Public Document Pack

People Overview & Scrutiny Committee

Monday, 9th March, 2020
6.00 pm

AGENDA

1. Welcome and Apologies

To welcome those present to the meeting and to receive any apologies for absence.

2. Declaration of Interest

To receive any declarations of interest on items on the agenda.

Declarations of Interest **3**

3. Minutes of the Previous Meeting

To receive and agree as a correct record, the minutes of the previous meeting held on 2nd December 2019.

Minutes of Previous Meeting **4 - 7**

4. Progress on the Corporate Priorities by Portfolio

To receive an update on the Corporate Priorities.

5. Youth MP and Deputies

To welcome the new Youth MP and Deputies and to receive an update on their key priorities for the forthcoming year.

6. Covid-19

To consider the authorities potential response to the Covid-19 virus and action plans that could be implemented.

Coronavirus EM Briefing March 2020 v1 03032020
Coronavirus_action_plan_-_a_guide_to_what_you_can_expect_across_the_UK
Frequently Asked Questions and Answers COVID

7. Coronavirus EM Briefing March 2020 v1 03032020

Coronavirus EM Briefing March 2020 v1 03032020 **Coronavirus_action_plan_-_a_guide_to_what_you_can_expect_across_the_UK** **Frequently Asked Questions and Answers COVID**	**8 - 42**

8. Integrated Care System and Population Health Plan Priorities.

To receive an update on the Draft Integrated Cars System Strategy.

ITEM 7 ICS Strategy_Population Health Plan Priorities v3 (003)	**43 - 46**

9. ICS Commissioning Reform

To receive an update from The CCG

ITEM 8 ICS System Commissioning Reform v3 **ITEM 8_Appendix_LSC_Commissioning_Reform_Case_for_Change**	**47 - 80**

Date Published: 28th February 2020
Denise Park, Chief Executive

DECLARATIONS OF INTEREST IN

ITEMS ON THIS AGENDA

Members attending a Council, Committee, Board or other meeting with a personal interest in a matter on the Agenda must disclose the existence and nature of the interest and, if it is a Disclosable Pecuniary Interest or an Other Interest under paragraph 16.1 of the Code of Conduct, should leave the meeting during discussion and voting on the item.

Members declaring an interest(s) should complete this form and hand it to the Democratic Services Officer at the commencement of the meeting and declare such an interest at the appropriate point on the agenda.

MEETING:

DATE:

AGENDA ITEM NO.**:**

DESCRIPTION (BRIEF):

NATURE OF INTEREST:

DISCLOSABLE PECUNIARY/OTHER (delete as appropriate)

SIGNED :

PRINT NAME:

(Paragraphs 8 to 17 of the Code of Conduct for Members of the Council refer)

PEOPLE OVERVIEW & SCRUTINY COMMITTEE
Monday, 2 December 2019

PRESENT – *Councillors; Liddle (In the Chair); Hussain, Oates and Smith.*

ALSO IN ATTENDANCE -
Also in Attendance
Cllr Maureen Bateson – Executive Member for Children's Services
Joanne Siddle – Head of Education
Sayyed Osman – Director of Adults and Prevention
Asad Laher – Head of Governance
Liz Clarkson – Youth Work Programme Officer
Uday Akram – Youth MP
Amine Gherensi – Youth Forum Member
Sarah Patel – Youth Forum Member

RESOLUTIONS

1 Welcome and Apologies

The Chair welcomed those present to the meeting and apologies were received from Cllrs P Akhtar; Afzal; Salton and Whittle. Apologies were also received from Jayne Ivory and Dominic Harrison.

2 Declaration of Interest

There were no Declarations of Interest received.

3 Minutes of the Previous Meeting

RESOLVED - That the minutes of the previous meeting held on 2nd December 2019 be approved as a correct record.

Matters Arising

Feedback from the Youth Forum

Councillor Bateson informed the Committee that the Takeover Challenge that was held on 28th November 2019 had been very successful and positive feedback had been received.

The Youth MP and two members of the Youth Forum also informed the Committee that the event was organised to raise awareness of knife and gang crime and whilst it was not a major problem in Blackburn with Darwen, there had been a number of tragic incidents over the years.

The Committee heard that the event was sponsored by the Our Community Our Future Board and that the Youth Forum had arranged for guest speaker Hezron Brown, who was a youth worker and motivational speaker from Birmingham, to open the event. Hezron himself overcame a life of crime and homelessness to help steer young people away from gangs and violence. More recently he had recently won the Pride of Britain award.

Discussions also took place around the Bright Spark Initiative which was an annual bonfire night safety campaign. In previous year there had been a high percentage of incidents relating to fires and fireworks. This year a different tactic was used with unmarked vehicles roaming the hotspots in Blackburn and Darwen. Cllr Smith was pleased to report back that the incidents had reduced this year as a result.

4 Children's Services- Delivering the Corporate Priorities Service Development Practice Plan

The Committee received a report which set out how the department sought to ensure that the Corporate Priorities were embedded in their work. The Committee heard that the Board met on a monthly basis and was chaired by the Director of Children's Services with all Heads of Services and Service Leads across the department attending to share RAG rated progress updates. In addition, the Local Government Association representative attended to provide external support challenge.

The Committee heard that the team consulted with 60 management staff at a business planning event to reflect on the corporate ambitions and set the departmental priorities for 2019-20. In addition, a further 10 priorities for 2019-20 were agreed. These were highlighted in Appendix A which was included in the agenda.

A Service Development and Practice Improvement Plan was also developed to set actions against the priorities and a Service Development Practice Improvement Board had been established to monitor the progress of the plan. The Plan was marked as Appendix B and was included in the agenda.

The Chair concluded that everything seemed to be working well and that an update should come to the next meeting in March.

RESOLVED – That the update be noted and that the item come back with a 2nd quarterly update at the meeting to be held on 9th March 2020.

5 Age well Strategy

The Committee received a presentation from the Director of Adults and Prevention, providing an update on the Age Well Strategy.

The Director of Adults and Prevention touched on the background of the Age Well Strategy, explaining that the Age Well Partner was part of the Health and Wellbeing Board delivery within the life course along with Live Well and Start Well, and worked as a multi-agency to deliver corporate priorities. There was an annual workshop to review progress and priorities, with the priorities being RAG rated.

The Committee heard of the Age Well Priorities, in particular the following were highlighted;

Age Friendly Place – 'International Day for Older People' had recently been celebrated and some of the feedback received in terms of making the Borough more able to support older people included the need for older people to have somewhere to sit in the Town Centre, accessible toilets, being able to get a

glass of water if needed, assistance packing shopping bags, not being rushed, asking people to be patient and a bit more kind.

Dementia – This was a growing problem and the need to promote awareness was a priority, especially in frontline and public facing services. So far 21 Elected Members had been trained on Dementia Awareness with the remaining Members to receive training shortly. The group were looking to increase support for people with early onset Dementia and widen promotion of activities for people living with Dementia.

Social Isolation – With an increased number of places closing down there had been a rise in social isolation. The group were working with Local Integrated Partnership and PL Integrated Care Partnership to develop social prescribing opportunities. The group were looking to promote local cultural events whilst ensuring organisers supported age friendly policies. The Committee were informed of the challenges faced around transport and that the group were looking to explore and improve connectivity ensuring transport was able to support older people accessing events and services.

Digital Inclusion – The Committee heard that there would be an increased network of digital champions to assist older people. There would also be Champion opportunities for intergenerational support such as linking in with scouts and schools.

Poverty and Housing – The Committee were informed that the group were looking to promote access to advice and information services for older people and that opportunities provided through the Healthy Homes Offer would be maximised.

Promoting Health Life Expectancy – In some cases, this was an underlying result of poverty and housing and therefore the group were looking to actively promote flu jabs and other screening, actively promote 5 ways to wellbeing, working with partnerships to increase and develop volunteering opportunities and to reinforce and promote a proactive approach to falls prevention.

Oversight of End of Life Care – The group were working with Pennine Lancashire Integrated Care Partnership to ensure improvement in end of life care. The group would also be looking to host a conference to promote better appreciation of cultural awareness and understanding choices.

The Committee were also informed of the challenges ahead, in the main being, the increase in demand and complexity of need, especially as the financial situation became ever more difficult.

Discussions took place around transport being a major concern for older people feeling isolated especially as a lot of routes had been stopped now. It was suggested that Community Transport such as Dial-A-Ride be promoted. The Chair also mentioned that previously older people had been supplied with slippers that prevented them from slipping and it was agreed that these be explored.

The Committee noted the next steps and asked that the Director of Adults and Prevention come back to a future meeting to provide a further update.

RESOLVED – That the Committee note the update and that the Director of Adults and Prevention be invited back to a future meeting to provide a further update.

6 Joint Health Scrutiny Committee

Members were informed of the requirement to appoint a Joint Health Overview and Scrutiny Committee with Lancashire County Council, South Cumbria County Council and Blackpool Borough Council as required under The National Health Service Act 2006 (as amended by the Health and Social Care Act 2012).

Members were reminded of the work of the Lancashire and South Cumbria Integrated Care System which was working on the reconfiguration of health provision in the region. This reconfiguration aimed to improve health outcomes for residents in the area and would lead to changes in the way that services were delivered both in hospitals and in the community.

The establishment of the Joint Committee was a requirement of the Act where a relevant Health Authority consulted more than one local authority's health scrutiny function about substantial reconfiguration proposals.

The Draft terms of reference for the proposed Joint Health Scrutiny Committee had been drawn up for consideration and were included in the agenda for Members perusal. These were being presented to each of the constituent bodies that would make up the Joint Committee.

RESOLVED –

- That the report be noted and the Terms of Reference be approved;
- That Members submit any views / comments to Asad Laher and Paul Conlon; and
- For the report and any additional comments to be taken to a future Executive Board meeting and then to Council Forum, for consideration

Signed: …….

Date: …….
Chair of the meeting
at which the minutes were confirmed

Coronavirus (COVID-19)

Elected Member Briefing 3rd March 2020

The coronavirus outbreak is a rapidly evolving situation. On Thursday 30 January the World Health Organisation declared this as a global health emergency and in response, the four UK Chief Medical Officers raised the risk to the public from low to moderate.

This briefing note is intended to support Elected Members in their efforts to help manage the spread and impact of the coronavirus in Blackburn with Darwen.

1. Information about the virus:

A coronavirus is a type of virus. As a group, coronaviruses are common across the world. Typical symptoms of coronavirus include fever and a cough that may progress to a severe pneumonia causing shortness of breath and breathing difficulties. Novel coronavirus (COVID-19) is a new strain of coronavirus first identified in Wuhan City, China

Generally, coronavirus can cause more severe symptoms in people with weakened immune systems, older people, and those with long-term conditions like diabetes, cancer and chronic lung disease.

Given that there is currently neither a vaccine against COVID-19 nor any specific, proven, antiviral medication, most treatment will comprise managing symptoms and providing support to patients with complications.

The majority of people with COVID-19 have recovered without the need for any specific treatment and the vast majority of cases will best be managed at home, as is the case for the common cold or seasonal flu.

2. Government action:

The UK is well prepared for disease outbreaks, having responded to a wide range of infectious disease outbreaks in the recent past, and having undertaken significant preparedness work for an influenza pandemic for well over one decade. Plans are regularly tested and updated locally and nationally to ensure they are fit for purpose. This experience provides the basis for an effective response to COVID-19.

Planning draws on the idea of a “reasonable worst case (RWC)” scenario. This is not a forecast of what is most likely to happen, but will ensure we are ready to respond to a range of scenarios.

The Health Protection (Coronavirus) Regulations 2020 have been put in place to reduce the risk of further human-to-human transmission in this country by keeping individuals in isolation where public health professionals believe there is a reasonable risk an individual may have the virus.

On 10 February, the Secretary of State for Health and Social Care, Matt Hancock, announced strengthened legal powers to protect public health.

On 3rd March the government published its **coronavirus action plan** setting out;

- What we know about the virus and the disease it causes
- How the government has planned for an infectious disease outbreak, such as this
- The actions taken so far in response to the current coronavirus outbreak
- Nest steps, depending upon the course the current coronavirus outbreak takes
- The role the public can play in supporting this response, now and in the future

The fundamental objectives are to deploy phased actions to **Contain, Delay**, and **Mitigate** the outbreak, using **Research** to inform policy development, as described below. The different phases, type and scale of actions depends upon how the outbreak unfolds over time.

- **Contain:** detect early cases, follow up close contacts, and prevent the disease taking hold in this country for as long as is reasonably possible

- **Delay:** slow the spread in this country, if it does take hold, lowering the peak impact and pushing it away from the winter season

- **Mitigate:** provide the best care possible for people who become ill, support hospitals to maintain essential services and ensure ongoing support for people ill in the community to minimise the overall impact of the disease on society, public services and on the economy.

- **Research – cross cutting:** to better understand the virus and actions that will lessen its effect; innovate responses including diagnostics, drugs and vaccines; and inform models of care

3. Local response arrangements:

Local response arrangements will vary depending on the phase of the disease response. During the **Containment** Phase Public Health England (PHE) will be the key partner responsible for many of the response arrangements including the following;

- The local Health Protection Team will notify the Director of Public Health of any confirmed case of COVID-19 in Blackburn with Darwen.
- PHE will be responsible for carrying out contact tracing and taking any appropriate public health action required following a confirmed case.
- If deemed necessary, PHE may convene an incident management team meeting of key stakeholders including the DPH following the Multi-agency Outbreak Management Plan
- The Council will be key in ensuring effective communication with the public

The Lancashire Resilience Forum (LRF) has convened a multi-agency Strategic Coordinating Group (SCG). This met on 3rd March and will hold weekly meetings every Tuesday. All category 1 responders under the Civil Contingencies Act such as police, local authorities, PHE and the NHS participate in these meetings. A Tactical Coordinating Group (TCG) for Lancashire is also being set up. The SCG is also establishing a communications cell and business continuity cell.

The NHS has also stepped up its response arrangements. On 3rd March the NHS has declared COVID-19 a level 4 incident. The Council is working with the Pennine CCGs and East Lancashire Hospitals Trust to ensure joined up planning and response arrangements.

Plans for the Councils annual corporate emergency planning/business continuity exercise, already scheduled for 26th March, are being updated to further support and develop our local response.

4. The role the public can play in supporting the response:

An effective response to COVID-19 requires the active participation of all partners, including a well-informed public. Everyone can help support our response by:

- Maintaining good hand, respiratory and personal hygiene
    - Wash hands often with soap and water following NHS guidelines on good hand hygiene
    - Use an alcohol-based hand sanitiser that contains at least 60% alcohol if soap and water are not available.
    - Avoid touching your eyes, nose, and mouth with unwashed hands
    - Avoid close contact with people who are sick
    - If you feel unwell, stay at home, do not attend work or school
    - Cover coughs and sneezes with a tissue, throw the tissue in a bin. See Catch it, Bin it, Kill it

    - Clean and disinfect frequently touched objects and surfaces at home and work

- Reducing the impact and spread of misinformation by sharing and using information from trusted sources, such as those set out in Appendix 1 of this document

- Checking and following the latest Foreign and Commonwealth travel advice when travelling and planning to travel

- Ensuring that vaccinations are up to date as this will help reduce the pressure on the NHS through reducing vaccine-preventable diseases

- Checking on elderly or vulnerable family, friends and neighbours

- If you are worried about your symptoms, please call NHS 111. **Do not go directly to your GP or other healthcare environment**

- Being understanding of the pressures the health and social care systems may be under, and receptive to changes that may be needed to the provision of care

- Accepting that the current advice for managing COVID-19 for most people will be self-isolation at home and simple over the counter medicines

- Checking for new advice as the situation changes.

Dominic Harrison
Director of Public Health and Wellbeing
3rd March 2020

APPENDIX 1: USEFUL SOURCES OF INFORMATION (COVID-19)

The links below are reviewed and updated regularly by expert guidance cells. They are therefore, the most of effective way of staying up to date with the latest information and reducing the spread and impact of misinformation.

