Healthier Lancashire & South Cumbria

Formal Integrated Care System (ICS) Board
3 March 2021, 10:00 am -12.30 pm
Via MS Teams Videoconference

Agenda

Item	Description	Owner	Action	Format
Routine Items of Business				
1.	Welcome, Introductions and Apologies	Chair	Note	Verbal
2.	Declarations of Interest/Conflicts of Interest Relating to the Items on the Agenda	Chair	Note	Verbal
3.	Minutes of Previous Formal ICS Board Meeting Held on 3 February 2021 and Matters Arising Minutes of Formal ICS Board Meeting held on 2 December 2020, for approval	Chair	Approve Approve	Attached Attached
4.	Key Messages • Vaccination Programme Progress • Operational Pressures	Dr Amanda Doyle	Note	Verbal
Future System				
5.	System Financial Recovery Plan	Gary Raphael	Approve	Attached
6.	New Hospitals Programme	Rebecca Malin	Discuss	Attached
7.	System Reform	Andrew Bennett	Discuss	Attached
8.	Embedding Action on Health Inequalities – Proposals for Lancashire and South Cumbria Approach	Julie Higgins	Discuss	Attached
9.	Mental Health Update	Caroline Donovan	Note	Presentation To Follow
Assurance				
10.	Maternity Quality Assurance/Ockenden Report	Vanessa Wilson	Approve	Attached
Routine Items				
11.	Items to Forward for the Next ICS Board Meeting	All	Note	Verbal
12.	Financial Report	Gary Raphael	Note/ Support	Attached
13.	Any Other Business	All	Note	Verbal

Date and Time of the Formal ICS Board Meeting:
Wednesday, 5 May 2021 – 10.00 am to 12.30 pm, MS Teams Videoconference

Item 3

Subject to ratification at the next meeting

Minutes of a Formal Meeting of the ICS Board Held on Wednesday, 3 February 2020 via MS Teams

Present		
David Flory	Independent Chair	Lancashire and South Cumbria ICS
Dr Amanda Doyle	Chief Officer	Lancashire and South Cumbria ICS
Andrew Bennett	Executive Director for Commissioning	Lancashire and South Cumbria ICS
Jane Cass	Director for Performance, Assurance and Delivery	Lancashire and South Cumbria ICS
Talib Yaseen	Executive Director of Transformation	Lancashire and South Cumbria ICS
Andy Curran	Executive Medical Director	Lancashire and South Cumbria ICS
Carl Ashworth	Director of Strategy and Policy	Lancashire and South Cumbria ICS
Gary Raphael	Executive Director of Finance and Investment	Lancashire and South Cumbria ICS
Caroline Donovan	Chief Executive	Lancashire and South Cumbria NHS Foundation Trust
Karen Partington	Chief Executive	Lancashire Teaching Hospitals NHS Foundation Trust
Geoff Jolliffe	Clinical Chair	Morecambe Bay CCG
Graham Burgess	Chair	NHS Blackburn with Darwen CCG
Roy Fisher	Chair	Fylde Coast CCGs
Peter Gregory	Chair	NHS West Lancashire CCG
Dr Stephen Hardwick	Chair	Local Medical Committee
Neil Jack	Chief Executive	Blackpool Council
Cllr Shaun Turner	County Councillor	Lancashire County Council
Eileen Fairhurst	Chair	East Lancashire Hospitals NHS Trust
Denis Gizzi	Accountable Officer	NHS Chorley/South Ribble and Greater Preston CCGs
Aaron Cummins	Chief Executive Officer	University Hospitals of Morecambe Bay NHS Foundation Trust
Mike Wedgeworth	Non-Executive Director	East Lancashire Hospitals NHS Trust
Ian Cherry	Non-Executive Director	Greater Preston CCG
Isla Wilson	Non-Executive Director	Lancashire and South Cumbria ICS
Peter Armer	VCFS Representative	Voluntary Community Faith Sector
In Attendance		
Vicki Ellarby (from item 8)	Programme Director – System Reform	Lancashire and South Cumbria ICS
Alex Heritage	Provider Collaboration Board Director/Chief Executive	NHS Transformation Unit
Neil Greaves	Head of Communications and Engagement	Lancashire and South Cumbria ICS
Martin Hodgson	Deputy Chief Executive (Attended on behalf of Kevin McGee	East Lancashire Teaching Hospitals NHS Foundation Trust
Rebecca Malin	Programme Director	Lancashire Teaching Hospitals NHS Foundation Trust

David Bonson	Director of Urgent and Emergency Care	Lancashire and South Cumbria ICS
Jane Scattergood	COVID-19 Vaccination Director	Lancashire and South Cumbria ICS
Seamus McGirr	Director of Nursing and Urgent Care/ Director of Integrated System and Clinical Analysis	Midlands and Lancashire CSU / Lancashire and South Cumbria ICS
Nicki Latham	Deputy Chief Executive/Director of Strategic Partnerships	Blackpool Teaching Hospitals NHS Foundation Trust
Stephanie Betts	Business Affairs Lead	Lancashire and South Cumbria ICS
Maria Louca	Executive Assistant to Dr Amanda Doyle	Lancashire and South Cumbria ICS
Sandra Lishman	Corporate Office Co-Ordinator (Minute Taker)	Lancashire and South Cumbria ICS
Public Attendees		
Sandra Cudlip		
Tricia Whiteside		
Cllr Peter Moss		
Ann Highton		

Routine Items of Business	
1.	**Welcome, Introductions and Apologies** **Welcome and Introductions -** The Chair welcomed all to the formal meeting of the Integrated Care System (ICS) Board held virtually via MS Teams. The meeting was held in public; no questions had been raised in advance of the meeting. Members were asked to send any comments on the minutes of the previous meeting, held on 2 December 2020, to healthierlsc.corporate.office@nhs.net. The final copy would be circulated in due course. **Apologies -** Apologies had been received from Kevin McGee, Chief Executive of BTH and ELHT (represented by Martin Hodgson for ELHT) and Jackie Moran, Director of Integration and Transformation, West Lancashire CCG.
2.	**Declarations of Interest** **RESOLVED: All members declared an interest in System Reform.**
3.	**Key Updates/Messages** As part of the NHS key priorities - essentially focussing on managing and delivering system performance, managing COVID and the health of the population - the following updates had been requested for members. • **COVID-19 Vaccination Update –** Jane Scattergood (JS) presented an update on the programme across Lancashire and South Cumbria. Members noted that the data within the presentation was recorded 48 hours prior to this meeting being held. Highlights included:- o All hospitals were now classified as hospital hubs and can receive vaccine o Vaccination hubs had been commissioned to serve remote areas

- Over 250,000 first dose vaccinations had been administered to date, with around 12,000 second dose vaccine administered early in the programme
- Cohort penetration demonstrated that Lancashire and South Cumbria was achieving priorities, recognising some people were hard to reach. Postponed vaccinations were being reviewed daily. Today's figures for cohort penetration were as follows:-
  - Over 80s nearly 91%
  - 70-74 year olds around 57%
  - 65-70 year olds at 8.1%; this age range was not in the priority cohort
- The North West was a national leader in numbers administered to date
- There was sufficient vaccine and capacity in Lancashire and South Cumbria to continue to vaccinate at the current rate
- Confidence that the target for the top 4 priority groups would be met by 14 February 2021.

Mass vaccination sites were now open, however, there was an initial issue at Blackburn Cathedral Crypt with members of the public having to queue outside prior to their vaccinations. Capacity had been stepped up to meet the national model and guidance, and buildings had been arranged with no seating in order to move people through quickly to minimise the risk of viral transmission. However, the cold weather conditions experienced on the day had led to longer than modelled contact times, as people took longer to remove clothing in order to receive their injections. Consequently, queues had built up outside of the building. Organisations involved in the vaccination programme responded quickly by revising patient flow, lengthening appointment slots and providing extra facilities. The Cathedral had been very supportive, opening the Cathedral for people in the queue.

JS confirmed that following the revised way of working, the queuing issue had been resolved. As characteristics of patients change, the queuing process would be revised in order to administer more vaccine; younger people would flow through the building more quickly. Learning had been received and the new way of working was replicated in the other mass vaccination sites. The sites in Kendal and Ulverston were due to be live that week with the new processes being implemented from the start. An action learning group had been set up with representatives including ICS mass vaccination nurses, pharmacists and estates. The group meet twice weekly to gather the learning points, which would be fed back to providers to ensure implementation.

Isla Wilson (IW) requested an update on challenges with national data and information on the position in terms of differential uptake of vaccine, particularly in the BAME community. JS responded that access to national patient level data was not yet available. JS also mentioned that primary care could move the AstraZeneca vaccine from different venues to Primary Care Network (PCN) sites, thus providing the opportunity to work in buildings more accessible to communities.

Geoff Jolliffe (GJ) commented that planning was required in the Summer in relation to administering a further dose of vaccine next Winter if required. In response, JS reported that Public Health England was working on the epidemiology of viral activity, etc. It was unknown at that stage which cohorts required the COVID immunisation for variant strains each winter and whether this would become part of 'normal business' each year in the future.

Recognition of Amanda Doyle and Jane Scattergood's effective leadership was expressed by board members, noting that the integrity and tenacity displayed motivates the rest of the teams in working around problems and delivering solutions. Members acknowledged the role

of all of the team involved in the vaccination programme for the amazing support and work undertaken in the background.

Aaron Cummins enquired about flow for people receiving second dose vaccine and when guidance on delivery logistics was expected. JS responded that vaccine supply had been constrained nationally. The AstraZeneca vaccine was coming from UK plants, therefore it should not be affected by international politics. A second dose of the Pfizer vaccine had been protected for those who had received their first dose. Staff would be unable to administer the second dose of vaccine prior to 77 days following the first. Supply would be protected for people within the ICS over 70 years old, the clinically vulnerable and NHS workers.

Shaun Turner asked for assurance that nationally it was recognised that apart from the 4 cohorts across the country, Lancashire needed to retain parity of access to vaccine due to the levels of deprivation in the ICS. JS reported that she had recently held positive discussions with the national team directing the vaccination programme; enough vaccine was being received for the priority cohorts and Jane had highlighted the deprivation issues, recognising this would become more important as teams moved down the cohorts, as there were thought to be higher numbers of clinically vulnerable people than currently sit on the extremely vulnerable lists.

The Board also acknowledged the important role of primary care in the vaccination programme, noting however that it had taken capacity away from normal primary care business. At some stage consideration would be needed on how to protect primary care capacity to be able to restore services at the end of the pandemic. Currently primary care was attempting to deliver business as usual services alongside the vaccination programme for the population.

- **Operational Priorities – Key priorities for managing service and maintaining patient flow –** Seamus McGirr (SM) presented a review and forward look at the Lancashire and South Cumbria Winter Hub and Gold Command function.

  A level 5 national incident required that a 'Gold Command' be established and Lancashire and South Cumbria was asked to establish this in September 2020. The 'hub' proposal was supported by the Lancashire and South Cumbria Urgent and Emergency Care Network and was developed and hosted by the Midlands and Lancashire Commissioning Support Unit (CSU). Both the hub and formal Gold Command are based in Jubilee House, Leyland. Gold Command was established in the week commencing 5th October 2020, running 7 days a week from 8 am to 6 pm.

  The Critical Care Network were aligning processes with the rhythm and pace of Gold Command. Information required to understand and make decisions about the Lancashire and South Cumbria position as a system is received each morning with a system plan put in place prior to 5 pm the same day.

  Gold Command is fully supported by CCGs, Trusts, ICS, NHS England, CSU; all parties join daily calls offering help and support to the system. The purpose of Gold Command is to ensure the population is kept safe throughout COVID and beyond, practicing new ways of working and ensuring effective governance of developments. Gold Command looks to recover activities reduced through COVID, monitor and report any adverse impact of COVID on normal business, co-ordinate effort, support challenged system partners, improve agility/pace of decision making, turn analysis into insight and action, record and learn. All providers offer mutual

support, with a single data set that all organisations had signed up to. The hub has a good data flow from all Trusts, down to patient level. Gold Command remains a statutory requirement of CCGs to manage systems and performance, identifying risk and mitigations several days ahead. Using business intelligence tools, Gold Command monitors emergency department performance, hospital flow, discharges, medically fit for discharges, elective activity and cancellations, NWAS pressures, care home pressures, repatriations and mutual aid.

Ongoing challenges include 'load sharing' on non-elective pressures. It is likely that COVID would occupy 10% of beds for the next 5 winters. Risks remain that new silos are built rather than new systems for information and insights; local priorities militate against resourcing the 'bigger picture', and that organisations compete for the same resources rather than do it once, well.

From a local authority perspective, Shaun Turner acknowledged good examples of working together with a marked improvement in closer working and good relationships. Dividing lines continued to exist, along with budget silos that must be persevered in order to overcome.

