### 1.2 Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

### 1.3 Movement of Assets within the Department of Health and Social Care Group

As Public Sector Bodies are deemed to operate under common control, business reconfigurations within the Department of Health and Social Care Group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies, the Department of Health and Social Care GAM requires the application of absorption accounting. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Department of Health and Social Care Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

### 1.4 Joint arrangements

Arrangements over which the ICB has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement. A joint arrangement is either a joint operation or a joint venture.

A joint operation exists where the parties that have joint control have rights to the assets and obligations for the liabilities relating to the arrangement. Where the ICB is a joint operator it recognises its share of, assets, liabilities, income and expenses in its own accounts.

The ICB's pooled budget arrangements are considered to fall under the provisions of a joint operation.

A joint venture is a joint arrangement whereby the parties that have joint control of the arrangement have rights to the net assets of the arrangement. Joint ventures are recognised as an investment and accounted for using the equity method.

The ICB does not consider itself to be involved in any joint ventures.

### 1.5 Pooled Budgets

The ICB has entered into pooled budget arrangements with local authorities in Lancashire and Cumbria. Under the arrangements, funds are pooled in respect of services for adults with learning disabilities, services to support integrated hospital discharges and the Better Care Fund (BCF) initiative. The BCF is designed to create a local single pooled budget to incentivise the NHS and local government to work more closely together around people, placing their well-being as the focus of health and care services.

Note 21 to the accounts provides details of the ICB's share of the assets, liabilities, income and expenditure for the ICB's pooled fund arrangements.

### 1.6 Operating Segments

The ICB considers itself to have one operating segment which is healthcare for its population.

### 1.7 Revenue

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:

• As per paragraph 121 of the Standard, the ICB will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,

• The ICB is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.

• The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the ICB to reflect the aggregate effect of all contracts modified before the date of initial application.

The main source of funding for the ICBs is from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

Payment terms are standard reflecting cross government principles.

The value of the benefit received when the ICB accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

**Notes to the financial statements**

1.8 **Employee Benefits**

1.8.1 **Short-term Employee Benefits**

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.8.2 **Retirement Benefit Costs**

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the ICB commits itself to the retirement, regardless of the method of payment.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.9 **Other Expenses**

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.10 **Grants Payable**

Where grant funding is not intended to be directly related to activity undertaken by a grant recipient in a specific period, the ICB recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accruals basis.

1.11 **Property, Plant & Equipment**

1.11.1 **Recognition**

Property, plant and equipment is capitalised if:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to the ICB;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and,
- The item has a cost of at least £5,000; or,
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.11.2 **Measurement**

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use; and,
- Specialised buildings – depreciated replacement cost.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are re-valued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

1.11.3 **Subsequent Expenditure**

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

**Notes to the financial statements**

1.12 **Intangible Assets**

1.12.1 **Recognition**

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the ICB's business or which arise from contractual or other legal rights. They are recognised only:

- When it is probable that future economic benefits will flow to, or service potential be provided to, the ICB;
- Where the cost of the asset can be measured reliably; and,
- Where the cost is at least £5,000.

Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised but is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- The technical feasibility of completing the intangible asset so that it will be available for use;
- The intention to complete the intangible asset and use it;
- The ability to sell or use the intangible asset;
- How the intangible asset will generate probable future economic benefits or service potential;
- The availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and,
- The ability to measure reliably the expenditure attributable to the intangible asset during its development.

1.12.2 **Measurement**

Intangible assets acquired separately are initially recognised at cost. The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost or the value in use where the asset is income generating . Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances. Revaluations and impairments are treated in the same manner as for property, plant and equipment.

1.12.3 **Depreciation, Amortisation & Impairments**

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the ICB expects to obtain economic benefits or service potential from the asset. This is specific to the ICB and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life.

At each reporting period end, the ICB checks whether there is any indication that any of its property, plant and equipment assets or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.13 **Donated Assets**

Donated non-current assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are treated in the same way as for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.14 **Government grant funded assets**

Government grant funded assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.15 **Non-current Assets Held For Sale**

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when:

- The sale is highly probable;
- The asset is available for immediate sale in its present condition; and,
- Management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification.

Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Net Expenditure. On disposal, the balance for the asset on the revaluation reserve is transferred to the general reserve.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

**Notes to the financial statements**

1.16 **Leases**

A lease is a contract, or part of a contract, that conveys the right to control the use of an asset for a period of time in exchange for consideration.
The ICB assesses whether a contract is or contains a lease, at inception of the contract.

1.16.1 **The ICB as Lessee**

A right-of-use asset and a corresponding lease liability are recognised at commencement of the lease.
The lease liability is initially measured at the present value of the future lease payments, discounted by using the rate implicit in the lease. If this rate cannot be readily determined, the prescribed HM Treasury discount rates are used as the incremental borrowing rate to discount future lease payments.

Lease payments included in the measurement of the lease liability comprise
-Fixed payments;
-Variable lease payments dependent on an index or rate, initially measured using the index or rate at commencement;
-The amount expected to be payable under residual value guarantees;
-The exercise price of purchase options, if it is reasonably certain the option will be exercised; and
-Payments of penalties for terminating the lease, if the lease term reflects the exercise of an option to terminate the lease.
Variable rents that do not depend on an index or rate are not included in the measurement the lease liability and are recognised as an expense in the period in which the event or condition that triggers those payments occurs.

The lease liability is subsequently measured by increasing the carrying amount for interest incurred using the effective interest method and decreasing the carrying amount to reflect the lease payments made. The lease liability is remeasured, with a corresponding adjustment to the right-of-use asset, to reflect any reassessment of or modification made to the lease.
The right-of-use asset is initially measured at an amount equal to the initial lease liability adjusted for any lease prepayments or incentives, initial direct costs or an estimate of any dismantling, removal or restoring costs relating to either restoring the location of the asset or restoring the underlying asset itself, unless costs are incurred to produce inventories.
The subsequent measurement of the right-of-use asset is consistent with the principles for subsequent measurement of property, plant and equipment. Accordingly, right-of-use assets that are held for their service potential and are in use are subsequently measured at their current value in existing use.

Right-of-use assets for leases that are low value or short term and for which current value in use is not expected to fluctuate significantly due to changes in market prices and conditions are valued at depreciated historical cost as a proxy for current value in existing use.
Other than leases for assets under construction and investment property, the right-of-use asset is subsequently depreciated on a straight-line basis over the shorter of the lease term or the useful life of the underlying asset. The right-of-use asset is tested for impairment if there are any indicators of impairment and impairment losses are accounted for as described in the 'Depreciation, amortisation and impairments' policy.
Peppercorn leases are defined as leases for which the consideration paid is nil or nominal (that is, significantly below market value). Peppercorn leases are in the scope of IFRS 16 if they meet the definition of a lease in all aspects apart from containing consideration.
For peppercorn leases a right-of-use asset is recognised and initially measured at current value in existing use. The lease liability is measured in accordance with the above policy. Any difference between the carrying amount of the right-of-use asset and the lease liability is recognised as income as required by IAS 20 as interpreted by the FReM.
Leases of low value assets (value when new less than £5,000) and short-term leases of 12 months or less are recognised as an expense on a straight-line basis over the term of the lease.

1.17 **Inventories**

Inventories are valued at the lower of cost and net realisable value.

1.18 **Cash & Cash Equivalents**

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.
In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the ICB's cash management.

1.19 **Provisions**

Provisions are recognised when the ICB has a present legal or constructive obligation as a result of a past event, it is probable that the ICB will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:
All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:
• A nominal short-term rate of 3.27% (2021-22: -0.47%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
• A nominal medium-term rate of 3.20% (2021-22: 0.70%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.
• A nominal long-term rate of 3.51% (2021-22 0.95%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.
• A nominal very long-term rate of 3.00% (2021-22: 0.66%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.
A restructuring provision is recognised when the ICB has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

**Notes to the financial statements**

1.20 **Clinical Negligence Costs**
NHS Resolution operates a risk pooling scheme under which the ICB pays an annual contribution to NHS Resolution, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with ICB.

1.21 **Non-clinical Risk Pooling**
The ICB participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the ICB pays an annual contribution to the NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.22 **Carbon Reduction Commitment Scheme**
The Carbon Reduction Commitment scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The ICB is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO2 emissions are made.
The carrying amount of the liability at the financial year end will therefore reflect the CO2 emissions that have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.
The liability will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances required to settle the obligation.
Allowances acquired under the scheme are recognised as intangible assets.

1.23 **Contingent liabilities and contingent assets**
A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the ICB, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.
A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the ICB. A contingent asset is disclosed where an inflow of economic benefits is probable.
Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

1.24 **Financial Assets**
Financial assets are recognised when the ICB becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.
Financial assets are classified into the following categories:

- Financial assets at amortised cost;
- Financial assets at fair value through other comprehensive income and ;
- Financial assets at fair value through profit and loss.

The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.24.1 **Financial Assets at Amortised cost**
Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.24.2 **Financial assets at fair value through other comprehensive income**
Financial assets held at fair value through other comprehensive income are those held within a business model whose objective is achieved by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest.

1.24.3 **Financial assets at fair value through profit and loss**
Financial assets measure at fair value through profit and loss are those that are not otherwise measured at amortised cost or fair value through other comprehensive income. This includes derivatives and financial assets acquired principally for the purpose of selling in the short term.

1.24.4 **Impairment**
For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the ICB recognises a loss allowance representing the expected credit losses on the financial asset.
The ICB adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).
HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The ICB therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the ICB does not recognise allowances for stage 1 or stage 2 impairments against these bodies.
For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.25 **Financial Liabilities**
Financial liabilities are recognised on the statement of financial position when the ICB becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

**Notes to the financial statements**

1.25.1 **Financial Guarantee Contract Liabilities**

Financial guarantee contract liabilities are subsequently measured at the higher of:

- The premium received (or imputed) for entering into the guarantee less cumulative amortisation; and,
- The amount of the obligation under the contract, as determined in accordance with IAS 37: Provisions, Contingent Liabilities and Contingent Assets.

1.25.2 **Financial Liabilities at Fair Value Through Profit and Loss**

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the ICB's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

1.25.3 **Other Financial Liabilities**

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health and Social Care, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.26 **Value Added Tax**

Most of the activities of the ICB are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.27 **Foreign Currencies**

The ICB's functional currency and presentational currency is pounds sterling and amounts are presented in thousands of pounds unless expressly stated otherwise. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the ICB's surplus/deficit in the period in which they arise.

1.28 **Third Party Assets**

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the ICB has no beneficial interest in them.

1.29 **Losses & Special Payments**

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the ICB not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.30 **Critical accounting judgements and key sources of estimation uncertainty**

In the application of the ICB's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

1.30.1 **Critical accounting judgements in applying accounting policies**

The following are the judgements, apart from those involving estimations, that management has made in the process of applying the ICB's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

The ICB's management has reviewed the organisation's lease arrangements and judged that two new right of use assets should be recognised in the financial statements under IFRS16: leases.

1.30.2 **Sources of estimation uncertainty**

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

There are a number of accruals within the Statement of Financial Position where estimation techniques are applied. This is because the outturn information is not available at the time of preparation of the financial statements. Examples of significant accruals involving estimates are prescribing costs and continuing healthcare costs.

1.31 **Gifts**

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.32 **New and revised IFRS Standards in issue but not yet effective**

- IFRS 14 Regulatory Deferral Accounts – Not UK-endorsed. Applies to first time adopters of IFRS after 1 January 2016. Therefore, not applicable to DHSC group bodies.
- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021. Standard is not yet adopted by the FReM which is expected to be April 2025: early adoption is not therefore permitted. It is not expected that adoption of this standard would have a material impact on the ICB accounts.

**Note 2: Financial performance targets**

NHS Integrated Care Boards have a number of financial duties under the NHS Act 2006 (as amended).
The NHS Integrated Care Board's performance against those duties was as follows:

| | 2022-23 Target | 2022-23 Performance | Target Achieved |
|---|---|---|---|
| Capital resource use does not exceed the amount specified in Directions | 3,504 | 3,383 | Yes |
| Revenue resource use does not exceed the amount specified in Directions | 3,043,217 | 3,043,217 | Yes |
| Revenue administration resource use does not exceed the amount specified in Directions | 26,450 | 26,372 | Yes |

## 3 Other Operating Revenue

| | 2022-23 Total £'000 |
|---|---|
| **Income from sale of goods and services (contracts)** | |
| Education, training and research | **1,961** |
| Non-patient care services to other bodies | **1,561** |
| Prescription fees and charges | **17,520** |
| Other Contract income | **11** |
| **Total Income from sale of goods and services** | **21,053** |
| | |
| **Other operating income** | |
| Other non contract revenue | **6,881** |
| **Total Other operating income** | **6,881** |
| | |
| **Total Operating Income** | **27,934** |

## 4 Disaggregation of Income - Income from sale of good and services (contracts)

| | Education, training and research | Non-patient care services to other bodies | Prescription fees and charges | Other Contract income |
|---|---|---|---|---|
| | £'000 | £'000 | £'000 | £'000 |
| **Source of Revenue** | | | | |
| NHS | 1,961 | (5) | 0 | 0 |
| Non NHS | 0 | 1,566 | 17,520 | 11 |
| **Total** | **1,961** | **1,561** | **17,520** | **11** |

| | Education, training and research | Non-patient care services to other bodies | Prescription fees and charges | Other Contract income |
|---|---|---|---|---|
| | £'000 | £'000 | £'000 | £'000 |
| **Timing of Revenue** | | | | |
| Point in time | 1,961 | 1,561 | 17,520 | 11 |
| Over time | 0 | 0 | 0 | 0 |
| **Total** | **1,961** | **1,561** | **17,520** | **11** |

## 5. Employee benefits and staff numbers

### 5.1 Employee benefits

| | Total | | 2022-23 |
|---|---|---|---|
| | Permanent Employees £'000 | Other £'000 | Total £'000 |
| **Employee Benefits** | | | |
| Salaries and wages | 20,560 | 3,639 | **24,199** |
| Social security costs | 2,395 | 0 | **2,395** |
| Employer Contributions to NHS Pension scheme | 3,542 | 0 | **3,542** |
| Apprenticeship Levy | 31 | 0 | **31** |
| Termination benefits | 2,698 | 0 | **2,698** |
| **Gross employee benefits expenditure** | **29,226** | **3,639** | **32,865** |

### 5.2 Average number of people employed

| | 2022-23 | | |
|---|---|---|---|
| | Permanently employed Number | Other Number | Total Number |
| **Total** | **446.27** | **46.56** | **492.83** |

**5.3 Exit packages agreed in the financial period**

| | 2022-23 Compulsory redundancies | | 2022-23 Other agreed departures | | 2022-23 Total | |
|---|---|---|---|---|---|---|
| | Number | £ | Number | £ | Number | £ |
| Less than £10,000 | 1 | 4,385 | 5 | 27,544 | 6 | 31,929 |
| £10,001 to £25,000 | 2 | 33,740 | 10 | 168,977 | 12 | 202,717 |
| £25,001 to £50,000 | 0 | 0 | 19 | 671,308 | 19 | 671,308 |
| £50,001 to £100,000 | 0 | 0 | 18 | 1,152,448 | 18 | 1,152,448 |
| £100,001 to £150,000 | 0 | 0 | 0 | 0 | 0 | 0 |
| £150,001 to £200,000 | 4 | 640,000 | 0 | 0 | 4 | 640,000 |
| **Total** | **7** | **678,125** | **52** | **2,020,277** | **59** | **2,698,402** |

**Analysis of Other Agreed Departures**

| | 2022-23 Other agreed departures | |
|---|---|---|
| | Number | £ |
| Mutually agreed resignations (MARS) contractual costs | 46 | 1,830,423 |
| Contractual payments in lieu of notice | 6 | 189,854 |
| **Total** | **52** | **2,020,277** |

Redundancy and other departure costs have been paid in accordance with the provisions of Agenda for Change.

Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.

Where **entities** has agreed early retirements, the additional costs are met by NHS **Entities** and not by the NHS Pension Scheme, and are included in the tables. Ill-health retirement costs are met by the NHS Pension Scheme and are not included in the tables.

**5.4 Pension costs**

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”. An outline of these follows:

**5.4.1 Accounting valuation**

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2023, is based on valuation data as 31 March 2022, updated to 31 March 2023 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

**5.4.2 Full actuarial (funding) valuation**

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The actuarial valuation as at 31 March 2020 is currently underway and will set the new employer contribution rate due to be implemented from April 2024.

**6. Operating expenses**

| | 2022-23 Total £'000 |
|---|---|
| **Purchase of goods and services** | |
| Services from other ICBs, CCGs and NHS England | 20,927 |
| Services from foundation trusts | 1,378,292 |
| Services from other NHS trusts | 588,654 |
| Purchase of healthcare from non-NHS bodies | 426,110 |
| Purchase of social care | 34,516 |
| Prescribing costs | 246,002 |
| Pharmaceutical services | 50,051 |
| General Ophthalmic services | 80 |
| GPMS/APMS and PCTMS | 261,929 |
| Supplies and services – clinical | 811 |
| Supplies and services – general | 11,949 |
| Consultancy services | 339 |
| Establishment | 3,207 |
| Transport | 312 |
| Premises | 11,669 |
| Audit fees | 290 |
| Other non statutory audit expenditure | |
| · Other services | 42 |
| Other professional fees | 2,174 |
| Legal fees | 456 |
| Education, training and conferences | 394 |
| **Total Purchase of goods and services** | **3,038,204** |
| | |
| **Depreciation and impairment charges** | |
| Depreciation | 165 |
| Amortisation | 28 |
| **Total Depreciation and impairment charges** | **193** |
| | |
| **Provision expense** | |
| Provisions | (1,754) |
| **Total Provision expense** | **(1,754)** |
| | |
| **Other Operating Expenditure** | |
| Chair and Non Executive Members | 166 |
| Grants to Other bodies | 1,444 |
| Inventories consumed | 29 |
| **Total Other Operating Expenditure** | **1,639** |
| | |
| **Total operating expenditure** | **3,038,282** |

The Integrated Care Board's contract with its external auditors (KPMG LLP) provides for a limitation of the auditor's liability. The principal terms of this limitation are as follows:
Liability for all defaults resulting in direct loss or damage to the property of the other party shall be subject to a limit of £1M. In respect of all other defaults, claims, losses or damages the liability shall not exceed £1M.

## 7 Better Payment Practice Code

| Measure of compliance | 2022-23 Number | 2022-23 £'000 |
|---|---|---|
| **Non-NHS Payables** | | |
| Total Non-NHS Trade invoices paid in the Year | 110,454 | 866,162 |
| Total Non-NHS Trade Invoices paid within target | 109,891 | 842,139 |
| **Percentage of Non-NHS Trade invoices paid within target** | **99.49%** | **97.23%** |
| | | |
| **NHS Payables** | | |
| Total NHS Trade Invoices Paid in the Year | 4,981 | 2,016,998 |
| Total NHS Trade Invoices Paid within target | 4,945 | 2,011,676 |
| **Percentage of NHS Trade Invoices paid within target** | **99.28%** | **99.74%** |

## 8. Other gains and losses

| | 2022-23 £'000 |
|---|---|
| Gain/(loss) on disposal of right-of-use assets other than by sale | (1) |
| **Total** | **(1)** |

## 9 Finance costs

| | 2022-23 £'000 |
|---|---|
| **Interest** | |
| Interest on lease liabilities | 4 |
| **Total interest** | **4** |
| **Total finance costs** | **4** |

**10. Net gain/(loss) on transfer by absorption**

Transfers as part of a reorganisation fall to be accounted for by use of absorption accounting in line with the Government Financial Reporting Manual, issued by HM Treasury. The Government Financial Reporting Manual does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

| | | 2022-23 | |
|---|---|---|---|
| | Total **£'000** | NHS England Parent Entities **£'000** | NHS England Group Entities (non parent) **£'000** |
| Transfer of Right of Use assets | 326 | 0 | 326 |
| Transfer of intangibles | 28 | 0 | 28 |
| Transfer of inventories | 6,321 | 0 | 6,321 |
| Transfer of cash and cash equivalents | 898 | 0 | 898 |
| Transfer of receivables | 13,934 | 0 | 13,934 |
| Transfer of payables | (168,005) | 0 | (168,005) |
| Transfer of provisions | (10,027) | 0 | (10,027) |
| Transfer of Right Of Use liabilities | (326) | 0 | (326) |
| Transfer of PUPOC provision | (98) | (98) | 0 |
| **Net loss on transfers by absorption** | **(156,949)** | **(98)** | **(156,851)** |

**11 Leases**

The ICB's right-of-use assets and associated lease liabilities reflect lease arrangements associated with ICB headquarters accommodation.

**11.1 Right-of-use assets**

| 2022-23 | Buildings excluding dwellings £'000 |
|---|---|
| **Cost or valuation at 01 July 2022** | 0 |
| Additions | 3,385 |
| Disposals on expiry of lease term | (380) |
| Transfer (to) from other public sector body | 380 |
| **Cost/Valuation at 31 March 2023** | **3,385** |
| **Depreciation 01 July 2022** | 0 |
| Charged during the year | 165 |
| Disposals on expiry of lease term | (217) |
| Transfer (to) from other public sector body | 54 |
| **Depreciation at 31 March 2023** | **2** |
| **Net Book Value at 31 March 2023** | **3,383** |

**11.2 Lease liabilities**

| 2022-23 | 2022-23 £'000 |
|---|---|
| **Lease liabilities at 01 July 2022** | 0 |
| Additions purchased | (3,385) |
| Interest expense relating to lease liabilities | (4) |
| Repayment of lease liabilities (including interest) | 165 |
| Disposals on expiry of lease term | 163 |
| Transfer (to) from other public sector body | (326) |
| **Lease liabilities at 31 March 2023** | **(3,387)** |

**11.3 Lease liabilities - Maturity analysis of undiscounted future lease payments**

| | 2022-23 £'000 |
|---|---|
| Within one year | (548) |
| Between one and five years | (1,467) |
| After five years | (1,686) |
| **Balance at 31 March 2023** | **(3,701)** |

All lease liabilities are with external counterparties i.e. outside of the NHS and DHSC group.

**11.4 Amounts recognised in Statement of Comprehensive Net Expenditure**

| 2022-23 | 2022-23 £'000 |
|---|---|
| Depreciation expense on right-of-use assets | 165 |
| Interest expense on lease liabilities | 4 |

**11.5 Amounts recognised in Statement of Cash Flows**

| | 2022-23 £'000 |
|---|---|
| Total cash outflow on leases under IFRS 16 | 165 |

**12 Intangible non-current assets**

| **2022-23** | **Computer Software: Purchased £'000** | **Total £'000** |
|---|---|---|
| **Cost or valuation at 01 July 2022** | **0** | **0** |
| Transfer (to)/from other public sector body | 188 | **188** |
| **Cost / Valuation At 31 March 2023** | **188** | **188** |
| **Amortisation 01 July 2022** | **0** | **0** |
| Charged during the year | 28 | **28** |
| Transfer (to) from other public sector body | 160 | **160** |
| **Amortisation At 31 March 2023** | **188** | **188** |
| **Net Book Value at 31 March 2023** | **0** | **0** |

**13 Inventories**

| | Loan Equipment |
|---|---|
| | £'000 |
| **Balance at 01 July 2022** | 0 |
| Additions | (29) |
| Inventories recognised as an expense in the period | 0 |
| Transfer (to) from other public sector body by Absorption | 6,321 |
| **Balance at 31 March 2023** | **6,292** |

| **14.1 Trade and other receivables** | **Current 2022-23 £'000** |
|---|---|
| NHS receivables: Revenue | 9,354 |
| NHS prepayments | 152 |
| NHS accrued income | 163 |
| Non-NHS and Other WGA receivables: Revenue | 32,756 |
| Non-NHS and Other WGA prepayments | 4,980 |
| Non-NHS and Other WGA accrued income | 10,136 |
| VAT | 125 |
| Other receivables and accruals | 131 |
| **Total Trade & other receivables** | **57,797** |
| **Total current and non current** | **57,797** |

**14.2 Receivables past their due date but not impaired**

| | 2022-23 | 2022-23 |
|---|---|---|
| | DHSC Group Bodies | Non DHSC Group Bodies |
| | £'000 | £'000 |
| By up to three months | 459 | 5,157 |
| By three to six months | 27 | 3,648 |
| By more than six months | 82 | 96 |
| **Total** | **568** | **8,901** |

The ICB reviewed its financial assets at 31 March 2023 and did not consider it to be necessary to provide for losses based on its portfolio.

## 15 Cash and cash equivalents

| | 2022-23<br>£'000 |
|---|---|
| **Balance at 01 July 2022** | 0 |
| Net change in accounting period | 580 |
| **Balance at 31 March 2023** | **580** |
| | |
| Made up of: | |
| Cash with the Government Banking Service | 580 |
| **Cash and cash equivalents as in statement of financial position** | **580** |
| | |
| **Balance at 31 March 2023** | **580** |

| **16 Trade and other payables** | **Current 2022-23 £'000** |
|---|---|
| NHS payables: Revenue | 31,554 |
| NHS accruals | 7,325 |
| Non-NHS and Other WGA payables: Revenue | 46,941 |
| Non-NHS and Other WGA accruals | 99,725 |
| Non-NHS and Other WGA deferred income | 49 |
| Social security costs | 521 |
| Tax | 986 |
| Other payables and accruals | 22,846 |
| **Total Trade & Other Payables** | **209,947** |
| | |
| Total current and non-current | **209,947** |

Other payables include £2,354k outstanding pension contributions at 31 March 2023.