Enquiry Type	Hyperlink
Coronavirus - what you need to know	Nationally, Public Health England are leading on the health response. They are updating their website daily with the latest information, please go to **Wuhan coronavirus information for the public.** This is your first point of contact for the latest information and any developments in the UK The **NHS Website** has more information about coronavirus and how to reduce the possible spread of infection. If you or any member of the public are concerned that you are unwell or unsure about your symptoms, **the NHS advice line is 111**
Guidance for social or community care and residential settings	**This guidance aims to assist social, community and residential care employers** in providing advice to their staff.
Guidance for educational settings	This guidance, developed with the Department for Education, aims to assist schools and other educational settings in **providing advice to pupils, students, staff and parents or carers**
Guidance for employers and businesses	This guidance, developed with the Department for Business, Energy and Industrial Strategy, aims to **assist employers and businesses in providing advice to their staff**.
Guidance for health professionals	**Guidance for health professionals** on the assessment and management of suspected UK cases
Guidance for staff in the transport sector	**Guidance on general precautions for staff in the transport sector** on the assessment and management of arrivals into the UK.
PHE blog: what is contact tracing?	One of the ways in which PHE seek to protect the public from infectious diseases like novel coronavirus (COVID-19) is contact tracing. In this blog **Nick Phin, Deputy Director at PHE's National Infections Service, answers some questions about what is contract tracing**
PHE blog: what is self-isolation and why is it important?	**PHE explains what self-isolation is**, why it is important, and which groups are currently being advised to self-isolate.
PHE Campaign Resource Centre: novel coronavirus	PHE has launched a UK-wide public information campaign to advise on how to slow the spread of coronavirus and reduce the impact on NHS services. The **Campaign Resource Centre** holds materials which can be distributed to communities

Coronavirus: action plan

A guide to what you can expect across the UK

Published 3 March 2020

Department of Health & Social Care

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Scottish Government
Riaghaltas na h-Alba
gov.scot

Llywodraeth Cymru
Welsh Government

Contents

1. Introduction

1.1 The current novel coronavirus (COVID-19) outbreak, which began in December 2019, presents a significant challenge for the entire world. The UK Government and the Devolved Administrations, including the health and social care systems, have planned extensively over the years for an event like this, and the UK is therefore well prepared to respond in a way that offers substantial protection to the public.

1.2 Of course, this is a new virus, and new technology and the increasing connectivity of our world mean that our plans need to be kept up to date, to reflect that illnesses – and news and information about them – travel much more quickly today than even ten years ago.

1.3 Recognising the respective roles and responsibilities of the UK Government and Devolved Administrations, this document sets out what the UK as a whole has already done - and plans to do further - to tackle the current coronavirus outbreak, based on our wealth of experience dealing with other infectious diseases and our influenza pandemic preparedness work. The exact response to COVID-19 will be tailored to the nature, scale and location of the threat in the UK, as our understanding of this develops.

1.4 This document sets out:

- what we know about the virus and the disease it causes
- how we have planned for an infectious disease outbreak, such as the current coronavirus outbreak
- the actions we have taken so far in response to the current coronavirus outbreak
- what we are planning to do next, depending upon the course the current coronavirus outbreak takes.
- the role the public can play in supporting this response, now and in the future.

2. What we know about the virus and the diseases it causes

2.1 Coronaviruses are a family of viruses common across the world in animals and humans; certain types cause illnesses in people. For example, some coronaviruses cause the common cold; others cause diseases which are much more severe such as Middle East Respiratory Syndrome (MERS) and Severe Acute Respiratory Syndrome (SARS), both of which often lead to pneumonia.

2.2 COVID-19 is the illness seen in people infected with a new strain of coronavirus not previously seen in humans. On 31st December 2019, Chinese authorities notified the World Health Organisation (WHO) of an outbreak of pneumonia in Wuhan City, which was later classified as a new disease: COVID-19.

2.3 On 30th January 2020, WHO declared the outbreak of COVID-19 a “Public Health Emergency of International Concern” (PHEIC).

2.4 Based on current evidence, the main symptoms of COVID-19 are a cough, a high temperature and, in severe cases, shortness of breath.

2.5 As it is a new virus, the lack of immunity in the population (and the absence as yet of an effective vaccine) means that COVID-19 has the potential to spread extensively. The current data seem to show that we are all susceptible to catching this disease, and thus it also more likely than not that the UK will be significantly affected. Among those who become infected, some will exhibit no symptoms[1]. Early data suggest that of those who develop an illness, the great majority[2] will have a mild-to-moderate, but self-limiting illness – similar to seasonal flu[3].

2.6 It is, however, also clear that a minority of people who get COVID-19 will develop complications severe enough to require hospital care[4], most often pneumonia. In a small proportion of these, the illness may be severe enough to lead to death[5]. So far the data we have suggest that the risk of severe disease and death increases amongst elderly people and in people with underlying health risk conditions (in the same way as for seasonal flu)[6] [7]. Illness is less common and usually less severe in younger adults[8]. Children can be infected[9] and can have a severe illness[10], but based on current data overall illness seems rarer in people under 20 years of age. So far, there has been no obvious sign that pregnant women are more likely to be seriously affected[11] [12].

2.7 Given that the data are still emerging, we are uncertain of the impact of an outbreak on business. In a stretching scenario, it is possible that up to one fifth of

employees may be absent from work during peak weeks. This may vary for individual businesses.

2.8 We do not yet have entirely complete data on this disease. But as we learn more about the virus, its effects and its behaviour (for example, the timing and extent of the peak of an outbreak, its precise impact on individuals), we will be able to revise estimates of its potential spread, severity and impact[13]. We will then review, and (where necessary) adapt this plan accordingly.

2.9 Work is in hand to contain the spread of the virus. This includes extensive guidance provided to individuals returning from areas where there are cases being reported, and encouraging self-isolation as the primary means to contain the spread of the disease. Given that there is currently neither a vaccine against COVID-19 nor any specific, proven, antiviral medication[14] [15], most treatment will therefore be towards managing symptoms and providing support to patients with complications. The majority of people with COVID-19 have recovered without the need for any specific treatment, as is the case for the common cold or seasonal flu - and we expect that the vast majority of cases will best be managed at home, again as with seasonal colds and flu.

3. How the UK prepares for infectious disease outbreaks

3.1 The table below shows the impact of some of the major respiratory virus pandemics and epidemics in the last 100 years.

Major respiratory virus outbreaks

Area of emergence	Estimated case fatality ratio*	Estimated attributable excess mortality worldwide	Estimated attributable excess mortality in the UK	Age groups most affected
Spanish Flu 1918 – 1919 Severe influenza pandemic				
Unclear	≥ 2%	20 – 50 million	200,000	Young adults, elderly and young children
Asian Flu 1957 – 1958 Moderate influenza pandemic				
Southern China	0.1 – 0.2%	1 – 4 million	33,000	Children
Hong Kong Flu 1968 – 1969 Moderate influenza pandemic				
Southern China	0.2 – 0.4%	1 – 4 million	80,000	All age groups
Swine Flu 2009 – 2010 Very mild influenza pandemic				

Area of emergence	Estimated case fatality ratio*	Estimated attributable excess mortality worldwide	Estimated attributable excess mortality in the UK	Age groups most affected
Mexico	<0.025%	18,000	457	Children, young adults and pregnant women
Middle East Respiratory Syndrome 2012 Continuing coronavirus pandemic threat				
Middle East	>30%	861	0	Elderly (60+)
Serious Acute Respiratory Syndrome 2002 - 2003 Severe coronavirus pandemic 'near-miss'				
China	<10%	774	0	Middle aged adults (45 - 65)
Seasonal flu epidemic 1989 - 1990 Severe influenza seasonal epidemic				
UK	Data not available	Not applicable	26,000 excess deaths in England & Wales	Elderly 75+

* the proportion of people who became ill with symptoms and subsequently died

3.2 The UK is well prepared for disease outbreaks, having responded to a wide range of infectious disease outbreaks in the recent past, and having undertaken significant preparedness work for an influenza pandemic for well over one decade (eg. our existing plan 'flu plans[16]). Our plans have been regularly tested and updated locally and nationally to ensure they are fit for purpose. This experience

provides the basis for an effective response to COVID-19, which can be tailored as more specific information emerges about the virus.

3.3 These plans ensure the UK is equipped to deliver a coordinated multi agency response to minimise wider societal impact that could arise from a significant outbreak. An effective response also requires the active participation of a well-informed public and all service providers.

3.4 Planning draws on the idea of a “reasonable worst case (RWC)” scenario. This is not a forecast of what is most likely to happen, but will ensure we are ready to respond to a range of scenarios.

Planning Principles

3.5 In preparing for, and responding to, a serious disease outbreak, the UK and the Devolved Administrations aim to:

- undertake dynamic risk assessments of potential health and other impacts, using the best available scientific advice and evidence to inform decision making
- minimise the potential health impact by slowing spread in the UK and overseas, and reducing infection, illness and death
- minimise the potential impact on society and the UK and global economy, including key public services
- maintain trust and confidence amongst the organisations and people who provide key public services, and those who use them
- ensure dignified treatment of all affected, including those who die
- be active global players - working with the World Health Organization (WHO), the Global Health Security Initiative (GHSI), the European Centre for Disease Prevention and Control (ECDC), and neighbouring countries, in supporting international efforts to detect the emergence of a pandemic and early assessment of the virus by sharing scientific information
- ensure that the agencies responsible for tackling the outbreak are properly resourced to do so, that they have the people, equipment and medicines they need, and that any necessary changes to legislation are taken forward as quickly as possible

- be guided by the evidence, and regularly review research and development needs, in collaboration with research partners, to enhance our pandemic preparedness and response.

3.6 The UK Government and the Devolved Administrations have been planning an initial response based on information available at the time, in a context of uncertainty, that can be scaled up and down in response to new information to ensure a flexible and proportionate response.

3.7 The fundamental objectives are to deploy phased actions to Contain, Delay, and Mitigate any outbreak, using Research to inform policy development.

3.8 The different phases, types and scale of actions depends upon how the course of the outbreak unfolds over time. We monitor local, national and international data continuously to model what might happen next, over the immediate and longer terms.

3.9 The overall phases of our plan to respond to COVID-19 are:

- **Contain**: detect early cases, follow up close contacts, and prevent the disease taking hold in this country for as long as is reasonably possible

- **Delay**: slow the spread in this country, if it does take hold, lowering the peak impact and pushing it away from the winter season

- **Research**: better understand the virus and the actions that will lessen its effect on the UK population; innovate responses including diagnostics, drugs and vaccines; use the evidence to inform the development of the most effective models of care

- **Mitigate**: provide the best care possible for people who become ill, support hospitals to maintain essential services and ensure ongoing support for people ill in the community to minimise the overall impact of the disease on society, public services and on the economy.

4. Our response to the current coronavirus outbreak

Current planning

4.1 There is similarity between COVID-19 and influenza (both are respiratory infections), but also some important differences. Consequently, contingency plans developed for pandemic influenza[17], and lessons learned from previous outbreaks, provide a useful starting point for the development of an effective response plan to COVID-19. That plan has been adapted, however, to take account of differences between the two diseases. Annex A sets out the structure for the UK's response to a disease outbreak.

4.2 Our response to COVID-19 is guided by the international situation, the advice of organisations such as the WHO, surveillance, data modelling based on the best available evidence and the recommendations of our expert bodies (Annex B). The Scientific Advisory Group for Emergencies (SAGE) provides expert medical scientific advice. The four UK governments' Chief Medical Officers (CMOs) continue to advise the health and social care systems across the UK, and government agencies in all parts of the UK involved in responding to this outbreak.

4.3 System wide response plans for pandemic influenza, focused on the continuity of public and critical services and the stability of the economy, have been adapted for COVID-19, based on the best available scientific evidence and advice. For the latest information on the current situation please refer to: www.gov.uk/guidance/wuhan-novel-coronavirus-information-for-the-public.

4.4 The nature and scale of the response depends on the course of the disease, which cannot be predicted accurately at this point. As our understanding of the disease increases and its impact becomes clearer, we will issue further detailed advice about what to expect if/when further measures become necessary.

The phased response - what we have done so far

4.5 As there are already cases in the UK, the current emphasis is on the Contain and Research phases, but planning for Delay and Mitigation is already in train.

The Contain phase - actions to date

4.6 Across the whole of the UK, public health agencies and authorities, the NHS, and Health and Social Care NI (HSCNI) have established plans and procedures to detect and isolate the first cases of COVID-19 as they emerge in the UK. Each nation's public health agencies have worked with Border Force, port operators and carriers to enhance port health measures. PHE teams are on site at appropriate international ports, and health advice and information has been widely cascaded, as part of our public communications plan, with appropriate arrangements also put in place in the Devolved Administrations (given that some aspects relating to the arrival of aircraft and shipping are devolved).

4.7 Border Force and the Foreign and Commonwealth Office (FCO) have assisted the repatriation of British nationals and their dependents from affected areas overseas. Where foreign nationals in the UK have been unable to return to affected areas, the Home Office have provided support enabling them to remain in the UK.

4.8 New regulations introduced in England under public health legislation provide new powers for medical professionals, public health professionals and the police to allow them to detain and direct individuals in quarantined areas at risk or suspected of having the virus. In Scotland Health Boards have powers to place restrictions on the activities of individuals who are known to have the disease, or have been exposed to the disease, and to prohibit them from entering or remaining in any place. Boards may also apply for court orders for quarantine and medical examination. In Wales, local authorities have powers to apply for an order to be made by the Justice of the Peace to isolate, detain or require individuals to undergo medical examination. Similar powers are available to the Public Health Agency in Northern Ireland. Welsh Ministers also have powers to make regulations equivalent to those now in place in England if the level of risk increases.

4.9 As part of the port health measures, direct flights arriving into the UK from countries within the UK's CMOs' case definition are required to provide a declaration (General Aircraft Declaration) to airport authorities stating that all their passengers are well, 60 minutes prior to landing. Similarly, The Maritime Health Declaration Form is required for all vessels arriving from any foreign port. For Scotland parallel measures are in place.

4.10 The health and social care systems and public health authorities in all parts of the UK have cascaded information widely to all health professionals on steps to take if they identify patients who may have COVID-19.

4.11 The NHS/HSCNI have well rehearsed plans that have enabled the provision of excellent care for all patients affected by this disease. The initial confirmed

patients are being cared for by specialist units with expertise in handling such cases, using tried and tested infection control procedures to prevent further spread of the virus. When necessary, the provision of care may move from specialist units into general facilities in hospitals

4.12 The NHS/HSCNI have expert teams in every ambulance service and a number of specialist hospital units with highly trained staff and equipment ready to receive and care for patients – these provide coverage across the whole of the UK. If the current outbreak takes a greater hold, we will use those lessons about effective treatment methods and apply them throughout our health services, across all hospital sites and into community settings.

4.13 Once a case has been detected, our public health agencies use tried and tested procedures for rapid tracing, monitoring and isolation of close contacts, with the aim of preventing further spread.

4.14 The UK maintains strategic stockpiles of the most important medicines and protective equipment for healthcare staff who may come into contact with patients with the virus. These stocks are being monitored daily, with additional stock being ordered where necessary.

4.15 We have provided UK residents and travellers with the latest information to make sure they know what to do if they experience symptoms and worked with NHS 111, NHS Direct Wales and NHS 24 in Scotland, to ensure people with symptoms are given appropriate advice. Public health advice has been widely publicised and is regularly updated at www.gov.uk/guidance/wuhan-novel-coronavirus-information-for-the-public

4.16 FCO Travel Advice gives British nationals advice on what they need to know before deciding whether to travel and what to do if they are affected by an outbreak of COVID-19 while travelling. Our Travel Advice and consular assistance also help to contain the spread of COVID-19 to the UK.