Ian Cherry asked if there were any plans for recovery of 52-week waiters, performance on which for Lancashire and South Cumbria had been reported in a recent HSJ article as being below average. SM responded that performance could be seen on a real time collective analysis tool. The most productive sites in Lancashire and South Cumbria could be seen and a shared waiting list/operational patient targeting list (PTL) was about to begin. The system had very dispersed health communities with high deprivation, making this a difficult task. The focus was to move at pace and get patients treated. Amanda Doyle agreed to provide a detailed report on long waits for elective recovery at a future meeting.

ACTION: A DOYLE

Geoff Jolliffe noted that primary care was currently receiving support from CCGs and asked if in future it was possible that an absence of this support could lead to problems. SM responded that the primary and secondary care records could be joined and challenges identified down to postcode and individual GP practice level; there was a need to ensure this functionality was not lost.

SM explained that future information systems need to be designed 5 years ahead, however, it takes 8 years to change a workforce. Designing better systems can therefore lead to changes more quickly than re-training workforces.

Primary care had been very responsive when asked to provide operational support, and GPs had taken their turn to run Gold Command.

Graham Burgess noted that CCGs monitored performance and provided support to PCNs as they developed. This needed to be built into the new system of PCNs, ICPs, ICS; it is essential that primary care continues to be supported in future.

Amanda Doyle commented that CCGs would be disbanded over the next 12 months, however, this would not lead to a vacuum as support functions were developed at ICP level; this underlined the importance of ICPs.

Neil Jack commented that problem solving among the partners and a lot of work undertaken last year had been helpful. Consideration should be given for ways to support the population

	to be healthier, particularly with families and young people, around health visiting, with less focus on hospitals and becoming more joined-up. Denis Gizzi suggested to look at where more digital methodology could be utilised to provide more optimal care to the public. **RESOLVED: Members noted the updates on COVID Vaccination and Operational Priorities.**
4.	**Pathology Collaboration** Mark Hindle (MH) updated members on future expected issues, highlighting the significant progress made to date. The pathology collaboration was a mandated programme across the country, in response to which the acute hospitals in Lancashire and South Cumbria had brought pathology departments together to increase efficiency and effectiveness of services. An element of the business case is how we plan to provide pathology services in the future. The Comprehensive Investment Appraisal Model (CIAM), a tool to evaluate capital spending, was being utilised. Two key options had been modelled; using the existing upgraded estate to provide services, or moving to a single multidisciplinary hub. The collaboration needed to be clinically and scientifically led, organising a future service for patient benefit, with consideration being made to geographical distance, travel times, sample integrity and the requirements of local communities. Urgent work would continue to be undertaken at current hospital sites with routine work being shared out. The Pathology Collaboration Board would oversee the needs of hospitals; Kevin McGee and Karen Partington, Chief Executive Officers of acute trusts were the joint chairs of the Board. An outline business case for the hub was to be completed and presented to the Collaboration Board for endorsement at the end of March 2021. Following endorsement, the business case would be presented to Trust Boards for approval towards the end of March/early April 2021. In parallel, the business case would also be submitted to NHS Improvement for agreement to £31.2m capital to access the model, with a view to open the new model of service and hub in April 2023. Centralising and co-ordinating information management and equipment across the service was being looked at. Aaron Cummins felt that this re-design was needed and the new model would deliver real benefit. The site of the hub was causing an emotional response, which had been managed well as a system. Karen Partington reported that Boards had been cited throughout the planning stage and involving clinicians helped to move plans along at a pace. Martin Hodgson, a member of the Collaboration Board, stressed that although it was planned to move to a hosted entity to manage services, going forward this would be through the Board and all Trusts had signed up to this. MH emphasised that as the laboratory and service comes together, one Trust would be asked (volunteer) to host the service; a process of due diligence needed to be undertaken with the final decision being evidence based. In West Lancashire it was understood that pathology services were provided through Southport and Ormskirk, therefore, they were not part of this collaboration. Inevitably, any issues in

	West Lancashire that needed addressing would be looked at, however, ultimately they should be picked up with Cheshire and Mersey STP. MH acknowledged that engagement with primary care colleagues had to date been limited, however, discussions had been taken through the ICS Board, with Amanda Doyle, also a GP, being a member, and MH was prepared to have individual discussions with GPs if required. The Practice Manager Network had also been involved. MH hoped to hold collective conversations with GPs post COVID, in the meantime the communications strategy was being pursued for much higher levels of engagement with primary care and others. The Chair commented that this was an example of good and effective collaborative working across the patch. Future updates would be brought to this meeting, as appropriate. **RESOLVED: The ICS Board noted the update on the Lancashire and South Cumbria Pathology Collaboration.**
5.	**ICS Response to National Consultation - Transformation of Urgent and Emergency Care: Models of Care** Andy Curran introduced the agenda item seeking ICS Board approval to a formal system response to the NHS England/NHS Improvement Transformation of Urgent and Emergency Care (UEC) consultation. David Bonson (DB) reported that the 'Transformation of Emergency Care; Models of Care and Measurement' report was issued by NHS England/NHS Improvement on 15 December 2020, setting out the final recommendations on the UEC standards from the 'Clinically-led Review of NHS Standards'. It provided an opportunity for consultation on the findings and described in detail how the proposed measures align with the strategy for transformation of UEC services, building on experiences through COVID-19 and developing the long-standing vision for urgent care services. The existing UEC strategy was approved by the Joint Committee of CCGs in September 2019 and formed part of the Clinical Services Strategy, that the ICS Board recently approved. Excellent progress had been made in Lancashire and South Cumbria, including NHS 111 First, where all areas developed the service ahead of the national timescale. The challenge was to build on this to ensure a truly effective service. The NHS England/NHS Improvement document provided a refresh of the national strategy and it was proposed to use this to develop a clear operational delivery plan from now into next year. Considering system reform, this was to be used as an opportunity of how we work as a system around delivering a more integrated urgent care system. Urgent care comprises many different organisations who need to integrate to their best effect. As well as setting out priorities for UEC, the proposed new measures to be implemented and the measures would help to provide a whole system view of performance. It was proposed that the current 4-hour single headline measure of performance would be replaced with a bundle of measures, better describing a whole system; this would raise awareness of areas struggling within systems, both locally and at system level. The measures had been subject to a substantial level of clinical and public engagement in development processes and had been field tested in 14 acute trust sites and local systems across the country to ensure effectiveness, with a strong recommendation for implementation. The 10 measures describe the whole patient pathway, pre-hospital through to A&E, in-hospital, and system response indicators where there were whole system pressures.

	The consultation was due to close on 12 February 2021. A system response was proposed, based on conversations previously held with the Lancashire and South Cumbria Urgent and Emergency Care Network, CSU clinical teams, individual clinicians, NWAS and other stakeholders. The response would include an overarching statement comprising feedback received. Organisations and individuals had also been encouraged to respond separately. DB took members through a presentation showing performance against current measures. Ian Cherry asked how we were measuring the extent to which patients were being treated in the right place. DB responded that measures of attendance were recorded at the urgent treatment centres, the use of 111 First was key and part of this was early clinical assessment of the patient's journey through 111 First to get people into the right service. This indicated that people were getting early advice and support and being signposted to services. It was difficult to measure how effective other services are in dealing with responses and how well they are taken up. The impact on attendances could be measured and if rising or reducing in certain areas, planning could be improved. 111 First could book appointments within the emergency department or urgent treatment centre, which could also be monitored. Caroline Donovan asked that focus be maintained on mental health; recent history showed that a significant number of 12-hour breaches in A&E were mental health patients. Seamus McGirr (SM) commented that mean times show higher performance when lower acuity patients attended A&E. There was tension within the new guidance; if the number of people who attended A&E was reduced, the richness of the case mix of those remaining would be increased. A conversation was required to take forward self-care and minor illness treatment through GPs, given the current design limitations. SM highlighted that mental health services had been remarkable during COVID with timely response to A&Es and reductions in long stays. Mental health continued to be challenging but had improved dramatically. Geoff Jolliffe raised from a patient perspective that there were many different organisations involved in urgent care; it was hoped that the ambition was for patients to move seamlessly through the system with information following them and very clear agreement through different providers as to the best place for the individual patient. The Chair commented that explanations for poorer performance could not be justified by suggesting that patients do not understand where they should be seen and he hoped the improved processes would help to ensure that patients could be directed clearly to the right services. **RESOLVED: The ICS Board:-** - Noted the future models for urgent and emergency care being proposed - Noted that a delivery plan would be prepared by the Urgent and Emergency Care Network for approval at a future ICS Board - Noted the proposed changes to the measures of performance in the transformed urgent care system - Noted that work had commenced to understand current performance against the proposed measures at an ICP and ICS level - Commented on and approved the proposed ICS response to the national consultation.
6.	**Financial Strategy**

	The Chair reflected positively on the previous examples of significant challenges and pressure on the health and care system on this agenda and the success in rising to the challenges. Improvements in outcomes and access to care through the ensuing period had been seen. However, throughout Lancashire and South Cumbria expenditure had been significantly higher than the income available to deliver services. The position was unsustainable and undermined a lot of the success being seen in other parts of the care delivery agenda. The Chair emphasised that effective action was required to ensure the system collaborated on operational issues; opportunities should be taken to enable the system to improve performance whilst eliminating waste and taking out duplication. The Chair reminded members that the ICS Board is responsible for financial improvement. The Chair asked that the Board be more active in this area and that it must highlight areas of inefficiency and waste, using comparative data in order to resolve financial issues. Gary Raphael (GR) emphasised that an annual planning round needed to be set within the context of a longer-term approach. Senior leaders across the system should set savings targets. GR estimated that the gap next year could be around the £300m mark, which required resolution over the next 3 to 5 years. Ian Cherry expressed his fear of a system continually out of financial balance, suggesting the need to move away from addressing deficits and consider wider system reform. The opportunity for system reform was clear and the need was to move to a clinically led financial strategy (rather than a strategy imposed on clinicians by Directors of Finance) and in doing so to achieve system ownership. Isla Wilson suggested that as efficiencies and opportunities were being looked at a firm grip needed to be kept on transformation; ensuring the current transformation focus was not lost during this time. GR reported that benchmarking information did not indicate evidence of sufficient savings to cover the entirety of our likely deficit, however, there was enough evidence to make substantial inroads into the shortfall. The ICS Board was asked to embark on annual planning for the next financial year, setting the level of ambition for future years. GR suggested looking for £50m or £60m a year for the next few years, following which, discussion could be held as to how to assign responsibilities for delivery of savings. The Chair stated that the ICS Board must seek, through discussions, for the system to come forward with the best plan possible to deliver a reduction in the deficit while maintaining services. Organisations needed to be as ambitious, determined and as focused as possible to eliminate the deficit as quickly as possible. The Chair proposed that each organisation needed to contribute to an efficiency programme, under Gary Raphael's leadership. It was recognised that both managerial and clinical involvement would be required to look at efficiency, with structural elements identified separately. All organisations need to be in support of the strategy with commitment to resolve the deficit. Amanda Doyle, Gary Raphael and ICS would look at how to put a process in place to ensure this was resolved by the system, not the Directors of Finance. The Chair continued that this size of challenge would be addressed by looking fundamentally at all that we do and we should only do the things that are contributing to our priorities. This was not

	about clinicians and operational people signing up to reduce spend, but signing up to the need to change the way they work, which is more difficult. It was also mentioned that patients too can enable the NHS to save money by modifying behaviour, demands, lifestyle, etc. **RESOLVED:** Members of the Board:- • Noted the run rate exercise being undertaken by finance directors • Noted a subsequent analysis to extrapolate this information into 2021/22 and taking account of factors specific to that year to determine a potential level of spending should we not do anything to change the pattern of expenditure • Noted the plan to develop a system 'diagnostic' to help us to understand the reasons for and patterns of expenditure • Noted a need, during April 2021, to determine a process for general and financial planning to underpin ICS decision making on the allocation of resources from quarter 2 to quarter 4 (should that requirement be confirmed by NHS England/Improvement) • Noted the support being received to develop financial frameworks at ICS and ICP levels • Asked for the ICS lead/finance lead to develop a system reform process that ensured clinical and managerial ownership of the service changes necessary to meet our priorities while simultaneously reducing expenditure ***ACTION: A DOYLE/G RAPHAEL***
7.	**New Hospitals Programme (HIP2)** Rebecca Malin (RM) reported that Matt Hancock (Health and Social Care Secretary) had re-named the Hospital Improvement Programme – it was now to be known as the New Hospitals Programme; the narrative and associated communications would be updated accordingly. In December 2020, NHS England/Improvement and the Department of Health and Social Care had sent out a letter detailing how the national team wish to move forwards. Key points included:- • The Lancashire and South Cumbria scheme would take place from 2025 onwards • There is a need to prioritise the first 3-6 months of 2021 to progress the feasibility work, improving readiness and thinking about the future sustainable operational model • Progress the work to define the clinical need and demand projections against a standard set of assumptions • All market engagement with construction contractors to be aligned via the national team • A 'round table' meeting is anticipated to be held in the very near future to clarify the scope of the programme and deliverability. Plans were underway for a virtual summit to be held in April 2021, hosted by Amanda Doyle and Chief Executives from each organisation to consider how best to involve the workforce throughout the programme and deliver consistent messaging across the ICS. The communications and engagement plan had been enacted and the improved narrative would come into effect soon. RM was working with the Strategic Oversight and Clinical Oversight Groups to produce guiding principles to help inform decisions throughout the programme. Critical milestones would be seen later this month. Rebecca was working on this with company secretaries and the Joint Committee of Clinical Commissioning Groups. **RESOLVED:** The ICS Board noted:-