## 17 Provisions

| | Continuing Care £'000 | Other £'000 | Total £'000 |
|---|---|---|---|
| **Balance at 01 July 2022** | **0** | **0** | **0** |
| Utilised during the financial period | (8,022) | (251) | **(8,273)** |
| Reversed unused | (1,754) | 0 | **(1,754)** |
| Transfer (to) from other public sector body under absorption | 9,776 | 251 | **10,027** |
| **Balance at 31 March 2023** | **0** | **0** | **0** |

The continuing care provision balance transferred from CCGs to the ICB was in respect of packages of continuing healthcare that were funded by local authorities. The funding for these cases however should have been provided by the NHS, according to national CHC framework guidance.

The continuing care provision has been used to settle the claims from the local authorities in this accounting period and the element of the balance that was not required has been reversed.

## 18 Contingencies

The Integrated Care Board had no contingent liabilities as at 31 March 2023.

## 19 Commitments

### 19.1 Capital commitments

The NHS Integrated Care Board had no contracted capital commitments not otherwise included in these financial statements as at 31 March 2023.

### 19.2 Other financial commitments

The NHS Integrated Care Board had no non-cancellable contracts (which were not leases, private finance initiative contracts or other service concession arrangements) as at 31 March 2023.

## 20 Financial instruments

### 20.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because NHS clinical commissioning group is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The clinical commissioning group has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the clinical commissioning group in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the NHS clinical commissioning group standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the NHS clinical commissioning group and internal auditors.

#### 20.1.1 Currency risk

The NHS clinical commissioning group is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The NHS clinical commissioning group has no overseas operations. The NHS clinical commissioning group and therefore has low exposure to currency rate fluctuations.

#### 20.1.2 Interest rate risk

The clinical commissioning group borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The clinical commissioning group therefore has low exposure to interest rate fluctuations.

#### 20.1.3 Credit risk

Because the majority of the NHS clinical commissioning group and revenue comes parliamentary funding, NHS clinical commissioning group has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

#### 20.1.4 Liquidity risk

NHS clinical commissioning group is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The NHS clinical commissioning group draws down cash to cover expenditure, as the need arises. The NHS clinical commissioning group is not, therefore, exposed to significant liquidity risks.

#### 20.1.5 Financial Instruments

As the cash requirements of NHS England are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS England's expected purchase and usage requirements and NHS England is therefore exposed to little credit, liquidity or market risk.

**20.2 Financial assets**

| | Financial Assets measured at amortised cost 2022-23 £'000 | Total 2022-23 £'000 |
|---|---|---|
| Trade and other receivables with NHSE bodies | 422 | 422 |
| Trade and other receivables with other DHSC group bodies | 19,257 | 19,257 |
| Trade and other receivables with external bodies | 32,861 | 32,861 |
| Cash and cash equivalents | 580 | 580 |
| **Total at 31 March 2023** | **53,120** | **53,120** |

**20.3 Financial liabilities**

| | Financial Liabilities measured at amortised cost 2022-23 £'000 | Total 2022-23 £'000 |
|---|---|---|
| Trade and other payables with NHSE bodies | 3,543 | **3,543** |
| Trade and other payables with other DHSC group bodies | 37,726 | **37,726** |
| Trade and other payables with external bodies | 170,509 | **170,509** |
| **Total at 31 March 2023** | **211,778** | **211,778** |

**21 Joint arrangements - interests in joint operations**

The ICB has entered into pooled budget arrangements for services for adults with learning disabilities, services to support integrated hospital discharges and Better Care Fund (BCF). The BCF is an integrated commissioning approach between local authorities and the ICB to help jointly plan and deliver local services.

The ICB's share of the assets, liabilities, income and expenditure handled by the pooled budget in the accounting period were:

| Name of arrangement | Parties to the arrangement | Description of principal activities | Amounts recognised in ICB Accounts 2022-23 | | | |
|---|---|---|---|---|---|---|
| | | | Assets | Liabilities | Income | Expenditure |
| | | | £'000 | £'000 | £'000 | £'000 |
| Learning Disabilities Pool | Lancashire County Council NHS Lancashire and South Cumbria Integrated Care Board | Services for Adults with Learning Disabilities | 0 | 0 | -1,564 | 9,355 |
| Learning Disabilities Pool | Cumbria County Council NHS Lancashire and South Cumbria Integrated Care Board | Services for Adults with Learning Disabilities | 0 | -149 | 0 | 1,467 |
| Better Care Fund | Lancashire County Council NHS Lancashire and South Cumbria Integrated Care Board | Services supporting the integration of Health and Social Care hosted by Lancashire County Council | 0 | -2,660 | -66,498 | 78,366 |
| Better Care Fund | Cumbria County Council NHS Lancashire and South Cumbria Integrated Care Board | Services supporting the integration of Health and Social Care hosted by Lancashire County Council | 0 | 0 | 0 | 7,509 |
| Better Care Fund | Blackpool Borough Council NHS Lancashire and South Cumbria Integrated Care Board | Services supporting the integration of Health and Social Care hosted by Lancashire County Council | 0 | 0 | -16,431 | 16,457 |
| Better Care Fund | Blackburn with Darwen Borough Council NHS Lancashire and South Cumbria Integrated Care Board | Services supporting the integration of Health and Social Care hosted by Lancashire County Council | 516 | 0 | -8,173 | 9,383 |
| Hospital Discharge Fund | Lancashire County Council NHS Lancashire and South Cumbria Integrated Care Board | Services to support integrated hospital discharges | 0 | 0 | -315 | 315 |
| Hospital Discharge Fund | Cumbria County Council NHS Lancashire and South Cumbria Integrated Care Board | Services to support integrated hospital discharges | 0 | 0 | -931 | 931 |
| Hospital Discharge Fund | Blackpool Borough Council NHS Lancashire and South Cumbria Integrated Care Board | Services to support integrated hospital discharges | 0 | 0 | -1,982 | 1,982 |
| Hospital Discharge Fund | Blackburn with Darwen Borough Council NHS Lancashire and South Cumbria Integrated Care Board | Services to support integrated hospital discharges | 0 | 0 | -5,151 | 5,151 |

**22 Related party transactions**

**Details of related party transactions with individuals during the financial period are as follows:**

| | Payments to Related Party £'000 | Receipts from Related Party £'000 | Amounts owed to Related Party £'000 | Amounts due from Related Party £'000 |
|---|---|---|---|---|
| Ebrahim Adia - Non Executive Member - Deputy ICB Chair People - Pro Vice Chancellor UCLAN (University of Central Lancashire) | 62 | 0 | 0 | 0 |
| Caroline Donovan (ICB Partner Board Member): Chief Executive of NHS Lancashire and South Cumbria Foundation Trust | 293,920 | (3,607) | 7,997 | (5,331) |
| David Flory - Chair - Chair of Lancashire Football Association | 1 | 0 | 0 | 0 |
| David Flory (ICB Chair): Chair of Liverpool University Hospitals NHS Foundation Trust | 11,547 | 0 | 703 | 0 |
| Dr Geoff Jolliffe (ICB GP Partner Member): Employed GP by Cumbria Health on Call (CHOC) | 3,980 | 0 | 0 | 0 |
| Dr Geoff Jolliffe (ICB GP Partner Member): Employed GP by Highland Health Board | 109 | 0 | 0 | 0 |
| Dr Geoff Jolliffe (ICB GP Partner Member): Wife is employed at Risedale Surgery | 853 | 0 | 41 | 0 |
| Dr Geoff Jolliffe (ICB GP Partner Member): Daughter is employed by University Hospitals of Morecambe Bay NHS Foundation Trust | 315,132 | (64) | 4,446 | 0 |
| Kevin McGee (ICB Partner Board Member): Chief Executive of Lancashire Teaching Hospitals NHS Foundation Trust | 330,526 | (72) | 7,225 | (98) |
| Jane O'Brien - Non Executive Member - Emeritus Professor Lancaster University | 34 | 0 | 0 | 0 |
| Maggie Oldham (ICB Chief Planning, Performance and Strategy Officer - secondment): substantive role is Chief Executive Officer Isle of Wright NHS Trust | 21 | 0 | 134 | 0 |
| Samantha Proffitt (ICB Chief Finance Offer): Common law partner is Deputy Chief Executive of Mersey Care NHS Foundation Trust | 5,577 | 0 | 288 | 0 |
| Angie Ridgwell - Partner Member Local Authorities - Chief Executive Officer Lancashire County Council | 52,073 | (1,564) | 24,776 | (36,641) |
| Angie Ridgwell - Partner Member Local Authorities - Director of Resources Lancashire County Council | 52,073 | (1,564) | 24,776 | (36,641) |

Please note that the above figures represent the total value of transactions between the ICB and the organisations identified as an interest. The values do
The above table concentrates on the interests and related transactions of the members of the ICB Governing Body only.

**22 Related party transactions continued**

The Department of Health and Social Care is regarded as a related party.
During the period the ICB had a significant number of material transactions with entities for which the Department is
Those bodies not already included in the table above with transactions greater than £1 million are:

East Lancashire Hospitals NHS Trust
North West Ambulance Service NHS Trust
Lancashire and South Cumbria NHS Foundation Trust
University Hospitals of Morecambe Bay NHS Foundation Trust
NHS Midlands & Lancashire CSU
Leeds Teaching Hospitals NHS Trust
Southport & Ormskirk Hospital NHS Trust
St Helens and Knowsley Hospital Services NHS Trust
Liverpool University Hospitals NHS Foundation Trust
Airedale NHS Foundation Trust
Alder Hey Children's NHS Foundation Trust
Blackpool Teaching Hospitals NHS Foundation Trust
Bolton NHS Foundation Trust
Bradford Teaching Hospitals NHS Foundation Trust
North Cumbria Integrated Care NHS Foundation Trust
Liverpool Heart & Chest Hospital NHS Foundation Trust
Manchester University NHS Foundation Trust
Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust
Northern Care Alliance NHS Foundation Trust
The Christie NHS Foundation Trust
Wrightington, Wigan & Leigh NHS Foundation Trust
NHS Property Services
Community Health Partnerships

In addition, the ICB has had a number of transactions with other government departments and other
Blackpool Borough Council
Cumbria County Council
Blackburn with Darwen Council

**23 Events after the end of the reporting period**

There were no events after the end of the reporting period.

**24 Losses and special payments**

**Losses**

The total number of NHS clinical commissioning group losses and special payments cases, and their total value, was as follows:

| | Total Number of Cases 2022-23 Number | Total Value of Cases 2022-23 £'000 |
|---|---|---|
| Fruitless payments | 5 | 0 |
| **Total** | **5** | **0** |

## Lancashire & South Cumbria

**ICS Total** **QE1**

| CDEL | | Plan Months 1-12 | Total Expenditure Months 1-3 | Budget Months 4-12 | Narrative on the main categories of expenditure Period covered M1 - M12 |
|---|---|---|---|---|---|
| Provider | Operational Capital | 110,539 | 12,142 | 98,397 | Main areas of spend include backlog maintenance (£11m), Routine maintenance (£15m), Equipment (£14m), IT (£16m), Fleet and Vehicles (£12m) and various new build schemes (£34m). Sources of funding £6.4m of RAAC Plank remiedial works funded by PDC. £2.7m pre-approved emergency loan funding. Remainder is self financed. |
| ICB | Operational Capital | 3,117 | 0 | 3,117 | Primarily Gp IT (£2.9m). |
| | Total Op Cap | **113,656** | **12,142** | **101,514** | |
| Provider | Impact of IFRS 16 | 9,121 | 0 | 9,121 | New equipment leases (£3m), new vehicle leases (£3.5m) and new building leases (£1.4m). Remainder is lease re-measurements |
| ICB | Impact of IFRS 16 | 0 | 0 | 0 | |
| Provider | Upgrades and NHP Programmes | 9,060 | 1,158 | 7,902 | £1m NHP and £8m pathology collaboration. Pathology scheme still awaiting approval. |
| Provider | National Programmes (diagnostics, Front line digitisation, Mental Health, TIF) | 51,918 | 1,175 | 50,743 | Elective recovery (£30m), CDC (£7m), Frontline digititisation (£1.6m) |
| Provider | Other (technical accounting) | 2,294 | 573 | 1,721 | PFI capital charges (residual interest) |
| | Total system CDEL | 186,049 | 15,048 | 171,001 | |



Appendix B

Appendix C

# Joint capital resource use plan – 2023/24

| REGION | North West |
|---|---|
| ICB / SYSTEM | NHS Lancashire and South Cumbria ICB |

## Introduction

*Figures based on M11 forecast outturn and exclude the impact of IFRS16.*

In 2022/23 the ICB incurred capital expenditure of £212m; £209m in providers and £3m in primary care. This was funded by £95m of trust internal resources, £23m of approved loans and lease liabilities and £94m of national Public Dividend Capital (PDC) funding. Of the £94m PDC funding £19m was spent on community diagnostic centres and a further £24m went to supporting recovery of elective activity.

The key priorities for 2023/24 are the completion of the elective recovery and community diagnostic centre schemes as well as the eradication of Reinforced Autoclaved Aerated Concrete (RAAC) from Trust premises. Further priorities are the implementation of electronic patient record systems where these are not currently present or fit for purpose as well as reducing backlog maintenance in Trust estates. Funding is also anticipated for the development of the business case to develop the Royal Preston and Lancaster Royal Infirmary sites as part of the New Hospital Program.

## Assumed Sources of Funding for 2023/24

As shown in Annex A, the total capital programme for 2023/24 is £184.6m. Excluding the impact of IFRS 16 the plan is £174m with the funding for this being as follows:

- Trust own resources £107m
- Pre-approved loan funding £1m
- PDC £63m
- Primary care £3m

This is considered to be low risk as all the funding has been confirmed.

## Overview of Ongoing Scheme Progression

In 2023/24 several large schemes which started in previous years will continue the main ones being:

- Elective Recovery £25m
- Community Diagnostic Centres £10m
- Eradication of RAAC £3m
- Front line digitisation £15m
- New Hospitals Programme (NHP) - ongoing development of the business case

## Risks and Contingencies

The main risk to capital plans in 2023/24 is the risk of inflation creating an in-year pressure on budgets. The risk will be managed through tight monitoring of spend in-year. Given the ICB and provider track records of spending within capital allocations the risk is considered as low risk.

## Business Cases in 2023/24

They main business case expected to be submitted in 2023/24 is for a new Electronic Patient Records (EPR) system at Blackpool Foundation Trust with £14.8m planned to be spent in 2022/23 (£23.4m in total). Work will also continue on the NHP business case with £1.2m planned to be spent in year.

## Cross System Working

Northwest Ambulance Service NHS Trust (NWAS) operates across all ICBs in the Northwest region and as such the capital expenditure incurred by them directly impacts these systems.

The ICB works closely with Cheshire and Merseyside ICB on capital plans for Southport and Ormskirk Hospitals NHS Trust.

## Capital Planning & Prioritisation

Community Diagnostic Centres and Elective Recovery schemes represent a prioritisation process that was operated by the system.
EPR funding has been directed towards those organisations with the lowest digital maturity.
Capital funding was allocated between providers based on their need to replace existing assets by using depreciation as the basis allocating funding.

**Annex A – NHS Lancashire and South Cumbria ICB 2023/24 CAPITAL PLAN**

| | CDEL | Lancashire and South Cumbria ICB £000 | Blackpool Teaching Hospitals NHS Foundation Trust £000 | East Lancashire Hospitals NHS Trust £000 | Lancashire and South Cumbria NHS Foundation Trust £000 | Lancashire Teaching Hospitals NHS Foundation Trust £000 | Northwest Ambulance Service NHS Trust £000 | University Hospitals of Morecambe Bay NHS Foundation Trust £000 | Total Full Year Plan £000 |
|---|---|---|---|---|---|---|---|---|---|
| Provider | Operational Capital | | 21,139 | 14,011 | 14,353 | 22,370 | 23,787 | 19,215 | 114,875 |
| ICB | Operational Capital | 3,113 | | | | | | | 3,113 |
| | Total Op Cap | | 21,139 | 14,011 | 14,353 | 22,370 | 23,787 | 19,215 | 117,988 |
| Provider | Impact of IFRS 16 | | 0 | 4,970 | 0 | 362 | 4,672 | 0 | 10,004 |
| ICB | Impact of IFRS 16 | 504 | | | | | | | 504 |
| Provider | Upgrades & NHP Programmes | | 0 | 0 | 0 | 880 | 0 | 350 | 1,230 |
| Provider | National Programmes (diagnostics, Front line digitisation, Mental Health, TIF) | | 22,748 | 4,924 | 1,408 | 12,708 | 0 | 10,667 | 52,455 |
| Provider | Other (technical accounting) | | 0 | 2,375 | 1 | 0 | 0 | 0 | 2,376 |
| | Total system CDEL | 3,617 | 43,887 | 26,280 | 15,762 | 36,320 | 28,459 | 30,232 | 184,557 |

Appendix D

# Lancashire and South Cumbria Integrated Care System

## Our NHS Joint Forward Plan for 2023 onwards

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# 1. Foreword

NHS Lancashire and South Cumbria Integrated Care Board (ICB) is responsible for developing a joint forward plan for the NHS over the next five years. The ICB forms part of the Integrated Care System across Lancashire and South Cumbria, the formal partnership of organisations working together to improve the health and wellbeing of our population.

Our plan describes how the NHS will meet the health needs of our population by working jointly with partners on prevention and by working with all organisations within the NHS family to transform the way healthcare services are provided.

**Our plan has been developed at a time of enormous challenges for health and care services**. The demands and expectations on services are ever-increasing alongside significant financial and workforce constraints.

We know we have faced many of these challenges for some time and we acknowledge we cannot solve them without changing the way we work as a health and care system. **We are clear on the 'what' and the 'why' but up until now we have not grasped the 'how'.** We are ready to take action and work very differently.

There are significant health and well-being issues within Lancashire and South Cumbria and the COVID-19 pandemic has made these worse, with health inequalities widening in some areas. The cost-of-living crisis is expected to worsen the position further still.

The pressures we face are not unique to us, but their impact on our communities is affected by our local demographics. Almost a third of our residents are living in some of the most deprived areas of England, with poor health outcomes and widening inequalities. There are significant differences in the number of years people can expect to live a healthy life across our area. We know many people in Lancashire and South Cumbria (LSC) could be living longer, healthier, happier lives than they currently do.

We need to work with partners and local communities to prevent people from becoming ill in the first place by tackling the wider determinants of health (the diverse range of social, economic and environmental factors which impact on people's health) and supporting people to make positive health and well-being choices while also improving access to health and care services.

The establishment of our Integrated Care Board is an opportunity to make a real difference to the health and lives of the people who live here and the quality of care in Lancashire and South Cumbria. This Joint Forward Plan outlines, at a high level, how we will work alongside our providers and other partners to meet the challenges set out above. It builds upon existing system strategies and activity that is already under way and provides an overarching narrative about what it is we are all trying to change and improve together.

We have developed an integrated care strategy with our partners in local government, the voluntary, community, faith, and social enterprise sector and local people. The strategy details a joined-up work programme across the whole life course of our population to

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improve prevention and integrate health and social care. It will drive integrated working at system, place, and neighbourhood, to improve the health and well-being of our population. This Joint Forward Plan responds to the commitments made by the NHS within this strategy.

Our system finance colleagues are developing a financial framework for the next three years that sets out the context for the difficult decisions we will need to make under harsher financial conditions, including the establishment of our formal recovery and transformation programme. This joint Forward Plan describes our financial framework and how it will influence our work over the coming years.

Fundamental to the delivery of the Joint Forward Plan will be our four places and the development of our place integration deal. This emerging deal sets out a clear vision and ambition for the places, as a key driving force in ensuring our residents have healthy communities, high-quality services and a health and care service that works for them.

Our communities will be at the centre of everything we do. With our partners we have agreed on how we will work with people and communities to listen, involve and co-produce our plans together. This will help to develop ways of working that focus on local people and their lived experience, putting our population's needs at the heart of all we do. Listening to communities, members of the public and partners has already contributed to the shaping of this plan. It is clear from this engagement that local communities also want to see action that improves services, reduces health inequalities and improves access by listening to communities and the experiences of our residents.

Together, we will achieve our vision of longer and healthier lives for our population across Lancashire and South Cumbria.

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**Kevin Lavery**
Chief executive of NHS Lancashire and South Cumbria Integrated Care Board

**David Flory CBE**
Chair of NHS Lancashire and South Cumbria Integrated Care Board

# 2. Introduction

When the NHS was established in 1948 it mainly focused on treating single conditions or illnesses. Since then, the health and care needs of our populations - and their demands and expectations of the NHS - have changed.

More people than ever are living longer with multiple, complex, long-term conditions and often need support from many different services, sectors and professionals. Unfortunately, people often receive care from different services that are not as joined-up as they could be and are not always centered around their needs. This is not a good use of vital NHS time and resources and can mean patients have a poorer experience of health and care, take longer to recover from illness or injury and have to 'tell their story' to lots of different teams.

In the past, while there have been connections between the organisations that have a role in health and well-being, often they have not formally worked in a joined-up or integrated way. This is because many organisations were encouraged to compete for resources, rather than collaborate.

The Health and Care Act 2022 marks a change from this competitive way of working. It sets out in law that the NHS must work in an integrated way with other organisations and partners.

Integrated care systems (ICSs) are geographically-based partnerships that bring together providers and commissioners of NHS services with local government and other local partners to plan, coordinate and commission health and care services.

Integrated care boards (ICBs) are tasked with improving the health and well-being of the whole population by harnessing the knowledge, skills and talents of all partner organisations within the ICS.

Together, all the partners in the ICS are responsible for improving outcomes, tackling inequalities, improving productivity and helping the NHS support broader social and economic development. This new structure expects and encourages collaboration at every level.

The Health and Care Act offers an opportunity for partners across Lancashire and South Cumbria to understand the important contribution each organisation makes to people's health and well-being and therefore how creating shared plans and forging new relationships will really benefit our population.

We intend to connect services across councils, the NHS, voluntary, community, faith, and social enterprise (VCFSE) organisations and beyond, to provide seamless and integrated services for our population, the majority of which will be planned and delivered within our places.

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This Joint Forward Plan for the NHS includes joint working between health and social care and within the NHS family of providers, including hospitals, primary care, community, mental health, and acute providers.

## A new way of working

To deliver improved health and well-being for our population by working in an integrated way we need to have the right structures in place to support and drive change. This means 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.

Our places and neighbourhoods put our residents, their families, their carers and wider communities at the centre of our integrated working. Most people's day-to-day care and support needs will be planned and delivered within a place and its neighbourhoods.

- **System**: Integrated working across Lancashire and South Cumbria.
- **Places**: Integrated working in the areas covered by our four place-based partnerships, covering Lancashire, Blackburn with Darwen, Blackpool and South Cumbria.
- **Neighbourhoods**: Integrated working in the areas covered by our 42 primary care networks and local neighbourhood teams.

## Components of the Lancashire and South Cumbria Integrated Care System

**Lancashire and South Cumbria**

| NHS and wider partners | Integrated working within the NHS family | | |
|---|---|---|---|
| **Lancashire and South Cumbria Integrated Care Partnership (ICP)**<br>A group of organisations and representatives that work together to improve the care, health and wellbeing of the population. | **Lancashire and South Cumbria Integrated Care Board (ICB)**<br>Established on 1 July 2022, the ICB is responsible for planning and buying health services in the region. | **Provider collaborative**<br>Health trusts working more closely together to jointly improve care and productivity for patients. | System |
| **Four place-based partnerships**<br>Our Blackburn with Darwen, Blackpool and Lancashire places cover the entire geography of their respective local authorities - Blackburn with Darwen Borough Council, Blackpool Council, Lancashire County Council and the twelve district councils.<br>Our South Cumbria place covers the geography of the newly created Westmorland and Furness Council, without the Eden District, some parts of the Borough of Copeland which sit within the newly created Cumberland Council, and some parts of the District of Craven which sit within the newly created North Yorkshire Council.<br>This means that we need to work with some local authorities and providers of health and care services that are outside of our borders. | | | System |
| **42 neighbourhoods**<br>Neighbourhoods are where communities come together to shape and join up health and care services, but also to address the wider things that have an impact on their health. The exact size and shape of neighbourhoods is agreed locally within places. This is because each neighbourhood is different – they are based around footprints that make sense to communities, often related to specific towns or villages, or centred around resources available within a community.<br>Integrated working in these areas includes district councils, community groups and organisations, primary care services and wider health and care teams which will come together to form neighbourhood teams. | | | System |

## The structure of the ICS

The Integrated Care System in Lancashire and South Cumbria was established under the Health and Care Act 2022 with statutory powers and responsibilities and is made up of two formal parts:

- **The Lancashire and South Cumbria Integrated Care Board (ICB)** is the statutory body responsible for commissioning (planning and buying) NHS services for the 1.8 million people living in Lancashire and South Cumbria. The ICB must work in partnership with local authorities and wider organisations and integrate services wherever possible to deliver the greatest possible improvement in health and well-being. Members of the ICB board include representatives from NHS providers, primary medical services and local authorities.
- **The Lancashire and South Cumbria Integrated Care Partnership (ICP)** is a statutory committee formed jointly between the NHS ICB and all upper-tier local authorities in Lancashire and South Cumbria (councils with responsibility for children's and adult social care and public health). The ICP brings together partners that have a role in improving the health and well-being of the population, with membership determined locally. The ICP is responsible for producing an Integrated Care Strategy which details how the local health and well-being needs of the population will be met.