4.17 Advice has been provided to first responders, employers, the justice system (including prison and probation services), educational settings, and the adult social care sector. The Department for Education provides advice about educational settings in England, which can be found on PHE's website. A DfE helpline is being set up to manage the flow of increasing queries, from providers and from parents of pupils.

4.18 Equivalent guidance for educational settings in Scotland can be found on the Health Protection Scotland website. This guidance provides links to further advice via NHS Inform and contact details for local Health Protection Teams. Scottish local authorities can also provide advice and support to education settings in their

areas, working closely with local Health Protection Teams and local and regional resilience partnerships.

4.19 In Wales, guidance for educational settings is provided on the Welsh Government website which also provides links to further public health advice - https://gov.wales/guidance-educational-settings-about-covid-19.

4.20 Department for International Trade teams around the globe continue to support British companies facing disruption due to the Coronavirus. The Department's officials across the globe are already working with UK businesses on the ground to relay public health advice and FCO travel advice, and provide practical and concrete support to firms, including engaging with local government and suppliers, and working with business associations to disseminate latest information on UK consular and visa services, and accessing existing UK Export Finance facilities.

4.21 All NHS and HSCNI emergency and urgent care facilities are working to establish coronavirus assessment services to lessen impacts on Emergency Departments and other clinical settings. This enables them to identify, isolate and contain cases, separate from other patients and the public, and in a way scalable to cope with expanding need. Specifically tailored and effective services responding to this outbreak have protected GPs, ambulance and hospital services for other patients.

4.22 The safety and security of British Nationals overseas will always be our top priority. Our initial focus has been helping those Britons who have found themselves at the greatest risk of exposure to the virus. Our crisis response team in the FCO has been working around the clock with our Embassies throughout the world to provide them with the care they need and reduce the risk of importation of Coronavirus into the UK. This includes the use of quarantine and self-isolation measures for those returning from at risk areas.

The Delay phase - actions to date

4.23 Many of the actions involved in the Contain phase also act to help Delay the onset of an epidemic if it becomes inevitable. These include case finding and isolation of early cases.

4.24 Many of the actions that people can take themselves - especially washing hands more; and the catch it, bin it, kill it strategy for those with coughs and sneezes - also help in delaying the peak of the infection.

4.25 Our experts are considering what other actions will be most effective in slowing the spread of the virus in the UK, as more information about it emerges. Some of these will have social costs where the benefit of doing them to Delay the peak will

need to be considered against the social impact. The best possible scientific advice and other experts will inform any decision on what will be most effective.

4.26 Delaying the spread of the disease requires all of us to follow the advice set out below. The benefits of doing so are that if the peak of the outbreak can be delayed until the warmer months, we can reduce significantly the risk of overlapping with seasonal flu and other challenges (societal or medical) that the colder months bring. The Delay phase also buys time for the testing of drugs and initial development of vaccines and/or improved therapies or tests to help reduce the impact of the disease. There is therefore a strong dependency between the different elements of our approach.

The Research phase - actions to date

4.27 The UK Government is liaising with the National Institute for Health Research (NIHR), UK Research and Innovation (UKRI) including the Medical Research Council (MRC) and other funders such as the Wellcome Trust to support and co-ordinate research during the COVID-19 outbreak.

4.28 Our Public Health Agencies are supporting the rapid development of specific tests for this coronavirus, in partnership with WHO and a global network of laboratories. This has been rolled out to NHS/HSCNI laboratories across the UK to enable faster confirmation of positive diagnoses.

4.29 The UK Government has already pledged £20 million to the Coalition for Epidemic Preparedness Innovations (CEPI) to develop new vaccines to combat the world's deadliest diseases, including vaccines for COVID-19, as quickly as possible, and is actively considering further investment.

4.30 The UK Government has also additionally announced £20 million for COVID-19 research via a joint rapid research call between UKRI and, through DHSC, the National Institute for Health Research (NIHR). This asks for proposals for projects to develop vaccines, therapeutics, and diagnostics; or to address the epidemiology, spread or underpinning knowledge of COVID-19.

4.31 Our health and social care departments across the UK are seeking to build on the relationships they have with institutions involved in Health Protection Research. A number of these are involved in research in relation to the COVID-19 epidemic.

4.32 This includes one on Emergency Preparedness and Response led by King's College London. It brings together experts on how to conduct important research that includes research on how to respond to infectious disease outbreaks such as COVID-19.

4.33 The UK is a world leader in the field of outbreak modelling and data analytics. The NIHR HPRU in Modelling Methodology led by Imperial College London has developed novel analytical and computational tools which exploit novel data streams on infectious diseases such as COVID-19. This group and other leading academic groups have developed tools to prepare for infectious disease outbreaks, which include real time infectious disease models, allowing policy decisions to be made using the best possible data and are actively modelling questions of relevance to dealing with the COVID–19 outbreak.

The role the public can play in supporting this response

4.34 Everyone can help support the UK's response by:

- following public health authorities' advice, for example on hand washing
- reducing the impact and spread of misinformation by relying on information from trusted sources, such as that on www.nhs.uk/, www.nhsinform.scot, www.publichealth.hscni.net, https://gov.wales/coronavirus-covid-19 and www.gov.uk/
- checking and following the latest FCO travel advice when travelling and planning to travel
- ensuring you and your family's vaccinations are up to date as this will help reduce the pressure on the NHS/HSCNI through reducing vaccine-preventable diseases
- checking on elderly or vulnerable family, friends and neighbours
- using NHS 111 (or NHS 24 in Scotland or NHS Direct Wales) (including online, where possible), pharmacies and GPs responsibly, and go to the hospital only when you really need to. This is further explained on the NHS website - www.nhs.uk/using-the-nhs/nhs-services/urgent-and-emergency-care/when-to-go-to-ae/ and http://www.choosewellwales.org.uk/home
- being understanding of the pressures the health and social care systems may be under, and receptive to changes that may be needed to the provision of care to you and your family.
- accepting that the advice for managing COVID-19 for most people will be self-isolation at home and simple over the counter medicines
- checking for new advice as the situation changes.

The phased response - what we will do next

4.35 In the event of the outbreak worsening, or a severe prolonged pandemic, the response will escalate, and the focus will move from Contain to Delay, through to Mitigate. During this phase the pressures on services and wider society may start to become significant and clearly noticeable.

4.36 The decision to step up the response from Contain to Delay and then Mitigate will be taken on advice from the UK's Chief Medical Officers, taking in to account the degree of sustained transmission and evident failure of measures in other countries to reduce spread.

4.37 To ensure that the health and social care system is prepared to respond to all eventualities, at all phases of a potential future pandemic, the NHS/HSCNI and local authorities have plans in place to ensure people receive the essential care and support services they need - and sometimes this might mean that other services are reduced temporarily. Plans are flexible to respond to different types of pandemics - ranging from a mild pandemic with a low impact on services (for example the 2009 H1N1 pandemic), through to a severe prolonged pandemic as experienced in 1918 ("Spanish Flu").

4.38 Similarly, potential pandemics are one of a wide range of risks that the owners and operators of our most essential services and systems plan for. The UK Government and Devolved Administrations are currently working with our critical national infrastructure partners to ensure that these plans are appropriate for COVID-19, and that we minimise any impacts that could disrupt the daily services on which the UK depends.

4.39 The Ministry of Defence has put in place plans to ensure the delivery of its key operations in the UK and overseas. There are also well practised arrangements for Defence to provide support to Civil Authorities if requested.

4.40 The UK Government will also step up the central co-ordination of its overall response using its proven crisis management mechanisms: COBR would meet as often as needed, bringing in system leaders to co-ordinate vital public services; and there will be more communication with Parliament, the media and the public. Ministers from across government will be designated to lead for their department on handling the outbreak; with senior officials and system leaders working intensively alongside them. The respective crisis management mechanisms across the Devolved Administrations have also been stood up and will operate in very similar terms to that of COBR within their own nations, and all four co-ordination centres are linked up on UK-wide planning and delivery of the response to Covid-19.

4.41 There will be regular meetings between the UK Government, and NHS/HSCNI and public health leaders, chaired alternately by the Secretary of State for Health and Social Care and his Permanent Secretary, to discuss the most recent advice from scientific experts and those delivering key services, and to decide next steps.

The Delay phase - next steps

4.42 If the disease becomes established in the UK, we will need to consider further measures to reduce the rate and extent of its spread. Based on experience with previous outbreaks, it may be that widespread exposure in the UK is inevitable; but slowing it down would still nonetheless be beneficial. For example, health services are less busy in the summer months when flu and other winter bugs are not driving GP consultations and hospital admissions. In the 2009 ‘swine flu’ pandemic school holidays significantly slowed transmission of the virus.

4.43 We will increase publicity about the need for good hygiene measures (hand washing, and catch it, bin it, kill it) and further promote the need for people with symptoms to stay at home for the full duration of their illness.

4.44 Other action will be considered to help achieve a Delay in the spread of the disease. We will aim to minimise the social and economic impact, subject to keeping people safe. Such judgements will be informed based on the best available and most up to date scientific evidence, and take into account the trade-offs involved.

4.45 Action that would be considered could include population distancing strategies (such as school closures, encouraging greater home working, reducing the number of large scale gatherings) to slow the spread of the disease throughout the population, whilst ensuring the country’s ability to continue to run as normally as possible. The UK governments' education departments' planning assumptions include the possibility of having to close educational settings in order to reduce the spread of infection.

4.46 We would consider such measures in order to protect vulnerable individuals with underlying illnesses and thus at greater more at risk of becoming seriously affected by the disease. The effectiveness of these actions will need to be balanced against their impact on society.

The Research phase - next steps

4.47 It is possible that an outbreak or pandemic of COVID-19 could occur in multiple waves (it is not known yet if the disease will have a seasonal pattern, like flu) and therefore, depending upon what the emerging evidence starts to tell us, it may be

necessary to ensure readiness for a future wave of activity. The intention is to gather evidence about effective interventions in order to inform decision-making going forward. The UK Government will keep emerging research needs under close review and progress research activities set out above.

The Mitigate phase - next steps

4.48 As and when the disease moves into different phases, for example if transmission of the virus becomes established in the UK population, the nature and scale of the response will change. The chief focus will be to provide essential services, helping those most at risk to access the right treatment. This means that:

- there will be further publicity of advice to individuals about protecting themselves and others
- treatment and the requirement for medicines and other clinical countermeasures might start to increase, with the need to draw down on existing stockpiles of the most important medicines, medical devices and clinical consumables
- health and social care services will work together to support early discharge from hospital, and to look after people in their own homes
- emergency services, including the police and fire and rescue services will enact business continuity plans to ensure they are able to maintain a level of service that fulfils their critical functions. For example, with a significant loss of officers and staff, the police would concentrate on responding to serious crimes and maintaining public order
- for businesses facing short term cash flow issues (for example, as the result of subdued demand), an effective mitigation already exists in HMRC's Time To Pay system. This is offered on a case by case basis if a firm or individual contacts HMRC about falling behind on their tax
- as NHS/HSCNI staff also start to become affected, and more seriously ill patients require admission, clinicians may recommend a significantly different approach to admissions. Some non-urgent care may be delayed to prioritise and triage service delivery. Staff rostering changes may be necessary, including calling leavers and retirees back to duty
- there could well be an increase in deaths arising from the outbreak, particularly amongst vulnerable and elderly groups. The UK Government and Devolved Administrations will provide advice for local authorities on dealing with this challenge

- there will be less emphasis on large scale preventative measures such as intensive contact tracing. As the disease becomes established, these measures may lose their effectiveness and resources would be more effectively used elsewhere.

4.49 Everyone will face increased pressures at work, as well as potentially their own personal illness or caring responsibilities. Supporting staff welfare will be critical to supporting an extended response.

4.50 We will implement a distribution strategy for the UK's stockpiles of key medicines and equipment (e.g. protective clothing). This will cover the NHS/HSCNI, and extend to social care and other sectors as appropriate.

4.51 We will consider legislative options, if necessary, to help systems and services work more effectively in tackling the outbreak.

4.52 The UK's health and social care systems will start to implement their business continuity plans, which cover:

- continuing to minimise the risk of infection to patients and those receiving care
- further identification of vulnerable persons to be supported
- arrangements for the continuation of essential services, to maintain normal business for as many people as possible for as long as possible
- plans to reduce the impact of absentees during the pandemic
- systems to lessen the impact of disruption to society and the supply chain.

4.53 The UK remains in a high state of readiness to respond robustly to any disease outbreak, and our track record of success means that we can offer a high degree of assurance that we will be able to maximise the effectiveness of our health and care systems, and in doing so also respond effectively to the outbreak.

4.54 As and when we discover more about the disease and what, if any, impact its course has on the UK, we will provide further updates on how our plans are being adapted to respond to specific, changing circumstances.

4.55 The UK Government is advising businesses to build their own resilience by reviewing their business continuity plans and following the advice for employers available on GOV.UK - www.gov.uk/government/publications/guidance-to-employers-and-businesses-about-covid-19

4.56 Businesses should also ensure that they keep up to date with the situation as it changes, at: www.gov.uk/coronavirus.

Annex A - responsibilities for pandemic preparedness and response

National responsibilities

The Department of Health and Social Care (DHSC) is the lead UK Government Department with responsibility for responding to the risk posed by a future pandemic.

The four UK CMOs provide public health advice to the whole system and government throughout the UK. The Scientific Advisory Group for Emergencies (SAGE) is responsible for ensuring that a single source of coordinated scientific advice is provided to decision makers in COBR.

The NHS works in partnership with Local Resilience Forums on pandemic preparedness and response delivery in healthcare systems in England and Wales. Public Health England provides specialist technical expertise to support both planning and delivery arrangements in England, working closely with public health agencies in Wales, Scotland and Northern Ireland. These organisations have developed plans for coordinating the response at a national level and supporting local responders through their regional structures. The tri-partite partnership of DHSC, PHE and NHS England provides strategic oversight and direction for the health and adult social care response to an influenza pandemic, with Department for Education (DfE) leading on the children's social care response. In Devolved Administrations, there are similar arrangements for multi-agency working with strategic oversight provided by the appropriate departments. These arrangements are supported by national co-ordination structures.

PHE and their equivalent in the Devolved Administrations lead the provision of expert advice on health protection issues and actively contributes to the planning and delivery of a multi-agency response. PHE provides health protection services, expertise and advice, delivering specialist public health services to UK national and local government (in England), the NHS/HSCNI and the public, working in partnership to protect the public against infectious diseases. There are comparable public health expert advisory support arrangements in each of the other three UK countries.

Local/Regional responsibilities

In England and Wales, local organisations (working jointly through the Local Resilience Forums and Local Health Resilience Partnerships in England, and NHS emergency planning structures in Wales) have the primary responsibility for planning for and responding to any major emergency, including a pandemic. Similar arrangements exist in

Scotland working through Regional Resilience and Local Resilience Partnerships. In Northern Ireland, Emergency Preparedness Groups coordinate emergency planning at the local level.

Multi-agency working

Multi-agency working at both a national and local level ensures joint planning between all organisations. A coordinated approach to ensure best use of resources to achieve the best outcome for the local area.

NHS England and NHS Improvement and partners have published a series of quick guides to assist multi-agency working and support local health and care systems manage increasing demand on their services. The series of guides can be found at www.nhs.uk/quickguides. Integration Authorities in Scotland have access to a range of government advice on priorities for multi-agency working, which supports existing local plans to optimise care pathways**.**

Social care is provided by a diverse range of local authority, private and third sector bodies. It is important that the role of social care provision in all sectors is central to contingency planning. Social care providers should remain in contact with local commissioners and resilience partners, review their business continuity plans and continue to practice proper infection control and good respiratory hygiene practice.

Other key public services

The Ministry of Justice's HM Courts & Tribunal Service have well established plans to deliver key services to protect the public and maintain confidence in the justice system. Similar plans are in place in the Devolved Administrations.

Annex B - expert advice and guidance

The UK Government and the Devolved Administrations have ensured that all of our actions are based on the best possible evidence, and are guided by the four UK CMOs.