	• The key points in the letter from NHS England/Improvement and the Department of Health and Social Care, in particular, the request to focus on digital readiness • A change in the programme name from HIP2 to the New Hospitals Programme • The intention of a summit in April 2021.
8.	**System Reform** Andrew Bennett (AB) had previously updated members on system reform, driven by national proposals around the development of integrated care systems. AB highlighted key points from a previously circulated report, providing a further update on the range of activities taking place to implement the ICS' System Reform Plan. Work had continued to move forward and proposals for legislative change to Parliament were expected before Spring 2021. The narrative in relation to place-based partnerships was previously approved by the ICS Board and would continue to be developed, explaining the purpose of working at system, place and neighbourhood levels. Provider collaboration, place-based teams, inequalities reduction, financial improvement and urgent care services would be included in the developmental work. Once leaders across the system had provided their input, the draft narrative would be presented to the ICS Board. AB continued that discussions had been held with the Joint Committee of CCGs regarding evolution of decision making for commissioning during 2021/22. A proposal would be made to each CCG Governing Body in Lancashire and South Cumbria to develop a Strategic Commissioning Forum and sub-committee structure. Roy Fisher raised an issue on figure 1 within the report about system reform workstreams, looking at development and transactional arrangements over the next year. He felt this could input into some of the financial issues over the next year. Workstreams being brought into place for the forthcoming year could be brought into early conversations. Ian Cherry asked that CCG Lay Members were kept involved, as it was currently unclear where they would fit in with proposals. **RESOLVED: ICS Board members:-** • Noted the update on on the range of activities taking place to implement the ICS' System Reform Plan • Endorsed the proposals for the creation of a Strategic Commissioning Committee to support the development of decision-making within the ICS during 2021/22.
Other Business	
9.	**Agenda Items for the Next ICS Board Meeting** There were no items raised at the meeting.
10.	**Any Other Business** There was no other business raised.
Date and Time of the next Formal ICS Board Meeting: 3 March 2021 – 10.00-12.00 noon, MS Teams Teleconference	

Minutes of the Formal ICS Board
Held in Public
Wednesday 2 December 2020 10:00-12:00
Microsoft Teams Teleconference

Name	Job Title	Organisation
David Flory	Independent Chair	Lancashire and South Cumbria ICS
Dr Amanda Doyle	Chief Officer	Lancashire and South Cumbria ICS
ICS Executive Directors		
Andrew Bennett	Executive Director for Commissioning	Lancashire and South Cumbria ICS
Jane Cass	Director for Performance, Assurance and Delivery	Lancashire and South Cumbria ICS
Talib Yaseen	Executive Director of Transformation	Lancashire and South Cumbria ICS
Andy Curran	Medical Director	Lancashire and South Cumbria ICS
Carl Ashworth	Strategy and Policy Director	Lancashire and South Cumbria ICS
Jackie Hanson	Director of Nursing	Lancashire and South Cumbria ICS
Gary Raphael	Executor Director of Finance	Lancashire and South Cumbria ICS
ICP Leads		
Kevin McGee	Executive Lead	Blackpool Teaching Hospitals NHS Foundation Trust
Caroline Donovan	Executive Lead	Lancashire and South Cumbria NHS Foundation Trust
Karen Partington	Executive Lead	Lancashire Teaching Hospitals NHS Foundation Trust
Geoff Jolliffe	Clinical Chair	NHS Morecambe Bay CCG
Alex Heritage	Chief Executive	NHS Transformation Unit
Dr Stephen Hardwick	Chair	Local Medical Committee
Neil Jack	Chief Executive	Blackpool Council
Eileen Fairhurst	Chair/Provider Collaborative Chair representative	East Lancashire Hospitals NHS Trust
Graham Burgess	Chair	NHS Blackburn with Darwen CCG
Peter Gregory	Chair	NHS West Lancashire CCG
Denis Gizzi	Accountable Officer	NHS Chorley South Ribble and Greater Preston CCGs
Aaron Cummins	Chief Executive Officer	University Hospitals of Morecambe Bay NHS Foundation Trust
ICS Non-Executive Lay Members		
Mike Wedgeworth	Non-Executive Director	East Lancashire Hospitals NHS Trust
Ian Cherry	Non-Executive Director	Greater Preston CCG

Isla Wilson	Vice Chair/Non-Executive Director	Lancashire and South Cumbria ICS
VCFS Representatives		
Peter Armer	VCFS Representative	VCFS
Local Authority Councillor Representatives		
Shaun Turner	Councillor Representative	Lancashire County Council
In Attendance		
Neil Greaves	Head of Communications and Engagement	Lancashire and South Cumbria ICS
Louise Barker	Senior Communications and Engagement Manager	Lancashire and South Cumbria ICS
Vicki Ellarby	ICP Programme Director	Fylde Coast ICP
Sarwar Shazad	Non-Executive Director	Lancashire and South Cumbria NHS Foundation Trust
Emily Kruger	Head of Programme Management Office	Lancashire and South Cumbria Foundation Trust
Rebecca Taylor-Rossall	Digital Communications Manager	Lancashire and South Cumbria Foundation Trust
Jane Scattergood	Director of Nursing and Quality/ Covid-19 Vaccination Director	Fylde Coast CCGs/ Lancashire and South Cumbria ICS
Rebecca Higgs	Business Manager	Lancashire and South Cumbria ICS
Maria Louca	Personal Assistant to Dr Amanda Doyle	NHS Fylde and Wyre CCG/ Lancashire and South Cumbria ICS
Pam Bowling	Governing Body Secretary (minute taker)	NHS Fylde and Wyre CCG

Item	Note	Action by
1	**Welcome, Introductions and Apologies** David Flory welcomed everyone to the meeting which was being held in public for the first time – an important step for openness and transparency. Members of the public had been invited to raise questions in advance of the meeting, although none had been received. Apologies for absence were received from Roy Fisher, David Bonson, Martin Hodgson, Ebrahim Adia, Graham Urwin and Claire Heneghan.	
2	**Declarations of Interest** It was recognised that members of the Board had a conflict of interest in the agenda item on system reform.	
3	**Minutes from Previous Meeting and Matters Arising – 4 November 2020** The minutes of the previous meeting were reviewed and were accepted as a true record subject to the following amendments; 1) In attendance: Jerry Hawker, Chief Officer (remove – 'on behalf of Sue Smith') 2) Removal of Professor Ebrahim Adia from the attendance list The updated matters arising/action log was noted.	
4	**Key Updates/Messages** Dr Doyle reported that the NHS 111 First programme - which encouraged people to dial 111 rather than attend A&E and subsequently diverted to alternative services as	

	appropriate - had been successfully rolled out across the patch. Initial feedback from both patients and staff had been positive. This was an initial 'soft' launch - a media campaign would be rolled out over forthcoming weeks to raise awareness to the approach. In response to a question Dr Doyle said it was too early to be able quantify the impact of the programme on A&E activity. 'Long COVID' services are being established in Lancashire and South Cumbria hosted by Lancashire and South Cumbria Foundation Trust, although a number of providers are involved in delivering support. These services assess the needs of individual post-COVID infection and signpost patients to appropriate ongoing support for management of a range of symptoms, including mental health (behavioural and organic), respiratory and neuro-muscular problems. Virtual wards are being rolled out across the patch whereby patients with COVID are managed at home, monitoring and reporting on their own oxygen levels. Dr Doyle was also pleased to report that the Safeguarding leads across Lancashire and South Cumbria, who recently attended the Board to seek support for a system wide approach to the safeguarding agenda, have won the NHS Safeguarding Initiative at the 2020 HSJ Patient Safety Awards. On 26 November 2020, NHSE/I published a document 'Integrating Care: Next Steps to building strong and effective integrated care systems across England'. Dr Doyle explained that the guidance aligns well with a lot of work that the ICS has already done. The paper seeks views on proposed options, and an ICS response will be developed to be agreed by the Board. Dr Doyle encouraged individual organisations and appropriate groups to also review and respond to the consultation.	
Sustainability		
5	**Current Financial and Operational Overview** <u>Phase 3 financial plans</u> Gary Raphael updated the Board on the conclusion of the phase 3 planning process following the allocation of system growth funding. Updated Lancashire and South Cumbria (L&SC) aggregated phase 3 financial plans were submitted to the Regional Team on 18 November 2020 and met the requirement set by the System Leadership Executive (SLE) of a £90m shortfall against the financial envelope of £1.74bn for the second half of the year. The Board was asked to endorse and approve the allocation of growth funding in line with the decision of the SLE to achieve the financial positions as outlined in table 1 of the report. Mr Raphael explained that the SLE noted that for tactical financial reasons ensuring CCG plans were balanced whilst deficits were shown in provider positions was the best option for the system, given that CCG overspends must be recovered in the following year, whilst trusts were able to borrow at 3.5% interest rate with no immediate requirement to repay the debt. On this basis, phase 3 is concluded and the Regional Team has confirmed that although the plans remain unaffordable, they are accepted as the final submission. By 4 December 2020, organisations are required to submit a revised forecast spend for the year to 31 March 2021 and the ICS finance team is working with Regional finance managers and organisational finance teams to ensure that there is a consistent approach to these estimates. Some of the issues which were suppressed in the phase 3 plans to meet the requirements of that scenario will be expressed as part of the wave 2 response - however, if there is a risk of exceeding the £90m deficit position on the financial envelope, there will need to be a decision made on what can be done to stay	

	within that figure. Mr Raphael added that plans for 2021/22 would need to start to be developed and reminded the Board not to lose sight of the system's underlying deficit. Mr Raphael concluded that in response to recommendations from the Finance Advisory Committee (FAC) and after having discussed the rationale for allocating system growth funding to assure budgetary balance in CCGs, the SLE had endorsed the approach to distributing growth funding and had also agreed that rather than holding a small reserve at system level (£8m) the deficits in providers should be reduced to the lowest level possible, as shown in the table on page 2 of the report. Members discussed the content of the report and supported the approach and position reached. Comments were made about the pressures and increased demand on mental health services and gaps in funding. The Chair suggested that a report on this specific issue would assist colleagues in understanding the challenges faced. Reference was made that the paper did not include Covid related costs for the second half of the year - therefore there was a need for the system to make strong representations in this regard and to have a clear understanding and clarity on the current gaps across the system. Dr Doyle referred to the huge piece of work around recovery and restoration, allowing staff to recover and building the workforce. There was a need to restore the system to a more balanced financial position over a period of time according to a plan which was deliverable. The Chair thanked everyone for their contributions to the debate and stressed the importance of the decisions that are made between now and the beginning of the next financial year in order that the position is as good as it can be and individuals are geared up to succeed in terms of the huge challenges faced. <u>Phase 4 planning</u> Carl Ashworth set out the planning expectations for 2021/22. Phase 4 planning guidance is expected in two parts, an initial letter setting out some of the expectations from NHSE/I about how the NHS will operate in 2021/22 and then detailed planning guidance at the end of January 2021. It is expected that the guidance will set out a system oversight framework to reflect an enhanced role for systems and preparation for powers and duties set out in the transition year towards April 2022. There will be a need for a continued balance between system response to Covid and recovery and restoration, and business as usual. It is expected that financial, activity, performance and workforce plans will need to be developed by mid-March 2021. It was proposed that the next Board meeting in January 2021 would provide an opportunity for a further conversation in advance of receipt of the detailed guidance due later in the month. **RESOLVED** **That the ICS Board endorse and approve the allocation of growth funding in line with the decision of the SLE to achieve the financial positions outlined in table 1 of the paper.**	
6.	**Covid Vaccination Update** Jane Scattergood provided an update to the Board on the development and mobilisation of the L&SC ICS COVID vaccination programme as follows:	

- Pfizer/BioNTech vaccine had met regulatory approval in the last 24 hours.
- During pre-regulatory phase plans were being developed for a whole adult vaccination programme and these plans can now be firmed up at pace.
- The Pfizer vaccine is challenging in terms of storage and transportation. The Oxford/Astra-Zeneca vaccine is more traditional and allows greater flexibility – this is expected to be approved before the end of the year. This will be easier to dispense to primary care and to Care Homes and housebound patients.
- Blackpool Teaching Hospitals and Lancashire Teaching Hospitals have ultra-low temperature freezers capable of storing the Pfizer vaccine and will receive initial supplies to begin vaccinating over 80s, high risk NHS staff and Care Home residents and staff.
- Delivery of vaccine then expected to flow to other hospital sites.
- Work underway to identify PCN sites to focus on vaccination of over 80s.
- Across Lancashire and South Cumbria there are a number of community site vaccination centres and three large scale centres being mobilised
- The system will create management oversight centre to deliver vaccine at large scale sites.
- Lot of support received from provider trusts who will register venues with CQC and work as a system in terms of governance, supply chain and clinical waste management work.
- Expect to vaccine over 50s by the end of February and all adults by the end of April.