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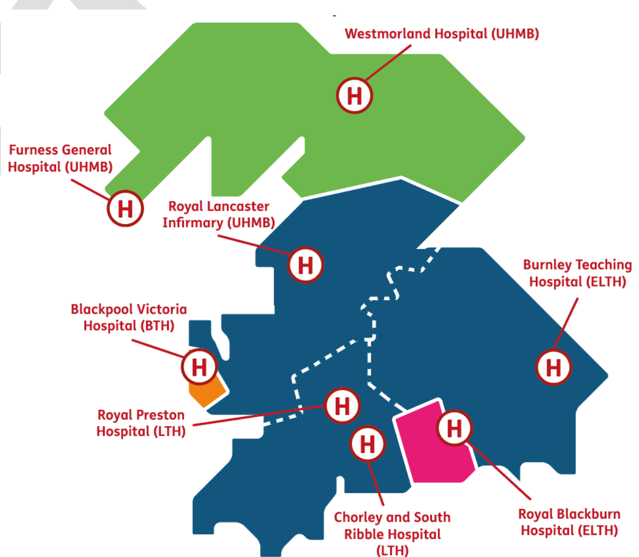
- **The Provider Collaborative** sees five acute, mental health and community providers in Lancashire and South Lancashire working together as one. They are:
    - Blackpool Teaching Hospitals NHS Foundation Trust (BTH)
    - East Lancashire Hospitals NHS Trust (ELHT)
    - Lancashire and South Cumbria NHS Foundation Trust (LSCFT)
    - Lancashire Teaching Hospitals NHS Foundation Trust (LTH)
    - University Hospitals of Morecambe Bay NHS Foundation Trust (UHMB)




Our provider collaborative will be the engine room for improving sustainability and transforming the delivery of acute care across the system.

- **The Recovery and transformation group** is made up of system partners and led by the ICB. The purpose of the group is to have collective organisational oversight of recovery and to deliver an assurance role to the ICB board. The Group will also be responsible for supporting the delivery of system-wide transformation programmes, seeking to accelerate the delivery of system change to improve sustainability, patient care and outcomes.

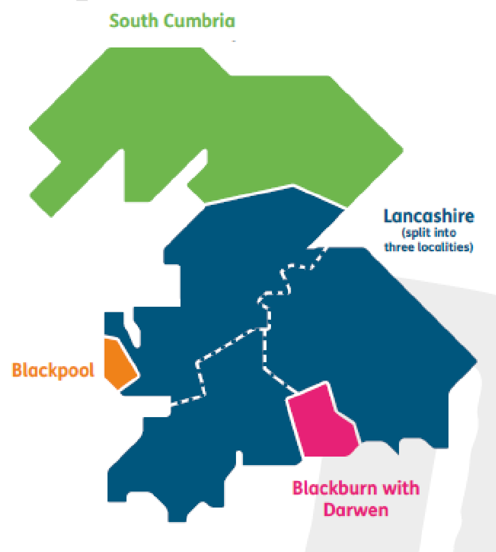
## Our system

| LOCAL AUTHORITIES |
|---|
| Six upper-tier local authorities:<br><br>Lancashire County Council, North Yorkshire Council (unitary), Cumberland Council (unitary), Westmorland and Furness Council (unitary), Blackpool Council (unitary), Blackburn with Darwen Council (unitary).<br>Twelve district councils<br><br>**Lancashire**: 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. |
| **NHS** |
| **Provider collaborative -** All five of the trusts below work together as part of the provider collaborative.<br><br>Four acute / community service providers:<br>Blackpool Teaching Hospitals NHS Foundation Trust (acute and community services), East Lancashire Hospitals NHS Trust (acute and community services), Lancashire Teaching Hospitals NHS Foundation Trust (acute services), University Hospitals of Morecambe Bay NHS Foundation Trust (acute and community services).<br><br>One mental health/community provider:<br>Lancashire and South Cumbria NHS Foundation Trust<br><br>One ambulance service provider:<br>North West Ambulance Service NHS Trust (NWAS).<br><br>Primary care:<br>42 primary care networks (PCN) 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. |
| **WIDER ORGANISATIONS** |
| Four local independent organisations that champion the views of patients and service users<br>**Healthwatch:** Blackburn with Darwen, Blackpool, Cumbria, and Lancashire. All four Healthwatch organisations work collaboratively as Healthwatch Together<br><br>Other partners:<br>This includes our local universities, colleges, police, fire and rescue services and wider industry. |

## Our places

There are four places within the Lancashire and South Cumbria Integrated Care System: South Cumbria, Lancashire, Blackpool and Blackburn with Darwen. We are forming place-based partnerships in each of these places. These 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.




- **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.

# 3. Scope and development of our Joint Forward Plan

This Joint Forward Plan for 2023 onwards outlines how the Lancashire and South Cumbria ICB will work with NHS providers of care, local government, VCFSE organisations and other partners to deliver our mission.

## Our mission

We are committed to improving the health and well-being of the 1.8 million people of Lancashire and South Cumbria, by working collaboratively with partners to:

| Reduce health inequalities | Secure better health and care outcomes | Provide the best care at the right time, to enable people to live healthy and fulfilling lives. |
|---|---|---|

We will deliver our mission by taking targeted action with partners across the four priority aims for integrated care systems.

## Our four pillars

| **Tackling inequalities** in outcomes, experience, and access | **Improving outcomes** in population health and healthcare | Enhancing productivity and value for money | Helping the NHS to support broader social and economic development |
|---|---|---|---|

We will also consider the effects of all our decisions on the three triple aims of integrated care systems, as outlined below:

| The health and well-being of our population (including inequalities) | **The quality of services provided** (including inequalities in benefits from those services) | The sustainable and efficient use of resources |
|---|---|---|

The ICB will always take account of contributions towards the triple aim within its decision-making and evaluation processes.

The NHS services that the ICB is responsible for are shown in the table below.

| **In scope** | | | | **Out of scope** |
|---|---|---|---|---|
| Primary care *including general practice, dentistry, optometry, and community pharmacy* | Community care | Acute care | Mental health and learning disability services | Specialised commissioned services (Currently commissioned by NHS England) |
| Our services cover all the healthcare needs of our population, from cradle to grave. Our valued service providers include the NHS, the independent sector and the voluntary sector. | | | | |

Specialised commissioned services may be impacted by decisions taken by the ICB - where necessary, due consideration and involvement of these services will take place.

## Our development journey

**OUR JOINT FORWARD PLAN**

Development Stage

| **ICB Inception** July 2022 | **Year 1** April 2023 | **Year 2** April 2024 | **Year 3** April 2025 | **Year 4** April 2026 | **Year 5** April 2027 |
|---|---|---|---|---|---|
| | High level NHS Joint forward Plan | Refreshed NHS Joint forward Plan | Refreshed NHS Joint forward Plan | Refreshed NHS Joint forward Plan | Refreshed NHS Joint forward Plan |

This first ICB Joint Forward Plan is intentionally high level because the ICB is a newly-formed organisation and so many of our plans, priorities and relationships are continuing to be developed. This plan sets out our intended vision, strategy and priorities for action. Working as a system provides a huge opportunity to work differently to tackle the urgent challenges we face. However, this will also be a significant programme of change.

This final draft of the Joint Forward Plan includes a summary of our statutory responsibilities, how we intend to deliver them and how this is reflected in our plans. This summary is available on the ICB website[1].

We will work through the detail and consult with our partners, our workforce and our population to ensure our plans, infrastructure, systems and processes are sustainable and provide the right foundations for integrated working.

This document builds on existing strategies and plans and sets out our aspiration to engage with our partners, staff, and population to refresh and further develop this plan for 2024/25 and beyond. We have taken account of expert advice from our local authority public health colleagues on population need captured within joint strategic needs assessments, the prevention, diagnosis, or treatment of illness and the protection or improvement of public health. We have sought advice informally and through formal governance arrangements with our local health and wellbeing boards. We have ensured our Joint Forward Plan reflects the health and well-being strategies that those health and wellbeing boards have developed and are committed to ongoing alignment of priorities across those plans.

In particular, this plan should be read alongside our **Integrated Care Strategy**[2] which has been developed through our Integrated Care Partnership and proposes how the ICB will work with local authorities and other partners to meet the health and well-being needs of our population.

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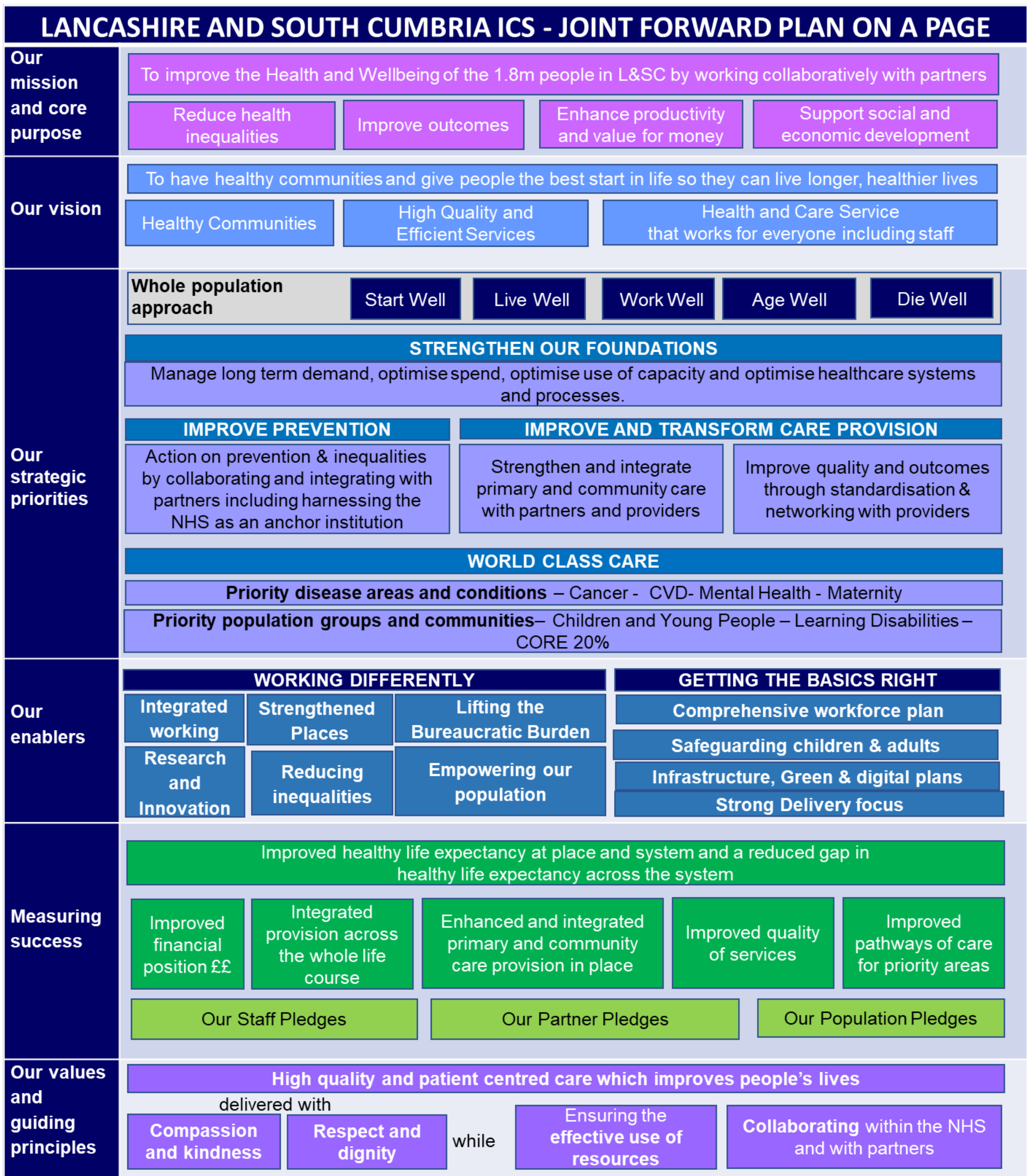
[1] https://www.lancashireandsouthcumbria.icb.nhs.uk/our-work/forward-plan

[2] https://lscintegratedcare.co.uk/our-work/our-strategy

# 4. Our Joint Forward Plan on a page

The diagram below summarises the Joint Forward Plan for improving the health and well-being of the people of Lancashire and South Cumbria.



# 5. Our current challenges

There is a mismatch 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.

| Factors driving an increase in demand | Factors limiting our capacity |
|---|---|
| **More people living with diseases** (the disease burden)<br>• High levels of deprivation, unhealthy lifestyle choices and variability in community resources and access to care, is affecting people's health.<br>• There are significant differences in life expectancy and healthy life expectancy between communities.<br>• More people than ever are living with more serious, long-term conditions. This is often also linked to deprivation.<br>**A population with varied levels of engagement with their health and well-being**<br>• There are varied levels of understanding in how to maximise positive health and wellbeing.<br>• Advancements in health innovation are creating increasing demand for services.<br>• People have become used to accessing healthcare on demand. | **Workforce gaps**<br>• Hospital workforce gaps mean we are spending more on agency staff.<br>• There are gaps in the primary and community care workforce which reduce our ability to support patients outside of hospital.<br>• Increasing numbers of people are choosing to leave the healthcare workforce.<br>• Some staff are feeling exhausted and low, particularly after the COVID-19 pandemic.<br>**Quality of physical infrastructure**<br>• There are issues with the quality of our physical buildings.<br>**Inconsistent quality and outcomes**<br>• There are differences in the quality of care across our system.<br>**The delivery model**<br>• Focused on hospitals<br>• There are barriers which impact upon providers working together, and the NHS working with its partners. |

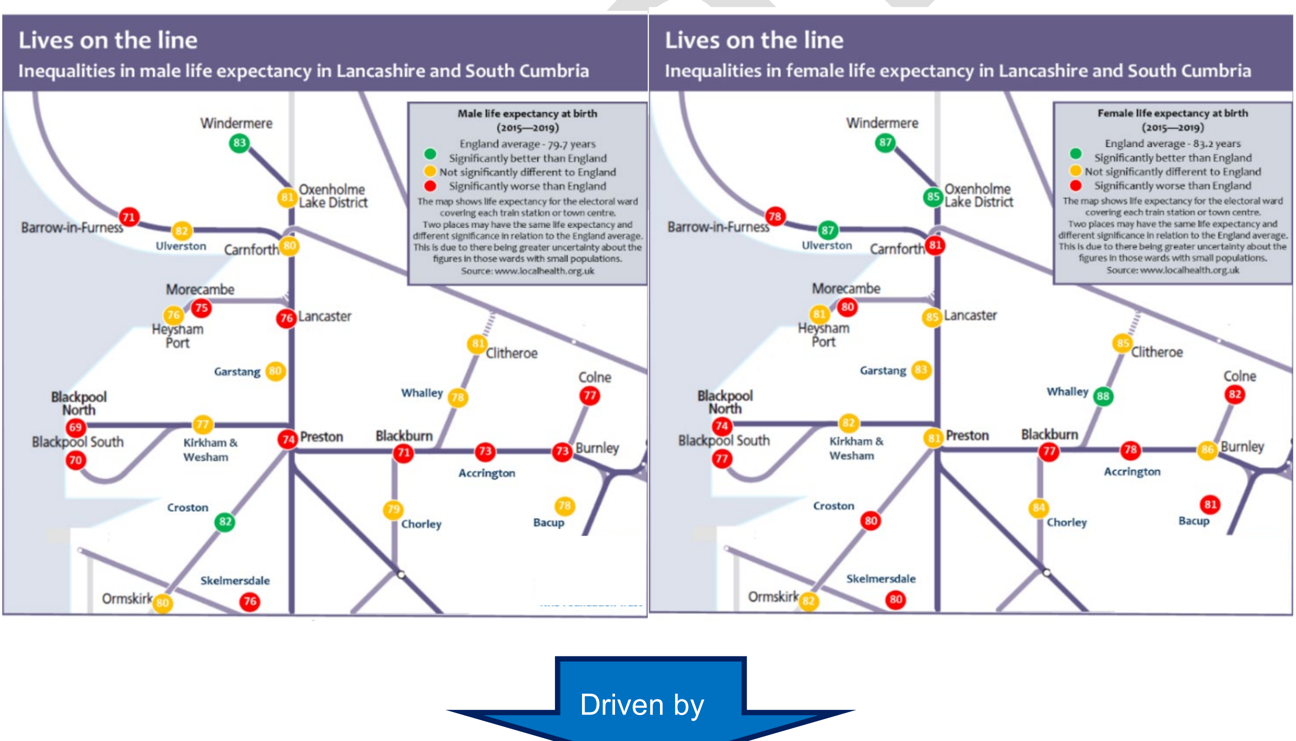
To ensure that our strategic priorities over the next ten years are the correct ones, it is critical that we have a detailed understanding of all the issues that are driving our financial position and how the issues are interconnected.

## 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.

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## Disease burden

The main causes of the lower healthy life expectancy in Lancashire and South Cumbria are cancer, conditions relating to the heart and lungs, mental health and conditions relating to the brain and nervous system. Around 21,000 people in the area have five or more long-term health conditions. The number of people living with common mental health disorders is higher than the rate across England. In addition, nine per cent of our population are from ethnically diverse backgrounds. Ethnicity can affect people's health differently, for example statistics show that people with a South Asian heritage are more likely to develop heart disease at a younger age and have a higher risk of stroke than the general population.

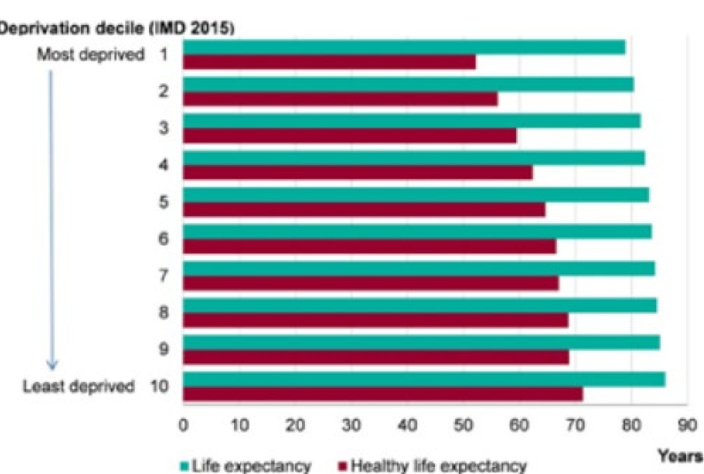
## Lifestyle choices

One of the biggest factors that affect people's healthy life expectancy is their lifestyle choices. Around 40 per cent of ill health is seen in people who smoke, do little physical activity, are obese or abuse substances such as drugs and alcohol. In Lancashire and South Cumbria, 18.5 per cent of adults smoke, compared with the national average for England of 17.2 per cent. Plus, only around a fifth of adults do the recommended levels of physical activity. These statistics vary markedly by place and neighbourhood.

## Demographics and deprivation

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).

The effect of deprivation on health is shown very powerfully on this chart. At the top of the chart is IMD decile one, representing the most deprived areas in England, and it shows the healthy life expectancy is only around 50 years, whereas those in the least deprived areas or IMD decile 10, 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.



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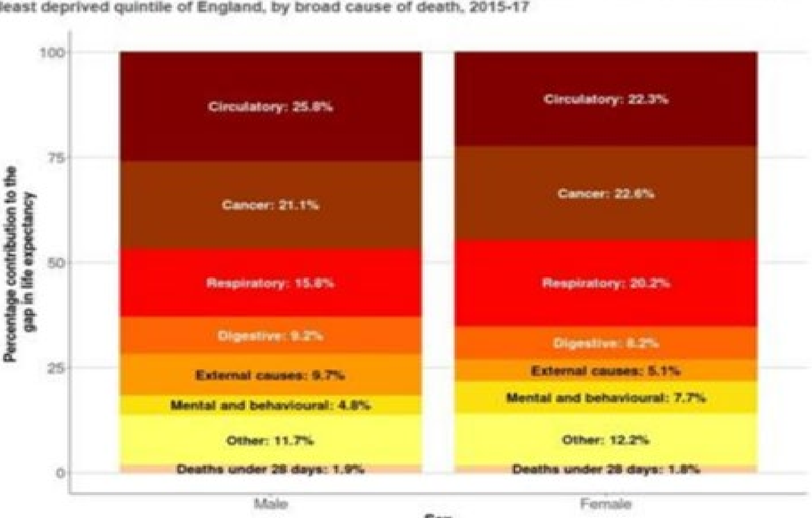
The table below shows the levels of deprivation across the wider Lancashire area, including Blackpool and Blackburn with Darwen. The decile shows the level of deprivation in each area, with a lower decile indicating higher deprivation; Blackpool, Blackburn, Hyndburn, and Burnley are all within decile one. The percentile shows their relative position, with Blackpool being the most deprived area within decile one, at 1.2 per cent. Within Lancashire there are four areas within decile one, and a further two areas within deciles two and three.

| Area | 2015 | | 2019 | | 2015 to 2019 | 2015 to 2019 |
|---|---|---|---|---|---|---|
| | Percentile | Decile | Percentile | Decile | Change in percentile | Change in decile |
| Burnley | 5.2% | 1 | 3.5% | 1 | -1.7% | 0 |
| Chorley | 57.1% | 6 | 60.6% | 7 | 3.5% | 1 |
| Fylde | 66.9% | 7 | 62.5% | 7 | -4.4% | 0 |
| Hyndburn | 8.6% | 1 | 5.7% | 1 | -2.9% | 0 |
| Lancaster | 38.3% | 4 | 35.3% | 4 | -3.0% | 0 |
| Pendle | 12.9% | 2 | 11.4% | 2 | -1.5% | 0 |
| Preston | 22.1% | 3 | 14.5% | 2 | -7.6% | -1 |
| Ribble Valley | 89.0% | 9 | 89.0% | 9 | 0.0% | 0 |
| Rossendale | 30.1% | 4 | 28.7% | 3 | -1.4% | -1 |
| South Ribble | 71.8% | 8 | 66.2% | 7 | -5.5% | -1 |
| West Lancashire | 50.3% | 6 | 56.2% | 6 | 5.8% | 0 |
| Wyre | 51.2% | 6 | 46.4% | 5 | -4.9% | -1 |
| Blackburn with Darwen | 7.4% | 1 | 4.4% | 1 | -2.9% | 0 |
| Blackpool | 1.2% | 1 | 0.3% | 1 | -0.9% | 0 |

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. 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.

The diseases that contribute to the gap in life expectancy between the most and least deprived areas across England is shown in the chart. Circulatory diseases (ones that affect the heart and circulation, such as stroke), cancer and respiratory conditions that affect the lungs and breathing all play a significant role for both men and women.




## Rising numbers of older people

In Lancashire and South Cumbria, we have more people aged over 50 than the national average. This increases the demand for healthcare in the area. There is also expected to be an increase in the number of people aged 85 and older which will further increase pressure on services.

## Children in care and care leavers

Lancashire and South Cumbria has a higher-than-average number of children in care (CIC) and care leavers (CL) within our population and this is increasing. This cohort of children and young adults experience greater health inequalities and overall poorer outcomes than their peers which can have a lifelong impact. They have poorer educational outcomes, higher rates of special educational needs, higher rates of emotional and mental health problems and when they leave care they experience higher rates of homelessness and unemployment when compared to their peers who are not looked after.

## Carers

Carers are everyday unseen heroes who support family members, friends and neighbours with their additional day-to-day needs. They play a hugely valuable and vital role in the lives of the people they care for and their contribution supports our health and care system.

They play a major role in the care of people with long-term conditions and can help prevent unnecessary stays in hospital. With increasingly limited resources and difficulties in recruiting staff it is often family and friends who step in to bridge the gap. Therefore, carers must be known to and supported by the health and care system. There are approximately 175,000 unpaid carers in Lancashire and South Cumbria according to the 2021 Census and Carers UK estimates the true number may be double that. Our carers range from children aged five to elderly people. As the proportion of older people and the number of people living with long-term conditions grows, the impact on carers will increase further.

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There are approximately 63,000 people across Lancashire and South Cumbria who provide more than 50 hours of unpaid care a week. Caring can take a heavy toll on individuals, affecting their physical and mental health, yet many carers are not registered with a local authority or GP practice and miss out on vital help and support.