The UK health departments preparations and response are developed with expert advice, ensuring that staff, patients and the wider public can be confident that our plans are developed and implemented using the best available evidence. These groups include:

- the Scientific Advisory Group for Emergencies (SAGE) – Chaired by the Government Chief Scientific Adviser and co-chaired by the CMO for England - provides scientific and technical advice to support government decision makers during emergencies, ensuring that timely and coordinated scientific advice is made available to decision makers to support UK cross-government decisions in the UK Cabinet Office Briefing Room

- the New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG) is an expert committee of DHSC and advises the CMOs and, through the CMOs, ministers, DHSC and other Government departments, and the Devolved Administrations. It provides scientific risk assessment and mitigation advice on the threat posed by new and emerging respiratory virus threats and on options for their management

- the Advisory Committee on Dangerous Pathogens (ACDP) - provides independent scientific advice to the Health and Safety Executive, to Ministers in DHSC and DEFRA, and to their counterparts in Scotland, Wales and Northern Ireland on all aspects of hazards and risks to workers and others from exposure to pathogens

- the Scientific Pandemic Influenza Group on Modelling (SPI-M) - gives expert advice to the Department of Health and Social Care and wider UK government and the Devolved Administrations on scientific matters relating to the UK’s response to an influenza pandemic (or other emerging human infectious disease threats). The advice is based on infectious disease modelling and epidemiology

- the Joint Committee on Vaccination and Immunisation (JCVI) advises UK health departments on immunisation

- FCO Travel Advice is informed by PHE and DHSC advice and gives British nationals advice on what they need to know before deciding whether to travel and what to do if they are affected by an outbreak of COVID-19 while travelling.

The actions we are taking to tackle the COVID-19 outbreak are being informed by the advice of these committees.

References

[1] Chan JF-W, Yuan S, Kok K-H, et al. A familial cluster of pneumonia associated with the 2019 novel coronavirus indicating person-to-person transmission: a study of a family cluster. Lancet 2020; 395: 514–23

[2] The Epidemioloigcal Characteristics of an outbreak of 2019 Novel COVID-19 – China 2020 (China CDC Weekly Vol 2 No. x)
https://github.com/cmrivers/ncov/blob/master/COVID-19.pdf

[3] Xu XW, Wu XX, Jiang XG, Xu KJ, Ying LJ, Ma CL, et al. Clinical findings in a group of patients infected with the 2019 novel coronavirus (SARS-Cov-2) outside of Wuhan, China: retrospective case series. BMJ. 2020 Feb 19;368

[4] Sun K, Chen J, Viboud C. Early epidemiological analysis of the coronavirus disease 2019 outbreak based on crowdsourced data: a population-level observational study. Lancet Digital Health 2020; published online Feb 20. https://doi.org/10.1016/S2589-7500(20)30026-1

[5] Liu Y, Yang Y, Zhang C, Huang F, Wang F, Yuan J, et al. Clinical and biochemical indexes from 2019-nCoV infected patients linked to viral loads and lung injury. Science China Life Sciences. 2020 Feb 9:1-1

[6] Chen N, Zhou M, Dong X, Qu J, Gong F, Han Y, et al. Epidemiological and clinical characteristics of 99 cases of 2019 novel coronavirus pneumonia in Wuhan, China: a descriptive study. The Lancet. 2020 Jan 30

[7] Huang C, Wang Y, Li X, Ren L, Zhao J, Hu Y, Zhang L, Fan G, Xu J, Gu X, Cheng Z. Clinical features of patients infected with 2019 novel coronavirus in Wuhan, China. The Lancet. 2020 Jan 24

[8] Li J, Li S, Cai Y, Liu Q, Li X, Zeng Z, Chu Y, Zhu F, Zeng F. Epidemiological and Clinical Characteristics of 17 Hospitalized Patients with 2019 Novel Coronavirus Infections Outside Wuhan, China. medRxiv. 2020 Jan 1

[9] Li, Q., et al Early Transmission Dynamics in Wuhan, China, of Novel Coronavirus-Infected Pneumonia. NEJM. 2020 Jan 29 DOI: 10.1056/NEJMoa2001316

[10] Wang X, Yuan J, Zheng Y, Chen J, Bao Y, Wang Y, et al. Clinical and Epidemiological Characteristics of 34 Children With 2019 Novel Coronavirus Infection in Shenzhen. Zhonghua Er Ke Za Zhi. 2020; 58(0): E008-E008

[11] Chen H, Guo J, Wang C, Luo F, Yu X, Zhang W, Li J, Zhao D, Xu D, Gong Q, Liao J. Clinical characteristics and intrauterine vertical transmission potential of COVID-19 infection in nine pregnant women: a retrospective review of medical records. The Lancet. 2020 Feb 12

[12] Qiao J. What are the risks of COVID-19 infection in pregnant women?. The Lancet. 2020 Feb 12

[13] Famulare, M. 2019-nCoV: preliminary estimates of the confirmed-case-fatality-ratio and infection-fatality-ratio, and initial pandemic risk assessment. Institute for Disease Modelling Feb 19 2020 https://institutefordiseasemodeling.github.io/nCoV-public/analyses/first_adjusted_mortality_estimates_and_risk_assessment/2019-nCoV-preliminary_age_and_time_adjusted_mortality_rates_and_pandemic_risk_assessment.html

[14] World Health Organization [Internet]. R&D Blueprint: Coronavirus disease (COVID-2019) R&D; accessed 23rd February 2020. Available from: https://www.who.int/blueprint/priority-diseases/key-action/novel-coronavirus/en/

[15] Coalition for Epidemic Preparedness Innovations [Internet]. CEPI launches new call for proposals to develop vaccines against novel coronavirus, 2019-nCoV; accessed 23rd February 2020. Available from: https://cepi.net/news_cepi/cepi-launches-new-call-for-proposals-to-develop-vaccines-against-novel-coronavirus-2019-ncov/

[16] https://www.gov.uk/government/publications/Responding-to-a-uk-flu-pandemic

[17] https://www.gov.uk/government/publications/Responding-to-a-uk-flu-pandemic

Emergency and Health Protection Directorate

www.gov.uk/dhsc

Frequently Asked Questions and Answers

What is coronavirus or COVID-19?

Coronavirus is a type of virus. There are many types of coronaviruses and some cause mild illness like the common cold. The "new or novel coronavirus" originated in China at the end of last year and causes a respiratory disease called COVID-19.

What are the symptoms?

The symptoms include fever, coughing, sneezing and shortness of breath. But if you have these symptoms it does not necessarily mean that you have Coronavirus (COVID-19). The symptoms are similar to other illnesses such as cold and flu.

Could my symptoms be Coronavirus (COVID-19)?

It is very unlikely to be coronavirus if you have not been in close contact with someone with confirmed coronavirus or have not travelled to certain parts of the world https://www.gov.uk/government/publications/covid-19-specified-countries-and-areas/covid-19-specified-countries-and-areas-with-implications-for-returning-travellers-or-visitors-arriving-in-the-uk

What should I do if I think I have Coronavirus (COVID-19)?

Use the 111 online coronavirus service to find out what to do next (https://111.nhs.uk/service/covid-19). Do not go to your GP practice, hospital or pharmacy.

How is Coronavirus (COVID-19) spread?

Because it is a new virus it is not yet known exactly how it spreads from person to person. However it is very likely that it spreads in the same way as other respiratory illnesses such as the flu. This means that it spreads via droplets produced when an infected person coughs or sneezes.

How do I avoid getting it?

The best way to reduce your risk of catching coronavirus is to wash your hands frequently with soap and hot water, cover your mouth with a tissue when you cough or sneeze and then put the tissue in the bin, and avoid touching your eyes, nose and mouth if your hands are not clean.

Should I wear a face mask?

There is very little evidence that wearing a face mask is of much benefit for the general public. Facemasks are only effective if they are worn correctly, changed frequently and removed and disposed of safely which can be difficult to do outside of a healthcare setting. The best way to protect yourself is to wash your hands frequently with hot water and soap.

I think someone at my child's nursery or school has just come back from one of the affected areas should I take my child out of school?

No, your child should continue to go to school as normal.

I think I've been in contact with someone with Coronavirus (COVID-19) what should I do?

Health professionals from Public Health England will be contacting all people who have been in contact with a confirmed case of coronavirus to provide advice.

But call 111 for advice if you think you have been in close contact with someone with confirmed coronavirus in the UK or overseas.

Have there been any cases in Blackburn with Darwen?

So far there have been no confirmed cases of coronavirus in Blackburn with Darwen and only five in the North West of England. It is likely however that in the coming weeks and months there will be cases and we are planning for this.

What is Blackburn with Darwen Council doing to prepare for Coronavirus (COVID-19)?

The council is working closely with our partners in the NHS and Public Health England. We have robust systems in place if and when a case of coronavirus is notified to us by PHE. We are also ensuring our schools have been sent the latest public health guidance.

Can I catch Coronavirus (COVID-19) from a package or mail that has shipped from China?

There is currently no evidence that you can catch coronavirus from parcels and mail. Coronaviruses are generally spread by respiratory droplets and how long the virus can survive will depend on a number of factors including the temperature, exposure to sunlight, type of surface etc. It is unlikely that a virus will survive outside the body for longer than 48 hours.

Is there a vaccine for coronavirus?

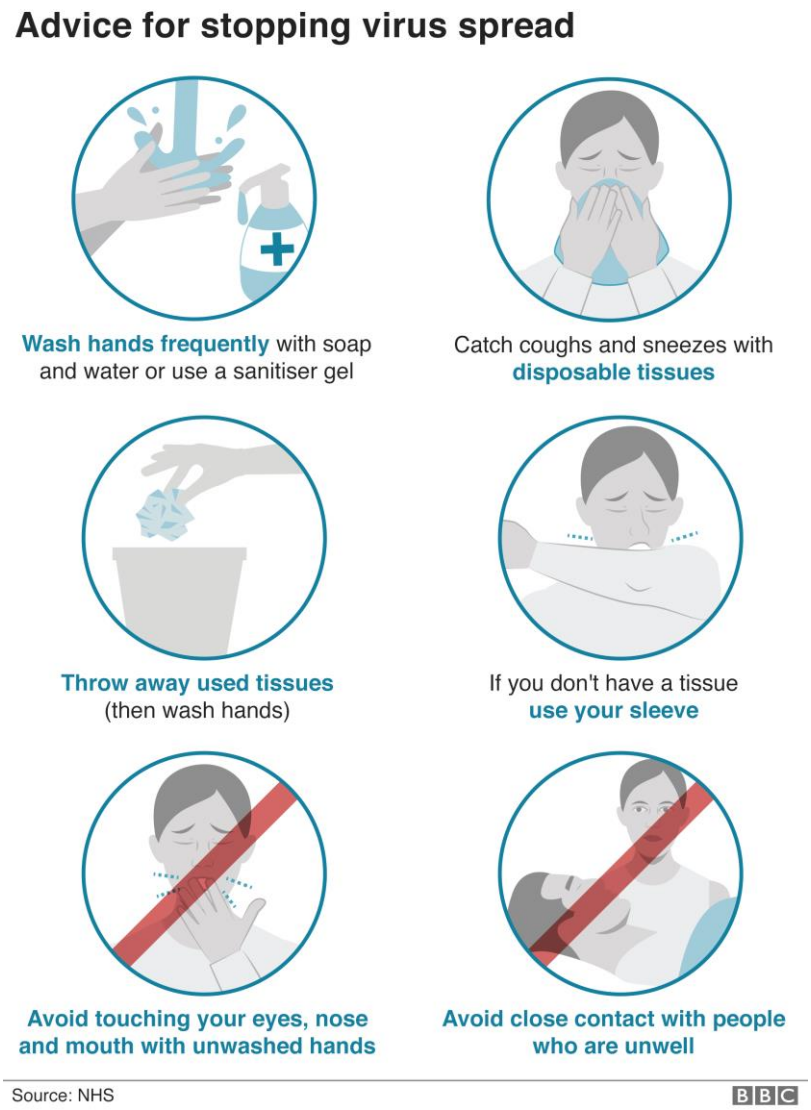
There is currently no vaccine for the COVID-19 coronavirus.

Where can I get the latest travel advice?

For the latest advice go to https://www.gov.uk/foreign-travel-advice

Where can I get more health advice?

Please visit the NHS website: https://www.nhs.uk/conditions/coronavirus-covid-19/ or the government website for the latest advice https://www.gov.uk/guidance/coronavirus-covid-19-information-for-the-public



HEALTH AND WELLBEING BOARD

TO:	Health and Wellbeing Board
FROM:	Healthier Pennine Lancashire Integrated Care Partnership, ICP, and Healthier Lancashire Integrated care System, ICS,
DATE:	17/02/2020

SUBJECT: Integrated Care System Strategy and Population Health Plan Priorities

1. PURPOSE

The draft Integrated Care System (ICS) Strategy (Appendix A) has recently been discussed by the Integrated Care System Board. The draft strategy identifies the Population Health Plan priorities:

- Best start in life
- Healthy Behaviours
- Zero Suicides
- Neighbourhood Development
- Work and Health

These are aimed at improving the health and wellbeing outcomes of our communities. A system wide approach to develop the Implementation Plan is under way, managed through the Population Health Steering Group of the Integrated Care System.

2. RECOMMENDATIONS FOR THE HEALTH & WELLBEING BOARD

The Health and Wellbeing Board is requested to:

(i) Receive, discuss and endorse the draft Integrated Care System Strategy.
(ii) Confirm commitment to the Population Health Plan priorities identified in the draft Strategy.
(iii) Engage with and support the development of the Integrated Care System Population Health Implementation Plan.
(iv) Endorse the alignment of the existing population health and prevention activity across the Integrated Care System work streams and Integrated Care Partnership/Multi-speciality Community Provider plans (in West Lancashire).

3. BACKGROUND

Background

1. Draft Strategy and Population Health Priorities

1.1 The draft Integrated Care System (ICS) Strategy (Appendix A) has recently been discussed by the Integrated Care System Board. The vision identifies the following ambitions:

- Healthy communities

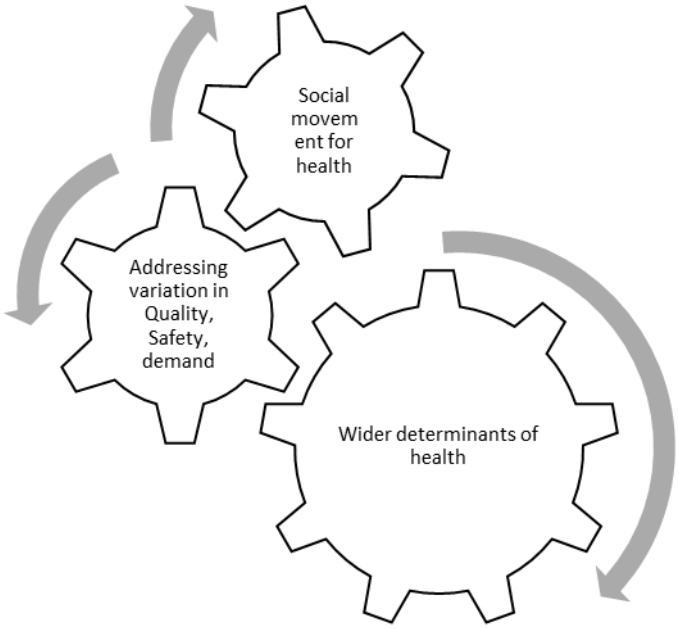
- High quality and efficient services
- Health and care service that works for everyone, including our staff

The strategy also identifies the Population Health Plan priorities, which are aimed at improving the health and wellbeing outcomes of our communities. Our overarching Population Health ambition is to achieve best health for all, with a focus on reducing health inequalities. The ambitions and objectives are informed by the latest national and local data and evidence based practice of what good looks like. The strength is our focus in places and neighbourhoods. We are building on a range of successful collaborations we already have across our system. The Strategy is well aligned to Blackburn with Darwen Health and Wellbeing Board priorities and Pennine Lancashire Integrated Care Partnership Strategic narrative.