The Chair thanked Jane for the presentation and acknowledged the huge amount of work done by Jane and her colleagues in preparing for the Vaccination Programme.

Reference was made to media attention relating to primary care about renegotiating their terms and conditions in order to deliver the vaccine and clarification was sought as to whether this was a risk to the programme. Dr Doyle advised that there had been a good response from General Practice - assurance had been given that they would not be impacted financially and that the system would work with and support them. A question was asked about the need for two doses of the vaccine and if there was a risk around the gap. In response it was confirmed that booking was being managed via a central portal for the two doses with a tracking and monitoring system. The VCFS representative offered support of mobilisation and Jane outlined the work that was already taking place in terms of capturing the volunteering response.

Building the Future System

7 **Clinical Strategy**

Andy Curran referred to the discussion at the last meeting when the Board had endorsed all the recommendations of the Clinical Strategy and to a further discussion held at the ICS Executive meeting to determine how to implement the Strategy, using comments and recommendations from SLE and Board for direction. Mr Curran presented the report which described how the ICS Executive proposed to implement the Clinical Strategy and build it into future planning. A series of high-level key principles were presented to guide current and future workstreams.

Mr Curran stressed the importance of the Clinical Strategy being a living document and recognised that it cannot stand alone as an isolated piece of work – it needs to be fully embedded into the ICS Strategy and relate to future planning and financial strategies. Engagement will be undertaken as part of the ICS Strategy work and through existing leads.

	Attention was drawn to the 6 pillars of the strategy, namely Health and Wellbeing of our communities, Living Well, Managing Illness, Urgent and Emergency Care, End of Life Care and Workforce - it was noted that work will be undertaken to map all the current work already underway to each of these pillars. The 5 high level principles were also described to enable future workstreams to be guided by the Clinical Strategy and the Board was asked to continue to support these principles. Members discussed the presentation and the following comments were noted. Reference was made to Principle 1 about embedding population health management and the need to include equality and diversity and remove health inequalities. Embedding digital solutions was welcomed but it was recognised that there would be a need for investment in this area. Reference was made to the first meeting of the People Board and the recognition that there will not be enough staff to deliver current service models in the future and a that there is need to change how things are done through redesign of pathways. This will require us to challenge the culture, behaviours and the way that clinicians work – an opportunity to grasp the future, do things differently and not hold on to the past by considering: • What are we going to stop doing? • What are we doing to do differently? • What are we doing to deliver in a different place? The Chair welcomed these three questions and suggested this was a helpful structure and framework for members to consider alongside the Strategy **RESOLVED:** **(1) That the Board note the progress made;** **(2) That the Board support the embedding of the clinical strategy into future planning processes;** **(3) That the Board receive future mapping of the workstreams to the 6 pillars** **(4) That the Board continue support of the 5 high Level principles.**	
8.	**System Reform: A common strategic narrative for Integrated Care Partnerships (ICPs) within the Lancashire and South Cumbria Integrated Care System (ICS)** Geoff Joliffe presented the report and asked the Board to formally approve the common ICP strategic narrative which had been updated to reflect feedback from the ICS Board at its last meeting and with continued extensive engagement across the ICS partnerships. Dr Joliffe stressed the need to move forward at pace on this element of system reform and highlighted the tight timetable moving forward. The Chair highlighted two key elements of ICP development: the importance of getting it right at 'place' level and the collaboration between providers taking a system view around many of the critical issues. Vicki Ellarby described the key changes in the common ICP strategic narrative, including key extracts from the NHSE/I Integrating Care document and the development of a separate executive summary. Following approval, a more user-friendly version of both the ICP strategic narrative and executive summary would be created to support the next stage of the programme. Step 2 of the work was described as agreeing and scoping the work programmes for ICP development which was to be approached in two phases: work programmes that could be scoped and begin implementation prior to receipt of NHS phase 4 guidance;	

	and work programmes that could only be partially scoped and were unlikely to begin implementation prior to receipt of NHS Phase 4 guidance. Delivery of the plan will be overseen by the ICP DAG with outputs reported to the System Leadership Executive and onward to the ICS Board where required. The Chair thanked Geoff and Vicki for the update and clarity on the direction and emphasised the need to move on with this programme of work. Dr Doyle added her appreciation for the work undertaken by the team and reiterated the need to understand that ICPs are not a 'son of CCGs' - they are a description of how partners in a place will work together at place to deliver shared objectives. It was noted that there was a range of maturity of PCNs but there was a strong group of PCN leads working with teams inputting into how this will work and are a key part of ICPs. There has been a lot of at scale working of PCNs which has provided confidence and they need to be allowed to continue to mature. Jane Cass referred to the significant amount of work that had taken place since the last meeting and supported Mr Joliffe's comments about not seeing this as a binding contract but the need to liaise and respond to local partners in developing the 'place'. Jane stressed the importance of the OD piece and was pleased to see that this was a priority area with clear alignment to the NHSE/I document. Kevin McGee referred to this being only part of the system development. There is an overall concept of what is being created across Lancashire and South Cumbria and ICP development is part of this wider piece of work. Karen Partington supported the need to get on with this work as many ICPs had already made good progress. Graham Burgess commented on the need for primary care to move forward at the same pace as ICPs and for the ICS to hold the ring on these two pieces of work to ensure integration and co-ordination. It was also vital to get local government and voluntary sector involved in discussions at place-based level. Dr Joliffe confirmed that the LMC would be involved at Step 2 of the process and confirmed that there would be appropriate communication across the whole system. Dr Joliffe thanked colleagues for the comments and said he was encouraged by the response and support. **RESOLVED:** **That the ICS Board:** **(1) Approve the common ICP strategic narrative and the executive summary noting the amendments made during November 2020 and strong alignment within the document 'Integrating Care: Next Steps to building strong and effective integrated care systems across England' issued by NHSEI;** **(2) Note the progress made with actions relating to Step 2;** **(3) Approve the continuation of Step 2 as outlined in the plan on a page, with support from NHSEI;** **(4) Note the publication of the National guidance which will continue to inform the development of ICPs and the wider ICS (Integrating Care: Next Steps to building strong and effective integrated care systems across England' issued by NHSEI - 26 November 2020).**	
9	**Strategic Assurance Framework** Gary Raphael presented the report which identified the need for a system assurance framework to be established to support the continued development and integration of the Lancashire and South Cumbria ICS partnership. In addition, an update was	

	provided on the strategic risks and issues identified and plans to make improvements to the management of this aspect of assurance, recognising this as an early phase of development work. **RESOLVED:** **(1) That the ICS Board members supported and agreed to engage with the development of a system assurance framework (including strategic objectives)** **(2) That the ICS Board support the establishment of a group, including ICP representatives to progress this work on behalf of the ICS Board** **(3) That the ICS Board support the approach to the strategic risks, as the first phase of the system assurance framework.**	
Performance and Outcomes		
10.	**Finance Report** Gary Raphael reported on the month 7 financial performance for L&SC partners and ICS central functions and explained that as the ICS transitions into the new financial regime, it will be monitored against a fixed financial envelope. The work on phase 3 financial planning spanned the period of reporting for month 7 and as such the month 7 tables do not take account of the new planning figures outlined later in the report. These will be included for month 8 reporting which will enable reporting on performance against the financial envelope. Mr Raphael explained that deficits will no longer be covered by top up payments as the financial envelope has been amended to include the ICS's share of system top up funding, Covid funding and growth funding. However, there were some costs that would attract national funding, such as testing, mass vaccination, hospital discharge programme and some independent sector costs. Attention was drawn to Table 5 in the report which showed how the months 7 to 12 financial envelope of £1.7b fit into the context of the overall L&SC system funding of £3.3b for 2020/21. With regard to capital, there was no significant change to the position reported at the last Board meeting. It was noted that, at the start of the year, before Covid struck, the system was reporting that it was just under £180m adrift of its control total of minus £97m, a £277m deficit. It is likely that resources from 2021/22 onwards will remain constrained as the economy struggles to recover. Attention was drawn to the clinical strategy which will assist in addressing at least one aspect of the deficit, which can be analysed as generating further efficiency; Service/delivery models which are most amenable to changes signalled in the clinical strategy; and structural change. **RESOLVED:** **That the Board note the updates to the financial position and look forward to involvement in articulating the ICS's ambitions for the forthcoming short and medium term planning rounds.**	
For Information		
11.	**Provider Collaboration Board Update** Eileen Fairhurst reported that the last meeting of the PCB was held on 27 November 2020 and focussed on a number of strategic issues relevant to the whole population. The NHSE/I publication on System Reform was welcomed by the Board for the benefit	

	of the whole ICS. A presentation was received on HIP2 and the strategic importance of this for the whole of the Lancashire and South Cumbria population was recognised. The Board also received positive assurance on the CAMHS services and endorsed key recommendations relating to system transformation work programmes including stroke, vascular and diagnostic radiology. The PCB will maintain oversight of these programmes. The Board is also very focussed on making sure there is increased alignment between the work of the Provider Collaborative Board and ICPs. **RESOLVED:** **That the contents of the report were noted.**	
12.	**High Level Programme Summary Report** The monthly updated summary position of the progress with delivery of ICS programmes was received. **RESOLVED:** **That the contents of the report were noted.**	
13.	**EU Exit Planning** Gary Raphael advised that there were no formal requirements relating to EU Exit placed on the ICS and provided an update on system actions. There is a very strong procurement team in Lancashire and South Cumbria who are focussing on the continuation of supplies in the NHS. Operationally 160 supply lines have been secured which represents 70% of supplies – for the other 30%, the procurement team are ensuring that business continuity plans are in place. There is a move towards a situation where a 'just in time' approach is being replaced with a position of contingency stock to take account of any delay. Staff that need to be registered to work in the NHS in England are being supported to ensure that they can remain. Detailed update reports are being provided to the SLE. The Chair asked that an updated report be provided at the next formal meeting in public in February.	
14.	**Agenda items for the next meeting** None noted.	
15.	**Any Other Business (AOB)** There being no futher items of business, the Chair commented that he was encouraged by today's meeting, in particular the positive way that people contributed and supported each other and constructively challenged. This support would essential to help get through the next period of significant change, subject to changes in legislation.	

Date and Time of the Next Informal ICS Board Meeting

Wednesday 13 January 2021 – MS Teams meeting 10:00-12:00

ICS Board – Action/Decision Log (Updated 10 February 2021)

Item Code	Title	Responsible Lead	Status	Due Date	Progress Update
ICSB210203 – 06	Financial Strategy – To look at strategy/process for efficiency plan, to include all organisations	Amanda Doyle Gary Raphael	In progress	03.03.21	
ICSB210203 – 03	Provide detailed report on long waits for elective recovery	Amanda Doyle	In progress	Future meeting	
ICSB210203 – 03	Gain assurance on and monitor differential vaccine update, especially in BAME populations (Action raised following the meeting on 3 February 2021)	Jane Scattergood Isla Wilson	In progress	03.03.2021	03.02.21 – At today's meeting, Jane clarified access to national patient level data is not yet available.
ICSB201202	Ensure process for equality impact assessments	Talib Yaseen	In progress	03.03.2021	
ICSB201202	Paper and analysis on the impact of the financial allocation of funding to be brought back to future Board meeting	Gary Raphael	In progress		

Healthier Lancashire & South Cumbria

ICS Board

Date of Meeting	3rd March 2021
Title of Paper	System Financial Recovery Programme
Presented By	Gary Raphael
Author(s)	Gary Raphael, Paul Havey
Agenda Item	5
Confidential	No

Purpose of the Paper

This paper proposes an approach to a system financial recovery programme developed by finance directors and recommends the areas where the system could generate system level savings in 2021/22.

Executive summary

In March 2020 the ICS reported in its draft operational plans a deficit of £277m, which is likely to have deteriorated by April 2021 because planned savings could not have been delivered fully during the response to Covid. The deficit position of the ICS must be rectified.

Finance Directors have recommended proposals for a Financial Improvement Board that will develop a Financial Improvement Programme, but this will not deliver proposals in time to enable the ICS to improve its finances from early 2021/22. Therefore the paper identifies a range of potential schemes that could be developed over the next two months for implementation from early 2021/22 and enable the system to improve its underlying financial position.