## Our operating model

The NHS has played an important role in primary prevention but there is an opportunity to extend this further and fully harness the benefits of integration by working more closely with the significant range of partner organisations that support the determinants of health. While the NHS and local authorities have collaborated on joint health and well-being strategies, more could be done to formally integrate approaches, teams and pathways.

The table on the next page highlights the range of organisations involved in supporting our population's health and wellbeing and the role of the NHS. It illustrates very powerfully the huge potential benefit for our population of the NHS working in an integrated way with partners at system, place and neighbourhood.

| Health and well-being roles | | | | | | |
|---|---|---|---|---|---|---|
| **Organisation** | | **Determinants of health** | **Health education** | **Social care** | **Healthcare** | **Well-being** |
| **Council**<br>*Provision varies depending on whether the council is upper tier* or district level.* | | Education *<br>Employment<br>Housing<br>Family Support<br>Environment | Disease prevention * | Social Care* | | Libraries *<br>Physical environment<br>Culture<br>Creativity |
| **NHS** | | Anchor institutions<br><br>Greener NHS | Prevention<br>NHS Awareness Campaigns<br>Making every contact count | | Care provision | |
| **VCFSE** | Charities<br>Faith sector<br>Community groups | Support services | | | | Services |
| | Social enterprises | Supporting business<br>Childcare<br>Education<br>Community<br>Environment | | Services | Services | Sports and leisure |
| **Private/independent sector** | | Services | | Care provision | Care provision | Provision |

## Capacity issues

The quality and outcomes of our healthcare in Lancashire and South Cumbria is affected by workforce availability, the size and quality of our buildings and spaces, our underpinning system and processes around care and our operating model. The amount of care we can provide is limited by the capacity we have available and our capacity is reduced by gaps in our workforce, the quality of our estate and our historic operating model which has not enabled us to share limited resources across our providers. Poor quality also increases costs. Where patients wait longer, their conditions deteriorate and are more expensive to treat; where there are inconsistent care processes and blockages, there are more errors and wastage; and where there are gaps in highly skilled clinicians, very expensive agency staff must be sought.

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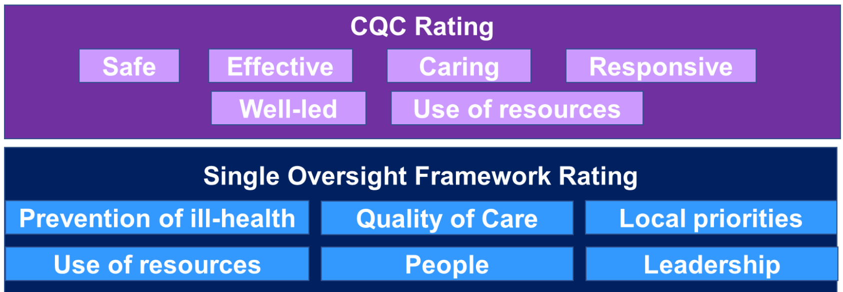
## The quality of our care

The quality of care can be measured via access and waiting times, care processes, patient safety and patient experience. The overall quality of our main providers is assessed by two bodies, the Care Quality Commission (CQC) and NHS England & NHS Improvement via the Single Oversight Framework (SOF).




The quality of care at the main providers in Lancashire and South Cumbria is shown in the table, highlighting significant room for improvement. The standard of care people receive in our area varies depending on where they live. Four of our five hospital trusts are rated as 'requires improvement', while one – East Lancashire Teaching Hospitals NHS Foundation Trust – is rated as 'good'. This difference in standards also has an impact on our health inequalities.

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| Trust | CQC rating | Single Oversight Framework |
|---|---|---|
| North West Ambulance Service (NWAS) | Good | 2<br>Plans in place to meet the challenges |
| East Lancashire Hospital Trust (ELHT) | Good | 2<br>Plans in place to meet the challenges |
| Blackpool Teaching Hospital (BTH) | Requires improvement | 3<br>Significant support required |
| Lancashire and South Cumbria Foundation Trust (LSCFT) | Requires improvement | 3<br>Significant support required |
| Lancashire Teaching Hospital NHS Foundation Trust (LTH) | Requires improvement | 3<br>Significant support required |
| University Hospitals Morecambe Bay (UHMB) | Requires improvement | 4<br>In actual or suspected breach of licence |

The table below outlines the rating for each provider against the key domains within the CQC assessment. Whileu all the providers offer a caring environment for our population, urgent action is needed to ensure improvements are secured in the other domains.

| CQC Ratings | | | | | | |
|---|---|---|---|---|---|---|
| Trust | Safe | Effective | Caring | Responsive | Well-Led | Use of resources |
| NWAS 2020 | | | | | | - |
| ELHT 2019 | | | | | | |
| BTH 2022 | | | | | | |
| LSCFT 2019 | | | | | | - |
| LTH 2019 | | | | | | |
| UHMB 2021 | | | | | | |

Waiting times for planned care have increased markedly over the past two years due to the cessation of routine surgery during COVID-19. The demand and waiting times for urgent care have also increased, and the patients presenting have greater acuity. Alongside this, our care processes and clinical pathways vary by geographical area, due to the level of available workforce in each location and the quality of the estate; all of this has a consequential impact on patient safety and experience. The historic operating model of the NHS which has encouraged providers to work in competition and isolation rather than working collaboratively to share scarce resources has been a huge barrier to improving quality. These are challenges shared across the country.

## Workforce

A significant factor which impacts the quality of our care is the availability, capacity and productivity of the workforce, and we have significant gaps within our hospitals which are also predicted to rise. Across Lancashire and South Cumbria, NHS hospitals employ around 40,000 people. We have higher vacancy rates than the national average, at nine per cent compared with 6.9 per cent across England and some of the highest levels of sickness absence in England. Furthermore, more than 20 per cent of our staff, approximately 8,000 people, are over the age of 55 and will therefore retire in the not-too-distant future. Alongside this, our ability to recruit is impacted by the condition of our infrastructure and the reputation and quality of our services. The consequence is a high level of agency staff usage, which comes at a considerable financial cost to the system and impacts the quality of care. The workforce gaps are shared by hospitals across the country which means hospital trusts often compete for the same staff. We face significant problems with recruiting the people we need and retaining them.

Our primary care workforce also faces significant challenges, with the number of GPs falling and half of the current GP workforce expected to have retired within the next two decades. The number of GPs reduced by 5.2 per cent from September 2019 to September 2022 and a quarter of the general practice workforce is aged 55 and older with a similar proportion aged 45 to 54.

The long-term sustainability of health and care is also dependent on having the right digital and data foundations in place to allow successful digitally-enabled transformation across our systems. Currently, 70 per cent of national digital transformation projects fall short of their objectives. Skilled digital, data, technology and clinical informatics talent within our system are therefore needed to implement, optimise and embed technologies for the benefit of our patients, citizens and the wider workforce.

## Estates

Our health estate needs both significant investment and radical reimagining if we are to deliver quality care and improved health outcomes for the future.

The condition of our hospital estate has a marked impact on the quality of care we can provide and also 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,

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developed for far fewer patients and to meet historical care standards. This impacts on overcrowding and creates risks around infection and patient experience.

Royal Lancaster Infirmary's emergency department sees 50 per cent more patients than it was designed for, while Furness General Hospital sees 44 per cent more patients. The rate of bed occupancy recommended by the National Institute for Care Excellence (NICE) is 85 per cent and across north and central Lancashire, 95 per cent of beds are occupied. This impacts the frequency of elective surgery being cancelled and contributes to the stress levels within our workforce.

Patients have a poorer experience of care than elsewhere due to limited facilities such as single rooms and the number of toilets and showers. This also increases the risk of infections spreading. Standards of care for mental illness across emergency departments are also not good enough because of a lack of space.

## Operating model

The cultural and legislative landscape of the NHS has been underpinned for more than 30 years by competition within an 'internal market' rather than collaboration. While initially competition drove productivity gains and innovation, more recently it has been recognised nationally that the market model has created waste and inefficiency. Despite the challenges around workforce being shared across Lancashire and South Cumbria, the legislative framework has actively discouraged working collaboratively and this has been a huge barrier to improving quality and has contributed to a significant cost burden for providers. This has proved very expensive and has adversely affected quality across Lancashire and South Cumbria and starved services of much-needed investment. Only in recent years have hospitals started to collaborate across geographical areas to address these issues, establishing regional centres of excellence and working together rather than against each other.

The long-term sustainability of the system depends on reducing the reliance on delivering healthcare within hospitals, which consumes a significant amount of our healthcare spend. While providing economies of scale, acute hospital care is still expensive and we have patients being cared for in a hospital setting because there is no other local community alternative. This is not an optimum model of care delivery either in terms of achieving best outcomes or securing value for money from the Lancashire and South Cumbria healthcare pound. Critical to increasing sustainability will be strengthening primary and community care while also integrating the provision of primary and community care with social care, wider local authority services and the VCFSE sector across our places and through integrated neighbourhood teams, harnessing the use of digital technology.

However, this will not be easy.

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Primary and community care and partners in the VCFSE sector are struggling under the strain of the ever-increasing demand for care, while also experiencing capacity challenges including significant workforce gaps and estates issues. These issues are impacted by a lack of integrated work with partners to support prevention upstream, which is driving demand for primary and community care through an ever-increasing burden of disease, alongside our population having low levels of engagement in managing their health and well-being.

We have significant pressures across our primary care and community health estate. While there has been some past localised investment, there is still a huge geographical disparity in the quality of community estate which impacts the ability to deliver quality care locally. In addition, we are not always sufficiently connected with partners across places and neighbourhoods in a way that enables us to maximise the value of the collective public sector land and estate (and wider infrastructure).

## Digital, data and technology

The maturity of our digital infrastructure, data and technology is variable across Lancashire and South Cumbria. One of our trusts recently went live with an electronic patient record system while another still relies on paper-based processes. Good progress has been made in the development of a Lancashire and South Cumbria shared care record, but data flows and access from out-of-hospital settings need to be developed further.

The use of data is largely fragmented and is predominantly used for retrospective performance reporting rather than supporting predictive analytics and insights leading to early intervention and action. A key priority for action to support this analysis is to improve the recording of ethnicity across all organisations across Lancashire and South Cumbria.

Through the capture and sharing of data, we are then able to support population health management which plays a crucial role in reducing health inequalities and there are already some innovative tools used within Lancashire and South Cumbria that start to gain insight into our populations. By harnessing the power of data analytics and insights we gain a deeper understanding of the complex factors that contribute to disparities in health outcomes among our different populations.

Furthermore, data enables us to collaborate among our partner organisations and as we further develop our capabilities by integrating health data with socioeconomic data we gain a more detailed understanding of the wider determinants of health effecting our population, leading to better data-driven decision-making across Lancashire and South Cumbria and enabling us to become a learning health system driving improvement across our system.

There are also some good examples of the usage of innovative technology to support care for our population but there are opportunities to scale these across Lancashire and South Cumbria such as remote monitoring, tele-care, technology-enabled virtual wards and patient-initiated follow-ups. However, digital poverty and lack of digital skills means many digital patient- or citizen-facing initiatives will still be unavailable to some of our most vulnerable people. While digital exclusion has reduced since the pandemic, 27 per cent of the



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population are still considered to have the lowest level of digital capability. Digital exclusion is a significant factor in health inequality and inequity.

Digital infrastructure and data provide significant opportunities for supporting improvements in the outcomes of our population's health and in tackling inequalities, experience and access and in supporting our system in effectively safeguarding children at risk of abuse or neglect. It can also play a pivotal role in increasing productivity and supporting financial sustainability.

## System finances

As a result of the demand and capacity drivers discussed above, as a system we are spending more money on health and care services then we receive in income. For the Lancashire and South Cumbria ICS to be in an underlying financial breakeven position by 2026/27, we have three years to make significant improvements and efficiencies in the way that we deliver services, while also tackling all of the demand and capacity issues. In addition, for each of those years, the system needs to plan for break-even in-year using non-recurrent options across the resources available.

## The implications

In conclusion, the analysis of our current issues tells us that, to improve the health and well-being of our population and to reduce the inequalities, we need to:

| Where our Joint Forward Plan needs to focus | |
|---|---|
| **1** | **Ensure we are spending our £4billion of healthcare resources wisely by exploring opportunities to work differently, reduce costs and ensure sustainability**<br>• *Explore opportunities to reduce costs and increase value for money* across the NHS by working differently including moving care closer to people's homes where possible.<br>• Explore opportunities to share resources across the NHS family.<br>• *Reduce long-term healthcare demand* by supporting people to stay well for as long as possible, reducing the pressure on the healthcare system (as below).<br>• Optimise the quality of care across Lancashire and South Cumbria. This will also reduce costs (as below).<br>• Reduce variation in the quality, consistency, and processes for care, as variation can create additional demands for care such as re-admissions. |
| **2** | **Reduce and manage the unsustainably increasing demand for care**<br>**Take action on prevention and address inequalities**<br>• Provide targeted support for communities and demographics with the greatest health issues by undertaking targeted action at system, place, and neighbourhood level.<br>• Take joined-up action with partners on the social determinants of health such as unpaid care.<br>• Support our population to make healthy lifestyle choices by offering NHS support services and connecting them to the wider service offers from our partners.<br>• Screen our population for diseases and intervene early to keep people well for as long as possible.<br>• Empower our population to actively manage their health and well-being, including support to access digital tools and applications. |

| Where our Joint Forward Plan needs to focus | |
|---|---|
| | • Work with our population to understand the drivers of their health choices and coproduce the development of any solutions.<br>**Proactive disease management**<br>• Implement evidence-based standardised care pathways for our most significant disease areas, population groups and communities.<br>**Integration**<br>• Support the health needs of our ageing population and those with long-term conditions by working in partnership.<br>• Integrate teams across the NHS and wider partners at neighbourhood, place and system level to support all-age population needs. |
| 3 | **Improve the quality of care and clinical outcomes**<br>**Work collaboratively across providers to:**<br>• Address the workforce gaps.<br>• Improve the quality of the hospital estate.<br>• Improve access to care.<br>• Standardise care and clinical pathways.<br>• Deliver world-class pathways for priority disease areas, conditions, population groups and communities. |

# 6. Our future vision

The Lancashire and South Cumbria Integrated Care System's long-term vision for our population is outlined below, together with our long-term aims. Our vision can only be achieved by working in partnership with all the organisations that contribute to the health and well-being of our population. These include upper and lower-tier local authorities, the NHS, the VCFSE sector, our universities and local people and communities. This vision is about health and well-being in its widest sense. This requires the NHS and all its partners to work very differently from how they have in the past.

| **Our vision** | We want our population to live longer and healthier lives which will be enabled by:<br>• Healthy communities.<br>• High-quality and efficient services.<br>• Health and care services that are centred around the needs of our communities and offer high-quality employment opportunities for our workforce. |
|---|---|

Together we will measure our long-term success over the next seven to 10 years by our ability to increase the healthy life expectancy of our population. We will track this across the system and within each of our places and communities to ensure inequalities are reduced.

| **NHS values** | We are committed to the NHS values, delivering high-quality, patient-centred care which improves people's lives with compassion, humanity, kindness, respect and dignity. We will make the most efficient and effective use of the healthcare resources across Lancashire and South Cumbria. |
|---|---|

## Our pledges

| **Our pledges to our population** | | |
|---|---|---|
| **1** | You will have healthy communities | You will *be supported to keep well both physically and mentally* by health and well-being services that are connected across organisations and at system, place and neighbourhood level. Your communities and places will be valued for what makes them unique. A commitment to deliver improvements. |
| **2** | You will have high-quality and efficient services | You will:<br>• *Have access to high-quality and patient-centred services*. We will ensure our providers work collaboratively to share their resources and expertise, offering access to the care that gives the best outcomes for patients.<br>• Have access to joined up and coordinated services and support, which is easier to navigate and access.<br>• Be treated with compassion, humanity, kindness, respect and dignity in accordance with the NHS values. |
| **3** | A health and care service that works for you | You will be provided with opportunities to make choices about your healthcare and have greater opportunities to design and coproduce local services to ensure they meet your needs. You will be well informed and involved in decisions. Your experiences of health and care will be valued and listened to. |

| Our pledges to our partners | |
|---|---|
| We will work together in partnership | • We will work collaboratively with you at every level of the system and coproduce our plans.<br>• We are committed to widening our understanding of the role and hugely valuable contribution of all our partners in health and well-being to ensure the programmes of work we jointly develop can meet the challenges our population faces and we can collectively make the biggest difference to the health and well-being of our population.<br>• We are committed to developing a sense of 'esprit de corps' across our system. A shared spirit of comradeship, enthusiasm and devotion to a very important cause. |

| Our pledges to our staff | |
|---|---|
| You will have access to more opportunities and more support for your health and well-being | We aspire to be a system that people want to work for. We want to attract and keep the best people to create high-performing teams with a strong, collaborative, can-do culture. We intend to work together with you to ensure we can build and strengthen our workforce. We welcome your suggestions and ideas as we recognise that the last few years have taken a heavy toll on our hugely valuable workforce.<br>• You will have access to a wider range of job opportunities and routes for development as we develop new roles across our system.<br>• You will have the opportunity to share your expertise and make a difference across a wider geographical area.<br>• You will be supported via digital tools to focus more time on patient care and less time on unnecessary bureaucracy.<br>• You will be offered more flexible working opportunities where possible to enable you to balance your work and home life.<br>• You will be provided with more added value health and well-being support including assistance with financial issues and mental health.<br>• You will be treated with compassion, humanity, kindness, respect and dignity, in accordance with the NHS values. |

## The importance of partnership working

Our work to support local people to live longer and healthier lives will rely on strong relationships between the NHS and all our partners which impact upon health and well-being.

The Lancashire and South Cumbria Integrated Care Partnership has developed an ambitious vision. It will work to harness the collective knowledge, skills and talents of partners to improve our population's health, wealth and happiness. The Partnership has already agreed outline priorities for collective action to enable our population to start well, live well, work well, age well and die well, as detailed in the Integrated Care Strategy. This joint programme of work has built upon a review of health equalities by the Health Equity

Commission and the joint strategic needs assessments (JSNAs) for each of the places across the system: Lancashire, South Cumbria, Blackpool and Blackburn with Darwen.

Our emerging place integration deal sets out how we will enable our four place-based partnerships to have the best, most effective arrangements to support the implementation of the Integrated Care Strategy. Over time this will pave the way for further innovations in integrated working with local government and wider partners in place to deliver our agreed actions.

## Engagement on our plans

This initial ICB Joint Forward Plan is high level and recognises we are on a developmental journey. It builds upon previous strategies and plans which are, in turn, built upon engagement with our partners and our population.

Most recently we have engaged with partners and with targeted sections of our population in the development of our 2023 Integrated Care Partnership Strategy, with support from local Healthwatch and VCSFE organisations.

Before this, as part of the development of our system response to the national 10-year long-term plan in 2020, we engaged with our partners and some of our local communities. This engagement revealed more work was needed on health inequalities, access to care, the quality of care and sustainability. All these elements are integral to our Joint Forward Plan and form part of our strategic priorities.

Although our current plan is fully aligned with the 2019-2029 long-term plan, much has changed in the health and care sector since COVID-19. The challenges our system faces are now greater with more significant gaps in terms of inequality, access, quality, outcomes and sustainability.

Consequently, having laid out the foundations of our draft Joint Forward Plan in March 2023, we undertook further engagement with partners, staff and the public on the main elements of this plan to gain more detailed and informed views and feedback from our population, staff, partners and other stakeholders. The primary feedback has been that around a quarter of respondents felt the vision and values within the draft plan were appropriate as they were and that almost half were happy with the public pledges. The vast majority of respondents indicated satisfaction with the existing vision, values and pledges in general, however a number suggested additions which have been taken into account.

However, many comments were made that people were more interested in whether we could deliver our vision and pledges under the current climate. A number of other comments both in the survey and face-to-face stated that there was some confusion with the Integrated Care Strategy of the Integrated Care Partnership which had only recently been engaged upon and was a factor in lower responses to the engagement than planned.

The most common comments in regard to suggestions for amendments to the vision and pledges were around communications, providing services in the community, supporting, recruiting and developing staff and prioritising prevention.

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This final version of the plan has taken account this feedback, particularly in shaping the vision, values and pledges for the population, recognising key themes which have been heard from members of the public including the need for a focus on delivery and the importance of involving local people and their experiences of health and care in improving services.

There are considerable learnings which have been captured as part of the engagement activity. These include:

- Positive connections which have been made with seldom-heard and vulnerable groups and the need for relationship-building in order to fully involve individuals in engagement programmes in the future. This is an important priority for the organisation.
- Challenges which have been captured around the restrictions of the national timetable for submitting the NHS Joint Forward Plan which has not given sufficient time to undertake the level of engagement which would have been preferred.
- The timing of this work being close to the Integrated Care Strategy and the public desire for delivery and improvements rather than conversations on strategies and plans.
- This work has laid an important foundation for future engagement and involvement in the delivery of the strategic priorities of the ICB in relation to system recovery and transformation programmes.

A plain English executive summary of this Joint Forward Plan has been produced as a public-facing version of our plans and is available on the ICB website[3].

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[3] https://www.lancashireandsouthcumbria.icb.nhs.uk/our-work/forward-plan

# 7. Our system strategy

We want our population to live longer and healthier lives. This will be enabled by healthy communities, high-quality and efficient services and a health and care service that is centred around the needs of our communities and offers high-quality employment opportunities for our workforce.

To deliver this vision we must address the root cause of our problems. We must vastly improve the cost, quality and value for money of our services while also acting earlier and, through closer working with our partners and our population, to prevent people from getting ill and to prevent their illness deteriorating.

| The problem | There is a mismatch between the demand for healthcare in Lancashire and South Cumbria, and the available capacity.<br><br>**The cost of the healthcare we provide in this system is greater than our level of income, and the gap is widening.** |
| --- | --- |

We have identified five strategic priorities, which together will enable our population to live longer and healthier lives.

1. **We must strengthen our foundations** by improving our financial situation with a fully-fledged financial recovery programme
2. **We must take urgent action to reduce the unsustainable 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 service delivery.
4. **We must ensure there is more consistent and high-quality care** among our providers. We will standardise, network and optimise our pathways of care.
5. **We must take targeted action to deliver world-class care for priority disease areas** and conditions, population groups and communities.

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## Our long-term strategic priorities

| STRENGTHEN OUR FOUNDATIONS | | |
|---|---|---|
| 1. **Improve our long-term financial sustainability** and value for money through transformation with providers. | | |
| IMPROVE PREVENTION | IMPROVE AND TRANSFORM CARE PROVISION | |
| 2. Prevent ill-health and reduce **inequalities** by collaborating with partners. | 3. Integrate and strengthen primary and community care at place with partners and providers. | 4. **Improve quality and outcomes** through standardisation and networking with providers. |
| WORLD CLASS CARE | | |
| 5. **Deliver world-class care** for priority disease areas, conditions, population groups and communities. | | |

Our urgent priority is to take immediate action to improve our long-term sustainability by reducing our costs and working differently across the NHS to share our resources. We have sought external expertise to ensure we make rapid progress is this area. The underlying financial risk forecast for 2023-24 was significant. In agreeing our system financial target for the year we have accepted the need to take urgent joint action on recovery across the whole NHS and with our partners, overseen by the establishment of our Recovery and Transformation Board.

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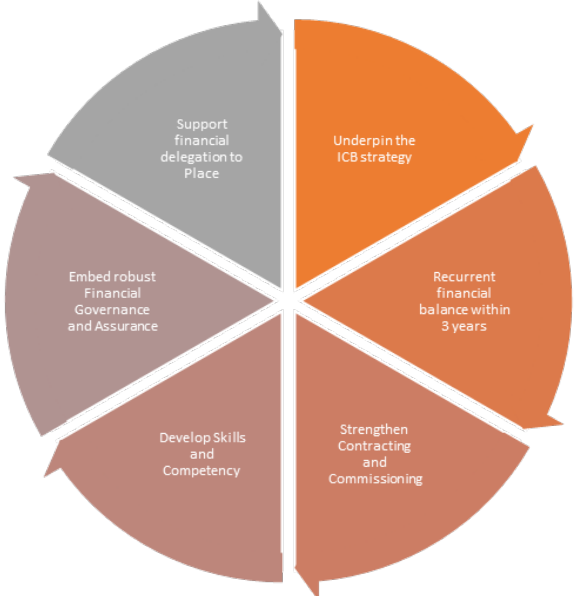
## Our financial strategy

Our highest priority in the short to medium term is to improve our financial sustainability. A financial strategy is being developed to underpin the Joint Forward Plan and within it the recovery and transformation programme. Principles for the strategy have been developed as follows:




The ICB capital plan for 2023/2025 is fully aligned with our strategic aims. It is focused on maintaining our current equipment and buildings so that our providers can make the best use of equipment and space. Due to issues with the quality of some of our hospital buildings we have higher estates costs than other ICBs. The consequence is that we have less money to spend on capital projects which focus on transformation. When there is additional national capital money available for transformation the ICB will take all necessary steps to apply for it to improve healthcare in Lancashire and South Cumbria.