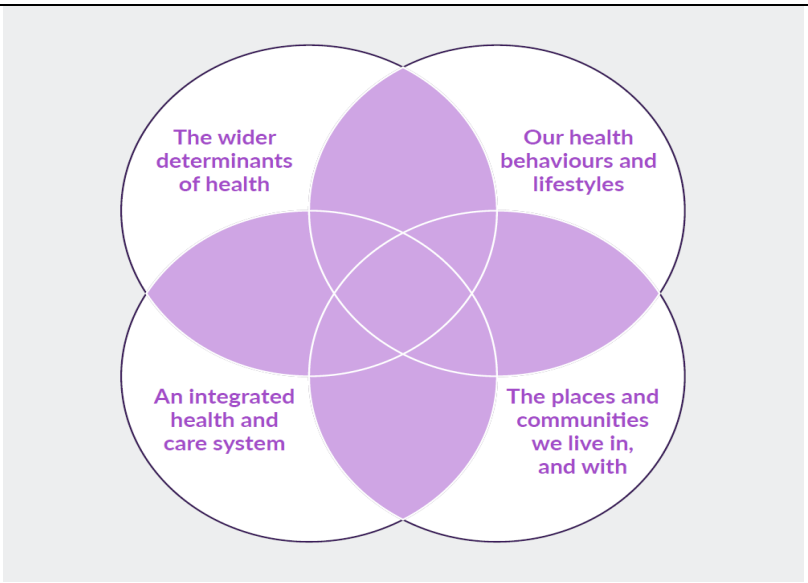
1.2 The Lancashire and South Cumbria Integrated Care System Board signed off our population health framework that includes our organising principles, strategic objectives and theory of change for improving health and care at scale in February 2018. These are aligned to the priorities identified by the four Health and Wellbeing Boards.

1.3 Our organising principle is to embed prevention in everything we do and provide place based, person centred care, by working with our residents.

1.4 Our theory of change for improving health and care outcomes at scale is illustrated below.



1.5 Our framework for population health is based on The Kings Fund Population Health Framework as well as Public Health England's (PHE) toolkit for place-based approaches to reduce health inequalities. This includes action to improve the wider determinants of health, healthy behaviours and lifestyles, the places and neighbourhoods we live in, and delivering person centred care.



The King's Fund. A vision for population health: Towards a healthier future. 2018. Available from: https://www.kingsfund.org.uk/publications/vision-population-health.

The Population Health approach will be embedded across every level of our system level as follows:

- Integrated Care System – whole system setting of quality, standards and population level health and wellbeing campaigns.
- Integrated Care Partnerships/Multi-speciality Community Provider – develop integrated population level prevention programmes tackling key health and care inequalities.
- Primary Care Networks – extend the Population Health Management accelerator to improve health outcomes and maximise the neighbourhood and community assets for local communities.

4. RATIONALE

The NHS Long Term Plan (LTP) was published in January 2019 and set out a range of ambitions for the NHS for the next 5 – 10 years. All 'Local health systems' were asked to produce local plans for implementing the commitments set out within the LTP. For South Cumbria, this means Lancashire and South Cumbria Integrated Care System.

Alongside this, and following an extensive period of engagement, the Healthier Pennine Lancashire Integrated Care Partnership (ICP) has agreed a forward plan.

The Lancashire & South Cumbria Integrated Care System (ICS) was required nationally to submit an ICS Strategic Plan by the 15th November, in response to the NHS Long Term Plan (LTP) and the local needs of our population over the next five years. The Plan has now been produced and a copy is attached – again the status of this is draft. Again, HWBB is asked to note development and consider the document.

5. KEY ISSUES

None.

6. POLICY IMPLICATIONS

None.

7. FINANCIAL IMPLICATIONS

None.

8. LEGAL IMPLICATIONS

None.

9. RESOURCE IMPLICATIONS

None.

10. EQUALITY AND HEALTH IMPLICATIONS

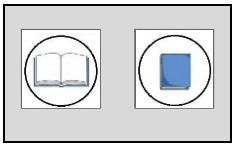
None.

11. CONSULTATIONS

None. Extensive engagement was undertaken over the last three years to develop the ICP Plan.

VERSION:	**3**

CONTACT OFFICER:	David Rogers, Head of Communication and Engagement, NHS East Lancashire and BwD CCGs.
DATE:	17/02/2020
BACKGROUND PAPER:	Appendix A ICS Strategy



HEALTH AND WELLBEING BOARD

TO:	Health and Wellbeing Board
FROM:	Healthier Pennine Lancashire ICP and Healthier Lancashire ICS
DATE:	17/02/2020

SUBJECT: Commissioning Reform

1. PURPOSE

This paper seeks to update Blackburn with Darwen HWBB members on upcoming discussions about the evolution of NHS commissioning in the Blackburn with Darwen CCG and Pennine Lancashire area, and across Lancashire and South Cumbria over the next two years.

In recent months, the Chairs and Chief Officers from all of the Lancashire CCGs have been reviewing the progress made in conjunction with NHS providers, local authorities and other partners to introduce new models of integrated care in local areas and across Lancashire and South Cumbria. Over time this has begun to change the roles undertaken by commissioners and for this reason, colleagues have agreed a road map for commissioning reform.

A case for change and options appraisal document has therefore been drafted and is attached. This document sets out how commissioning organisations can work to continue the development of these local integrated health and care partnerships.

2. RECOMMENDATIONS FOR THE HEALTH & WELLBEING BOARD

The Health and Wellbeing Board is requested to:

(i) Receive the paper and,
(ii) Provide feedback on the proposals

3. BACKGROUND

Based on the collective vision to continue this journey of integrated care in neighbourhoods, local places and across Lancashire and South Cumbria, commissioning leaders have identified a number of options for the commissioning arrangements which can best support this next stage of development. Each option has been assessed against the following criteria:

- Tackle inequalities and improve outcomes for patients
- Get our resources and capacity in the right place to support our integrated place-based models in Primary Care Networks, local health and care partnerships and (where there is value in acting collectively) across the Integrated Care System
- Reduce duplication of commissioning processes, governance arrangements and the use of staff time
- Support a consistent approach to standards and outcomes

- Be affordable, reduce running costs and support longer term financial sustainability
- Offer the potential for further development of integrated commissioning between the NHS and Local Authorities
- Be deliverable
- Be congruent with the NHS Long Term Plan expectation that there will "typically" be a single CCG for each Integrated Care System area.

The Case for Change document (appendix) recommends an option which would lead to the creation of a single CCG for Lancashire and South Cumbria. This option is also clear that the single CCG will discharge a range of its functions through locality-based commissioning teams working with partners in each of the five localities: Central Lancashire, Fylde Coast, Morecambe Bay, Pennine Lancashire and West Lancashire.

The place based commissioning teams will be the key commissioning link with each locality and will retain many of the benefits the member practices have indicated are important to them including; local clinical leadership, engagement and commissioning of primary care, population health improvement, local performance, quality and financial management.

Following an agreement by the Joint Committee at its meeting in January 2020, the next steps are to commence a period of formal engagement from February to April 2020 with member practices, CCG/CSU staff and other stakeholders including providers, Local Authorities and patient/public groups.

No decisions have been taken at this point in time about future configuration of CCGs. The formal decision about any option to change the number of CCGs will be taken according to each CCG's constitution through a vote of member GP practices which is planned to take place in May 2020.

If the outcome of this vote is to support the creation of a single CCG, then a full set of merger submission documents will be prepared in line with NHS England guidance. A formal merger application will be submitted to NHSE by 30 September 2020 with the aim of a single CCG for Lancashire and South Cumbria operating in shadow form from October 2020 and being fully established on 1 April 2021.

Feedback on the attached case for change is requested from HWBB members so this can be taken into consideration in the detail on which the GP membership will vote.

4. RATIONALE

Commissioning leaders have a clear intention of building on the best work undertaken with our partners to improve health and join up health and care services and community assets in neighbourhoods, five local health and care partnerships (Central Lancashire, Fylde Coast, Morecambe Bay, Pennine Lancashire and West Lancashire) and across the whole of Lancashire and South Cumbria.

This work aims to create a focus for the health and care system to work very differently, agreeing plans to improve the whole population's health, using partnerships to improve the quality of health services and bringing the system back into financial balance.

We have also acknowledged that there is a need to address several examples of fragmented or variable commissioning in the current system. Examples include our approach to complex, individual packages of care, cancer services and the care of people with learning disabilities.

5. KEY ISSUES

None.

6. POLICY IMPLICATIONS

None.

7. FINANCIAL IMPLICATIONS

None.

8. LEGAL IMPLICATIONS

None.

9. RESOURCE IMPLICATIONS

None.

10. EQUALITY AND HEALTH IMPLICATIONS

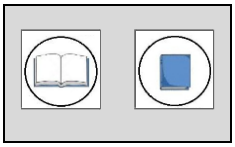
None.

11. CONSULTATIONS

The draft proposals are currently the subject of engagement. Should the proposal be agreed, a period of formal staff engagement will be undertaken in line with our statutory obligations.

VERSION:	**V3**

CONTACT OFFICER:	David Rogers, Head of Communication and Engagement, NHS East Lancashire and BwD CCGs.
DATE:	17/02/2020
BACKGROUND PAPER:	Appendix: ICS Commissioning Reform Case for Change



Lancashire and South Cumbria CCGs

Supporting Commissioning Reform and Integrated Care in Lancashire and South Cumbria

A Case for Change

Executive Summary

This paper aims to support consideration and discussion about the evolution of NHS commissioning in Lancashire and South Cumbria (L&SC) over the next two years. It sets out a case for changing the way that commissioning organisations work in order to accelerate the development of local integrated health and care partnerships. These increasingly ambitious partnerships offer a vehicle for commissioners, providers, local authorities and other partners to work very differently together, agreeing plans to improve the whole population's health, using collaboration rather than competition to improve the quality of health services and agreeing priorities to bring the system back into financial balance.

The context for the document is the work led by CCGs since 2013 to respond to a number of significant challenges in each area: poor outcomes and health inequalities, fragmented services, increasing demand compounded by workforce pressures and the need for financial sustainability [section 1]. This work has led to a broad consensus of the need for partners to work effectively together in neighbourhoods, in local places and across Lancashire and South Cumbria.

Over the next 2-3 years, CCG leaders have already stated their commitment to the continuing development of these integrated partnership models [section 2]. Clinical colleagues working in 41 Primary Care Networks are finding new ways to join up care in each neighbourhood and engage members of the public in their own health and wellbeing. As PCNs develop, they will have an increasing influence on the priorities of our evolving Integrated Care Partnerships (ICPs) in Morecambe Bay, Fylde Coast, Central Lancashire and Pennine Lancashire and a Multi-specialty Community Provider (MCP) in West Lancashire. Where there are opportunities across Lancashire and South Cumbria for collective action, learning and development, these are also being taken forwards by the wider Integrated Care System (ICS) partnership.

Looking further ahead (3-4 years) and as these partnerships continue to mature, there is further potential for them to take on more formal organisational responsibilities for improving the health of local people [section 3]. Our thinking at this stage is that a so-called "integrated care organisation" could be responsible for between 150-500,000 residents, delivering care directly and using alliances with other providers to create an effective local system of care. In doing so, we would expect this model of organisation to have demonstrated a transformational shift in its approach to population health, clinical leadership, board governance and accountability. The "integrated care organisation" would work under contract to the new single Commissioner which is charged with assuring progress of the ICP/ICO, setting consistent standards and securing improved outcomes across Lancashire and South Cumbria, achieving national policy priorities and financial value for taxpayers.

Currently, however, the 8 CCGs in Lancashire and South Cumbria are relatively small organisations. It is becoming increasingly clear that there is insufficient capacity and capability in the system as a whole to support PCNs/neighbourhoods and ICPs/MCP to

develop at the pace that is needed - and to tackle the challenges we face. This is in spite of the examples of joint decision-making and shared management arrangements which have developed over the last seven years.

In section 4, this paper begins to review the way that commissioning is currently organised and evaluates a number of potential future options against the following criteria:

- Tackle inequalities and improve outcomes for patients
- Get our resources and capacity in the right place to support our integrated place-based models in PCNs, ICPs, MCP and (where there is value in acting collectively) across the ICS
- Reduce duplication of commissioning processes, governance arrangements and the use of staff time
- Support a consistent approach to standards and outcomes
- Be affordable, reduce running costs and support longer term financial sustainability
- Offer the potential for further development of integrated commissioning between the NHS and Local Authorities
- Be deliverable
- Be congruent with the NHS Long Term Plan expectation that there will "typically" be a single CCG for each ICS area.

As a consequence of the ambitions to reform the commissioning arrangements, the option recommended is to form a new single CCG from April 2021 with aligned local commissioning teams to each Integrated Care Partnership / Multispecialty Community Provider, to support this next stage of development.

Key issues

A number of key issues have been raised by Governing Body representatives and member practices during the development work which has led to the production of this document. These issues [section 5] clarify and confirm how the process of change in commissioning arrangements would build on the existing strengths in Lancashire and South Cumbria and can be summarised as follows:

Governance, leadership and local decision-making

The single CCG will have a constitution approved by member practices across Lancashire & South Cumbria and will ensure strong local commissioning remains in each place.

It is proposed that the single CCG will have a governing body which is constituted with general practice members (Clinical Director), lay representatives, and a Managing Director who will represent each of the 5 places (Central Lancashire, Fylde Coast, Pennine Lancashire, West Lancashire and Morecambe Bay) that form the Lancashire & South Cumbria ICS.

In line with all CCG Constitutions, there will also be an Accountable Officer, Chief Finance Officer, Chief Nurse and Secondary Care Doctor.

The 5 Clinical Directors, 5 Managing Directors and 5 lay representatives who sit on the Governing body will also lead each place-based commissioning team, together with local clinical leadership and commissioning expertise. . The place based commissioning teams will retain many of the benefits member practices have indicated are important to them including responsibilities for practice engagement, primary care commissioning, population health improvement, improved service quality and financial management.

The method of appointment to the CCG governing body and place-based commissioning teams would be agreed as part of the new constitution.

The place-based commissioning teams will hold a delegated set of commissioning responsibilities through the single CCG's scheme of reservation and delegation and will act as the key NHS commissioning partner on each ICP/MCP Partnership Board. Local authority membership of local partnership boards will also drive this place-based approach.

There is a clear recognition from commissioning leaders that further development work is required in each of the local partnerships to ensure that effective leadership, decision-making and accountability arrangements are established and agreed by all partners. As local partnerships mature, it is also vital that they demonstrate how they will involve local communities and patients in decisions about their own health and wellbeing.

Clinical Leadership

It is proposed that the new single CCG Chair and the Clinical Directors will agree practical engagement arrangements with member practices in each ICP/MCP.

Place-based commissioning teams will also work closely with the PCN leaders, GP federations and LMC representatives as appropriate in each area.

The CCG also expects that PCN leaders will be formally represented within the ICP partnership arrangements.

Financial allocations for commissioning

There is a clear commitment to maintain the financial allocation for each Clinical Commissioning Group based on their "place footprint" (ICP/MCP) in line with the CCG allocations published by NHS England for the years 2021/22 until 2023/24.

Overarching financial principles would be developed and agreed as part of the engagement process, but we propose that:

- From April 2024, a single CCG could devise an allocations model which could address any remaining "distance from target" factors and top-slice specialised services commissioned across the whole of Lancashire and South Cumbria (e.g. Ambulance services.)
- From April 2024, a single CCG could also consider differential growth towards areas of higher deprivation and health inequality in Lancashire and South Cumbria, if a change to the existing allocation methodology could be evidenced as being in the best interests of the Lancashire & South Cumbria population. It is likely that a pace of change policy would be required to underpin this approach.

Commissioning general practice services

The funding for GMS/PMS contracts will continue to be nationally negotiated for all practices and will not be affected by the creation of a single CCG.