Recommendations

i. The ICS Board is asked to:
ii. **Note** the financial position of the ICS's NHS organisations as reported in the last draft planning returns from March 2020.
iii. **Approve** the establishment of a Financial Improvement Board, chaired by the ICS Chief Officer. This will draw on various system-wide resources and groups to develop a financial improvement programme on the back of a system diagnostic to enable implementation of any early schemes during 2021/22.
iv. **Support** the convening of the Investment Committee and look for early confirmation that the rules underpinning investment and spending decisions are validated, agreed and applied.
v. **Note** the historic levels of CIP and QIPP planned by the system and the opportunity to implement any schemes held in abeyance during the response to Covid, together with new schemes that have been developed in the background more recently.
vi. **Set** for the system an ambitious savings target of 5% or £200m for 2021/22, noting that attribution of targets to specific sectors or ICPs will need to be determined during the forthcoming planning process.
vii. **Agree** that the system-wide schemes and the amounts identified in the report,

	and/or other alternatives that may arise from subsequent discussions, are developed in the next two months to enable implementation from early 2021/22.
viii.	**Ensure** efficiencies and cost reductions driven by changes in practice over the past 12 months are identified and embedded in current practice and a similar rapid improvement process is adopted for 2021/22.

Governance and Reporting

(List Other Forums that have Discussed this Paper)

Meeting	Date	Outcome
FAC for aspects of this paper	12/02/2021	The FAC supported the proposals for a system diagnostic programme and agreed the investment/disinvestment principles shown in appendix 1

Conflicts of Interest Identified

None

Implications

Quality Impact Assessment Completed	**Yes**	☐	**No**	☐	**N/A**	☒
Equality Impact Assessment Completed	**Yes**	☐	**No**	☐	**N/A**	☒
Privacy Impact Assessment Completed	**Yes**	☐	**No**	☐	**N/A**	☒
Financial Impact Assessment Completed	**Yes**	☐	**No**	☐	**N/A**	☒
Associated Risks	**Yes**	☐	**No**	☐	**N/A**	☒
Are Associated Risk Detailed on the ICS Risk Register?	**Yes**	☐	**No**	☐	**N/A**	☒
If Yes, Please Provide a Risk Description and Reference Number	N/A					

Healthier Lancashire & South Cumbria

System Financial Recovery Programme

Introduction

1. At the last Board meeting I reported that the ICS's financial deficit in 2021/22 could be within the range of a £240m to £340m, based on outturn spending forecasts for 2020/21 and depending on the amount of any non-recurring allocation support received from Treasury (as indicated by NHSEI nationally in outline planning guidance on 23rd December). This sum is consistent with the position reached a year ago prior to Covid (a £277m deficit **after** £163m savings had been planned) albeit that it is worse because in 2020/21 we, like all other systems, have not sought to fully implement cost improvement programmes while we have been responding to the impact of Covid 19 on health and social care services. This estimate will need to be validated and refined as we enter the formal planning process for 2021/22.

2. Detailed planning guidance for 2021/22 has been delayed until early in April 2021 to allow health services some recovery time following a difficult winter. Consequently, it has been proposed nationally that the financial regime operating in the second half of 2020/21 will continue into the first quarter of 2021/22, with the aim of implementing any new national arrangements and local plans from July 2021 (Q2).

3. Whatever national targets are set for Lancashire and South Cumbria ICS, it is clear that we have a profoundly challenged financial position requiring a longer term approach to be agreed, while we simultaneously ensure that in the shorter term substantial progress is made towards achieving any improvement targets we set for ourselves and those set by NHSEI. This paper summarises an approach to both the short and longer term agendas for approval by the ICS Board.

Position reached in March 2020 draft operational plans

4. The tables below summarise the financial position reached by the ICS last March 2020, before the NHS response to Covid 19 overturned extant planning assumptions and requirements.

5. The financial position across sectors and ICP footprints was reported as follows:

2020/21 Draft Operational Plans as at 05/03/2020

Sector	QIPP/CIP	Surplus / (Deficit)
	£m	£m
CCG's	72.1	(24.2)
Trusts	91.2	(253.4)
TOTAL	**163.3**	**(277.5)**

ICP	QIPP/CIP	Surplus / (Deficit)
	£m	£m
Central Lancashire ICP	32.0	(100.9)
Fylde Coast ICP	24.4	(48.6)
Morecambe Bay ICP	35.8	(89.0)
Pennine Lancashire ICP	42.5	(35.1)
West Lancashire MCP	4.9	(2.4)
Lancashire & South Cumbria FT	11.2	(1.3)
North West Ambulance Trust	12.5	(0.2)
Total	**163.3**	**(277.5)**

6. The position across trusts and CCGs:

NHS Blackburn with Darwen CCG	7.6	1.3
NHS Blackpool CCG	3.5	7.4
NHS Chorley and South Ribble CCG	7.6	(13.4)
NHS East Lancashire CCG	17.9	0.0
NHS Fylde and Wyre CCG	4.5	2.0
NHS Greater Preston CCG	8.4	(19.0)
NHS Morecambe Bay CCG	17.7	0.0
NHS West Lancashire CCG	4.9	(2.4)
Sub-total CCGs	**72.1**	**(24.2)**
Blackpool Teaching Hospitals NHS FT	16.4	(58.0)
East Lancashire Hospitals NHS Trust	17.0	(36.4)
Lancashire Care NHS FT	11.2	(1.3)
Lancashire Teaching Hospitals NHS FT	16.0	(68.5)
North West Ambulance Service NHS Trust	12.5	(0.2)
University Hospitals Of Morecambe Bay NHS FT	18.1	(89.0)
Sub-total providers	**91.2**	**(253.4)**
System Total	**163.3**	**(277.5)**

7. The Board will note that deficits sat primarily with providers, representing the shortfall between income based on national tariffs and expenditure. 2020/21 was the first year in which it was forecasted that more than one CCG in Lancashire and South Cumbria was to slip into deficit. A position where CCGs were mainly in balance and trusts in deficit was not replicated across England; the picture was mixed in the different parts of the country.

8. The Board will be aware that in line with the historic pattern in Lancashire and South Cumbria and the incentives inherent within this year's financial regime, CCGs have planned to stay in balance while the deficits have manifested in providers.

Nevertheless, there is agreement within our System that deficits must be regarded as system deficits (ICP and ICS) and not left for resolution solely by the organisations within the deficits happen to sit.

9. The agenda we face as a system is not to hope for more income to fund our costs, but to change how our services are configured and organised within the amount of money we actually receive as a system, while improving health outcomes and service quality – a major challenge indeed.

What opportunities exist to make better use of resources?

10. In last month's report I identified what opportunities RightCare and Model Hospital analytics provided in relation to potential improvements in cost effectiveness and cashable savings. I reported that the analyses were indications of places to look, rather than the solutions we actually need, this latter being something we must develop ourselves.

11. Overall I advised that if one excludes from consideration any double counting of savings opportunities identified by the two methodologies, we may be able to count on up to £200m savings, which is short of the amount we need but nevertheless represents a substantial proportion of the total of up to £340m that may be required. The choices facing us as a System are which opportunities should be tackled first and what collective action is required?

System diagnostic

12. Whilst the finance community has previously identified potential savings opportunities, the pressure for change has not been sufficient to enable a substantial improvement in system finances to be achieved. Therefore finance directors are recommending that a Financial Improvement Board is constituted as part of the ICS Governance structure. This would be responsible for a Financial Improvement Programme (FIP) that would be sponsored and chaired by the ICS Chief Officer. The FIP would also require a programme director which should be at CEO/AO level of seniority.

13. The FIP would be supported by:
    - A dedicated finance group from Trust/CCG deputies to undertake detailed/forensic financial analysis to identify opportunities that fall into the following categories:
        - Individual organisation efficiency programme
        - ICP wide efficiency programme
        - ICS wide efficiency programme
        - Potential areas requiring regulator support
    - Reconstituted hospital cell = provider collaborative

    - Strategic commissioning committee of the ICS
    - Investment Committee
    - Work programmes that cut across system(s)

14. It is also essential that this is supported by the System Leadership Executive to:
    - ensure buy-in from medical, nursing and operational leads including time to engage
    - ensure that the ICS strategy informs and supports this work
    - develop a communication strategy to ensure this system wide approach prevails ahead of individual organisational needs
    - engage with regulators and local authority bodies where significant change is required
    - inform future capital expenditure

15. An important aspect of governance would be input from an independent advisor with knowledge of other systems, who could provide an external perspective on outputs from our processes and interpretations and judgements made by us.

Stratification of the components of excess expenditure and costs/timing issues

16. A fundamental aspect of any FIP outputs is the ability to classify and distinguish cost analyses across structural, service offer and efficiency components. Clearly it would be expected that efficiency programmes that enable the system to deliver the same or better services for less cost would be first for implementation, while changing service offers/pathways and especially structural changes are more likely to take much longer to achieve, particularly if regulator support/public consultation is required.

17. Similarly, while we are undertaking the diagnostic we must ensure that we do nothing to worsen our financial position, which requires us to agree rules about major spending decisions and capital investment. To that end it is planned to convene the Investment Committee, whose first task will be to develop rules for the consideration of large spending/capital proposals, prior to assessing a pipeline of specific proposals. Rules could be that:
    - Any proposals for service changes must result in net reductions to recurring expenditure as a system (except in any rare circumstances that are agreed by the ICS Board and which must be accompanied by substantial benefits e.g. saving lives)
    - Any extra non-recurring spending (financed from a change management reserve established at ICS level) must support proposals that will result in recurring reductions

18. In addition to the above, the Finance Advisory Committee has agreed a set of principles to underpin investment and disinvestment decisions, which are shown in appendix 1. These will need to be tested and validated by the Investment Committee.

19. The system diagnostic cannot be concluded in time to inform 2021/22 plans, but the ambition will be to have completed a first stage output in time for agreed schemes to be in place by the end of 2021/22, to ensure we are moving into 2022/23 with a strategic programme of savings.

20. In the meantime and for implementation during 2021/22, a short list of major efficiency schemes must be agreed and started during the year to enable the ICS's aggregate position to be significantly better by 31st March 2022 than it was at the start of the year. This requirement, combined with the rules mentioned in paragraphs 17 and 18 above, should enable an estimate about our best efforts to be made for planning purposes. This will be a key aim of the forthcoming planning round to be endorsed and approved by the ICS and organisational boards and governing bodies.

Proposals for short term savings

21. In 2020/21 plans a total of £163m savings (including NWAS) were identified in order to reach a deficit position of £277m. Without these planned savings a 'do-nothing' scenario would have been a deficit of £441m. Clearly the ICS must establish a new baseline taking account of our experience of Covid in order to enable savings targets to be set, which will be determined as part of the forthcoming formal planning round, but recent history suggests that the system will need to deliver more than the historic level of savings in order to improve our underlying position. Therefore, it is proposed that the system should aim for an aggregated savings target of 5% of estimated expenditure levels in 2021/22 = circa £200m. The rationale for this figure is as follows:
    - In recent years the aggregated savings of CCGs and providers have moved above 4% (a couple of our trusts were close to 5%). We now need to leverage the benefits of working effectively as a system and to that end I am proposing a 1% supplement for system-wide solutions on top of the historic 4% figure, for 2021/22.
    - £200m is significantly higher than the £164m originally planned for 2020/21 (and in all previous years) and demonstrates that as a system we are moving in the right direction from 2021/22, pending the outputs from the diagnostic, which will help us on the longer term plans

22. If the rationale for a 5% savings target is supported for the system, a subsequent discussion is recommended for how that should be attributed to the different ICPs across the ICS, as it could be argued that those with a higher level of deficit should be required to achieve more than the average of 5%, while those that are reporting a lower level of deficit should have a lower savings target too. We will not know where each ICP stands until plans have been developed, but it should be an aim of the ICS that spending targets are set for organisations in their ICPs or sectors, rather than savings targets applied to a deficit number.

23. As a system we must agree plans for 2021/22 before we receive the outputs from the diagnostic. There are a number of sources of information that will assist us to do this:
    - The original plans for 2020/21 CIPs/QIPP (£163m) that were put into abeyance when we started to respond to the Covid pandemic, many of which may be capable of being started in 21/22 if they have not already been implemented and are still relevant
    - Work that has been undertaken behind the scenes during the current year, on transport, agency costs, booking services
    - Evidence we have for potential savings from model hospital and RightCare

- Developments implemented quickly in response to Covid that should continue and new ones that could be implemented if we take a similar approach to system development in 21/22, which is justifiable given the urgent needs we have on elective care, inequalities and finance

24. Based on the above the system-wide savings we may look to progress in addition to extant CIPs and QIPPs:
    - Non-clinical/support services expenditure – the data suggests there is up to £67m potential excess cost in these areas – the amounts may not be huge for individual services but it is incumbent on managerial and support functions to lead the way in delivering savings. The main focus of savings would be within the hospital system, but there are some opportunities for CCGs, including booking services. For estates, a refresh of our strategy starts on 2nd March with a view to bringing proposals to the Board for approval at the June meeting. So what should the ambition be in relation to non-clinical/support services? £20m in 2021/22 across the system and £20m more in 2022/23?
    - Agency and Locum costs – HR Directors were already working together on this aspect of our agenda prior to Covid, but there is a need to follow through here. The issues will not just be about agreement on rate cards for a range of positions, but also how we as a system are able to continue with the good work undertaken as part of our Covid response to make the most of mutual aid and support across organisations to reduce our overall reliance on agency and locum staffing. Level of savings to aim for in 2021/22 - £20m?
    - Our elective care group is developing proposals for elective services. Clarity on our approach to elective care will include the system for prioritisation of patients and their matching to available, planned capacity. Theatre utilisation, again the subject of previous studies, will no doubt form part of any improvement proposals. An aim of this programme must be to ensure that our elective capacity is utilised efficiently and effectively, perhaps repatriating activity that was previously sent to the IS at premium cost. Similarly, there is still evidence that procedures not commissioned by us as a system were still being undertaken immediately prior to Covid and these must not be reinstated as we step up elective activity. If these issues can be addressed as a system, it should lead to savings and a more modest figure of £10m may be appropriate to signal at this stage. Given the large backlog in elective activity, it may be necessary to consider spending more overall on elective services as part of Covid recovery, using any NR sources of money that may become available for this purpose, but this should not detract from the need to make elective care more efficient overall.
    - CHC – there is evidence that were the variation in approvals across CCGs in L&SC to be reduced, savings in the order of £10m to £15m could be achieved.
    - Any others that could be agreed.