## Our enablers

To deliver our strategy we must work differently at system, place and neighbourhood levels and take action to get the basics right, including action to improve our buildings, systems and workforce. To support all this we need a comprehensive delivery plan that sets out which organisations are responsible for delivering results and how improvement will be measured.

| Working differently | | | |
|---|---|---|---|
| **Research and innovation** | **Reducing health inequalities** using population health management and public health expertise. | **Integrated working** within the NHS and with our system partners. | **Lifting the bureaucratic burden.** Longer-term partnerships with high-performing providers. |
| | **Empowering our population** including public and patient engagement and personalised care. | **Strengthened places and neighbourhoods.** | Harnessing our role as an **anchor institution.** |

| Getting the basics right | | | |
|---|---|---|---|
| **Comprehensive workforce plan** across all organisations and sectors. | **Buildings, infrastructure, digital and environment.** | **A strong focus on delivery** with clear delivery plans, joint accountability frameworks and performance measures. | **Safeguarding** children and vulnerable adults. |

## Measuring success

We will measure our success for each of our five strategic priorities using the measures in the table below. Our system delivery plan will detail the programmes of work and key performance metrics for system, place and neighbourhood for each of our priority areas.

| STRENGTHEN OUR FOUNDATIONS | | |
|---|---|---|
| Improved sustainability of the system as measured via the overall financial position. | | |
| **IMPROVE PREVENTION** | **IMPROVE AND TRANSFORM CARE PROVISION** | |
| Improved healthy life expectancy at system and place. | Enhanced and seamless care provision within our neighbourhoods. | Improved quality of care across all our providers as measured via their CQC and Single Operating Framework assessments. |
| **WORLD CLASS CARE** | | |

Improved pathways of care across the system as measured via our adherence to national recommendations for world-class care within the NHS Long Term Plan.

## Delivering the aims of the ICB

The five ICB strategic priorities can be mapped to delivery of the four key priority aims for integrated care systems:

| Contribution to the Integrated Care System priority aims | | | | | |
|---|---|---|---|---|---|
| | | Reduce inequalities | Improve outcomes | Enhance productivity | Support broader social and economic development |
| 1 | Strengthen our foundations | | | ✓ | ✓ |
| 2 | Improve prevention and reduce inequalities | ✓ | ✓ | ✓ | ✓ |
| 3 | Integrate and strengthen primary and community care | ✓ | ✓ | ✓ | |
| 4 | Improve quality and outcomes | ✓ | ✓ | ✓ | |
| 5 | Deliver world-class care for priority areas | ✓ | ✓ | ✓ | |

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## Our new operating model

Working in an integrated way with all our partners means the NHS must work in a different way than it has before. The ICB is not simply a combination of the eight separate clinical commissioning groups (CCGs) that existed before. It has a different role and scope. The NHS will now be working holistically with partners to improve health and well-being at system, place and neighbourhood levels as well as providing healthcare. Each organisation across the health and well-being landscape has its own culture and ways of working and to really benefit from working together all organisations need to be open-minded and willing to learn from each other.

To achieve true integration, we need an operating model that clearly defines the rules of engagement with our partners and all organisations within the NHS family, at system, place and neighbourhood levels.

An essential part of this new way of working will be making the best use of all our combined assets: our people, our partners, our infrastructure and our

resources. We need to make this change in our ways of working quickly, and this will require innovation, commitment and collaboration, together with a great deal of enthusiasm. We must look for opportunities to innovate while being realistic about which factors are within our control. The table below outlines our historical operating model and the opportunities that we must urgently harness as we move forward.

| USING OUR ASSETS DIFFERENTLY | | |
|---|---|---|
| | **Our historical operating model** | **Our opportunity** |
| **Our people**<br>Workforce across the NHS and partners | Organisations working largely independently with a fragile workforce across providers and partners. | To collaborate with providers and partners at system, place and neighbourhood level, to share knowledge, skills and expertise.<br>To develop shared teams, shared systems and shared processes. |
| **Our partners**<br>Our system partners and our population | **Our partners**<br>Historically there has been some joint working and some joint plans.<br><br>**Our population**<br>The consumers of healthcare in Lancashire and South Cumbrie have had varied levels of involvement in decisions about their care with some choices and some engagement and coproduction on service developments. | **Our partners**<br>To develop a shared strategy for prevention across all partners with a focus on the communities which need targeted support.<br><br>**Our population**<br>• To enable and empower our population and our patients to take a lead in choices about their health and care.<br>• To harness local knowledge to coproduce initiatives and service developments to respond to the increasing demand for care. |

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| | Our historical operating model | Our opportunity |
|---|---|---|
| **Our infrastructure**<br>Our estates and digital infrastructure<br> | **Buildings and estates**<br>The way we deliver healthcare is expensive. It is mostly face-to-face and in ageing hospitals with costly parking.<br><br>**Anchor role**<br>As a major employer, the NHS is an 'anchor institution', however our contribution to the local economy could be greater.<br><br>**Digital**<br>Historically, there has been limited sharing of information and data between organisations. This has impacted on patients being able to easily flow between one organisation and another. Also, data isn't being used to its maximum potential to help prevent ill health. There is also real potential for technology to improve the way we work and give more choice to the people we serve. | • To develop and use technologies to prevent ill-health, self-care and self-serve where possible.<br>• To use digital tools to improve people's experience of healthcare, to offer care closer to, or in, the home and to enable patients to safely leave hospital sooner.<br>• To support our workforce with digital tools to do their job as safely, effectively and efficiently as possible.<br>• To bring together clinical and corporate information systems across NHS providers and better share information across local authorities and VCFSE organisations.<br>• To use data to support population health intelligence, research, quality improvements and service evaluation.<br>• To develop and use technologies to prevent ill-health and offer care closer to, or in, the home. |
| **Our resources**<br> | In the past, our focus has been on treating illness, usually in hospital. This is not sustainable as the demand for care increases.<br><br>Organisations work in isolation and there is little sharing of resources and functions. | • To focus on preventing ill-health, reducing the number of people living with long-term conditions and improving healthy life expectancy.<br>• To increase value for money by moving care delivery into the community and using digital tools.<br>• To increase efficiency by sharing programmes and administrative work across providers. |

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# 8. Our strategic priorities

## Strategic priority one - Strengthening our foundations

**We will strengthen our foundations by improving our financial sustainability and value for money through a transformation programme with providers**

The underlying financial risk forecast for 2023/24 was significant. In agreeing our system financial target for the year we have accepted the need to take urgent joint action on recovery across the whole NHS.

Lancashire and South Cumbria ICS has to be in an underlying financial breakeven position by 2026/27. We therefore have three years to make significant improvements and efficiencies in the way we deliver services. In addition, for each of those years, the system needs to plan for break-even in-year using non-recurrent options across the resources available.

Eliminating our system's financial deficit over the next three years will involve addressing the underlying demand and capacity drivers of our financial position which is linked to how our services are delivered.

To strengthen the long-term sustainability of the NHS within Lancashire and South Cumbria we need to manage demand for healthcare services over the long term and make the best use of our financial resource our capacity to deliver care and our systems and processes.

A formal System Recovery and Transformation Board will be established to oversee the work plan and provide assurance to the ICB board. A three-year plan will outline how the financial gap will be closed.

| | What we need to do | How will we do it |
|---|---|---|
| 1 | Optimise the spend and value for money of the system's £4billion budget | • We will develop programmes to make the ICB and our providers more efficient.<br>• We will secure the expertise of a regional turnaround team and leave no stone unturned in the search for efficiency and effectiveness.<br>• We will take tight control of spending and remove any unfunded costs.<br>• We will reduce duplication, combine back-office functions across providers and reduce administrative costs wherever possible.<br>• We will reduce the ICB back-office costs and our carbon emissions by enabling our workforce to work in an agile way.<br>• We will work with our local authorities through our place-based partnerships to ensure the Better Care Fund is used to enable patients to be discharged from hospital when they no longer need to be there. |



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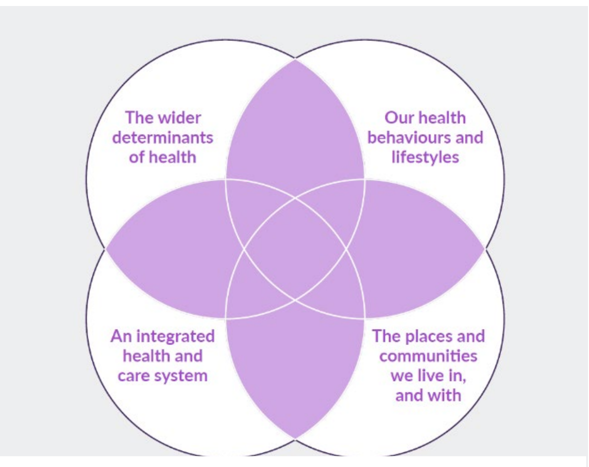
| | What we need to do | How will we do it |
|---|---|---|
| 2 | Make the best use of our capacity to deliver health and care | • We will network and reconfigure our clinical teams to increase their resilience and reduce costs.<br>• We will reduce the environmental impact of our buildings and vehicles.<br>• We will improve patient experience and reduce the cost of delivering healthcare by moving care closer to home wherever possible by:<br>o Expanding and strengthening primary and community care including integrated neighbourhood teams.<br>o Enhancing intermediate care including the use of remote monitoring and virtual wards. |
| 3 | Make the best use of our systems and processes | • We will increase the efficacy of clinical and care pathways.<br>• We will develop seamless pathways across providers and partners. |
| **Critically underpinned by:** | | |
| | A reduction in the long-term demand for healthcare services | • We will work with our partners to prevent ill-health and reduce the long-term demand for healthcare. This will include integrating health and social care teams and working closely with our wider partners at system, place and neighbourhood level.<br>• We will work with local people to empower them to take more responsibility for their health and well-being, signposting them to services and providing coaching.<br>• The work programme with partners for this area is detailed within the next section. |

## Strategic priority two - Preventing ill health and reducing inequalities

**We will improve prevention and reduce inequalities by collaborating with our partners**

To improve the health and well-being of our population we will connect and integrate health and well-being services across the system. This will improve our ability to prevent illness and, over the long term, it will reduce the burden of disease, increase healthy life expectancy and reduce inequalities. As the level of disease in our population reduces, this will impact upon the level of healthcare spending although this is reliant on our population making positive lifestyle choices. To prevent ill-health the NHS needs to increase its contribution to population health and well-being. Underpinning this is the intention to level-up health and well-being for our population and, with partners, to address systemic inequalities in their life chances.




(2018), Buck et al, A vision for population health: Towards a healthier future, The King's Fund

We know we need to work together with our partners to improve the overall health of the Lancashire and South Cumbria population. As the diagram above shows, to make a real difference action is needed across the wider determinants of health, health behaviours, communities and the healthcare system.

A priority focus for support to encourage healthier behaviour is to address tobacco usage. A joint plan has been developed in collaboration with the Lancashire and South Cumbria Public Health Collaborative with the intention of making a concerted effort to reduce tobacco usage in all areas to less than five per cent by 2030.

## Our plan to reduce health inequalities

As well as taking a holistic approach to health and well-being we will take targeted action within communities and population groups where there are significant health inequalities. Critical to this will be using population health data and intelligence to understand the health challenges faced by different communities and the causes of varying outcomes, alongside evidence-based research on what makes a difference. This will enable us to level-up the health and well-being playing field.

We have a comprehensive approach to address health inequalities and ensure it is a priority for action across all work programmes and functions. The goal is to keep our population well and reduce avoidable health inequalities with a clear focus on driving down the inequalities in access, outcomes and experience for people experiencing the greatest deprivation as measured by decile one and two within the index of multiple deprivation. This group is described as the 'core 20' per cent with the greatest health inequalities. It also includes taking action to support particular population groups which experience inequalities, described as the 'plus groups'. Alongside this, targeted action within five key clinical priority areas, as detailed nationally. All of this is set out in the national 'Core20plus5' guidance for adults and children.

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The five key clinical areas for adults are maternity, severe mental illness (SMI), chronic respiratory disease, early cancer diagnosis and hypertension case finding. The children's priority areas are asthma, diabetes, epilepsy, oral health and mental health.

We are applying population health management approaches to predicting and detecting those at greatest risk of ill-health, including:

- Earlier cancer detection/diagnosis in line with Core20 plus5.
- Improving take-up of vaccinations and immunisations for those in our community experiencing the greatest health inequalities.
- Improving uptake of cancer screening for those in our community experiencing the greatest health inequalities.
- Improving uptake of NHS health checks for those in our community experiencing the greatest health inequalities.
- Increasing the percentage of patients receiving appropriate management including for hypertension and lipid lowering therapies.

We are undertaking targeted work in priority wards (those wards with greater level of non-elective service usage than anticipated for their level of deprivation) to understand the drivers leading to non-elective service usage and address these with the intention of increasing access to preventative and planned services.

We are also working with people and communities to understand barriers to access and coproduce creative solutions to ensure services meet people's needs and improve access, experience and outcomes.

We will measure success in the long term by the extent to which we have added life to years in terms of healthy life expectancy at system and place. We will also measure the extent to which we are reducing the variation in healthy life expectancy across our system. In the medium term we will monitor disease prevalence and admissions. In the short term we will ensure seamless and integrated provision is in place within every community.

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| | What we need to do | How will we do it |
|---|---|---|
| 1 | **Develop a joint programme of work across all partners to improve health and well-being** | • We will review the joint strategic needs assessments for each place in Lancashire and South Cumbria to identify the areas we could collaborate on so we can improve the life chances of our population.<br>• We will implement an Integrated Care Strategy across all partners, detailing joint programmes of work across the whole life course of our population, integrating services and improving people's experiences of health and care.<br>• We will ensure the mobilisation of effective place-based partnerships as the key delivery vehicle for our joint working at place.<br>• We will act at system, place and neighbourhood level, responding to different communities' needs to ensure health inequalities are addressed.<br>• We will use population health management expertise to understand the reasons for differences in health across Lancashire and South Cumbria and use it to design innovative ways to improve health and well-being in our communities.<br>• We will implement digital tools to support our population to stay well for longer and manage their health and illness, ensuring digital inequalities do not further increase the risk of health inequalities. |
| 2 | **Support healthy lifestyles** | • We will work with local people and communities to provide additional support using digital tools where possible to encourage our population to stay well for as long as possible, including services for smoking, drinking and obesity. |
| 3 | **Improve prevention** | • We will undertake targeted action within priority pathways to help prevent the progression of key diseases. The priority work programmes as identified nationally in the NHS Long Term Plan (LTP) are cancer, mental health and cardiovascular disease.<br>• We will prioritise implementation of the NHS LTP-funded tobacco dependency treatment pathways in maternity, mental health and acute inpatient services.<br>• We will ensure prevention plans focus on tobacco and inequalities and are developed with local government public health colleagues.<br>• We will sign the NHS Smokefree Pledge as endorsed by the NHSE chief executive and various other esteemed organisations including the Association of Directors of Public Health. We will support regional models for tobacco control. |

| | What we need to do | How will we do it |
|---|---|---|
| 4 | **Reduce inequalities** | • We will undertake targeted work to support a reduction in health inequalities at system, place and neighbourhood level. This will include initiatives to support those with the greatest health inequalities including specific population groups with poorer than average access, experience and/or outcomes. This work is supported by the national Core20PLUS5 programme.<br>• We will undertake targeted work to improve outcomes for adults within five nationally identified clinical pathways including maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis and hypertension.<br>• We will undertake targeted work to improve outcomes for children within five nationally identified clinical pathways, including asthma, diabetes, epilepsy, oral health and mental health.<br>• We will apply the outcomes from the Learning Disability - Learning from Lives and Deaths review (LeDeR) to inform improvements to the clinical pathway such as cancer, diabetes, epilepsy, respiratory alongside impact and learning from the dynamic support register and annual health checks. |
| 5 | **Support broader social and economic development** | • We will harness the role of the NHS as an anchor institution to make a difference in our communities.<br>• We will drive social value and inclusive economic development via the commissioning and procurement of goods and services.<br>• We will work with educational establishments and local employment services, to encourage people to take up health careers. |

Our Integrated Care Strategy, as outlined below, sets out our intention to take joined-up action with our partners to enable our population to thrive by starting well, living well, working well, ageing well and dying well.

| Lancashire and South Cumbria Integrated Care Strategy priorities | |
|---|---|
| **Starting Well** | **Together with our partners we will support our population to start well.**<br>• **Integrated support for families**: We will develop family hubs across Lancashire and South Cumbria providing integrated and joined-up support for children and their families, including carers who are parents and young carers. This will include a comprehensive start-for-life offer.<br>• **Supporting those with the poorest health**: We will reduce health inequalities and vulnerabilities by taking targeted action to address differences in access to services and improve health and well-being outcomes for children and their families, including parental carers and young carers. We will provide support for breastfeeding, reduce childhood obesity, promote safer sleeping and reduce smoking during pregnancy.<br>• **Support for children to achieve their potential at age three**: We will support all our children to be as healthy as they can be by their third birthday including joined-up child health and development services, support for all pre-school children with additional needs and support for school readiness. It will include support for families, parental carers and young carers. |
| **Living Well** | **Together with our partners we will support our population to live well.**<br>• **Support for the unwell:** We will support people with existing mental and physical ill-health with a particular focus on those who face the greatest inequalities in access, experience and outcomes.<br>• **Support for healthy lifestyles**: We will support our residents to make healthy lifestyle choices with the greatest focus on those experiencing the biggest health inequalities.<br>• **Support for the causes of ill health**: We will address the causes of poor health and care, working together to address the things that can have an impact on health and well-being. |
| **Working Well** | **Together with our partners we will support our population to work well.**<br>• Career support for young people: We will support young people to feel more interested in their future careers, helping them to gain the life skills needed for work and encouraging them into jobs with good career opportunities.<br>• Skills development: We will support our working-age population into stable and healthy workplaces, helping individuals, particularly from disadvantaged communities, to gain confidence and skills that enable them to compete for jobs as equals.<br>• Support for well-being at work: We will create workplaces and cultures that encourage good health and well-being, identifying the signs of ill-health and well-being early and offering support where needed.<br>• Support for local development: We will encourage large organisations and local businesses to support social and economic development in their area. |

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| Lancashire and South Cumbria Integrated Care Strategy priorities | |
|---|---|
| **Ageing Well** | **Together with our partners we will support our population to age well.**<br>• Integrated support for frail older people: We will provide joined-up, wrap-around support for our most vulnerable and frail residents, their families and carers. This will include the development of older people's hubs.<br>• Choice and control over care: We will make sure support is in place when circumstances change for an individual or their carers, supporting people to be as independent as possible.<br>• Keeping older people active: We will keep our maturing population mentally and physically active as well as involved and contributing to their communities. |
| **Dying Well** | **Together with our partners we will support our population to die well.**<br>• Talking about dying: We will encourage our residents to feel comfortable talking about death and dying.<br>• Personalised end-of-life planning: We will ensure end-of-life care is made more personal, regardless of where they live or their condition.<br>• Bereavement support: We will provide outstanding support for people who have lost a loved one, their families and carers with an approach that meets their individual needs. |

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## Strategic Priority three – Integrating and strengthening primary and community care

### Strengthening primary and community care with partners and providers

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.

Enhancing and strengthening community care supports hospitals by:

- Reducing the number of people needing to enter the front door – helping patients to be cared for at, or closer to, home and avoid unnecessary hospital admissions.
- Increasing the flow of patients out of the back door – working in the community to ensure there are safe and suitable places for people to move on to when they no longer need to be cared for in hospital.

By better using digital technology and enhancing the care we provide out of hospital for people with long-term conditions we can keep people well for longer. It also has a role in supporting acute-based planned care services, some elements of which could be moved into the community via a hub and spoke model.

We will measure success by the extent to which the current primary and community care provision has been strengthened and, in the longer term, the extent to which enhanced primary and community care provision is in place, including integrated neighbourhood teams.

### Mental health community service transformation

Our ambition is to establish new and integrated models of primary and community mental health care to support at least 370,000 adults and older adults nationally per year who have severe mental illnesses by 2023/24, so they will have greater choice and control over their care and be supported to live well in their communities. A new inclusive generic community-based offer based on redesigning community mental health services in and around primary care networks will include improved access to psychological therapies, improved physical health care, IPS/employment support, personalised and trauma-informed care, medicines management and support for self-harm and coexisting substance misuse. This includes maintaining and developing new services for people who have the most complex needs including EIP, personality disorder, rehabilitation and adult eating disorders.

Core community mental health services (CMHS) will be redesigned in partnership with primary care networks, local authorities, VCFSE, service users and carers to create a new, flexible, proactive model of community-based mental health care for people with moderate to severe mental illnesses.

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| | What we need to do | How will we do it |
|---|---|---|
| **The foundations** | | |
| 1 | Strengthen primary care | • We will strengthen the existing primary care provision and improve access to primary care.<br>• We will integrate primary care with community services into primary care networks. |
| 2 | Strengthen community services | • We will review community services to understand the gaps. |
| **Transformation** | | |
| 3 | Transform primary and community care provision | • We will develop integrated neighbourhood teams that support proactive prevention and provide integrated care within the community, reducing downstream demand on hospitals, by September 2025.<br>• We will empower people to take greater control over their health and well-being by offering them personalised choices about their care. |
| 4 | Transform intermediate care provision | • We will coordinate care and enhance services to avoid patients being admitted to hospital where it can be avoided and help them leave hospital faster when they are ready.<br>• We will transform intermediate care provision. |
| 5 | Transform community mental health services | • We will ensure there is no cliff edge of lost care and support by moving away from an approach based on referrals and discharge.<br>• We will increase access for people who currently fall through the gaps between services or are deemed to not meet current clinical ‘thresholds’ for treatment by secondary care teams.<br>• We will adopt the principle of inclusivity and assess/address workforce gaps accordingly. |

## Strategic priority 4 - Improving quality and outcomes

### Improving quality and outcomes through standardisation and networking with providers

Our vision is that people in Lancashire and South Cumbria will have equal access to joined-up care that is consistently safe, delivered with compassion and on a par with regional and national averages.

Where health and care services are not as good as they should be there is a real impact on patients’ recovery and long-term health. This in turn means people often need further care which is negative for the patient and costly for the system.

Our quality of care across Lancashire and South Cumbria is variable as evidenced by the NHS SOF ratings of our providers. Alongside this, the way the system currently works is

expensive and unsustainable. Our action in this area has the potential to improve quality and reduce spending in the medium term.

| Trust | CQC rating | | Single Oversight Framework | |
|---|---|---|---|---|
| | 2022-23 | Plan | 2022-23 | Plan |
| North West Ambulance Service NHS Trust (NWAS) | Good | Maintain good | 2 | Maintain SOF 2 |
| East Lancashire Hospitals NHS Trust (ELTH) | Good | Maintain good | 2 | Maintain SOF 2 |
| Blackpool Teaching Hospitals NHS Foundation Trust (BTH) | Requires improvement | Good during 2024/25 | 3 | SOF 2 by 2025-26 |
| Lancashire and South Cumbria NHS Foundation Trust (LSCFT) | Requires improvement | Good during 2024/25 | 3 | SOF 2 and maintain during 2023/24 |
| Lancashire Teaching Hospitals NHS Foundation Trust (LTH) | Requires improvement | Good during 2024/25 | 3 | SOF 2 by 2025/26 |
| University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBT) | Requires improvement | Good during 2024/25 | 4 | SOF 3 by 2023/24 and SOF 2 by 2025/26 |

We will establish an oversight and assurance framework to support delivery of the system's objectives. This will be done with providers and report to the ICB board via the Recovery and transformation group.

The Recovery and transformation group will assure organisation-level progress on financial, performance and quality metrics with a view to progressing segmentation ratings and sustaining them. It will also assure the transformation workstreams and facilitate delivery.

In the medium and longer term success will be measured by improved healthcare outcomes and patient experience, as measured through the implementation of optimised pathways, an improved healthcare estate and an enhanced workforce.

| | What we need to do | How will we do it |
|---|---|---|
| 1 | Enhance the consistency of the pathways and processes around care including access | • We will enhance clinical and care pathways across providers.<br>• We will take action to ensure our pathways of care for key disease areas, conditions, population groups and communities are world-class (see in the next section).<br>• We will improve our urgent care pathways including access to urgent care and better intermediate care.<br>• We will improve our planned care pathways.<br>• We will optimise referrals.<br>• We will reduce waiting times for care.<br>• We will redesign planned care pathways to improve quality, outcomes and patient experience and move care closer to home.<br>• We will reduce clinical variation and low-value activity. |
| 2 | Improve the estate/physical care environment | • We will significantly improve the quality of our estates via the New Hospitals Programme.<br>• We will support achievement of NHS net zero ambitions, including reaching net zero emissions by 2040 for both existing and new estate. |
| 3 | Increase the productivity and resilience of our workforce | • We will build a workforce plan for the system which includes workforce networks across providers. |
| 4 | Robust governance and oversight | • We will lead and effectively respond to recommendations and learning from any partnership inspections which are across our health and social care system. |

## Implementing NHS Impact: Improving patient care together

Partners across our ICS are working together to implement NHS Impact, the new single shared NHS improvement approach focused on improving patient care together.