Local enhanced services contracted from General Practice by CCGs will continue to be funded until March 2022. Funding after 2022 will only change if agreed by the local place-based commissioning team as a partner on the local ICP. The exception to this principle would be if a new national DES schemes was to be introduced and duplicated an existing local incentive scheme.

Over time, it can be expected that the single CCG will publish a common set of primary care standards for general practice in Lancashire and South Cumbria.

In the meantime, however, there is a clear commitment to member practices that payments made by CCGs to practices for locally negotiated quality incentive schemes will be maintained until March 2022.

Engagement and Next Steps

Once this case for change has been approved, a formal process of engagement will commence with member practices, CCG staff, partner organisations, patient and public groups. [section 6] More details on the proposed timeline for this process are set out in section 7.

Contents

Introduction

This paper aims to support consideration and discussion about the evolution of NHS commissioning in Lancashire and South Cumbria (L&SC) over the next two years. It sets out the challenging context facing commissioners and communities. It also confirms the opportunities to continue a journey of integrated care which builds on the best work undertaken by CCGs and our partners in recent years. The document contains an options appraisal for future commissioning arrangements which is based on a number of criteria and recommends a preferred option for change. The paper also includes next steps and a high-level timeline for implementation of the preferred option.

This version of the Case for Change has been written for initial consideration by CCG governing bodies, member practices and the Joint Committee of CCGs. Wider engagement with commissioning staff, providers, local authorities and other partners will also be essential as this process develops.

Section 1: The Challenges We Face

As local commissioners, CCGs have been working with other partners since 2013 to respond to a range of familiar challenges:

Inequalities and Poor Health Outcomes

In Lancashire and South Cumbria, people in many of our communities experience ill health from an early age and die younger, especially in areas with higher levels of deprivation. There are high levels of physical and mental health problems, and we have seen increased levels of suicide in some of our communities. Cardiovascular disease, heart failure, hypertension (high blood pressure), asthma, dementia and depression are more common than the national average.

Persistent inequalities in health, employment, education and income are damaging the life chances of many citizens. There is increasing recognition that we need to support people and communities to help them to make changes in their own health and wellbeing. In future, therefore, commissioners will need to co-create a sustainable response from a range of public bodies to these issues, working with communities themselves.

Fragmented services and systems

There are multiple examples of fragmented pathways and services across the health and care system which leave patients uncertain as to where to access the most appropriate care or health professional.

At a systemic level in Lancashire and South Cumbria, the NHS model of commissioners and providers created nearly 30 years ago appears to have reinforced fragmentation in spite of the best efforts of many frontline professionals and leaders. Multiple contracts between several commissioners with the same provider e.g. for mental health services have created differential expectations and outcomes; competing organisational strategies have not enabled a clear focus on standards and outcomes. There are several examples e.g. improving stroke services, where decision-making on critical improvements has been painfully slow to achieve as individual organisations reconsider the proposals. These are not isolated examples: many have been discussed over the years in each Governing body and in our collective meetings across the whole of Lancashire and South Cumbria.

Our local providers are committed to working differently to repair this fragmentation: groups of general practices are working in neighbourhoods with other community and social care services to develop primary care networks. Attention will increase on these services with the

imminent publication of national standards/specifications for a range of community-based services.

Our major NHS providers are also exploring new models of collaboration, working firstly with general practice and community services to integrate care pathways in ICPs. They are also considering how "group" models of provision across Lancashire and South Cumbria can, for example, increase the sustainability of fragile services, create efficiencies in diagnostic and operating theatre services and improve the performance of cancer services.

Commissioners need to be working at the heart of these new models of delivery – but there is neither capacity nor resources to support these new approaches and maintain the infrastructure of eight separate CCGs.

Increasing Demand

Our health and care services are struggling to tackle the level of illness and poor overall health we face in Lancashire and South Cumbria. As demand for care increases, some people don't receive the quality of care they need and commissioners cannot afford to fund escalating levels of activity.

Workforce

Workforce pressures in the health and care sector are well documented – traditional multidisciplinary models of care are increasingly hard to sustain and this requires new thinking about workforce roles and support for frontline staff. The full benefits of new technology can only be realised if they are introduced into more integrated services, pathways and teams.

Financial Sustainability

In 2019/20 there is an estimated financial gap of £200m across the L&SC ICS, based on the allocations received by the 8 CCGs. Whilst funding for the NHS is set to increase over the next few years, tackling the challenges of persistent inequalities, fragmentation, increasing demand and workforce change is more urgent than ever. We need to consider every opportunity to streamline our systems and processes, and reduce duplication. Our aim has to be to make our financial position sustainable and our collaborative work on the Long Term Plan is progressing with that aim.

Over the last twelve months, all CCGs have been required to plan for a 20% reduction in running costs and this has already led to decisions to integrate management functions between CCGs and within ICPs/MCPs, hold staffing vacancies, review clinical leadership roles, reduce accommodation costs and work differently with the CSU.

The direction of travel towards 5 local place-based commissioning teams working through a single CCG will free up a proportion of running costs, particularly in relation to the costs of 8 Boards as well as taking further opportunities to consolidate or share management functions.

Some simple examples of where a single CCG would be more productive without affecting local clinical leadership and decision making include:

- We currently have to procure extrernal and internal auditors eight times and produce 8 sets of statutory accounts.
- As eight separate CCG's we hold collectively over 100 meetings per year to meet our statutory and constitutional duties. This could be vastly reduced freeing clinical time to focus on local place-based work.

- Commissioning areas like Ambulance services, cancer services and CHC would be much more effectively managed improving patient care and releasing savings and staff to reinvest locally.

It is vital to emphasise that the primary objective here is to reduce duplication of functions in order to redirect resources to support clinical leadership in PCNs and ICPs. There is a clear commitment to retain the expertise of CCG management staff in order to provide resources for population health improvement, planning and transformation activities in PCNs, ICPs and across L&SC.

The table below summarises the pattern of running costs across the 8 CCGs:

Organisations	**Population**	**No. of Practices**	**2019/20 Allocation £m**	**201/20 Running Cost Allocation £m**
NHS Blackburn with Darwen CCG	177,841	23	271.3	3.5
NHS Blackpool CCG	175,012	20	333.1	3.5
NHS Chorley and South Ribble CCG	186,154	30	287.2	3.9
NHS East Lancashire CCG	387,324	50	647.6	7.8
NHS Fylde and Wyre CCG	178,682	19	310.5	3.6
NHS Greater Preston CCG	210,857	23	311.8	4.4
NHS Morecambe Bay CCG	348,208	35	570.0	7.2
NHS West Lancashire CCG	113,532	15	177.8	2.4
TOTAL	**1,777,610**	**215**	**2,909.3**	**36.3**

In summary, maintaining the costs of eight separate statutory bodies at a total cost of £36m is difficult to justify when there is such financial pressure on health spending.

Section 2: Our Journey to Develop Integrated Health & Care in Lancashire and South Cumbria

We know that tackling the challenges set out in Section 1 is not something that any single commissioning organisation can achieve in isolation. For this reason, the CCGs in Lancashire and South Cumbria have a long history of working collaboratively together and with partners across the Integrated Care System (ICS) footprint. The publication of the NHS Five Year Forward View in 2014 achieved a new level of consensus that commissioners, providers local authorities and other partners should pursue approaches to integrating health and care – joining strategies, partnerships, resources and leadership to respond to the triple aim of better health, better care, delivered sustainably.

By 2018, this journey of integrated care development was accelerating the development of 4 maturing Integrated Care Partnerships (ICPs) in Morecambe Bay, Fylde Coast, Central Lancashire and Pennine Lancashire and a Multi-specialty Community Provider (MCP) in West Lancashire. These partnerships offer a vehicle for providers, commissioners, local authorities and other organisations to work very differently, agreeing plans to improve the whole population's health, using collaboration rather than competition to improve the quality of health services and bring the system back into financial balance.

CCGs have also begun to deploy significant resources and expectations into the early development of 41 Primary Care Networks (PCNs), building on the integrated care models which have developed in neighbourhoods. There is a clear expectation in each ICP that the clinical leadership offered by GPs and other frontline professionals should be endorsed and refocused to ensure the success of PCNs and ICPs. There is also further potential to use the development of PCNs and ICPs to encourage new approaches of integrated commissioning with our local authorities.

At the same time, a Joint Committee of CCGs was established "to carry out the functions relating to decision-making on pertinent L&SC wide commissioning issues" arising from the ICS's main change programmes. This means the CCGs across L&SC already act together as the Commissioning Board (NHS) of the ICS. The terms of reference for the Joint Committee have recently been reviewed and updated and an annual work programme has been agreed. This ensures that decision-makers and CCG Governing Bodies are clear how collective oversight and/or decisions arising from our main work programmes will take place.

The evolution of commissioning set out in this paper is not therefore a sudden jolt in our current arrangements. Our direction of travel builds on the place-based approaches being endorsed by CCGs in neighbourhoods, ICPs and across Lancashire and South Cumbria.

Recognising that the development of integrated care models would impact on the future of commissioning arrangements, in January 2018, the Joint Committee approved a Commissioning Development Framework for Lancashire and South Cumbria. The framework gave a system wide commitment to

- Listen to our communities about their priorities for health and wellbeing, connecting up the natural assets in each neighbourhood with the resources available across the public sector;
- Make shared, strategic decisions, with key partners and clinical leaders about the allocation of resources;
- Implement new, integrated models of service provision which can make significant improvements in the quality and outcomes of health and care;

- Streamline the way we do things to reduce waste and make the most efficient use of our resources.

Following approval of the Commissioning Framework, CCG commissioning colleagues across the system worked together to apply it to their workstreams and develop recommendations for place-based commissioning activity in the future. Their work addressed several examples of fragmented or variable commissioning in the current system which are leading to poor outcomes for many people. Examples include our approach to complex, individual packages of care, the availability of robust community services for people with learning disabilities and the variability of performance in cancer services. The Joint Committee agreed the recommendations and asked workstreams to develop operating and support models.

We have therefore made significant progress on our journey to develop integrated health and care for the people of L&SC and in doing so have established solid foundations for further development. ICPs/MCP and PCNs/neighbourhoods, are the fundamental foundations for a strong and effective health and care system going forward.

However, CCGs are relatively small organisations. It is becoming increasingly clear that there is insufficient capacity and capability in the system as a whole to support PCNs/neighbourhoods and ICPs/MCP to develop at the pace that is needed - and tackle the challenges, work with our communities, improve the overall quality of our health and care services and achieve better financial outcomes.

There is significant duplication in operating eight membership councils and governing bodies and the associated governance, many CCGs have similar groups to solve the same problems. Individual members of staff are trying to maintain work on several critical priorities at the same time and the work to implement new collaborative commissioning operating models across L&SC is progressing, though slowly. We therefore need to review the way we are currently organised, building on and accelerating our joint working to date, agree how best to organise ourselves to meet our challenges and deliver our vision to create a health and care system that is fit for now and the future.

Section 3: Vision

Our published vision for Lancashire and South Cumbria is that communities will be healthy and local people will have the best start in life, so they can live longer, healthier lives.

At the heart of this are the following ambitions:

- We will have healthy communities
- We will have high quality and efficient services
- We will have a health and care service that works for everyone, including our staff.

Over the next 4-5 years, we expect our system to continue its journey of integrated care, joining up the priorities of health and care organisations to achieve consistent standards of service performance and improved outcomes for patients and the public.

We are placing a premium on:

- Developing partnerships across the public sector (education, employment, housing, business, local government and NHS) in order to reduce the generational inequalities in health and life chances between our communities.
- Working with each of our communities to understand the assets available which can help people to become more engaged in their own health and well being.
- Joining up primary, community, mental health and social care services in local areas whilst at the same time ensuring that sustainable and efficient models of specialised services can be offered to the whole population.

Over the next 2-3 years, CCG leaders have already stated their commitment to the continuing development of integrated partnership models [section 2]. Clinical colleagues working in 41 Primary Care Networks are finding new ways to join up care in each neighbourhood and engage members of the public in their own health and wellbeing.

Looking further ahead (3-4 years) and as these partnerships continue to mature, there is further potential for them to take on more formal organisational responsibilities for improving the health of local people [section 3]. Our thinking at this stage is that a so-called “integrated care organisation” could be responsible for between 150-500,000 residents, delivering care directly and using alliances with other providers to create an effective local system of care. In doing so, we would expect this model of organisation to have demonstrated a transformational shift in its approach to population health, clinical leadership, board governance and accountability.

The “integrated care organisation” would work under contract to the new single Commissioner which is charged with assuring progress of the ICP/ICO, setting consistent standards and securing improved outcomes across Lancashire and South Cumbria, achieving national policy priorities and financial value for taxpayers.

In moving towards our vision, over the next 2-3 years we will continue to strengthen our partnerships in local places and across the whole Lancashire and South Cumbria system. Our priorities here are to:

- Ensure our clinical and other frontline leaders are able to lead the work to create sustainable care models in our neighbourhoods, place-based partnerships and across Lancashire and South Cumbria.

- Demonstrate to patients and communities that the ways in which we organise health and care services are leading to improved access and outcomes.
- Tackle our most difficult challenges (workforce, finance, service resilience) by agreeing clear priorities across the ICS and the decision-making arrangements we will use.
- Sustaining an open dialogue with the public about our future models of health and care.

The proposals for commissioning reform which are laid out in this document are therefore designed to help us make the next steps on this ambitious journey.

Section 4: Options for Commissioning System Reform

In developing and considering options for future commissioning reform, it is important that we do so in the context of the challenges we face, the progress made to integrate care and our commitment to build on the partnerships which commissioners have already developed. The following criteria have therefore been developed to support these considerations. If we are going to organise ourselves differently, any new model must:

- Tackle inequalities and improve outcomes for patients
- Get our resources and capacity in the right place to support our integrated place-based models in PCNs, ICPs, MCP and (where there is value in acting collectively) across the ICS
- Reduce duplication of commissioning processes, governance arrangements and the use of staff time
- Support a consistent approach to standards and outcomes
- Be affordable, reduce running costs and support longer term financial sustainability
- Offer the potential for further development of integrated commissioning between the NHS and Local Authorities
- Be deliverable
- Be congruent with the NHS Long Term Plan expectation that there will "typically" be a single CCG for each ICS area.

Options Appraisal

Current Arrangements

There are currently eight CCGs within the L&SC ICS footprint with a number of CCGs operating shared commissioning arrangements that are aligned to the ICP footprints:

- NHS East Lancashire CCG and NHS Blackburn with Darwen CCG have a single Accountable Officer, a newly-created single Management Team and integrated workforce. Their Governing Bodies remain separate but already have a number of common working arrangements
- NHS Blackpool CCG and NHS Fylde & Wyre CCG have a single Accountable Officer, a newly-created single Management Team and integrated workforce. Their Governing Bodies remain separate but already have a number of common working arrangements.
- West Lancashire CCG shares the same Accountable Officer as the two Fylde Coast CCGs (from January 2020).
- NHS Chorley & South Ribble CCG and NHS Greater Preston CCG have a single Accountable Officer, a single Management Team and integrated workforce. Their Governing Bodies remain separate but already have a number of common working arrangements.
- NHS Morecambe Bay CCG was formed in 2018 following a boundary change process to incorporate South Cumbria. There is a single Accountable Officer and Governing body and clinical and executives are increasingly taking "system roles" within the ICP.

Across the ICS footprint, the CCGs oversee collaborative programmes of work and are able to make joint decisions relating to L&SC-wide issues through the formally constituted Joint Committee of CCGs, in line with an agreed annual work programme. This ensures that decision-makers and CCG Governing Bodies are clear how collective oversight and/or

decisions arising from our main work programmes will take place. The work programme is also used to seek appropriate delegations from CCG Governing Bodies into the Joint Committee where appropriate. The scope of delegation to the Joint Committee is limited at the current time.