Conclusion

25. The Finance Advisory Committee has developed proposals for a system diagnostic to be undertaken as the basis for developing a strategic approach to system/financial

improvement that has a high level of ownership across the ICS. Outputs from the diagnostic will inform our longer term programme.

26. However, these proposals will not lead to solutions that will help the System to significantly improve its financial position in 2021/22 and therefore a short term programme has been suggested based on extant CIP/QIPPs that were prepared last year but not fully implemented, together with a range of suggestions drawn from existing workstreams. If these suggestions are not supported, others will need to be identified.

27. It is not possible at this point to set precise targets for the different parts of the ICS, that will only be possible once some baseline estimates have been made as part of the planning process due to start in April, but the recommendations made in this report should be sufficient to enable the various groups to be established for the longer term work and a short term savings programme to be initiated.

Recommendations

28. The ICS Board is asked to:
    i. **Note** the financial position of the ICS's NHS organisations as reported in the last draft planning returns from March 2020.
    ii. **Approve** the establishment of a Financial Improvement Board, chaired by the ICS Chief Officer. This will draw on various system-wide resources and groups to develop a financial improvement programme on the back of a system diagnostic to enable implementation of any early schemes during 2021/22.
    iii. **Support** the convening of the Investment Committee and look for early confirmation that the rules underpinning investment and spending decisions are validated, agreed and applied.
    iv. **Note** the historic levels of CIP and QIPP planned by the system and the opportunity to implement any schemes held in abeyance during the response to Covid, together with new schemes that have been developed in the background more recently.
    v. **Set** for the system an ambitious savings target of 5% or £200m for 2021/22, noting that attribution of targets to specific sectors or ICPs will need to be determined during the forthcoming planning process.
    vi. **Agree** that the system-wide schemes and the amounts identified in the report, and/or other alternatives that may arise from subsequent discussions, are developed in the next two months to enable implementation from early 2021/22.
    vii. **Ensure** efficiencies and cost reductions driven by changes in practice over the past 12 months are identified and embedded in current practice and a similar rapid improvement process is adopted for 2021/22.

Gary Raphael
Executive Director of Finance and Estates
23rd February 2021

Appendix 1

Lancashire and South Cumbria Investment/Disinvestment Principles

In anticipation of system wide investments and/or disinvestments a detailed set of principles have been discussed with finance leads within NHS organisations in Lancashire and South Cumbria so that they can be referred to and decisions aligned to them when making investment and disinvestment decisions. The principles will remain live and shall be reviewed on a periodic basis prior to each planning cycle and amended where relevant.

These principles will be in operation from the date of agreement at FAC 12/02/2021

Principle 1: Where costs can be terminated without materially impacting on an outcome or another part of the system then early action will be taken to negate expenditure.

Principle 2: Where costs can be reduced, early action will be taken to negate/minimise expenditure provided it does not materially impact on an outcome or another part of the system.

Principle 3: Where costs cannot be mitigated and they continue to be reasonable; funding should be made available as a prior commitment until a formal agreement can be put in place asap.

Principle 4: Where possible providers and commissioners should manage aligned disinvestments in unison as well as investments, taking due consideration to the system gains or losses and in some cases this may require transitional funding support.

Principle 5: All agreed net additional revenue costs will be required to be prioritised against commissioner growth monies and provider income in a fair and transparent way provided that the investment decision fulfils agreed system wide investment criteria by contributing beneficially to run-rate and patients outcomes.

Principle 6: Where necessary, financial risks should not sit within the individual organisation(s) that have agreed to host a contract or service on behalf of the Integrated Care System. As such it will be assumed that there will be an implicit risk share agreement in place until a formal risk share agreement can be put in place.

Principle 7: Organisations should be open and transparent, welcome peer review and CFOs should collectively commit to clear and consistent communication of system wide financial challenges to all parts of our system and staff.

Agreed and ratified at Lancashire and South Cumbria Finance Advisory Committee 12th February 2021

Healthier Lancashire & South Cumbria

ICS Board

Title of Paper	New Hospitals Programme Report		
Date of Meeting	3 March 2021	Agenda Item	6

Lead Author	Rebecca Malin, Programme Director		
Contributors	N/A		
Purpose of the Report	Please tick as appropriate		
	For Information	X	
	For Discussion		
	For Decision		
Executive Summary	This is the monthly update report of progress of the New Hospitals Programme. Notable updates this month include the planned launch of the New Hospitals communications and engagement plan and the publication of the draft case for change.		
Recommendations	The Board is requested to note the contents of the report and receives a further report at its meeting in April 2021.		
Next Steps	Progress as per plan with the next Board update scheduled for April 2021.		
Equality Impact & Risk Assessment Completed	Yes	No	Not Applicable
Patient and Public Engagement Completed	Yes	No	Not Applicable
Financial Implications	Yes	No	Not Applicable
Risk Identified	Yes		No
If Yes : Risk			

ICS Board

NEW HOSPITALS PROGRAMME REPORT
February 2021

1. Background

1.1 Colleagues will be aware that University Hospitals of Morecambe Bay NHS FT (UHMB) and Lancashire Teaching Hospitals NHS FT (LTHTr) were awarded £5m each as seed funding to progress the required business cases to secure capital investment to redevelop/replace the ageing estate which is no longer fit for purpose.

1.2 This is a once in a generation opportunity to secure around £1bn funding to build brand new hospital facilities for local people in Lancashire and South Cumbria. We want to use this investment to help improve the health of local people by offering patients and staff access to advanced, purpose-built hospital facilities in our area.

1.3 This funding is for hospitals, but we understand that it is only one part of broader health services and cannot improve our population's health on its own. This is a collaborative programme, involving all NHS organisations in our area and will be part of a wider programme of improvements in healthcare provision.

1.4 Clearly, this is a fundamental and critical programme which will shape the future service model for our people; those who work within it, those cared by it and the wider population of Lancashire and South Cumbria for a whole generation.

1.5 This monthly report details items for the members to be sighted on.

2. Communications and engagement

2.1 This month the Programme Strategic Oversight Group (SOG) received a presentation on the communications and engagement plan. The plan aims to communicate:

- **excitement** about this once in a generation opportunity
- **raise awareness** and **drive involvement** in the process
- we are **reaching out** to the excluded
- led by **clinical and patient voices**
- stakeholders can **trust our methods and intentions**
- people should feel they **know what is going on**
- there is a **rolling programme** of information and involvement opportunity
- to leave a **positive communications legacy**

2.2 We now have approved core narrative, key messages, media release and are aiming to introduce our internal and external communications and engagement wk. 1st March 2021. This includes a letter to our stakeholders across Lancashire and South Cumbria (L&SC) and launching a website, social media and a digital engagement platform.

2.3 Over the coming months our plan will build and make use of a variety of methods in order to reach our wide population and workforce. This includes a New Hospitals Programme colleague summit hosted by Amanda Doyle, Chief Officer for the L&SC ICS in April 2021.

3. Clinical and operational leadership

3.1 Via the Clinical Oversight Group (COG) the programme has secured some excellent clinical and operational colleagues to join the programme team. A number of clinicians (Acute, Community and Primary Care) have already started in post and more will take up post over the coming weeks. Evidence suggests transformation such as this is far more successful and sustainable when led by clinicians. I am therefore delighted to have appointed approximately 25 clinicians who will play a critical leadership role in designing our future clinical service models.

3.2 The programme will continue to review requirements via the COG and respond accordingly.

4. Developing clinical service models

4.1 A series of workshops involving clinical and operational colleagues from across the ICS continued in January. This concluded phase 1 drawing together the 'as is' position and agreeing the principles (for each clinical area) they will use to guide the development of clinical service models. Throughout February and March our health planning team continues to work with clinicians to design clinical service models. Draft models will be published for partners to review and comment in March along with further workshops led and attended by our clinical colleagues.

4.2 Our aim is for the clinical service models to be endorsed in April ahead of the North West Clinical Senate validation at the end of the month. This is an essential element as we progress developing of a long list of options in May 2021.

5. Developing our case for change

5.1 Workshops were held in January and February to shape our case for change. These were attended by our workforce, governors and patients from across the ICS and provided a range of perspectives and valuable insight regarding why we need new hospitals in L&SC. We specifically discussed opportunities, benefits, what may get in our way and how we may address these. It is essential we create a compelling case for change that our clinicians and patients advocate. I would like to thank all who attended and helped develop our first draft case for change.

5.2 We have now assimilated the output and combined with valuable messages from the clinical workshops. Along with supplementary desktop research and analysis this has formed our draft case for change which is published for partner review throughout Feb-March 2021 prior to publishing a subsequent draft at the end of March. Our case for change will continue to evolve as we progress our thinking this year.

6. Progress against plan

6.1 The Programme Management Group (PMG) meets monthly and receives/discusses progress against the timeline, critical milestones and key risks.

6.2 This month the group focused. As at February 2021 progress is on track against the critical path milestones. A weekly deep dive of progress against plan is undertaken with risks identified with associated mitigation and/or escalation as per governance arrangements.

7. Working with the national DHSC-NHSEI team

7.1 As anticipated, representatives from the L&SC New Hospitals Programme and the national programme team from NHSEI and DHSC will come together for a round table discussion in March 2021. This will largely focus on clarifying the scope of the programme and its deliverability. Our team will be led by Amanda Doyle and preparatory work is underway.

8. Engaging with other HIP programmes

8.1 To avoid reinventing the wheel and to learn from each other, the programme team has connected with other schemes namely Leeds Teaching Hospitals, University Hospitals of Leicester and South Devon and Torbay. In addition, PWC and ETL have established networks of other schemes. Sessions have included estates advice, governance, carbon zero and developing the PCBC.

9. Conclusion

9.1 This update covers the period January – February 2021.

10. Recommendations

10.1 The Board is requested to note the contents of the report and receives a further report at its meeting in April 2021.

Rebecca Malin, Programme Director
February 2021

ICS Board

Date of Meeting	3rd March 2021
Title of Paper	System Reform
Presented By	Andrew Bennett
Authors	Andrew Bennett, Alex Heritage
Agenda Item	7
Confidential	No

Purpose of the Paper

The purpose of this paper is to update the ICS Board on the range of activities taking place to implement the ICS's System Reform Plan.

Actions are now taking place following the national publication of a Government White Paper which contains proposals to place ICSs onto a statutory footing by April 2022.

Executive summary

Members of the Board will be aware that the government has now published a White Paper (*Integration and Innovation: working together to improve health and social care for all*) which will lead to legislative changes for the whole system.

The ICS will continue its wide-ranging System Reform programme with 2021/22 acting as a transitional year.

This paper confirms the actions currently being taken to:

- Agree the oversight arrangements for the System Reform programme in Lancashire and South Cumbria;
- Agree the proposed Strategic Commissioning Committee to be established from April 2021;
- Progress the priorities of the Provider Collaboration Board;
- Confirm that the ICP Development Programme is continuing with workshops in March 2021;
- Continue discussions between Local Government and NHS colleagues about the joint priorities for partnership working in the light of the White Paper.

Recommendations

The ICS Board is asked to:

1. Discuss the implications of the White Paper for the current System Reform programme in Lancashire and South Cumbria.
2. Note the update on on the range of activities taking place to implement the ICS's System Reform Plan.

Governance and Reporting (List Other Forums that have Discussed this Paper)		
Meeting	**Date**	**Outcome**

Conflicts of Interest Identified
Given the implications of system reform for changes in organisational and leadership models, a number of colleagues are declaring financial interests prior to discussion on the issues raised.

Implications						
Quality Impact Assessment Completed	**Yes**	☐	**No**	☐	**N/A**	☒
Equality Impact Assessment Completed	**Yes**	☐	**No**	☐	**N/A**	☒
Privacy Impact Assessment Completed	**Yes**	☐	**No**	☐	**N/A**	☒
Financial Impact Assessment Completed	**Yes**	☐	**No**	☐	**N/A**	☒
Associated Risks	**Yes**	☐	**No**	☐	**N/A**	☒
Are Associated Risk Detailed on the ICS Risk Register?	**Yes**	☐	**No**	☐	**N/A**	☐
If Yes, Please Provide a Risk Description and Reference Number	Mark Yes, No or Not Applicable Above and Provide a Risk Description and Risk Reference Number in this Box if there are Any Associated Risks					

System Reform

Introduction

The purpose of this paper is to update the ICS Board on the range of activities taking place to implement the ICS's System Reform Plan. Actions are now taking place following the publication of a White Paper which contains proposals to place ICSs on to a statutory footing by April 2022.