Our teams understand that by creating the right conditions for continuous improvement and high performance we can deliver better care for patients and better outcomes for our communities. This includes building a shared vision and purpose, investing in people and culture, developing leadership behaviours, building improvement capability and capacity and embedding improvement into management systems and processes.

## Strategic priority five – World-class care for priority areas

The NHS long-term plan highlighted areas where targeted action is required across the NHS to improve health outcomes. These areas are detailed in the table below together with the core deliverables. It includes work to reduce inequalities within these areas. There are national resources to support improvement in these areas, however achieving the desired outcomes will be impacted by workforce availability.

**Improving pathways and care** for priority disease areas, conditions, population groups and communities

<table>
<tr><th colspan="2">What we need to do</th><th>How will we do it</th></tr>
<tr><td>1</td><td>Priority disease areas and conditions – cancer, mental health, maternity, cardiovascular disease, respiratory</td><td>
Pregnancy: We will improve the quality of care for women who are pregnant.<br>
• We will improve the support for pregnant mothers including continuity of care and perinatal mental health support.<br>
• We will reduce the number of stillbirths.<br>
• We will support a reduction in inequalities by taking action to improve care for women from black and minority ethnic communities and from the most deprived groups.<br><br>
Cardiovascular disease: We will improve care for people with cardiovascular disease.<br>
• We will improve prevention by providing access to cardiac rehabilitation and defibrillators.<br>
• We will improve the outcomes after a stroke including access to thrombectomy and thrombolysis.<br>
• We will improve prevention for diabetes by offering structured education and improved monitoring.<br>
• We will improve support for those with respiratory conditions.<br>
• We will support a reduction in inequalities by optimising blood pressure and minimising the risk of myocardial infarction and stroke for those with hypertension.<br><br>
Mental health: We will improve the care we provide to those who need mental health support.<br>
• We will improve the support for those in a crisis including a single point of access and support within acute hospital emergency departments.<br>
• We will improve early intervention for people with psychosis.<br>
• We will provide more support for people with depression and anxiety.<br>
• We will improve the support for those with serious mental illness.<br>
• We will improve the support and reduce health inequalities for those with serious mental illness (SMI) by ensuring that 60 per cent of those living with SMI, receive an annual health check.<br><br>
Cancer: We will improve outcomes for those with cancer.<br>
• We will increase the proportion of people diagnosed early.<br>
• We will increase the level of lung cancer spotted early via lung health checks.<br>
• We will support a reduction in inequalities by ensuring that 75 per cent of cases are diagnosed at stage one or two by 2028.<br><br>
Respiratory: We will support a reduction in inequalities by increasing vaccination uptake for those with chronic obstructive pulmonary disease. This will reduce the level of infective exacerbations and the linked emergency hospital admissions.
</td></tr>
</table>

| | What we need to do | How will we do it |
|---|---|---|
| 2 | **Priority population groups** – Children and young people, learning disabilities | **Children and young people**: We will improve healthcare outcomes for children.<br>• We will support children who are obese to improve their health.<br>• We will provide more access to mental health services including eating disorder services.<br>• We will work with our partners to ensure there is support and protection for children at risk of abuse and neglect.<br>• We will provide access to more cancer treatments for children including CAR-T and proton beam therapy.<br>• We will improve our response to conducting statutory heath care assessments for children in care.<br>• We will deliver the commitments in the Care Leavers Covenant.<br>• We will ensure we are supporting our children as they transition into adult services.<br>• We will support a reduction in inequalities by undertaking targeted work within five priority pathway areas: asthma, diabetes, epilepsy, oral health and mental health.<br><br>**Learning disabilities and autism:** We will improve healthcare outcomes for people with learning disabilities.<br>• We will improve the quality of life for those with learning difficulties by moving people out of hospitals.<br>• We will improve the health of people with learning difficulties and autism by ensuring they are registered with a GP and we regularly monitor their health via regular checks. |

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# 9. Our financial strategy

A financial strategy is being developed to underpin the ICB strategic direction. Principles for the strategy have been developed and the full strategy will be in place by September 2023. The core principles are shown in the diagram below.

The key areas of work within each of these areas is described below.

## Our financial strategy principles

| Principle | Key areas of work |
|---|---|
| **Underpin the ICB strategic priorities** | • Place integration.<br>• Community redesign and vertical integration.<br>• Strong out-of-hospital offer.<br>• Investment in population health through place.<br>• Available capital aligned to strategy. |
| **Recurrent financial balance within three years** | • Recovery approach to transform the system finances – joint ICB and provider three-year recovery plan.<br>• Tight spending controls, governance and processes in line with national protocols, firmly in place for ICB and providers.<br>• Effective, efficient delivery each year. |
| **Strengthen contracting and commissioning** | • Strong commissioning strategy and contract review process.<br>• Greater openness and transparency in working collaboratively with partners.<br>• Mechanisms and governance to review acute contracts at place level. |
| **Develop skills and competencies** | • Strong focus on finance skills development and financial controls across the system.<br>• Ensure the highest level of finance staff development accreditations.<br>• Ensure all opportunities to attract and retain the best talent with a strong focus on equality and diversity.<br>• Financial training, development and tools for senior leaders and clinicians across the system. |
| **Embed robust financial governance and assurance** | • High level of assurance in audit opinions.<br>• Strengthen financial governance within the maturing ICB.<br>• Ensure Healthcare Financial Management Association (HFMA) governance handbook recommendations are in place across the system.<br>• Develop the financial assurance framework for system working.<br>• Memorandum of understanding in place between organisations. |
| **Support financial delegation to place** | • Senior financial leadership in each place.<br>• Develop a clear financial framework for allocations and place integration aligned to the place integration deal.<br>• Delegation of primary care, population health and community budgets by 2024. |

# 10. Our enablers

To tackle the significant health issues our population faces and to enable delivery of all our strategic priorities we will work differently and effectively at system, place and neighbourhood levels. We will work together with local people, ensuring communities are at the heart of our plans and will vary our approach based on local needs.

Key enablers are as follows:

| **Working differently** | | | |
|---|---|---|---|
| Research and Innovation | Reducing inequalities using population health and public health expertise. | Integrated working within the NHS and with our system partners. | Lifting the bureaucratic burden.<br>Longer-term partnerships with high-performing providers. |
| | Empowering our population including public and patient engagement and personalised care. | Strengthened places and neighbourhoods. | Harnessing our role as an **anchor institution.** |

| **Getting the basics right** | | | |
|---|---|---|---|
| Comprehensive workforce plan across all organisations and sectors. | Buildings, infrastructure, digital and environment. | A strong focus on delivery with clear delivery plans, joint accountability frameworks and performance measures. | **Safeguarding** children and vulnerable adults. |

## Working differently

### Research and innovation

There are a lot of strengths to build on across Lancashire and South Cumbria in terms of research capability and infrastructure and in line with recent NHSE guidance to ICSs on maximising the benefits of research. It is our intention to facilitate and promote research and to systematically use evidence from research when exercising the ICB's functions. We have already established an ICB-led Research and Innovation Forum and this group will develop an ICS research strategy in line with the guidance and that supports our Integrated Care Strategy priorities. We have ambitions to grow research activity across Lancashire and South Cumbria significantly and to grow and develop a clinical academic workforce.

To enhance our sustainability and to ensure we are delivering optimum pathways of care we will review best practice research and innovation and look at the national and international evidence base, particularly in support of our strategic priority of improving quality and outcomes. We are building capability for the adoption and spread of proven innovation by

working with our local academic health science networks and other local partners to support the identification and adoption of new products and pathways that align with population health needs and address health inequalities. We are fortunate to have the Health Innovation Campus at Lancaster University within our patch and all our HEIs are members of the new Research Forum and keen to be a partner in research activity. We fully intend to harness these opportunities.

The heads of research and innovation from across our five key providers have agreed priority areas of focus: innovation and digital, workforce development, academia and working with industry to increase sustainability. There is a joint commitment across providers to advancing individual and regional research, innovation and development functions, capacity and capabilities.

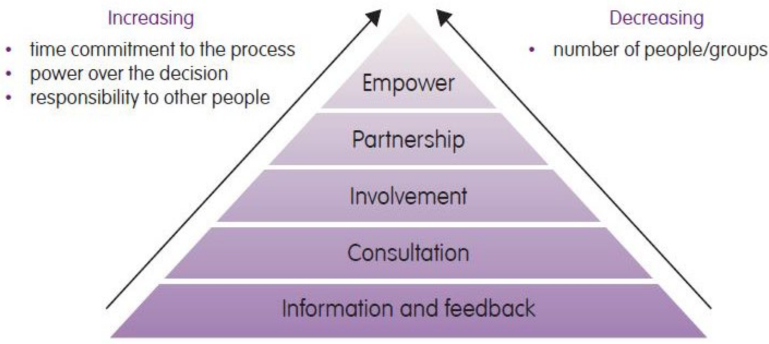
Our commissioning plans will take account of and be underpinned by research and evidence-based guidance and we will encourage our providers to support and be involved in research delivery. It is our ambition to establish a robust research culture across all our partners. Our workforce plans include the development of our research workforce and we will support collaboration across local National Institute for Health and Care Research (NIHR) networks. We recognise our system has untapped research potential in terms of our diverse population. A system approach to attract prominent research studies, trials and projects, both commercial and non-commercial, is of paramount strategic importance.

## Reducing inequalities

Reducing inequalities is a priority for every area of commissioning. We will use population health data and intelligence to understand our communities' differing health and combine this with research, innovation and best practice on what makes a difference. Population health management expertise will be critical to our strategic priority on prevention and inequalities. It will work hand in hand with expertise from our public health colleagues in the local authorities.

## Empowering our population

Our intention is to completely change the relationship between our health care services and our population. Traditionally our services have informed and consulted with our population to notify them of how to access services and how they can provide feedback on their patient experience.

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To improve the long-term sustainability of our system we will develop a completely different relationship with our most important stakeholder. We want to *involve* and work in *partnership* with our population to design new models of integrated health care delivery and *empower* our population to feel in the driving seat of their health and wellbeing, to understand what they can do to improve their lives and be able to make choices about their care. We have agreed principles across our partners for how we will work with people and communities to listen, involve and co-produce our plans together. This will help to develop ways of working that really are focused on local people, their lived-experience and have our population's needs at the heart of all we do.

Empowering our population to take greater control of their health and well-being is at the forefront of this. As part of our personalised approach to care delivery, we will offer a wide range of choices, including support with digital health technologies, to our population about their care. This will be integral to the model of care delivery within our neighbourhoods and communities.

| **Empowering our population via personalised care** | |
|---|---|
| | **What we will do** |
| **Whole population** | We will support you to understand your treatment and support options, to weigh up the risks and benefits and make choices over your care which fit around your life. The decisions about your care will be undertaken collaboratively. The options over your care may include:<br>• **Technology** to help you manage your health conditions from the comfort of our home or place of residence, such as COVID-19 oximetry, virtual wards, health and wellbeing applications and blood pressure monitoring.<br>• **Community-based support** which you can access via community-based link workers such as social prescribers or community connectors. |
| **People with long term physical and mental health conditions** | We will undertake personalised conversations with you to design your care, taking account of your clinical needs, as well as your wider lifestyle. The options over your care may include:<br>• **Community-based support** which you can access via community-based link workers such as social prescribers or community connectors.<br>• **Health coaching, education and peer support** to enhance your knowledge and confidence in managing your condition.<br>• **Joint ownership of your health budget** to enable you to be in the driving seat of your health and wellbeing and to procure the services which best meet your needs. |

## Integrated working and strengthened places

To improve health and well-being across the system we will harness the opportunities of working in collaboration with all organisations within the NHS and all our wider partners. It will involve integrated working at system, place and neighbourhood levels, across all our partners and integrated working across the NHS family.

Our key vehicles to achieve this are:

- The Recovery and transformation group
- The provider collaborative
- Lancashire and South Cumbria Integrated Care Partnership
- Place-based partnerships
- Neighbourhood teams

Effective integration will also require a leadership and organisational development programme across all organisations to facilitate a system mindset and a shared culture.

## Recovery and transformation group

The Recovery and transformation group is made up of system partners and led by the ICB. The purpose of the group is to have collective organisational oversight of recovery and to deliver an assurance role to the ICB board on improvement on system segmentation objectives. The Group will also be responsible for supporting the delivery of system-wide transformation programmes, seeking to accelerate the delivery of system change to improve sustainability, patient care and outcomes.

## Provider collaborative

The aim of the provider collaborative is to pool the collective knowledge, skills and talent from across the system to quickly deliver a small number of high-priority Lancashire and South Cumbria-wide projects. At the same time the providers will continue to improve the quality of their services at a local level.

## Lancashire and South Cumbria Integrated Care Partnership

The Lancashire and South Cumbria Integrated Care Partnership is tasked with working across organisational boundaries to improve health and well-being. It has developed a strategy to improve our population's health, wealth and happiness by taking collective action to enable our population to start well, live well, work well, age well and die well. The delivery of services will be transformed by collaboration and integration between teams and the reorientation of resources towards prevention. To facilitate partners working differently we will review how we invest, provide and manage services. Critical to the delivery of our system strategy is our place integration deal for greater integration of health and care in places and neighbourhoods to ensure services are delivered as close to patients as possible.

## Place-based partnerships

Our long-term plan is for place-based partnerships to be at the forefront of the design of local health services, with only those things that are best done on a larger scale being led at system level across Lancashire and South Cumbria. This will enable local authorities and the VCFSE sector to play a greater role in improving the health and well-being of their local population. Our local authority colleagues in unitary, district and county councils have vast

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knowledge, experience and understanding of the needs of their communities which is a huge asset to improving the life chances of our population.

Our commitment to the development of our places can be summarised as follows:

| | What we will do |
|---|---|
| **Place development priorities** | • We will develop a phased place integration deal and supporting work programme from July 2023. It will include articulation about how the following priorities can be enabled through delegation to our places – continuing healthcare, primary care, community services, the Better Care Fund and population health. A critical element of the plan will be ensuring the right decisions are made in the right place in order to drive agile and effective service delivery. It will include the adoption of neighbourhood working across the ICB area.<br>• We will develop a three-year phased investment programme to strengthen community services, aligned to ambitions of our place-based partnerships. It will include proposals to expand virtual wards (hospital at home), intermediate care, domiciliary care, prevention priorities, a proactive approach to primary care to reduce unnecessary hospital admissions and integration between health and care.<br>• We will develop an operating framework for place as part of our place integration deal. It will include budget delegation, staffing, operating rules, roles and functions and the culture needed to work well together and succeed. |

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## Cross-boundary flows

It is recognised that patients registered with our GP practices will flow into cross-border providers and similarly that people who live within our borders but are registered with neighbouring GPs will be cared for within our services. While associated care will be covered by relevant contractual agreements, we will work closely with our partner ICBs to ensure that, through our approaches to service integration, the needs of these patients will be met.

## Harnessing our role as anchor institutions

The ICB and our partner NHS providers will support the development and delivery of local strategies to influence the social, environmental and economic factors that impact on the health and well-being of our population. This includes our role as strategic partners to local authorities and others within their system as well as our direct contribution as planners, commissioners and providers of health services and as anchor institutions within their communities.

Anchor institutions are defined as large, public-sector organisations that are unlikely to relocate and have a significant stake in a geographical area. They are effectively anchored in their surrounding community. They have sizeable assets that can be used to support local community wealth building and development through procurement and spending power, workforce and training and buildings and land.

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 employers.
- As purchasers and commissioners for social value.
- As land and capital asset holders.
- As leaders for environmental sustainability.
- As partners across a place.

There is a major opportunity for the ICB to use its role in the commissioning and procurement of goods and services to drive social value and inclusive economic development and to reduce inequalities and reduce environmental impact. We have a health and wellbeing role in the determinants of health through the employment of local people and via health education of our staff. In addition we are taking action with educational establishments and local employment services to encourage people to take up health careers.

The NHS trusts across Lancashire and South Cumbria have already started to undertake a range of activities to develop their roles as anchor institutions through local charters and compacts in partnership with their local communities and/or with other organisations. Several trusts have also expressed an interest in developing their role as a Marmot Trust.

## Getting the basics right

### Safeguarding our children and vulnerable adults

We are fully committed to delivering all our statutory and partnership safeguarding responsibilities. Safeguarding is a shared responsibility across the health and care economy and wider multiagency partnerships and we work alongside our partners and provider organisations to ensure we have robust and effective systems to safeguarding children and adults with care and support needs. Our teams drive improvements through local and regional collaborative working to embed responsive safeguarding practice. This enables us to address national and local priorities and influence safe and effective care and commissioning.

Our local safeguarding partnerships are an essential vehicle to support us in delivering our safeguarding responsibilities. Working together to improve effectiveness of these partnerships is a key priority. This includes how we learn lessons and embed better practice across our whole workforce.

Effective safeguarding at both system and organisational levels relies on systems that ensure safeguarding is integral to daily business. We are committed to:

- Strengthening collaboration and communication.
- Improving training and awareness.
- Early identification and intervention.



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- Strengthening partnership working.
- Enhancing monitoring and evaluation.
- Empowering service users.
- Promoting a culture of safeguarding.

We recognise the vital need to share information to safeguard children and we have agreed to deliver a robust digital programme around the implementation of child protection information sharing (CP-IS) across the health and social care partnerships.

Serious violence is a major cause of ill-health and poor well-being and is related to the difference in health status, social determinants of healthcare and health-related behaviours between areas and communities. In achieving our responsibilities under the Serious Violence Duty, the ICB has committed to work with our partners delivering preventative interventions. These are aimed specifically at reducing inequalities to prevent violence, including domestic abuse, address its root causes, especially those in early childhood and adolescence, and to support the particular needs of victims of abuse. Our aim is to improve multiple long-term outcomes including reduction of violence and improved education, employability and health.

## Workforce strategy

To meet our ambitions for the next five years we need to enhance and strengthen our workforce and ensure the health and care system in Lancashire and South Cumbria is a great place to work. There is a shortage of health and care staff which will not be resolved without working very differently than we have in the past.

It is our intention to apply education and training as an essential lever of an integrated workforce plan that supports the delivery of services in the short, medium and long term. Our developing workforce strategy will include an education plan that will articulate the role of education and research in securing healthcare staff supply and responding to changing service models as well as the role of trainees in service delivery. The plan will include:

- ✓ Upskilling the current workforce and the use of apprenticeships.
- ✓ Development of a pan-Lancashire and South Cumbria strategic education collaborative with providers, careers, social care, HEIs and FEs, primary care training hub.
- ✓ Connecting improvement with CPD and workforce development funding.
- ✓ Developing a social care training hub to underpin education and training as an essential lever across integrated care.
- ✓ Developing a belonging strategy for inclusive recruitment, retention, education and training and more.
- ✓ Development of successful pan-Lancashire and South Cumbria strategic careers portal for integrated workforce across integrated care.

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The workforce strategy will support the following ICB priorities:

- **Financial recovery and sustainability** (corporate collaboration, bank and agency, workforce transformation and productivity, operating plan workforce reductions, operating plans).
- **Health and care integration** (Place development – place workforce plans, new roles, integrated employment models/vehicles and career pathways).
- **Partnerships and collaboration** (leveraging VCFSE workforce capacity, building strong supply routes with schools, colleges and universities, promoting careers in health and care, to secure the workforce of the future).
- **Improving quality and outcomes** (professional training and education, workforce flexibility, multi-professional models).
- **Developing system leadership** (OD and leadership development)**.**
- **Integrated workforce planning** (operating plan, workforce efficiencies, recovery).

A core function of the Integrated Care Board is 'leading system implementation of people priorities'. This includes the delivery of the NHS People Plan and People Promise by aligning partners across the ICS to develop and support one workforce through closer collaboration across the health and care sector, with local government, the voluntary and community sector. The ICB's people board is charged with providing assurance to the ICB board across the strategic system-wide workforce agenda for Lancashire and South Cumbria.

Five ICB workforce priorities for 2023-24 have been approved by the Lancashire and South Cumbria people board:

- ✓ A sustainable workforce model.
- ✓ Develop the culture of equality, diversity, inclusion and belonging for our people.
- ✓ Transform and innovate through people digital.
- ✓ Improve the health and well-being of our people.
- ✓ Optimise workforce productivity and transformation across our system.

| Our workforce strategy | |
|---|---|
| **Training, development and support** | • We will provide education, training and development opportunities for our people.<br>• We will provide additional health and well-being support for our staff to enable a reduction in sickness absences. The rates in Lancashire and South Cumbria are higher than the national average for England. Services include support with financial issues and workplace health issues, particularly focusing on mental health and musculoskeletal conditions that can be brought on or affected by work. |
| **Workforce planning** | • We will take an integrated approach to demand and capacity planning for our future workforce.<br>• We will improve our long-term workforce planning. We have undertaken a review of our current and future workforce including discussions with training providers and higher education institutions to understand the numbers of candidates expected to join the system, alongside leavers' data, staff turnover and future demand profiling. |



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| Our workforce strategy | |
|---|---|
| **Culture** | • We will strengthen our approach to equality, diversity and inclusion to ensure we have a diverse and representative workforce at all levels and across all parts of our system. We are implementing a comprehensive belonging strategy in conjunction with the inclusion networks from across our provider trusts, local authority and wider partner agencies.<br>• We will support our workforce to embed and enact learning from safeguarding reviews to ensure our workforce is confident and skilled in responding to abuse and neglect.<br>• We will strive to have a trauma-informed workforce across our providers and partners to support staff in recognising the impact of trauma for each other and our population. |
| **Addressing workforce gaps** | • We will develop new roles within our providers, to help with staff shortages. This includes roles such as nursing associates, physician associates and assistant practitioners, which can support GPs, nurses, and other health professionals to look after lower-risk patients, freeing them up to spend more time with their most complex cases.<br>• We will network our staff across a wider geographical area to enable skills and expertise to be shared on a wider footprint. The new roles which will develop will cover a wider remit in terms of geography and the service they provide which will support gaps in the workforce. The national additional roles reimbursement scheme (ARRS) allows primary care networks to fund staff that work across all GP practices within their network. We will also explore the possibility of networking clinical teams across more than one trust to fill vital gaps and optimise care provision. This approach already exists for some services where there are clear opportunities for better use of a smaller number of people, such as stroke and maternity.<br>• We will harness digital technology to reduce the amount of time clinical staff have to spend on administrative tasks.<br>• We will explore how we can make our employment offer more attractive. This will include flexible and portfolio career packages and agile working patterns for many support services, where appropriate.<br>• We will take action to bring the nursing vacancy rate down to five per cent. This will involve working closely with chief nurses across the NHS and investing in developments to address the shortage of nurses both in hospitals and in care homes.<br>• We will support staff retention via our involvement in and learning from, a national programme which has an agreed consistent approach to agency and ‘bank’ staff.<br>• We will take innovative approaches to the recruitment, retention, development, and support of our staff. |
| **Supporting our communities** | • We will create job opportunities within the NHS for those within our communities, harnessing the role of the NHS as an anchor institute. It will include careers and employment programmes designed to reach out to many different groups of people. |

## Estates infrastructure, environment, and digital strategy

We are updating our health infrastructure strategy to 2040. It will help us to address our key challenges in terms of our ageing buildings, issues with specific sites and our aim of keeping up with the best healthcare facilities across the globe. It will explore the radical way in which our infrastructure will need to evolve in the future and how we can make better connections across the local ecosystem to sustainably improve buildings and accommodation.

## Delivering a 'Net Zero' National Health Service

On 1 July 2022, the NHS became the first health system in the world to embed net zero into legislation, through Health and Care Act 2022. Net zero means cutting greenhouse gas emissions that cause global warming to as close to zero as possible, with any remaining emissions re-absorbed from the atmosphere by oceans and trees. National NHS Goals are:

- Emissions we control directly to be net zero by 2040, with ambition to reach an 80% reduction by 2028-2032
- Emissions we can influence to be net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

…by the year 2040, this trajectory would save an estimated 5,770 lives per year from reductions in air pollution alone.

Supporting the environment and reducing the ICS carbon footprint helps our residents to live longer and healthier lives. Residents who are more disadvantaged are often the people who suffer the effects of climate change most acutely. Our mission - to reduce health inequalities and to secure better health and care outcomes - is supported by this work.

As an ICB, we play a key role in reducing emissions, influencing our providers, and building healthier communities. Our ICB Green Plan was published in March 2023 and outlines how we will support NHS England and the UK government in fulfilling these emission goals.

Our Green Plan is delivered through a collaborative, system level programme which includes input from Trusts, Primary Care and the Integrated Care Board (ICB); from which the ICB's Chief Finance Officer leads the programme as Senior Responsible Officer (SRO). It is divided into nine areas of focus, each with clear goals for delivery – these are set out in the table on the following page.

Collaborative working across health and social care, the voluntary and private sectors as well as our local communities will ensure we develop a joined-up, system-wide approach to tackling climate change in Lancashire and South Cumbria and provide a wealth of additional initiatives and learning opportunities.