Drawing on the criteria set out above a number of options for future commissioning system reform have been generated and appraised:

Option 1	*No change to current arrangements*
Option 2	*Merger to create five CCGs aligned with ICP footprints*
Option 3	*Single Accountable Officer and Executive Team for all eight L&SC CCGs*
Option 4	*Single CCG (all functions)*
Option 5	*Single CCG which aligns commissioning functions to each Integrated Care* ***Partnership/****Multispecialty Community* ***Partnership***
Option 6	*Single CCG which discharges an agreed set of commissioning functions through a contract with each Integrated Care* ***Provider/*** *Multispecialty Community* ***Provider***

A detailed appraisal of these options is set out in Appendix A. In the light of this assessment, option 5 is recommended to commence from April 2021. The details of this option are shown below.

Our Preferred Option and Benefits

Option five is our recommended option to commence from April 2021. In advance of this, shadow arrangements would be developed during 2020/21.

Option 5: Single CCG which aligns commissioning functions to each Integrated Care Partnership/Multispecialty Community Partnership

Under this option, the eight L&SC CCGs would merge to form a single new CCG which would take responsibility for all statutory functions through a single governing body. Under this option, it is proposed that the single CCG's governing body will be constituted with general practice members (Clinical Director), lay representatives, and a Managing Director who will represent each of the 5 places (Central Lancashire, Fylde Coast, Pennine Lancashire, West Lancashire and Morecambe Bay) that form the Lancashire & South Cumbria ICS.

In line with all CCG Constitutions, there will also be an Accountable Officer, Chief Finance Officer, Chief Nurse and Secondary Care Doctor.

The 5 Clinical Directors, 5 Managing Directors and 5 lay representatives who sit on the Governing body will also lead each place-based commissioning team, together with local clinical leadership and commissioning expertise. . The place based commissioning teams will retain many of the benefits member practices have indicated are important to them

including responsibilities for practice engagement, primary care commissioning, population health improvement, improved service quality and financial management.

The place-based commissioning team will hold a delegated set of commissioning responsibilities through the single CCG's scheme of reservation and delegation and will act as the key NHS commissioning partner on each ICP/MCP Partnership Board.

The ICP Partnership Boards will support the development of PCNs/Neighbourhoods and ICPs/MCP and accelerate the progress of place-based commissioning.

Collaborative commissioning programmes at the L&SC level would be overseen and managed through the governance structures of the new CCG.

This option requires change to existing structures and organisations. It would see the majority of commissioning activity focussed on the ICP footprint, reducing duplication and maximising economies of scale. It also supports a consistent approach to setting standards and outcomes. This option ensures capacity is secured in PCNs/Neighbourhoods and ICPs/MCP to support place-based commissioning, allowing time and support for ICPs/MCP maturity to develop.

The single CCG will retain clinical commissioning capacity and resources in order to commission services for a population in excess of any one ICP/MCP (i.e. 500,000+). It will also commission those service areas in which recommendations have already been made to commission at L&SC level. Commissioners working at this level will retain specific links to local ICPs and neighbourhoods. In the context of expectations that all CCGs will achieve 20% running cost savings this option would be affordable and would be consistent with the expectations set out in the NHS LTP.

Merging into a unified, more strategic commissioning organisation with a strong local focus delivered through locality commissioning teams aligned to the five ICPs/MCP best supports our ambitions as described below:

1. Tackle inequalities and improve outcomes for patients

We know there are significant health inequalities across L&SC which create challenges for services and result in poorer outcomes for some of our most vulnerable and deprived communities. Our work to tackle health inequalities will be better supported by having Locality Commissioning Teams aligned to the five ICPs/MCP. This will enable us to:

- Maintain strong links and engagement with the local population;
- Ensure specialist analytics and population health capabilities can develop across L&SC and be available for each ICP/PCN to support local priorities
- Undertake service planning and targeted delivery to reflect the specific needs of local communities – working closely with local authorities;
- Ensure effective communication and engagement with local populations including seldom heard groups of people to enable them to share their views and concerns which will shape not just what services are provided but how they are delivered.

Only by organising ourselves differently can we begin to deliver the improvements that are needed for our patients

2. Get our resources and capacity in the right place to support our integrated place-based models in PCNs, ICPS, MCP and (where there is value in acting collectively) across the ICS

Locality commissioning teams will be aligned to the five ICPs/MCP. They will exercise an agreed set of commissioning functions on ICP/MCP and PCN footprints, working collaboratively with partners through ICP Partnership Boards to agree plans for population health improvement, improved service quality and financial recovery. The Local Partnership Boards will support the development of PCNs/Neighbourhoods and ICPs/MCP and accelerate the progress of place-based commissioning with the ultimate aim of supporting ICPs/MCP and PCNs to reach a level of maturity over the next 2-3 years whereby commissioning functions and budgets can be contracted for through an Integrated Care Provider Contract. The single CCG will retain clinical commissioning capacity and resources in order to commission services for a population in excess of any one ICP/MCP (i.e. 500,000+). It will also commission those service areas in which recommendations have already been made to commission at L&SC level. Commissioners working at this level will have specific linked roles to local ICPs and neighbourhoods.

3. Reduce duplication

There will be a significant reduction in duplication both in terms of the capacity required to support the existing eight CCG governance structures and that deployed to support commissioning activity across eight CCG footprints. We know that our commissioning workforce is finding it increasingly challenging to balance the demands of collaborative commissioning activity across L&SC with ICP/MCP commissioning work to support the development of PCNs and neighbourhoods.

It is vital to emphasise that the primary objective here is to reduce duplication of functions in order to redirect resources to support clinical leadership in PCNs and ICPs. There is a clear commitment to retain the expertise of CCG management staff in order to provide resources for population health improvement, planning and transformation activities in PCNs, ICPs and across L&SC.

4. Support a consistent approach to standards and outcomes

As a strategic commissioner the CCG will focus on a key set of commissioning functions and activity related to standard setting for the whole population. It will focus on macro-level population health management and improving outcomes for patients.

Further development work is now being led by CCGs to set out the commissioning functions which will be exercised by Locality Commissioning Teams.

5. Be affordable, reduce running costs and support longer term financial sustainability

By streamlining our decision-making infrastructure and commissioning activity, doing things once where it makes sense to do so (e.g. finance, corporate services, committee meetings) we will reduce running costs. By re-focussing commissioning time and energy for those service areas in which recommendations have already been made to commission at L&SC level, we will make better use of clinical and managerial time and be better placed to deliver the financial efficiencies as required by NHS England and Improvement.

6. Offer the potential for further development of integrated commissioning between the NHS and Local Authorities

We will establish Locality Commissioning Teams to exercise key commissioning functions through ICP Partnership Boards, of which Local Authorities are key members. The new arrangements will support the continued journey towards more integrated health and social care at place level with ICP Partnership Boards being well placed to explore practical ways of integrating health and social care commissioning and delivery.

7. Be deliverable

Creating a single CCG with a combination of system-wide and locality-based leadership offers a deliverable and affordable model of commissioning in an integrated care system.

8. Be congruent with the NHS Long Term Plan expectation that there will typically be a single CCG for each ICS area

The NHS Long-Term Plan (LTP) is clear that each ICS will need streamlined commissioning arrangements to enable a consistent set of decisions to be made at system level. It talks about CCGs becoming leaner, more strategic organisations that support care providers through ICPs/MCP to partner with other local organisations to deliver population health, care transformation and implement the requirements of the LTP. It also talks about CCGs developing enhanced management capability for more specialist functions, such as estates, digital and workforce. Option five will allow us to bring together CCG clinical and managerial time to respond to the requirements of the LTP, and ensure capacity is secured in PCNs/Neighbourhoods and ICPs/MCP, to support place-based commissioning, allowing time and support for ICPs/MCP maturity to further develop.

In summary, a single CCG which operates as a strategic organisation, working with well-resourced local teams aligned to each of our local partnerships is recommended for the next stage on our journey of integrated care.

Section 5: Governance and Decision Making

As indicated above, the importance of effective governance and decision-making will be a critical success factor for this next stage of commissioning development in Lancashire and South Cumbria. This is particularly the case in order to build on the legacies of existing CCGs, move away from competition to partnership models of healthcare delivery and ensure that local organisations remain accountable to their communities.

Under the option for a single CCG, this will clearly operate as a membership organisation with a formal Constitution and scheme of reservation and delegation agreed with the members and approved by NHS England.

Membership of the Governing Body of the CCG will include the roles formally required including Accountable Officer, Chief Finance Officer, Secondary Care Doctor, Nurse and Lay members.

Locality-based decision-making

In order to emphasise the importance of place-based leadership and decision-making in Lancashire and South Cumbria, the governance of the new CCG will include a formal approach to leadership and decision-making in each locality. It is proposed that the single CCG will have a governing body which is constituted with general practice members (Clinical Director), lay representatives, and a Managing Director for each of the 5 places (Central Lancs, Fylde Coast, Pennine, West Lancs and Morecambe Bay) that form the Lancashire & South Cumbria ICS.

The 5 Clinical Directors, 5 Managing Directors and 5 lay representatives who sit on the Governing body will also lead each place-based commissioning team, together with local clinical leadership and commissioning expertise. The place based commissioning teams will retain many of the benefits member practices have indicated are important to them including responsibilities for practice engagement, primary care commissioning, population health improvement, improved service quality and financial management.

Local authority membership of ICP/MCP partnership boards will also drive this place-based approach and working relationships are expected to become increasingly close.

Given the size of the CCG, there need to be practical arrangements for ensuring member practice involvement in the accountability arrangements and governance of the organisation, particularly as many practices also want to be engaged effectively in the development of local Primary Care Networks (on the basis of 30-50000 population) as well as in their ICPs/MCP.

There is a clear recognition from commissioning leaders that further development work is required in each of the local partnerships to ensure that effective leadership, decision-making and accountability arrangements are established and agreed by all partners. As local partnerships mature, it is also vital that they demonstrate how they will involve local communities and patients in decisions about their own health and wellbeing.

Clinical Leadership

Effective clinical leadership has been at the heart of clinical commissioning in recent years. There is an explicit commitment to retain these benefits in the leadership and governance of any reformed commissioning arrangements agreed for the future.

In line with current legislation, the single CCG will remain a membership organisation with all general practices as members. We recognise that clinical leaders will continue to be involved in developing the strategy, governance and accountability of a new commissioner

(e.g. through membership of the Governing Body), as well as working with provider colleagues to drive change and improvements across the health and care system.

In the next stage of our system's development, we also know that a group of GPs and other clinicians have been asked to lead our integrated PCN models in neighbourhoods: a key driver for reorganising the resources which are currently available within CCGs. It is understood that plans are being developed in each area for PCN leads to play a full part in the governance of each ICP/MCP.

Whatever option is agreed for changes in commissioning, there will be an obligation to operate under a formal constitution with a clear model for clinical leadership which is developed and agreed with member practices.

It is proposed that the new CCG Chair and the 5 place-based Clinical Directors will agree practical engagement arrangements with member practices in each ICP/MCP. Place-based commissioning teams will also work closely with the PCN leaders, GP federations and LMC representatives as appropriate in each area.

Finance & Allocations

As indicated above, many of the NHS organisations within the ICS are currently projecting substantial deficits. These will require effective, strategic decisions to be taken if the system is to return to a stable financial base. It is recognised that existing CCGs are in different financial positions and spending on services will be variable. Much of this will be driven by historic funding variations.

It is also understood that Governing Bodies and member practices have concerns about the impact of commissioning reform on existing allocations and commitments. At this stage, therefore, it is vital therefore that the following explicit commitments are made.

In relation to commissioning allocations:

- There is a clear commitment to maintain the financial allocation for each Clinical Commissioning Group based on their "place footprint" (ICP/MCP) in line with the CCG allocations published by NHS England for the years 2021/22 until 2023/24.
- From April 2024, a single CCG could devise an allocations model which could address any remaining "distance from target" factors and top-slice specialised services commissioned across the whole of Lancashire and South Cumbria (e.g. Ambulance services.)
- From April 2024, a single CCG could also consider differential growth towards areas of higher deprivation and health inequality in Lancashire and South Cumbria, if a change to the existing allocation methodology could be evidenced as in the best interests of the Lancashire & South Cumbria population. It is likely that a pace of change policy would be required to underpin this approach.

In relation to the commissioning of general practice services:

- The funding for GMS/PMS contracts will continue to be nationally negotiated for all practices and will not be affected by the creation of a single CCG.
- Local enhanced services contracted from General Practice by CCGs will continue to be funded until March 2022. Funding after 2022 will only change if agreed by the local place-based commissioning team as a partner on the local ICP. The exception to this principle would be if a new national DES schemes was to be introduced and duplicated an existing local incentive scheme.
- Over time, it can be expected that the single CCG will publish a common set of primary care standards for general practice in Lancashire and South Cumbria.

- In the meantime, however, there is a clear commitment to member practices that payments made by CCGs to practices for locally negotiated quality incentive schemes will be maintained until March 2022.

Section 6: Stakeholder Engagement

Since June 2019, CCG Chairs and Chief Officers have worked together with ICS colleagues to draft a roadmap and a statement of intent, setting out a direction of travel for commissioning development. These have been shared with each CCG's Governing Body and take forward a dialogue to understand concerns, answer questions and consider the options outlined in this paper. In addition, a written briefing has been cascaded to staff working in CCGs and the Midlands and Lancashire CSU which has been supported in regular staff briefings held within organisations.

It is vital that a clear approach to communication and engagement now takes place, particularly with our member practices and to ensure staff in CCGs are informed and involved at each stage. CCGs wishing to consider organisational change are also required by NHS England to demonstrate effective engagement about the plans with other key system partners and the public.

To support this process, a communications and engagement plan will be developed to deliver the following objectives:

- Demonstrate we have been able to take account of the views of key stakeholders – in particular our staff, GP membership and four local Healthwatch organisations- in developing our plans for a strategic commissioner
- Ensure key audiences are aware of our plans and in particular what this might mean for them
- Ensure stakeholders – and existing CCG staff in particular – are able to ask questions and give comments, with a robust feedback mechanism
- Ensure stakeholders – and existing CCG staff in particular – are engaged in bringing the new organisation together
- Ensure staff and members are aware of any additional roles and responsibilities they may have in helping to create the new strategic commissioner.

Our communications and engagement principles are

- The communications and engagement plan is based on clear, consistent messaging that describes both the benefits of merger and any dis-benefits
- Employing a principle of 'early communication and engagement' so there are 'no surprises' particularly amongst key stakeholders
- With effective and meaningful engagement channels to capture views, timely responses to questions and feedback and published FAQs (regularly updated)
- The plan covers both internal and external audiences across all eight CCGs, including staff, memberships and practice staff, the LMC, leaders/staff across the ICS, our regulators, Healthwatch, PPGs and engagement fora, the community/ voluntary sector, other local partners, media and wider public
- With messages and approach tailored appropriately
- Underpinned by a clear activity plan and timeline which uses existing communications/engagement channels wherever possible

Section 7: Next Steps and Timeline

This Case for Change and the Options Appraisal contained in appendix A have undergone a number of iterations during the past two months based on feedback from CCG Chairs and Chief Officers, Governing Bodies and member practices. In particular, work has been undertaken to set out a vision for the continued development of integrated care in neighbourhoods, local places and across the system. More detailed proposals have been set out relating to governance, local decision-making, clinical leadership including commitments relating to financial allocations and the commissioning of general practice services.