1. Legislative recommendations to Government and Parliament

On 11th February 2021, the NHS published a formal report summarising the outcomes of the consultation on the *Integrating Care* policy paper which began in late November. The consultation report makes 5 recommendations to the Government and Parliament about legislating for the further development of ICSs. These recommendations are as follows:

Legislative recommendation 1: The Government should set out at the earliest opportunity how it intends to progress the NHS's own proposals for legislative change.

Legislative recommendation 2: ICSs should be put on a clear statutory footing, but with minimum national legislative provision and prescription, and maximum local operational flexibility. Legislation should not dictate place-based arrangements.

Legislative recommendation 3: ICSs should be underpinned by an NHS ICS statutory body ***and*** a wider statutory health and care partnership. Explicit provision should also be made for requirements about transparency.

Legislative recommendation 4: There should be maximum local flexibility as to how an ICS health and care partnership is constituted, for example using existing arrangements such as existing ICS partnership boards or health and wellbeing boards where these work well.

The composition of the board of the NHS ICS body must be sufficiently streamlined to support effective decision-making. It must be able to take account of local circumstances as well as statutory national guidance. Legislation should be broadly permissive, mandating only that the members of the NHS ICS Board must include a chair and CEO and as a minimum also draw representation from (i) NHS trusts and Foundation Trusts, (ii) general practice, and (iii) a local authority. As with CCGs now, NHSE/I should approve all ICS constitutions in line with national statutory guidance.

Legislative recommendation 5: Provisions should enable the transfer of primary medical, dental, ophthalmology and pharmaceutical services by NHS England to the NHS ICS body. Provision should also enable the transfer or delegation by NHS England of appropriate specialised and public health services we currently commission. And at the same time, NHS England should also retain the ability to

specify national standards or requirements for NHS ICSs in relation to any of these existing direct commissioning functions.

2. Publication of Government White Paper

On the 11th February, the Government also published a White Paper called "Integration and Innovation: working together to improve health and social care for all."

A link to the key document is set out here:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/960548/integration-and-innovation-working-together-to-improve-health-and-social-care-for-all-web-version.pdf

The key measures set out in the White Paper are as follows:

- Support for the proposal to create statutory Integrated Care Systems (as set out above).

- Support for the proposal to scrap mandatory competitive procurements by which NHS staff currently require a significant amount of time to undertake tendering processes for healthcare services. Under the proposals, the NHS will only need to tender services when the NHS itself considers this has the potential to lead to better outcomes for patients. The Competition and Market Authority will no longer be involved in NHS oversight. Local NHS services will have more power to act in the best interests of their communities.

- The safety of patients is at the heart of NHS services. The upcoming Bill will put the Healthcare Safety Investigations Branch permanently into law as a Statutory Body so it can continue to reduce risk and improve safety. The Healthcare Safety Investigations Branch already investigates when things go wrong, so that mistakes can be learned from, and this strengthens its legal footing.

- Support for the proposal to formally fold Monitor and the Trust Development Authority (i.e. NHS Improvement) into NHS England.

- A package of measures to deliver on specific needs in the social care sector. This will improve oversight and accountability in the delivery of services through new assurance and data sharing measures in social care, update the legal framework to enable person-centred models of hospital discharge, and improve powers for the Secretary of State to directly make payments to adult social care providers where required.

- The pandemic has shown the impact of inequalities on public health outcomes and the need for Government to act to help level up health across the country. Legislation will help to support the introduction of new requirements about

calorie labelling on food and drink packaging and the advertising of junk food before the 9pm watershed.

NHS Leaders are keen to emphasise the importance of supporting staff through the period of organisational change which is implied by the legislation. This includes an employment guarantee for colleagues in the wider health and care system who are directly affected.

3. Supporting the development of Integrated Care Systems

To support implementation of the legislation, colleagues in the national and regional team have indicated that further guidance will be issued during 2021/22 after a process of co-development with local systems. We understand that this will cover areas such as:

- Functions, governance and accountability
- Financial Framework
- Digital and Data
- People and Culture
- Change Management, ICS Establishment and Organisational development
- Ongoing System Support and Development
- System Partnerships and Engagement

There will also be an ICS maturity matrix (known as a System Development Progression Tool) to support continued development over the next year. The development tool is designed to help ICSs identify and describe their key priorities for accelerating and embedding system working, including the development of capacity and capabilities they will need to be an effective, self-managing ICS by 1st April 2022. There will be opportunities to update the tool on a regular basis during the year.

4. Oversight of the System Reform programme – Lancashire and South Cumbria

In our System Reform plan in October 2020, we confirmed that a number of groups would take forwards the detailed work to progress our plans. There has been a distributed approach to the leadership of key pieces of work which is producing outputs for consideration by system leaders, boards and governing bodies.

As agreed with the ICS Board, during January and early February, a review has taken place of both the scope and the oversight arrangements of the System Reform workstreams. These are major areas of work with multiple interdependencies.

The scope of each area of work is now summarised in **Appendix 1** below.

The developing governance arrangements required to oversee this programme are summarised in **Appendix 2** below.

The Board is asked to note that an ICS development Oversight Group (ICS OG) is now being established with the following key roles:

- To act on behalf of the ICS Board to develop a statutory ICS, including a strategic commissioning function and place-based functions, in line with national publications and local thinking. This will include:
- Oversight of the overall System Reform Programme critical path
- Development of a Strategic Narrative which describes what it means to be an ICS in Lancashire and South Cumbria
- Development of a strategic commissioning function within the ICS (including. commissioning decision-making from April 2022)
- Development of a model for system support
- Development of a model of ICS Governance
- Development of a model of ICS Leadership

The ICS Oversight Group will also oversee and co-ordinate the work of a number of cross cutting workstreams including:

- The Quality, Performance and Assurance model for an ICS
- The Financial Framework for an ICS and for ICPs
- Workforce & HR
- Communications & Engagement

The ICS Independent Chair will chair the Oversight Group and invitations to colleagues from across the partnership have been circulated. The Group will meet for the first time in early March.

5. Commissioning Reform

CCG Governing Bodies have been meeting between the 15th-24th February to consider the recommendations to create a Strategic Commissioning Committee for Lancashire and South Cumbria. This will use the vehicle of the existing Joint Committee of CCGs to take decisions for the whole system.

As these meetings are still taking place, a verbal update on the outcome of these discussions will be provided to the ICS Board.

Preparatory work has also begun to develop a number of sub-committees which will enable the SCC to discharge its functions during the transitional year 2021/22.

6. Provider Collaboration

The Provider Collaboration Board (PCB) has continued to prioritise a defined number of collaborative programmes on behalf of the ICS Board.

Given the imminent national guidance, more work will be required to find both the scope of provider collaboration and the resources required to allow provider collaboration to deliver its complex agenda.

National and Regional colleagues have set up a development process to advance effective models of provider collaboration. Lancashire and South Cumbria have been offered the chance to work with Regional and National colleagues in taking this forward.

In advance of this support, a draft PCB Transition Plan has been developed and shared with PCB members to start the initial scoping of the future PCB.

Initial objectives for the PCB Transition Plan have been developed to support a Target Operating Model:

- To describe how the current Provider Collaboration Board will evolve in response to new National Policy, Technical Guidance and anticipated legislative change as a key component of an Integrated Care System.
- Successfully transition the responsibilities and accountabilities of the pandemic cellular structures to ensure continuity and best practice is maintained on cessation of the national incident requirements.
- Clearly identify the system wide transformation programmes that the PCB will be accountable for, ensuring clarity of leadership, resource and their contribution to delivering against the ISC Clinical Strategy and Financial Recovery Plan.

7. ICP development

The ICP Development Advisory Group is continuing to oversee the next stage of ICP development work, as agreed by the ICS Board in December 2020.

Partners within each ICP have been completing the ICP Maturity Matrix which is followed by a dedicated feedback session to review responses by sector and consider what this means for each ICP.

Peer-to-peer reviews are now planned for the first half of March 2021, which will be facilitated by AQuA. The peer group will be selected from ICP Chairs, members of the ICP Development Advisory Group, and external subject matter experts provided via NHS England / Improvement and the Local Government Association. The Independent Chair of the ICS will participate in all sessions.

The first development workshop considering the success measures for ICPs took place on Thursday 11th February. This was a really positive session attended by a diverse mix of representatives from all sectors in the ICS and externally facilitated. Further workshops are planned in March relating to ICP leadership and ICP governance.

Due to the operational pressures linked to the pandemic which have been experienced in the first weeks of 2021, there has been a one month delay in the timeline of this work. This means that the proposals developed during these workshop sessions will now be shared and discussed more widely with senior leaders via a system wide workshop on 21st April 2021. A report on the outcomes will then be presented to the ICS Board at its meeting in May.

8. Local Government Reorganisation

In the light of the White Paper, Local Government and NHS colleagues are taking the opportunity to hold further discussions about the priorities for partnership working in Lancashire and South Cumbria. There are a number of significant opportunities to strengthen current arrangements in relation to population health and inequalities, adult and children's social care, support for vulnerable groups, mental health and learning disability services, care sector and intermediate care services.

Recommendations

The ICS Board is asked to:

1. Discuss the implications of the White Paper for the current System Reform programme in Lancashire and South Cumbria.

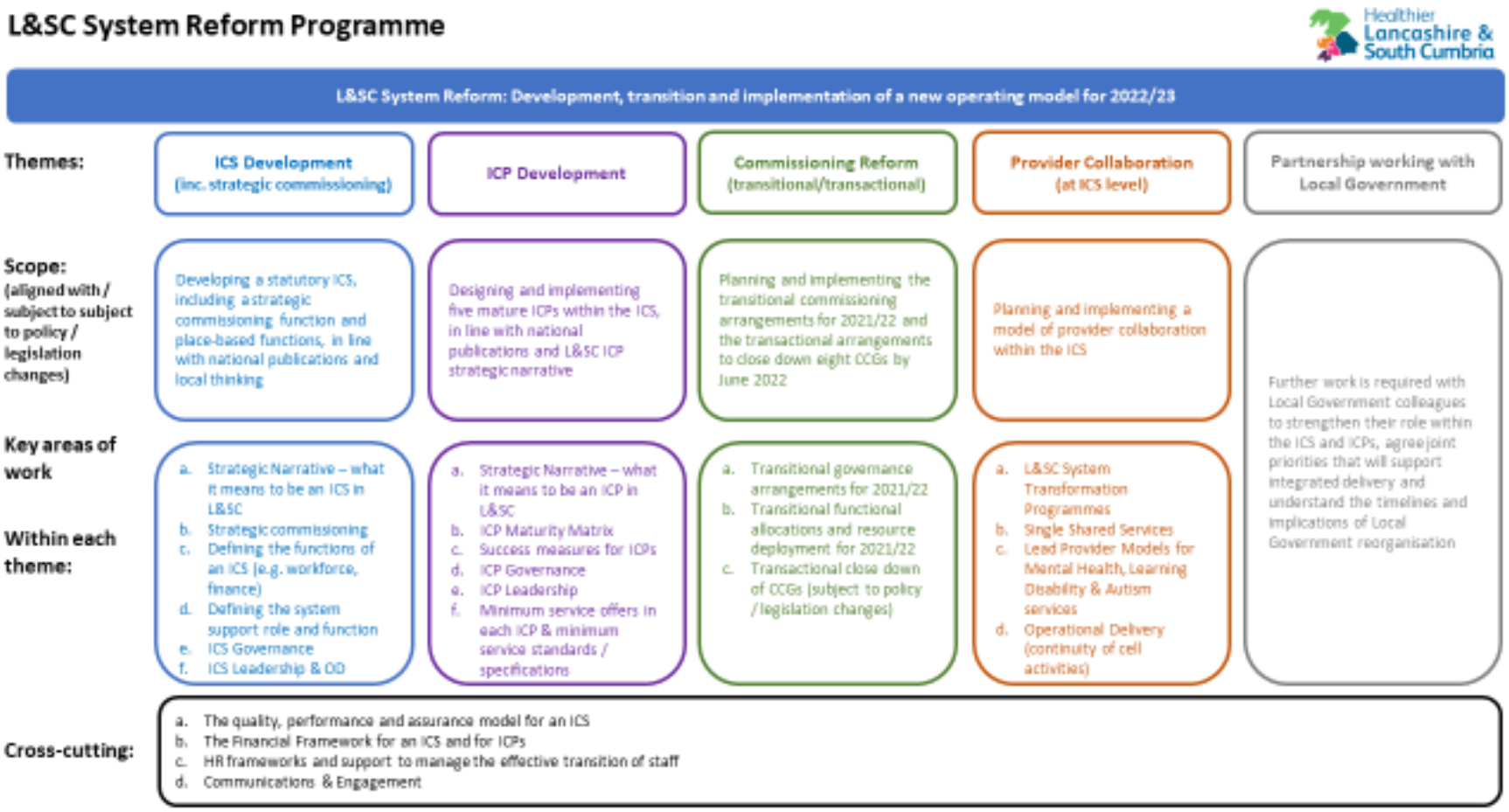
2. Note the update on on the range of activities taking place to implement the ICS's System Reform Plan.