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<table>
<tr><th colspan="2">Our estates, Infrastructure, and digital strategy</th></tr>
<tr><td>Estate</td><td>
<ul>
<li>We will reduce and consolidate the estate which housed our corporate and management staff, in line with changes to working practices which commenced during the COVID-19 pandemic. Many of our staff now work either from home or in a hybrid or ‘agile’ way, without a permanent desk in an office building. This will reduce unnecessary costs.</li>
<li>We have developed plans to significantly improve the quality of our hospital sites through our New Hospitals Programme, support for which has now been confirmed. This will make Lancashire and South Cumbria a world-leading centre of excellence for hospital care. It offers us a once-in-a-generation opportunity to transform some of our oldest and most outdated hospital buildings and develop new, cutting-edge hospital facilities. It will help us to offer the absolute best in modern healthcare, providing patients with high-quality, next-generation hospital facilities and technologies. The hospital buildings will be designed in a way to meet demand while remaining flexible and sustainable for future generations. They will also be aimed at helping to support local communities, bringing jobs, skills and contracts to Lancashire and South Cumbria businesses and residents.</li>
<li>We are developing plans to understand our requirements for health accommodation and infrastructure across our places and neighbourhoods and will identify our investment requirements to improve the quality of our out-of-hospital estate.</li>
<li>We will consider how our estate needs will change and be shaped by advances in technology, digital services, and new models of care. We will consider less-traditional approaches to both the development and use of accommodation, as well as increasingly focus on the role of infrastructure in prevention and reducing health inequalities.</li>
</ul>
</td></tr>
<tr><td>Digital</td><td>
<ul>
<li>We will improve the responsiveness of services by utilising real-time information to change how care is provided, where resources are coordinated and plan future care.</li>
<li>We will develop a common electronic patient record (EPR) across the system to enable Lancashire and South Cumbria to be a digitally mature system. Other work includes the ongoing development of tele-health and tele-care and an assessment of the possibilities surrounding virtual and augmented reality, machine learning and Artificial Intelligence.</li>
<li>We will enable care to be integrated across organisations by providing shared records to all partners involved in patient care. For example, medication history and information on long-term conditions, so information from one organisation will directly benefit care provided by another.</li>
<li>We will transform how patients interact with services, technology will support timely messaging and improve the experience for patients. We are developing a digital front door for people in Lancashire and South Cumbria to engage with health services. This portal will build on the capability of the NHS App.</li>
<li>We will develop a data driven culture, encouraging the use of data and analytics to recognise the value of data in improving patient care and organisational efficiency. This will require training and education to enhance data literacy and analytical skills, with a greater focus on data science and real-time analytics.</li>
<li>We will support population health management by further developing our population health intelligence, driven by robust data analysis and the effective use of data sharing across our system partners. This will in turn support a more collaborative approach in tackling health inequalities from multiple angles.</li>
</ul>
</td></tr>
</table>

| Our estates, Infrastructure, and digital strategy | |
|---|---|
| **Green** | • Workforce and Leadership- We must ensure everyone understands their role in reducing their carbon footprint, embedding carbon reduction and sustainability in our core business and across all clinical services.<br>• Sustainable models of care- We will develop new models of care with less of an impact on our environment, using less resources and causing less pollution, focusing on preventative care.<br>• Digital transformation- We will use technology improve the sustainability of healthcare, reducing travel and paper while improving patient care.<br>• Travel and transport - We will reduce and decarbonise our travel and transport improving air quality while supporting safe and active travel of staff, patients, and visitors.<br>• Estates and facilities -A range of interventions are planned for the next 5 to 10 years that will result in waste reduction, energy efficiency, expansion of green space and sustainable capital projects. We will optimise our resource use and reduce emissions from our estate in line with the national target of 80% reduction by 2032<br>• Medicines - We will reduce the environmental impact of our medicines through optimisation of prescribing, use of low-carbon alternatives, and appropriate disposal<br>• Supply chain and procurement - Our providers will be encouraged to focus on the environment and social value through changes to procurement and contract monitoring. We will use our supplies more efficiently, consider low-carbon alternatives, and collaborate on the decarbonisation of our suppliers.<br>• Food and nutrition – Sustainable, healthy, locally sourced food will be promoted to our staff & patients.<br>• Adaptation (adapting to environmental change) – Our adaptation Plans will ensure our healthcare facilities can withstand the impacts of climate change such as floods and heatwaves. |

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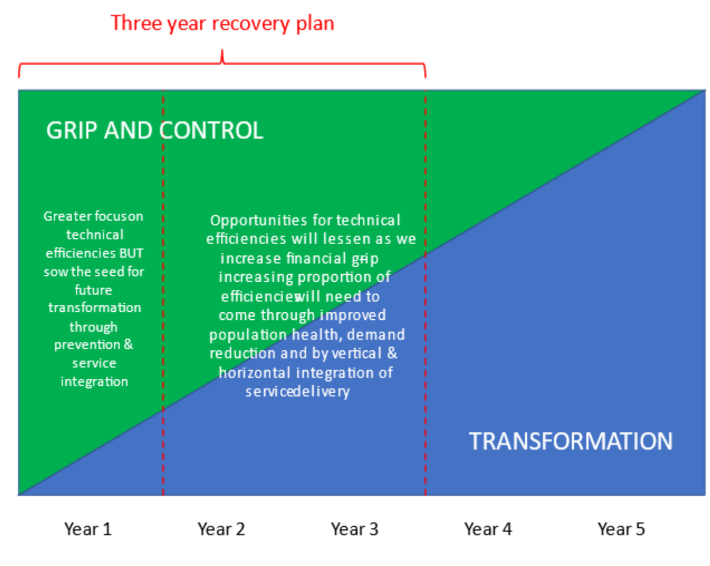
## 11. A strong delivery focus

Our plan to improve the health and well-being of our population is ambitious and we are confident it will deliver over the long term, but it will require patience, tenacity, and enthusiasm. It is vital that financial grip and control are maintained in the early phasing of delivery of our recovery plan - our focus will then move fully to the vital transformation work that we need to enable the improvement of the quality of our care and to support improvements in population health and reductions in demand on services.




Considering the expectations of our three-year recovery plan alongside this phasing shows that in year one (2023/24) we would expect most savings to come from technical efficiencies with increasing contributions from transformation and integration in years two and three, at the end of which we should have achieved recurrent financial balance.

This will allow us to close the financial gap and create a sustainable system where we can operate within our budget and provide access to high-quality services.

### Delivering our five strategic priorities

The table below shows how we will measure the delivery of our five strategic priorities. We will do more work through the development of our system delivery plan to identify the delivery implications for system, place, and neighbourhood.

| Strategic priorities | | Short-term 1-3 years | Medium-term 4-6 years | Long-term 7-10 years |
|---|---|---|---|---|
| 1 | **Strengthen our foundations** | Three-year system financial plan | Financial balance across the NHS system | |
| 2 | **Improve prevention and reduce inequalities** | Seamless and integrated provision is in place within every community. | Reduced admissions and disease prevalence | Seamless and integrated provision is in place within every community. |
| 3 | **Integrate and strengthen primary and community care** | Strengthened primary and community care<br>Reduced demand on hospital services | Enhanced and integrated primary and community care provision in place | |

| | Strategic priorities | Short-term 1-3 years | Medium-term 4-6 years | Long-term 7-10 years |
|---|---|---|---|---|
| 4 | **Improve quality and outcomes** | Improved CQC and SOF ratings for the six providers | Optimised care and clinical pathways<br>Improved quality of estates<br>Enhanced workforce | |
| 5 | **World-class care** | Short term actions on priority areas | Medium term actions on priority areas | Short term actions on priority areas |

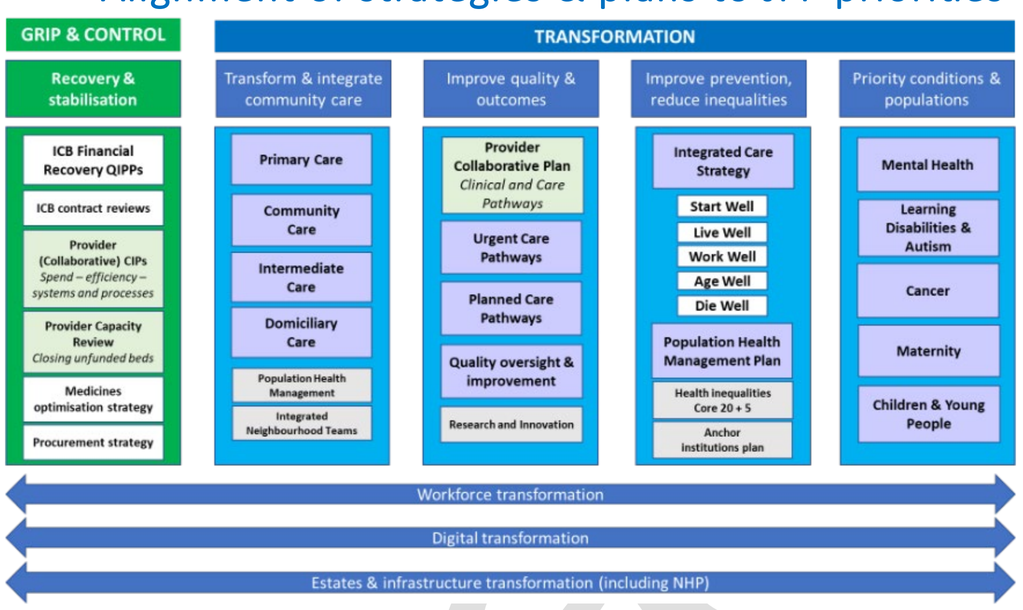
Further work will be undertaken within the delivery plan to develop the underpinning performance framework; this will incorporate metrics from the NHS constitution, the 2023/24 national priority metrics, the National Oversight Framework metrics, and others. There will be careful consideration of which metrics should be monitored at which level, system, place, or neighbourhood.

The 2023/24 operational plan objectives – and the commitments we made as a system to achieving them – can be mapped to the JFP strategic priorities as follows:

<table>
<tr><th colspan="2" rowspan="2">LANCASHIRE AND SOUTH CUMBRIA Joint Forward Plan Strategic Priorities</th><th colspan="2">23-24 core objectives of the NHS</th></tr>
<tr><th>Recovering core services</th><th>LTP and transformation</th></tr>
<tr><td colspan="2">Strengthen our foundations</td><td>Use of resources</td><td></td></tr>
<tr><td colspan="2">Improve prevention and reduce inequalities</td><td></td><td>Prevention and health inequalities</td></tr>
<tr><td colspan="2">Integrate and strengthen primary and community care</td><td>Primary care<br>Community health services</td><td></td></tr>
<tr><td colspan="2">Improve Quality and Outcomes</td><td>• Urgent and emergency care<br>• Diagnostics<br>• Elective care</td><td>Workforce</td></tr>
<tr><td rowspan="2">World Class Care</td><td>Priority care and disease pathways</td><td>• Cancer<br>• Maternity</td><td>Mental health</td></tr>
<tr><td>Priority population groups</td><td></td><td>People with a learning disability and autistic people</td></tr>
</table>

These objectives and associated metrics and trajectories will be aligned within the development of the system delivery plan.

To support the development of the system delivery plan, we have mapped system strategies and plans – and the work of the teams who deliver those plans - to the JFP strategic priorities:




Further detailed work is underway to align the above mapping to the scope of the system recovery and transformation programme.

## Our risks

Our most significant risk is that the demand and capacity mismatch increases, leading to further increases in costs and a wider gap between our allocation and our spend. We will have a three-year financial framework and a clear programme of work across our providers and the ICB to reduce our costs, but there are many factors, which are outside of our control.

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<table>
<tr><th>Within our control</th><th>Within our influence</th><th>Outside our control</th></tr>
<tr>
<td>Our plan<br>Our strategy to address our challenges and the underpinning governance structure to support our programmes of work and enable collaborative working.<br><br>The way we choose to operate<br>In collaboration with providers and partners across the whole system, at place and within neighbourhoods.<br><br>Our behaviours and values<br>A culture built on pragmatism, collaboration, learning, enthusiasm, and compassion.<br><br>Our mindset<br>We can play our cards to the best of our ability, harnessing the collective expertise, talent, knowledge, and skills across the system to find innovative and transformative solutions.</td>
<td>The level of demand<br>• The action we take to reduce the pressure on services including action to support the prevention of ill-health.<br>• Action to help people to take better care of themselves and make positive lifestyle choices.<br>• Action to ensure patients are seen in the most appropriate, cost-effective, location.<br><br>How we use our capacity<br>• Action with partners to make the best use of our resources including staff, financial resources, buildings, and action to attract and retain staff.</td>
<td>Available resource<br>• The amount of money we receive<br>• Laws which limit our ability to work differently<br><br>Demand<br>• The impact of inflation on our population's basic life conditions which drives demand for health care.<br><br>Capacity<br>• The impact of inflation on the cost of running services<br>• The size of the workforce pool nationally and locally that we can draw from.<br>• The levels of recruitment we can achieve.</td>
</tr>
</table>

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## What we can do

- ✓ We can ensure that every penny of the allocated Lancashire and South Cumbria healthcare pound is being used in the best possible way.
- ✓ We can ensure that the quality and outcomes from our care are the best they can be, that they are provided in the right place and are as high-quality and sustainable as possible

## 12. Next steps

This initial Joint Forward Plan is described at an intentionally high level – nonetheless, we hope that it provides a clear overview of our future vision, strategy, and priorities for action. Our new system offers an opportunity to work differently to tackle the urgent challenges that we face. The next stage of implementation of our plan will include working through the detail with our partners to ensure our plans, infrastructure and services are sustainable and joined-up. Part of this detail is articulated in our emerging Place Integration Deal.

A detailed system delivery plan with measurable goals, annual milestones, targets, performance ambitions and trajectories for providers, places and neighbourhoods is under development, aligned with the System Recovery and Transformation plan. The system delivery plan will inform a clear accountability framework for delivery between organisations and residents and patients and will support clear governance and oversight arrangements.

We will work with partners to develop a more comprehensive updated plan for 2024/25 onwards with the opportunity for further engagement, collaboration and co-design.

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## 13. Glossary of terms

**Anchor institutions** - used to describe organisations that are important to a local area because they employ lots of people, spend large amounts of money buying products or services from other businesses, and own large buildings or areas of land. They are called anchors because they are unlikely to relocate because of their connection to the local population and because they have a big influence on the health and wellbeing of communities. Some examples of anchor institutions are local authorities, NHS trusts and foundation trusts, large local businesses and universities.

**Commissioning -** The process of planning services for a group of people who live in a particular area.

**Economic prosperity** - a term used when a person or a community is doing well financially. This could be through good levels of employment, fair wages, or new businesses coming into an area. All of these increase the amount of money in a local community.

**Elective care -** Elective care covers a broad range of non-urgent services, usually delivered in a hospital setting, from diagnostic tests and scans, to outpatient care, surgery and cancer treatment.

**Healthwatch** - an independent voice that makes sure NHS leaders and other decision makers listen to resident feedback and improve standards of care.

**Health and wellbeing boards (HWBs)** - Health and wellbeing boards were established under the Health and Social Care Act 2012 to act as a forum in which key leaders from the local health and care system could work together to improve the health and wellbeing of their local population. They became fully operational on 1 April 2013 in all 152 local authorities with adult social care and public heath responsibilities.

**Health inequalities** - the unfair and unacceptable differences in people's health that happen because of where we are born, grow, live, work and age.

**Inequalities** - when a service or approach is better for some people and not others, for no reason other than their circumstances.

**Integrated Care Board (ICB)** - Integrated care boards (ICBs) replaced clinical commissioning groups (CCGs) in the NHS in England from 1 July 2022 as the statutory body responsible for planning and funding most NHS services in their local area.

**Integrated Care Partnership (ICP)** - a group of organisations and representatives that work together to improve the care, health and wellbeing of the population. There is a legal duty for the local authorities and the NHS to form this partnership, however other partners are involved such as the voluntary, community, faith and social enterprise sector, independent businesses and education. There are 42 ICSs across the country. Within each ICS there is an Integrated Care Partnership.



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**Integrated Care System (ICS)** - when we use this phrase, we are talking about the whole health and care system across Lancashire and South Cumbria. There are 42 ICSs across the country. Within each ICS there is an Integrated Care Partnership.

**Integrated Neighbourhood Teams (INT)** - Integrated Neighbourhood Teams (INT) is a new project aimed at integrating care in local neighbourhoods to help keep local people safe and well in their own home.

**Integration of services** - this involves the coordination of different services and organisations working together to make the health and care system easier to navigate and also to stop things from being done more often than they need to, for example shared records across services means that a patient only needs to be asked questions once and different health and care professionals can see the same information.

**Joint Strategic Needs Assessments** - a process where local authorities and organisations that plan and deliver health services look at the current and future health, care and wellbeing needs of the local community to inform local decision making.

**Local authority/local authorities** – an organisation that is part of the government that is responsible for all the public services and facilities in a particular area.

**Locality/localities** – Due to the size and population of the Lancashire Place, it has been split into three localities to make sure that decisions can still be made at a very local level. The localities are: North Lancashire, Central and West Lancashire and East Lancashire

**Long term condition** - a condition that can't be cured but can be controlled by medication and therapies.

**Neighbourhoods** - areas based on local populations of between 30,000 and 50,000. Neighbourhoods, in some instances, they may align with Primary Care Networks and Integrated Care Communities.

**Net zero carbon emissions** - a term used to describe the reduction of greenhouse gas emissions that are causing changes to our climate. Carbon dioxide is emitted when oil, gas and coal are burned in homes and factories and to power transport. Although it isn't the only greenhouse gas, carbon dioxide is the most significant so the term 'carbon emissions' is used. Reaching net zero means balancing the carbon emitted into the atmosphere and the carbon removed from it. This balance – or 'net zero' – will happen when the amount of carbon we add to the atmosphere is no more than the amount removed.

**NHS trusts and foundation trusts** - an organisation within the NHS that serves a geographical area or a specialised function.

**Place/places** - in Lancashire and South Cumbria there are four places: Blackburn with Darwen, Blackpool, Lancashire and South Cumbria.

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**Place-based partnerships (PBP)** - planners and providers work together across health, local authority and the wider community, to take collective responsibility for improving the health and wellbeing of residents within a place.

**Primary care** - the first point of contact for healthcare for most people. It is mainly provided by GPs (general practitioners) but also includes community pharmacists, opticians, dentists and other community services.

**Provider Collaborative** - Partnerships that bring together two or more NHS trusts (public providers of NHS services including hospitals and mental health services) to work together at scale to benefit their populations.

**Social value** - how we make social, economic and environmental benefits for our population in addition to providing health and care to make the most positive impact on the lives of our communities to improve health and wellbeing.

**Sustainable** - something that can continue to be delivered over a long period of time.

**Voluntary, community, faith and social enterprise sector** - also sometimes referred to as the third sector, these organisations are often in the heart of the community, delivering services and sharing the voice of service users, patients and carers.

**Please visit our website to view our full glossary -**
**www.lancashireandsouthcumbria.icb.nhs.uk/about-us/glossary**

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If you need this plan in another format
or language, please contact us on:
0800 032 2424 or lsc.icb@nhs.net

**Lancashire Health and Wellbeing Board**
Meeting to be held on Tuesday, 18 July 2023

| **Corporate Priorities:**<br>Delivering better services; |
|---|

**Place Integration Deal**
(Appendix 'A' 'B' and 'C' refer)

Contact for further information:
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**Brief Summary**

This report is provided to the Health and Wellbeing Board to update on the recent decision of the Integrated Care Board to delegate responsibility for some NHS services to all four Places in the Lancashire and South Cumbria Integrated Care System including Lancashire Place. It provides information on the rationale and content of the delegation arrangements, with some practical examples for additional context provided in the attached appendix. It also explains the impact of the integration deal on the governance options appraisal timeline, alongside an update on the Lancashire Place Partnership workshop; the outputs of which are being used to inform the next phase in development of the Place Partnership.

The integration deal is a significant decision for the Integrated Care Board with implications for the County Council who will also be expected (in due course), in the spirit of supporting deeper integration between health and care, to adopt a similar approach in order to achieve better outcomes and experiences for Lancashire residents as well as value for money.

**Recommendations**

The Health and Wellbeing Board is asked to:

i) Receive a verbal update on the outcome of the decision made at the Integrated Care Board on 5 July 2023.
ii) Receive a verbal update on the recommendations agreed by Lancashire County Council's Cabinet on 6 July 2023.
iii) Endorse the ongoing work and timeframes in relation to the development of governance arrangements for the Lancashire Place and how this will connect into the Health and Wellbeing Board.

**Detail**

At the previous update in May 2023, Health and Wellbeing Board Members were informed of the initial thinking on, and potential opportunities for delegation. The Integrated Care Board had signalled that not all services should be planned and delivered at a system (Lancashire and South Cumbria) wide level, and that there is a conversation to be had about what could be planned and delivered jointly with partners at a Place (Lancashire) level to drive efficiency and opportunity of joint planning and commissioning. For example, there are some services provided locally within our communities that could achieve better outcomes or value for money if they were organised with partners within Lancashire.

This report outlines in further detail, a new opportunity in the developing landscape of health and care integration, the Place Integration Deal (Appendix 'A'), which sets out the proposed delegation from the NHS to the four Places to manage and deliver improved outcomes as well as improve integrated performance and efficiency.

This is the first stage of the Place Integration Deal, focusing on how the Integrated Care Board will work with Places. However, it lays the foundations for more formal arrangements for integrated working with local government, which are expected to follow in a future stage. This will allow partners on the (interim) Lancashire Place Partnership to jointly determine how these resources are used to proritise prevention, address inequalities in access and provision and strengthen high quality care and support in the community.

In the first instance, this delegation from the NHS will be via the Lancashire and South Cumbria Integrated Care Board (which includes the Lancashire County Council Chief Executive to represent the local authorities), to the Director of Health and Care Integration as a joint employee of the Integrated Care Board and County Council. This decision will be taken at the Integrated Care Board meeting on 5 July 2023.

A report on this decision has also been submitted to Lancashire County Council's Cabinet, for its meeting on 6 July 2023. Cabinet have been asked to endorse the proposals for a phased approach to delegation, in the spirit of supporting deeper integration between health and care.

It is also worth noting that this work has impacted the timeline of the governance options appraisal piece for the ongoing management of Lancashire Place, the detail of which is outlined within this report.

**Context - Lancashire Place**

As the Health and Wellbeing Board will know, in July 2022 the boundaries of the Integrated Care Board were aligned with those of the four upper tier authorities. The next stage of that alignment is that now ,12 months later, the Integrated Care Board has proposed a 'Place Integration Deal', which is due for discussion at its July 2023 board. This signals the intention to introduce a phased approach to delegating responsibility for the majority of non-hospital services and budgets to each of the four Places. This is intended to make decision-making closer to communities, with their

increased involvement in that decision making process and facilitate better joint planning and integrated commissioning and delivery.

The Lancashire Place Partnership have had oversight in the development of this Deal and have advocated a measured and considered approach. It will be necessary for the Lancashire Place Partnership to evolve to reflect the progression of the Lancashire Place through the various stages within the Integration Deal to ensure that it is capable of holding delegations from the Integrated Care Board and enacting place-based decision-making. This will include formalising the governance arrangements, the links with the Lancashire Health and Wellbeing Board and the locality level arrangements (including district level Health and Wellbeing Partnerships), illustrated in Appendix 'B'.

This collaborative locality working will be managed via district Health and Wellbeing Partnerships which it is envisaged could be a critical vehicle for managing further devolved funding and decisions with accountability to the Lancashire Place Partnership for operational delivery and improvement of outcomes for certain priorities. These partnerships will need to evolve to a certain level of maturity to progress to this future state.

As part of this commitment to work alongside the districts, and to bring decision making closer to our communities, the Director of Health and Social Care Integration (Lancashire) met with the Chief Executives of the Lancashire District Councils to discuss the Place Integration Deal. Discussions were held on how Lancashire will work with the District Councils to operationally deliver improvements to health and wellbeing outcomes. There is a further workshop proposed on 13 July 2023 with the same Chief Executives of District Councils to consider how the delegation of population health and partner Voluntary, Community, Faith and Social Enterprise (VCFSE) allocations might be used as a test case for integrated working.

**The Place Integration Deal**

In preparation for delegation, all four places are working together and focused on their state of readiness to receive delegated responsibility from the Integrated Care Board for population health, Primary Care, Community Services, Continuing Health Care (CHC), Better Care Fund and Urgent and Emergency Care, in particular the services that support admission avoidance and effective hospital discharge, as part of the first phase of delegation. Future phases of delegation may vary across places dependent upon state of readiness and following assessment within the Lancashire and South Cumbria system assessment framework by local partners.

Detail of all of this is provided in Appendix 'A'. The design and implementation of the Place Integration Deal is likely to be a 2-3 year development journey for our Places and those organisations that are key partners in places and across the system.