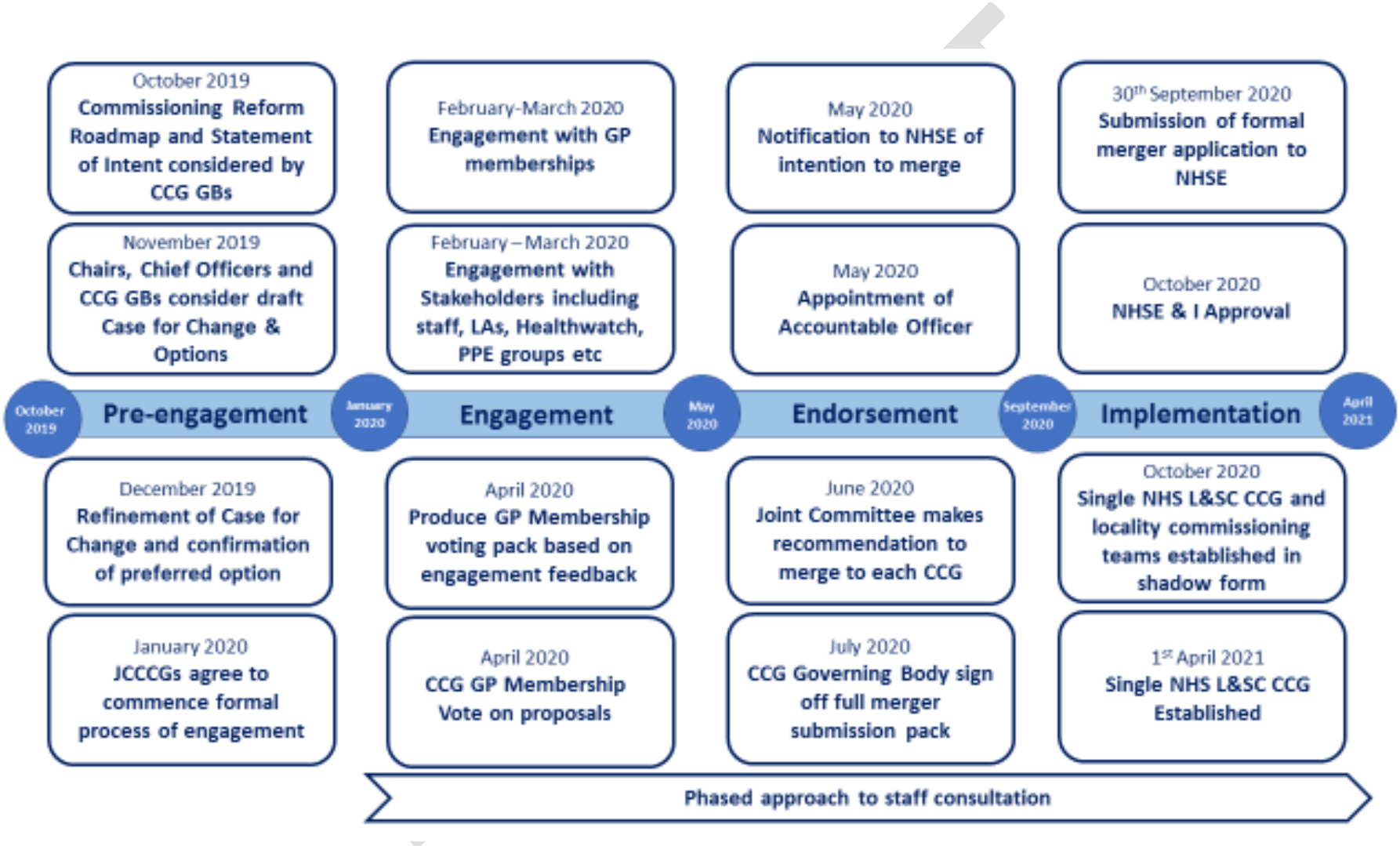
Subject to agreement by the Joint Committee at its meeting in January 2020, the next steps are to commence a period of formal engagement from February-March 2020 with member practices, CCG staff and other stakeholders including Local Authorities, Healthwatch and patient/public groups.

Work will also be completed in early January to develop proposals for the future delivery of commissioning functions at place and system levels. The outputs from this work, alongside this Case for Change and Options Appraisal will form the basis for the formal engagement process.

Following the engagement process, and taking account of any feedback received, it is proposed that a GP membership voting pack will be developed and considered by the Joint Committee of CCGs prior to a CCG GP Membership vote in May 2020. Subject to the outcome of this vote, a full set of merger submission documents will be developed in line with NHSEI guidance. Following consideration by Joint Committee and sign off by Governing Bodies, a formal merger application will be submitted to NHSE on 30th September 2020 with the aim of a single CCG for L&SC operating in shadow form from October 2020 and being fully established on 1st April 2021.

A high-level timeline for the process described above is set out below. Work is underway to develop a detailed programme plan which will incorporate development plans for the ICPs/MCPs.

Commissioning System Reform – High Level Timeline



APPENDIX A - Commissioning System Reform Options Appraisal

Option	Number of CCG's	Pro's	Con's
1. No change to current arrangements	8	Local commissioning focus continues Minimum structural change	Continuing duplication Limits capacity to support ICP and PCN development, place-based commissioning Does not support a consistent approach to standards and outcomes across L&SC Unaffordable Holds limited potential for integrated commissioning Inconsistent with NHS LTP Reliant on JCCCG to be vehicle for strategic commissioning
2. Merger to create five CCGs aligned with ICP footprints	5	Local commissioning focus continues Some structural change Partial release of capacity and resource to support ICPs/MCP and PCN development and place-based commissioning Potential for further integration with Local Authorities based on sharing priorities and resources (rather than straightforward co-terminosity)	Continuing duplication of resource maintain five CCG governance structures Does not support a consistent approach to standards and outcomes across L&SC Unaffordable Inconsistent with NHS LTP Reliant on JCCCG to be vehicle for strategic commissioning

Option	Number of CCG's	Pro's	Con's
3. Single Accountable Officer and Executive Team for all 8 L&SC CCGs	8	Local commissioning focus continues Limited structural change May offer small efficiencies in management costs Offers potential to support a consistent approach to standards and outcomes	Continuing duplication Limits capacity to support ICP/MCP and PCN development, place-based commissioning Unaffordable Holds limited potential for integrated commissioning Inconsistent with NHS LTP Reliant on JCCCG to be vehicle for strategic commissioning Not deliverable, unworkable for a single Exec Team to relate to eight Governing bodies
4. Single CCG (all functions)	1	Reduces duplication Supports consistent approach to standards and outcomes across L&SC Economies of scale Affordable Consistent with NHS LTP Potential for further integration with Local Authorities based on sharing priorities and resources (rather than straightforward co-terminosity)	Limits capacity to support ICP/MCP and PCN development, place-based commissioning Significant structural change

Option	Number of CCG's	Pro's	Con's
5. Single CCG which aligns commissioning functions to each Integrated Care Partnership/Multispecialty Community Partnership	1	Ensures capacity is secured in each ICP/MCP and PCN to support place-based commissioning Reduces duplication Supports consistent approach to standards and outcomes across L&SC Maximises economies of scale in deployment of resources, capacity and skills for collective action across all ICPs/MCP Affordable Consistent with NHS LTP Potential for further integration with Local Authorities based on sharing priorities and resources (rather than straightforward co-terminosity)	Significant structural change
6. Single CCG which discharges an agreed set of commissioning functions through a contract with each Integrated Care **Provider/** Multispecialty Community **Provider**	1	Ensures capacity is secured in each ICP/MCP and PCN to support place-based commissioning Reduces duplication Supports consistent approach to standards and outcomes across L&SC Maximises economies of scale in deployment of resources, capacity and skills for collective action across all ICPs/MCP	Significant structural change Requires Integrated Care Providers /Multispecialty Community Provider to have reached a stage of maturity to be able to take on commissioning functions on behalf of the single CCG

Option	Number of CCG's	Pro's	Con's
		Affordable Consistent with NHS LTP Potential for further integration with Local Authorities based on sharing priorities and resources (rather than straightforward co-terminosity)	

Option 1: No Change to Current Arrangements

The eight existing CCGs continue to take individual responsibility for their statutory functions and the operation of their local system, whilst at the same time working with other CCGs and with local partners to support the further development of ICPs/MCP and PCNs/Neighbourhoods.

Collaborative commissioning programmes would continue to be overseen and collaborative decisions made through the Joint Committee, though accountability would remain with the existing CCGs

This option would mean that commissioning activity remains focussed on the local CCG footprints and would not require structural change. Duplication of governance structures and commissioning activity will continue, and we will not benefit from opportunities for greater collaboration and economies of scale offered by other options. This option also limits capacity to support the development of PCNs/neighbourhoods and ICPs/MCP and to accelerate the progress of place-based commissioning. This would hamper our ability to address current pressures, improve patient outcomes, reduce health inequalities and tackle inefficiencies. In the context of expectations that all CCGs will achieve 20% running cost savings this option is increasingly unaffordable whilst also being inconsistent with the expectations set out in the NHS LTP. This option also holds limited potential for further development of integrated commissioning with Local Authorities.

Option 2: Merger to create five CCGs aligned with ICP footprints

A number of the existing CCGs would merge to form five CCGs across the L&SC ICS footprint which are aligned with the five ICPs/MCP:

- Morecambe Bay
- Central Lancashire
- Fylde Coast
- West Lancashire
- Pennine Lancashire

The new CCGs would continue to take individual responsibility for their statutory functions and the operation of their local system, whilst working with local partners to support the further development of ICPs/MCP and PCNs/Neighbourhoods. Each CCG would retain a separate governing body and governance structure, AO and Executive Team.

Collaborative commissioning programmes would continue to be overseen and collaborative decisions made through the Joint Committee in line with an agreed work programme, though accountability would remain with the existing CCGs

This option would mean that commissioning activity is focussed on the local ICP footprints and offers the partial release of capacity to support ICPs/MCP and PCN/Neighbourhood development and place-based commissioning. The potential for further integration with Local Authorities would be based on sharing priorities and resources (rather than straightforward co-terminosity). This option does not support a more consistent approach to standards and outcomes across the ICS footprint and would see duplication of governance structures and commissioning activity continue. This option does not benefit from opportunities for greater collaboration and economies of scale offered by other options. In the context of expectations that all CCGs will achieve 20% running cost savings this option

would also be unaffordable and would be inconsistent with the expectations set out in the NHS LTP.

Option 3: Single Accountable Officer and Executive Team for all L&SC CCGs

The eight existing CCGs appoint a single Accountable Officer and Executive Team for the whole Lancashire and South Cumbria footprint. Individual CCGs would retain responsibility for the delivery of statutory functions but Accountable Officer (AO) decision making would be held at the Lancashire and South Cumbria level. The AO and Executive Team would be responsible for working with their local partners to support the further development of ICPs/MCP and PCNs/Neighbourhoods. The single AO would be responsible for providing assurance to each governing body for statutory functions that continue within the CCG and for appropriate adherence to standards, targets and performance expectations.

Collaborative commissioning programmes would continue to be overseen and collaborative decisions make through the Joint Committee, though accountability would remain with the existing CCGs

This option would mean that commissioning activity remains focussed on the local CCG footprints and would require limited structural change. It also offers the potential to support a more consistent approach to standards and outcomes across the ICS footprint and may offer small efficiencies in management costs. Duplication of governance structures and commissioning activity will continue, and we will not benefit from opportunities for greater collaboration and economies of scale offered by other options. This option also limits capacity to support the development of PCNs/neighbourhoods and ICPs/MCP and to accelerate the progress of place-based commissioning. This would hamper our ability to address current pressures, improve patient outcomes, reduce health inequalities and tackle inefficiencies. In the context of expectations that all CCGs will achieve 20% running cost savings this option would also be unaffordable and would be inconsistent with the expectations set out in the NHS LTP.

The key issue with this option is that it would be undeliverable in practical terms for a single AO and Executive Team to relate to eight Governing bodies.

Option 4: Merger of CCGs to form a single NHS L&SC CCG (all functions)

The eight L&SC CCGS would merge to form a single new CCG which would take responsibility for all the statutory functions of the current eight CCGs and the operation of the system across L&SC working with local partners to support the further development of ICPs/MCP and PCNs/Neighbourhoods.

Collaborative commissioning programmes would be subsumed within the governance arrangements of the single CCG.

This option would see all commissioning activity focussed on the ICS footprint and would benefit from economies of scale. In the context of expectations that all CCGs will achieve 20% running cost savings this option would be affordable and would be consistent with the expectations set out in the NHS LTP. However, with all commissioning functions focussed on ICS level activity this would limit the extent to which capacity and resource could be redirected to better support the development of PCNs/Neighbourhoods and ICPs/MCP and to accelerate the progress of place-based commissioning. This would hamper our ability to

address current pressures, improve patient outcomes, reduce health inequalities and tackle inefficiencies. It would also require significant structural change.

Option 5: Single CCG which aligns commissioning functions to each Integrated Care Partnership/Multispecialty Community Partnership

Under this option, the eight L&SC CCGs would merge to form a single new CCG which would take responsibility for all statutory functions through a single governing body. Under this option, it is proposed that the single CCG's governing body will be constituted with general practice members (Clinical Director), lay representatives, and a Managing Director who will represent each of the 5 places (Central Lancashire, Fylde Coast, Pennine Lancashire, West Lancashire and Morecambe Bay) that form the Lancashire & South Cumbria ICS.

In line with all CCG Constitutions, there will also be an Accountable Officer, Chief Finance Officer, Chief Nurse and Secondary Care Doctor.

The 5 Clinical Directors, 5 Managing Directors and 5 lay representatives who sit on the Governing body will also lead each place-based commissioning team, together with local clinical leadership and commissioning expertise. . The place based commissioning teams will retain many of the benefits member practices have indicated are important to them including responsibilities for practice engagement, primary care commissioning, population health improvement, improved service quality and financial management.

The place-based commissioning team will hold a delegated set of commissioning responsibilities through the single CCG's scheme of reservation and delegation and will act as the key NHS commissioning partner on each ICP/MCP Partnership Board.

The ICP Partnership Boards will support the development of PCNs/Neighbourhoods and ICPs/MCP and accelerate the progress of place-based commissioning.

Collaborative commissioning programmes at the L&SC level would be overseen and managed through the governance structures of the new CCG.

This option requires change to existing structures and organisations. It would see the majority of commissioning activity focussed on the ICP footprint, reducing duplication and maximising economies of scale. It also supports a consistent approach to setting standards and outcomes. This option ensures capacity is secured in PCNs/Neighbourhoods and ICPs/MCP to support place-based commissioning, allowing time and support for ICPs/MCP maturity to develop.

The single CCG will retain clinical commissioning capacity and resources in order to commission services for a population in excess of any one ICP/MCP (i.e. 500,000+). It will also commission those service areas in which recommendations have already been made to commission at L&SC level. Commissioners working at this level will retain specific links to local ICPs and neighbourhoods. In the context of expectations that all CCGs will achieve 20% running cost savings this option would be affordable and would be consistent with the expectations set out in the NHS LTP.

Option 6: Single CCG which discharges an agreed set of commissioning functions through a contract with each Integrated Care Provider/ Multispecialty Community Provider

The eight L&SC CCGs would merge to form a single new CCG which would initially take responsibility for all the statutory functions of the current eight CCGs. An agreed set of commissioning functions, which it makes sense to undertake on ICP and PCN footprints, would be contracted for, alongside a capitated budget with each IC Provider/MC Provider through an Integrated Care Provider contract.

Collaborative commissioning programmes would be overseen and managed through the governance structures of the new CCG.

This option would require significant structural change. It would see the majority of commissioning activity focussed on the ICP footprint, would reduce duplication and would maximise economies of scale. It would also support a consistent approach to standards and outcomes. This option would ensure capacity is secured in PCNs/Neighbourhoods and ICPs/MCP to support place-based commissioning, allowing time and support for ICPs/MCP maturity to develop.

The single CCG will retain clinical commissioning capacity and resources in order to commission services for a population in excess of any one ICP/MCP (i.e. 500,000+). It will also commission those service areas in which recommendations have already been made to commission at L&SC level. Commissioners working at the Lancashire and South Cumbria level will retain links with local ICPs and neighbourhoods. In the context of expectations that all CCGs will achieve 20% running cost savings this option would be affordable and would be consistent with the expectations set out in the NHS LTP.

This option requires ICPs/MCP to have reached a level of maturity whereby integrated care provider contracts could be established and budgets delegated. At this point in time, it is proposed that further development of local partnerships is required to reach this stage of maturity.