There has, however, been good progress already on accelerating development between the Integrated Care Board and Council on joint procurement of care at home services, previously approved by Council for procurement, in advance of the delegation decision by the Integrated Care Board. This has ensured Lancashire Place Partnership, Lancashire County Council and the Integrated Care Board, have not

missed an opportunity to lock into an agreed price framework in order to stabilise the care market and balance capacity and demand.

A phased approach is proposed by the Integrated Care Board to financial delegations, with accountability/responsibility managed through appropriate governance arrangements (e.g., delegations to the Directors of Health and Care Integration in the first instance), with the following to be implemented by April 2024:

- Better Care Fund
- Population Health

To this end, the development of the Lancashire Better Care Fund Board, and strengthening of the understanding and management of the Better Care Fund and its decision making and reporting arrangements will support the preparation for delegation.

**Creating an Effective Place**

The (interim) Lancashire Place Partnership held a joint workshop on the 19 June 2023 with Members of the Health and Wellbeing Board. After receiving an update on developments in relation to the formal Integrated Care Board delegation process, Members heard about the experiences of a neighbouring system from the Chief Nursing Officer, Lancashire and South Cumbria Integrated Care Board, where delegation is more advanced. This then formed the basis of the discussion to consider the implications of delegation and associated governance required to support this.

Appendix 'C' sets out the themes which were highlighted as instrumental aspects of the positive outcomes delivered by working in an integrated way and the key pitfalls to avoid. These outputs will be used to inform both Place development and Place Partnership development plans with associated actions and timescales.

The next meeting, on 10 July 2023 of the interim Lancashire Place Partnership will explore where the biggest challenges lie in Lancashire, and what it can do together to address these and identify and agree areas which can be moved forward together more quickly.

**Governance Arrangements**

At the same time as agreeing priorities and quick wins there is a need to establish effective governance.

In spring this year, Lancashire Health and Wellbeing Board members requested work be undertaken to consider the possibility of it taking on functions of a Lancashire Place Partnership. A task and finish group were duly established to undertake the development and evaluation of all available governance options to support this. This group has recognised that the development of the Place Integration Deal is intrinsically linked to the outputs of the options appraisal.

Given how intrinsically linked these two elements are in designing appropriate formal governance options for the Lancashire Place Partnership, it was agreed analysis of

available options should follow the decision on the Place Integration Deal. This enables future governance of the Lancashire Place Partnership, and the Health and Wellbeing Board to be designed to meet required roles and purpose, taking into account what delegations may be coming to Lancashire and what governance it might require. It will also ensure that appropriate options can be identified which support the chosen delegation at Place and not run the risk of deciding 'form before function'.

This means that the task and finish group will review and apply statutory guidance, existing organisational governance and the outcome of discussions at the Integrated Care Board on the 5 July 2023 and Lancashire County Council's Cabinet meeting on 6 July 2023, to develop and analyse the available options. The group will submit their report to the Health and Wellbeing Board on 5 September 2023. This will contain an options appraisal, and a preferred option. The Health and Wellbeing Board will be asked to endorse this report before it is submitted to Lancashire County Council's Cabinet and Integrated Care Board Executives for agreement.

To date the task and finish group has reviewed the range of model options contained within the implementation guidance 'Thriving places: Guidance on the development of place-based partnerships as part of statutory integrated care systems' (Local Government Association and NHS England, September 2021) which provides a set of governance forms which Place forums can adopt.

These are listed and explained below:

1. **Consultative Forum**
   A collaborative forum to inform and align decisions by relevant statutory bodies, such as the Integrated Care Board or local authorities, in an advisory role. In this arrangement, the decisions of statutory bodies should be informed by the consultative forum.
2. **Individual executives or staff**
   Statutory bodies may agree to delegate functions to individual members of staff to exercise delegated functions, and they may convene a committee to support them, with membership that includes representatives from other organisations.
3. **Committee of a statutory body**
   A committee provided with delegated authority to make decisions about the use of resources. The terms of references and scope are set by the statutory body and agreed to by them.
4. **Joint committee**
   A committee established between partner organisations, such as the Integrated Care Board, local authorities, statutory NHS providers or NHS England and NHS Improvement. The relevant statutory bodies can agree to delegate defined decision-making functions to the joint committee in accordance with their respective schemes of delegation. A budget may be defined by the bodies delegating statutory functions to the joint committee, to provide visibility of the resources available to deliver the committee's remit.
5. **Lead provider**
   A lead provider manages resources and delivery at place-level, as part of a provider partnership, under a contract with the Integrated Care Board and/or local government, having lead responsibility for delivering the agreed outcomes for the place (including national standards and priorities) for the defined set of services.

Subject to whichever decision is made on the delegations at the Integrated Care Board and endorsed by Lancashire County Council's Cabinet, the task and finish group will analyse the model options available to Place and suggest the preferred option to the Health and Wellbeing Board (including adopting the responsibilities of the Lancashire Place Partnership).

The following timetable shows the formal schedule for endorsement of the options for governance and agreement of the preferred governance option, which follows the decision made on the Integration Deal. The intervening period will be utilised by the task and finish group to undertake the necessary work.

| Forum | Date | Output |
|---|---|---|
| **Integration Deal** | | |
| Integrated Care Board meeting | 5 July 2023 | Decision |
| Lancashire County Council Cabinet meeting | 6 July 2023 | Endorse proposals |
| **Options Appraisal** | | |
| Interim Lancashire Place Partnership | 21 August 2023 | Endorse the options appraisal and preferred option |
| Health and Wellbeing Board | 5 September 2023 | Endorse the options appraisal and preferred option |
| Lancashire County Council Cabinet meeting | 5 October 2023 | Endorse the options appraisal and agree the preferred option |
| Integrated Care Board Executives | 10 October 2023 | Endorse the options appraisal and agree the preferred option |

**Consultations**

**a) Integrated Care Board and Lancashire County Council's Chief Executive discussions (ongoing)**

Initial discussions have been had with Lancashire County Council and Integrated Care Board Chief Executives along with Directors of Health and Care Integration to consider the scope of the Place Integration Deal.

**b) Health and Adults Services Scrutiny Panel – 12 May 2023**

Director of Health and Care Integration attended to discuss the scope of the Place Integration Deal.

**c) Lancashire Chief Executives (including District Councils) - 8 June 2023**

The Director of Health and Social Care Integration (Lancashire) met with the Chief Executives of the Lancashire District Councils to discuss the Place Integration Deal and within that the proposal for how Lancashire will work with the District Councils to operationally deliver improvements to health and wellbeing outcomes. There is a further workshop proposed on 13 July 2023 with the same Chief Executives of District Councils to consider how the delegation of population health and Voluntary,

Community, Faith and Social Enterprise (VCFSE) allocations might be used to this end.

**d) Interim Lancashire Place Partnership (including additional Health and Wellbeing Board Members) -19 June 2023**

The Director of Health and Social Care Integration (Lancashire) hosted a workshop for the (interim) Lancashire Place Partnership that included Members of the Health and Wellbeing Board. Members heard about the experiences of a neighbouring system from the Chief Nursing Officer, Lancashire and South Cumbria Integrated Care Board, where delegation is more advanced. This was used as a basis to consider the implications of delegation and associated governance required to support this.

**Appendices**

Appendices A, B and C are attached to this report. For clarification they are summarised below and referenced at relevant points within this report.

| Appendix | Title |
|---|---|
| Appendix 'A' | Place Integration Deal Slides |
| Appendix 'B' | Background briefing information on the Place Integration Deal |
| Appendix 'C' | Fundamentals of an effective partnership - themes from workshop 19th June 2023 |

# Lancashire and South Cumbria Integrated Care System Proposals for a Place Integration Deal

ICB Board Meeting
05 July 2023



Appendix A

# Our vision for places as part of the LSC system

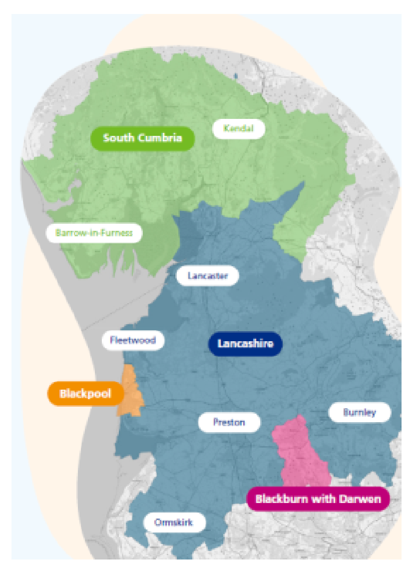
It is our ambition in Lancashire and South Cumbria to have a world class, all age, community centric, integrated care system which has our four places at its heart, acting as the engine room for driving the transformation and changes that we need to see to **improve health outcomes and experiences, responding to the needs of our population.**

## Our aims

- A much stronger focus on prevention
- A step change in community-based services to a more integrated approach across health and care
- Delivering world class care for priority diseases, conditions, population groups and communities
- Getting better value from our collective resources
- Using data and intelligence to focus on local needs
- Strengthening places and neighbourhoods to ensure decision-making happens closer to people and with local communities

## The impact for our people

# What is the Place Integration Deal?




**The 'Place Integration Deal' sets out the way in which places will operate as part of the Lancashire and South Cumbria integrated care system, specifically in relation to the NHS Lancashire and South Cumbria Integrated Care Board (ICB).**

It describes:

- Why the Place Integration Deal is key to meeting national and local expectations

- What will be planned and delivered in places

- How the Place Integration Deal will be implemented

**This is the first stage of the Place Integration Deal. It sets out the way in which the ICB will work with places at the centre of our integrated care system and lays the foundations for more integrated working with local government.**



In line with our strategic narrative for places and the Directors of Health and Care Integration holding shared roles across the NHS and our local authorities, **the next stage will be to consider the '*what*' and the '*how*' from the perspective of local authorities, thus enabling deeper integration in each place**. This will mean agreement to joint leadership, decision making and financial arrangements between the ICB and partners in our places. Detailed design and implementation of the Place Integration Deal is likely to be a 2- to 3-year development journey for our places and those organisations that are key partners in places and across the system.

**Increasing maturity of places, the ICB,**

- Begin delivery of operational priorities in places as DsHCI act as convenors of place partnerships
- Agreement of Place Integration Deal and start of delegations from ICB to places through DsHCI

**and local authorities with earned autonomy**

- Formalised delegations from ICB to places, with place-based governance arrangements
- Agreement of local authority delegations to places
- Increased pooling of funding across NHS and local authority

**freedom and flexibility for places**

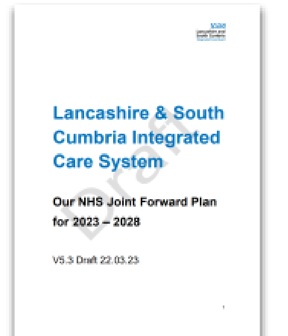
- Formalised delegations from local authorities to places, with local decision-making
- Further pooling of funding across NHS and local authority
- Integration of NHS and local authority teams

# Implementation of the Place Integration Deal will enable delivery of key commitments…

**Integrated Care Strategy (April 2023) – five long-term measures of success for our system**

**Development of this strategy included review and inclusion of key elements from the local authority Health and Wellbeing strategies.**

- Early years development
- Years in good health
- Avoidable mortality
- Unemployment rate for the working age population
- Life satisfaction



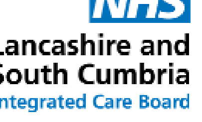

**Joint Forward Plan (March 2023 – in draft) – sets out six long-term measures of success for the NHS**

- Improved financial sustainability
- Improved healthy life expectancy
- Enhanced and seamless care provision within our neighbourhoods
- Improved quality of care across all providers
- Improved pathways of care across the system

**'Turning challenges into opportunities – The state of our system report' (March 2023) and the ICB financial recovery programme – set out key ambitions for a sustainable system**

- All trusts will be high performing
- Maximise efficiency across emergency and elective care
- Rationalize our system for greater efficiency
- Invest in community services
- Reconfigure the ICB itself to support this approach.

# The scope in relation to the ICB – key areas of NHS planning and delivery in our places




**This is the first stage of the Place Integration Deal. It sets out the way in which places will operate as part of the Lancashire and South Cumbria integrated care system, specifically in relation to the NHS via the ICB and working with key partners.** Therefore, we have set out the NHS functions / services where we envisage planning and delivery to happen at place, but recognise that this will evolve over time as places and the ICB mature, and as delegations happen from other partners in place.

| Health creation | Prevention, self help and care navigation | Anticipatory neighbourhood based care | Ongoing support to remain at home | Community based, short term crisis intervention |
|---|---|---|---|---|
| • All age population health and wellbeing | • All age population health and wellbeing, including health checks, smoking cessation, healthy weight, etc.<br>• Secondary prevention<br>• Care navigation<br>• Social prescribing | • Population health management approach<br>• Primary care (non-core)<br>• Integrated neighbourhood teams (all age)<br>• Community nursing and therapies (all age) across physical and mental health, learning disabilities and autism<br>• Pharmacy / medicines management | • Long term condition management for specific programmes / specific pathways (e.g., frailty, mental health)<br>• Enhanced care at home – bed and non-bed based | • Falls<br>• Community stroke services<br>• Discharge to Assess<br>• 2-hour urgent community response<br>• Virtual wards<br>• Primary Care Enhanced Access and Out-of-Hours<br>• Mental health initial response service<br>• Continuing Health Care<br>• Care market sustainability<br>• Winter operational schemes |

Greater use of a population health management approach to planning
Joint commissioning in place, including VCFSE commissioned services and the scope of the Better Care Fund
Engagement, coproduction and evaluation with our communities

# Maintaining clear focus on delivery - priorities across our places

From 2023/24

**Operational delivery**

**Common priorities for operational delivery through leadership in places from 2023/24**

- Population health – addressing inequalities
- Primary care – development of Integrated Neighbourhood Teams (INTs) and transformation
- Scope of the Better Care Fund (BCF) and Section 75/256 agreements
- Community services – transaction and transformation
- Continuing Health Care (CHC)

| | Phase 1 | Phase 2 | Phase 3 |
|---|---|---|---|
| **Blackburn with Darwen** | • Integrated neighbourhoods incl. Physical, Mental, Family Hubs & Fuller *<br>• Improve care sector quality *<br>• Focused interventions based on need – start, live, age, die well – frailty<br>• Community services (incl. enhanced care at home)<br>• Population health<br>• Winter operational schemes<br>(*inc meds optimisation) | • CHC and Personal Health budgets – roll out wider<br>• Discharge to assess and effective step-up care<br>• Local primary care quality and access improvement (GP)<br>• Joint commissioning opportunities with Council<br>• Focused interventions based on need – start, live, age, die well – mental health | • Local primary care quality and access improvement (dental, optometry, pharmacy)<br>• Focused interventions based on need – start, live, age, die well – children and young people |
| **Blackpool** | • Continuing Health Care / Personalised Health Budgets<br>• Community services – transaction / transformation (including enhanced care at home)<br>• Focused interventions based on need – specific cohorts | • Long term conditions pathways<br>• Personal Health budgets – roll out wider (offer to host on behalf of all areas) | |
| **South Cumbria** | • Community wellness centre<br>• Enhanced Care at Home programme<br>• Workforce model – Local workforce analysis<br>• Whole System Flow Programme<br>• Thriving Communities - alignment of Community Development; Population Health & Public Health priorities and programmes | • Community wellness centre<br>• MBRN roll out south Cumbria (subject to investment proposal)<br>• Whole System Flow programme<br>• Joint governance arrangements between ICB and Local Authority (to oversee the BCF and Section 75/256 agreements)<br>• Focussed interventions based on need – reflecting JSNA | • Community wellness centre<br>• Whole System Flow Programme<br>• Focused interventions based on need – reflecting JSNA |
| **Lancashire** | • Integrated Commissioning of Care at Home Services<br>• Alignment of Care Navigation/ Brokerage of Care Sector<br>• ASC and ICB workforce-agreed approach to recruitment and rostering of agency workers<br>• Discharge to Assess (D2A) | • Learning Disabilities Pooled Budgets | • Urgent Care Services (such as out of hospital emergency care, including Urgent Treatment Centres, and on the day urgent Primary and Community Care)<br>• TBC following engagement with District Council Chief Execs |

# Impact for our people

Considering the scope of place, the phased approach to delegations, and the priority areas for delivery, we envisage that a core set of metrics could be adopted to measure successful integration and the impact of integration in our places. These will evolve as our places increase in maturity and further work will be undertaken with residents and partners in order to scope what these metrics could be.

**People will live in a places that actively supports economic development and has a culture of enabling them and their families to take care of themselves and their communities**

**People will have to access help, advice and signposting when they need it**

**People will get more help or support in the community to help them remain at home**

**People get the right care, from a trained professional, in the right place, when they need it**

**People will receive intensive, short term care or longer term support in the community, which enables them to maintain their independence, or in some cases remain safe**

## Initial Metrics

- Smoking cessation rates
- Annual health checks for people with a learning disability
- Access to mental health support for children & young people
- Access to GP appointments
- People 65+yrs with a recorded frailty score have a care plan
- Use of 2hr urgent community response
- Lengths of hospital stays

# Phased approach to governance arrangements

We recognise that delegation of decision-making to places will evolve as as our places and the ICB mature, and as confidence grows in place-based ways of working. Our decision making arrangements in place will evolve across three stages of maturity – 'in development', 'in shadow' and 'ready for delegation'.

**In development**

- Interim Place-Based Partnership Board established as a 'consultative forum'
- Partners come together to undertake the core responsibilities of each place
- This may be through:
  - Members of the board having delegated decision-making from their own organisation;
  or
  - The consultative forum making recommendations for approval by individual organisations

**In shadow**

- Place-Based Partnership Board confirmed as a 'shadow board' and operates as if it has delegations
- DHCI has delegated authority from the ICB around any NHS budget allocated to place
- Some DsHCI may also have delegated authority from the upper tier/unitary local authority, depending on their role
- DHCI exercises some/all delegations via the Place-Based Partnership Board to support collective decision-making between partners in place

**We anticipate all places should have reached this phase by April 2024**

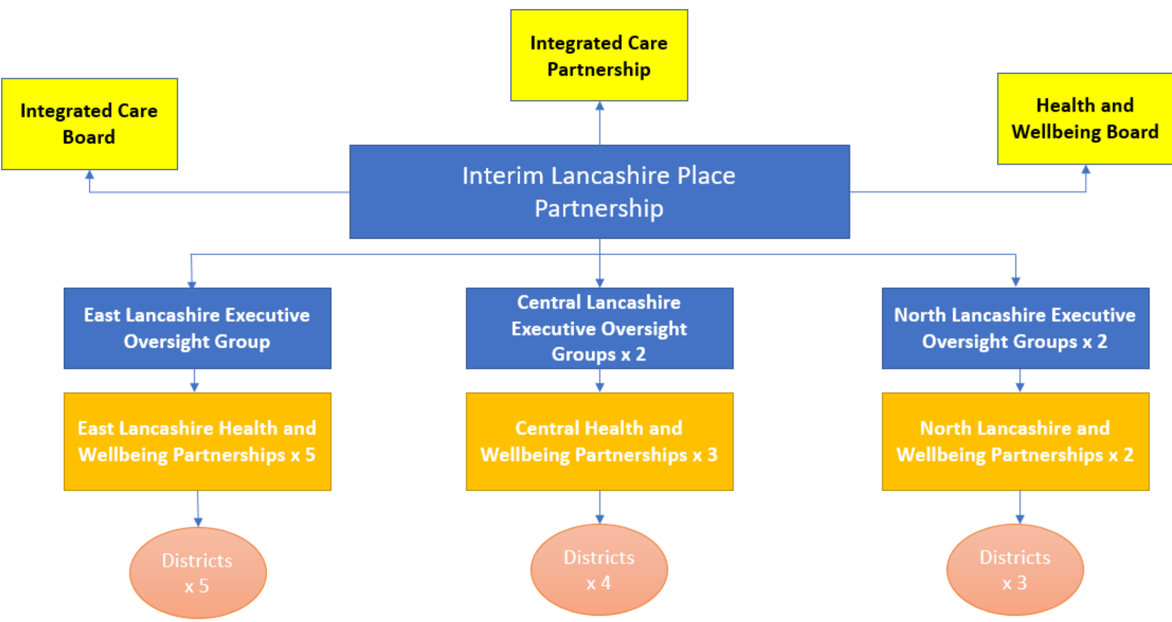
**Ready for delegation**

- Place-Based Partnership Board fully constituted as a committee of the ICB (or a joint committee of the ICB and local authority if local authority delegations are also included)
- There is an appointed chair of the Place-Based Partnership
- Terms of Reference are formally agreed by all place partners
- The ICB SORD (and local authority Constitution if relevant) confirm any delegations
- Over time, wider partners may delegate into the committee.

Our governance will be an enabler to achieving:

- Improved experiences and outcomes for our local people
- Joined up care and delivery
- Bringing decision-making closer to our local people
- Making decision-making more focused on local population needs
- Creating greater transparency and accountability to the public

## Appendix B – Current Governance Arrangements




An interim Lancashire Place Partnership has been established which currently reports into the Lancashire Health & Wellbeing Board. It creates a further opportunity to strengthen collaborative working and integration across Lancashire for the benefit of the public and communities and is focussed on delivering services and support that tackles avoidable health issues and inequalities plus enabling independence in the community.

The interim Lancashire Place Partnership has an independent Chair and will oversee the development of an options appraisal to determine the longer-term joint arrangements between the Lancashire Health and Wellbeing Board and the formal Lancashire Place Partnership Board which are necessary to receiving delegated authority for NHS budgets, resource and performance. It will act as a 'place-based partnership' until any new arrangements are established and has responsibility for agreeing a collective vision, ways of working, priorities and associated delivery plans.

Membership includes the chair of the Lancashire Health and Wellbeing Board; Director of Health and Care Integration for Lancashire (and Integrated Place Leaders); the ICB Chief of Health and Care Integration; a representative from the Provider Collaborative*; and Chief Executive level representatives from District Councils; Hospices; Voluntary, Community, Faith and Social Enterprise Sector; Healthwatch; Social Care Providers and a Clinical and Care Professional representative. As the formal arrangements for the Lancashire Place Partnership Board are agreed and implemented during 2023/24, this will require a review of membership

**The Provider Collaborative is a partnership that brings together the five NHS provider trusts in Lancashire and South Cumbria to improve health and healthcare. The collaborative is about working together as equal partners to make sure*

*patients, their families, and communities benefit across the whole of the area.*

**Locality Chief Executive and System Leader Involvement**

Within each locality area (Central, East and North Lancashire), Chief Executives and Senior Leaders are coming together on a regular basis (Executive Oversight Groups) to further build relationships, trust, share opportunities and accelerate place delivery.

**Locality Health and Wellbeing Partnerships**

Health and Wellbeing Partnerships are also being used as a mechanism for driving engagement and collaborative working between partners at a local level. They also provide a forum to discuss the strategic and operational co-ordination in the delivery of services. In this forum, the political, clinical, professional and community leaders from across our health and care system will come together to deliver the strategic direction set by the Health and Wellbeing Board and Integrated care Partnership in addition the development and delivery of our agreed local priorities to improve the health and wellbeing of our local populations and reduce health inequalities. They are often at district or multi-district level.

**Appendix C- Fundamentals of an effective partnership - themes from workshop 19th June 2023**

The key recommendations with the presentation from Chief Nursing Officer, Lancashire and South Cumbria ICB, included:

- Having a clear vision – focus on resident & keep it simple.
- Building resilient, transparent relationships & system leaders.
- Inclusive partnership board, including strong General Practitioner voice and involvement of housing organisations.
- Setting a small number of priorities and focus on delivery.
- Having a democratic mandate.
- Self-assessment of place partnership.
- Much can be achieved without touching the finances.
- **Collaborate, collaborate, collaborate.**

Key pitfalls to avoid included:

- Unrealistic expectations – deep integration takes time & perseverance.
- Changing staff terms and conditions, organisational policies & cultures. These are very different across NHS & local government, don't force convergence.
- Traditional contracting & commissioning approach.
- Disproportionate focus on resource.

In conjunction with the highlights above, learning points captured from the conversations and groupwork undertaken during the session are listed below:

**Construct**
An all age approach taken from the outset.
Clarity on what we wanted to achieve was prioritised.
Local providers were included as key partners.
People involved were those who could lead system partnership.
As many wider partners as possible were included.
Strong GP involvement and membership at strategic level.

**Practicalities/joint working**
Implemented co-location of workforce where this made sense to do so, however didn't alter existing contracts or employment arrangements.
Joint teams and joint working around S.75 agreements where possible.
Roll out of a shared care record.
Single point of contact established- one telephone number for all enquiries.
Common menu of services developed for residents.
Support was provided by an organisational development specialist.

**Governance**
Hill Dickinson supported the development of a Memorandum of Understanding.
Community Safety Partnership and the Health and Wellbeing Board merged into a strategic oversight group.
Executive meetings were established and included partners from housing and providers, with sub-groups to drive delivery.
A joint committee was established to oversee the financial elements of pooled budgets within S.75.
The JSNA was used to inform decision making.
A framework of assessment was developed to review progress.