Andrew Bennett **Executive Director of Commissioning**

Alex Heritage **Director, Provider Collaboration Board**

23rd February 2021

Appendix 1: System Reform Workstreams



Appendix 2: System Reform - Governance Arrangements

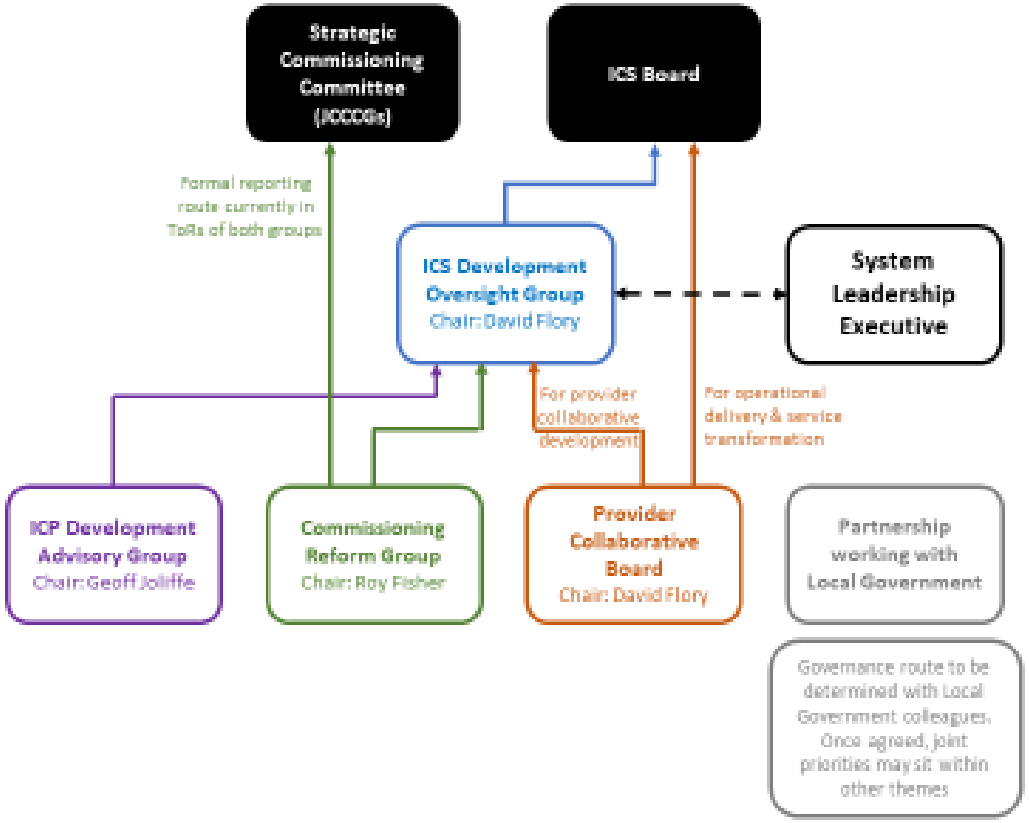
Governance Arrangements – Working draft

Healthier Lancashire & South Cumbria

The ICS Development Oversight Group will have oversight of the whole of the System Reform Programme (critical path, interdependencies, key risks, etc).

Progress on cross-cutting workstreams will be monitored by the ICS Development Oversight Group

It will also act as the route in/out of the NW ICS Oversight Group.



Increased use of SLE as a forum to discuss key outputs from all system reform groups with senior system leaders across different sectors.

This will provide an opportunity to test/ discuss /refine prior to public meetings of the ICS Board and SCC (JCCCGs).

ICS Board

Title of Paper	Embedding Action on Health Inequalities – Proposals for Lancashire and South Cumbria Approach		
Date of Meeting	03 March 2021	Agenda Item	8

Lead Author	Julie Higgins		
Contributors			
Purpose of the Report	Please tick as appropriate		
	For Information		
	For Discussion		
	For Decision	x	
Executive Summary			
Recommendations			
Next Steps			
Equality Impact & Risk Assessment Completed	Yes	No	Not Applicable
Patient and Public Engagement Completed	Yes	No	Not Applicable
Financial Implications	Yes	No	Not Applicable
Risk Identified	Yes		No
If Yes : Risk			
Report Authorised by:			

Healthier Lancashire & South Cumbria

ICS Board

Embedding Action on Health Inequalities – Proposals for Lancashire and South Cumbria Approach

1. Introduction

1.1 Whilst our health and care organisations remain under extreme pressure coordinating our Covid-19 responses and vaccination deployment, there are opportunities presented now that we cannot afford to miss, particularly in how we design and deliver our responses, that could allow us to mitigate some of the pandemic impact and protect our most vulnerable people. With a focus to then build on our immediate responses, through the horizons of Covid-19 over coming months and years, we recognise that we must begin to build an infrastructure that is focused on population health and improving outcomes for all.

1.2 The outline proposals for legislative change for ICSs, clearly outline a direction of travel for ICSs as vehicles for addressing health inequalities and improving health outcomes, with a particular proposal to introduce a "triple aim" duty on NHS organisations and this will become a key focus in future assurance frameworks. As a system we have received positive feedback from NHSEI on our approach to embedding action on health inequalities and we received a "green" rating as having made good progress on delivering against the Phase 3 Urgent Actions on Health Inequalities, but we have much still to do.

1.3 Over the Summer of 2020, a number of regional and national guidance documents were published that, between them, set out clear expectations for how the NHS in particular should take steps to address inequalities. This report aims to summarise the breadth of these asks, anchoring them in the pressures our system has had and will continue to have from Covid-19, making recommendations for tangible steps the ICS and its constituent organisations can take to embed action on health inequalities.

2. Key issues

2.1 The key issues pertaining to the actions required on health inequalities are set out in the attached report "Embedding Action on Health Inequalities – Proposals for a Lancashire and South Cumbria Approach".

3. Conclusion

3.1 The fact that Health Inequalities are present within Lancashire and South Cumbria is not a new concept, with areas of significant deprivation, poor housing, high levels of long term conditions and poor mental health clearly recognised by all public sector partners. However, Covid-19 has highlighted and worsened the health inequalities that exist within society and in particular, the North West, like never before.

3.2 The economic shockwave that will ripple beyond the waves of the pandemic will, by all accounts, drive up poverty and deprivation to levels not seen in a generation. With no uncertainty, this will increase demands for health and care services, physical, mental

and social, long after Covid vaccines are deployed. We have an opportunity now to build on the common purpose we forged through our Covid response, to take action with our local authorities, VCFSE partners and residents to support our communities through this shockwave and go beyond this to addresses these inequalities, to address the causes of ill health and prevent further detrimental outcomes.

4. Recommendations

The ICS Board is recommended to endorse the following:

4.1 That all organisations/systems undertake a short self-assessment against the requirements of the Phase 3 guidance and North West Community Risk Reduction Framework and look to identify areas for improvement or where support is required – relevant capacity within organisations will be needed to complete this.

4.2 That the ICS Board and Out of Hospital Cell prioritise the investment in and continued development of the Population Health Management programme and Call to Action.

4.3 The establishment of a L&SC Health Inequalities Commission to take an independent, cross-sector view on the tangible things that can and need to be done to drive improvement on health inequalities.

4.4 That the following actions be undertaken, overseen by Dr Julie Higgins:

- Engagement, on behalf of the ICS, with all local authority chief executives and leaders to start conversations and scope the potential for a L&SC Health Inequalities Commission and linkages to/ownership by the three Health and Wellbeing Boards
- Establishment of a Health Inequalities Summit in March/April and development of background work to support
- Delivery of the Commission through April-June, with recommendations from the Commission being delivered by July 2021.

4.5 That the ICS Board commit to freeing up capacity from within their organisations to support the leadership and development of the Health Inequalities Commission, when the full scope has been identified and agreed with local authority leaders

4.6 That the ICS Board commit to delivering the recommendations of the Commission and reporting to the ICS on the progress against delivering these.

4.7 That the ICS Board will support the establishment of an ICS health inequalities action plan by 31st March 2021.

Name of Author: Philippa Cross

Date Produced: 23.03.2021

Embedding Action on Health Inequalities – Proposals for Lancashire and South Cumbria Approach

Dr Julie Higgins, Nominated ICS Lead for Health Inequalities

ICS Board March 2021

Overview and context

Whilst our health and care organisations remain under extreme pressure coordinating our Covid-19 responses and vaccination deployment, there are opportunities presented now that we cannot afford to miss, particularly in how we design and deliver our responses, that could allow us to mitigate some of the pandemic impact and protect our most vulnerable people. With a focus to then build on our immediate responses, through the horizons of Covid-19 over coming months and years, we must begin to build an infrastructure that is focused on population health and improving outcomes for all.

The outline proposals for legislative change for ICSs, clearly outline a direction of travel for ICSs as vehicles for addressing health inequalities and improving health outcomes, with a particular proposal to introduce a "triple aim" duty on NHS organisations. In advance of these proposals being enacted, NHSEI are shifting performance and assurance focus onto health inequalities, creating "RightCare type" place dashboards, system maturity frameworks and moving to ensure there is accountability for additional, inequalities focused, finance. As a system we have received positive feedback from NHSEI on our approach to embedding action on health inequalities. Our system has received a "green" rating as having made good progress on delivering against the Phase 3 Urgent Actions on Health Inequalities, but we have much still to do.

The economic shockwave that will ripple beyond the waves of the pandemic will, by all accounts, drive up poverty and deprivation to levels not seen in a generation. With no uncertainty, this will increase demands for health and care services, physical, mental and social, long after Covid vaccines are deployed. We have an opportunity now to build on the common purpose we forged through our Covid response, to take action with our local authorities, VCFSE partners and residents to support our communities through this shockwave.

We have collective power and resources as a health system, as a major employer and purchaser of goods and services, that can be harnessed to support a focus on economic recovery, sustainable employment opportunities and raising aspirations for our residents. We also have a collective voice, which can support our local authority leaders in lobbying Government for enhanced investment and support throughout our Covid recovery. Our communities need and deserve, more than their "fair share", if they are to survive this pandemic and turn the tide on the structural inequalities that have made them so vulnerable.

This paper sets out a number of proposed actions, for short and medium term delivery, for consideration by the ICS Board.

Tackling Health Inequalities – Making sense of the asks

Four key national/regional documents:

- National Phase 3 Guidance for Health – Urgent Actions on Inequalities
- NW Covid-19 Community Risk Reduction Framework
- PHE Beyond the data: Understanding the impact of COVID-19 on BAME groups
- NHSE/I Key Lines of Enquiry for Health Inequalities

A review of these frameworks confirms that six key areas for action emerge:

Summary of health inequalities required actions

Leadership and Accountability

- Named lead for HI on each Board/PCN
- Boards must publish action plan showing how board and senior staffing will match BAME composition of workforce/local community
- Boards should demonstrate use of PHM Intelligence in decision making on HI
- Regularly publishing outcome and risk data, details of actions take to address HI and details of how inequalities funding has been spent – by 31.03.21 for CCGs
- System plans should set out clinical/non-clinical interventions to address inequalities
- Demonstrate progress through an accountability/assurance framework and provide an account of all actions by 31.03.21
- Move to become "anchor institutions", making best use of the Social Value Act

Covid Mitigation and Protection

- Prioritise Covid testing & other protective interventions to individuals at risk
- Improve uptake of the flu vaccination in underrepresented 'at risk' groups
- Use culturally competent occupational risk assessment tools and support for staff
- Improve GP registration for those without proof of identity or address
- Co-produce and implement culturally competent Covid education and prevention campaigns
- Regularly update plans for protecting people at greatest risk during the pandemic

Population Health Management

- Ensure Covid recovery strategies actively reduce inequalities
- GPs, with analytical teams and system partners, should use capacity released through modified QOF for 2020/21 to develop priority lists for preventative support and LTC management
- Use pandemic learning to develop longer-term plans to address underlying causes of health inequality from 2021/22. Plans should be data driven, co-produced and built on an understanding of the needs of local inclusion health groups
- Prioritise fully funded, sustained and meaningful approaches to tackling ethnic inequalities
- Consider bolstering the primary care workforce, especially in deprived areas through Additional Roles and Reimbursement Scheme and help increase number of GPs in under-doctored areas

Coproduction and Culturally Competent Engagement

- Develop and support community participatory research to understand the social, cultural, structural, economic, religious and commercial determinants of Covid in BAME communities, and to develop readily implementable and scalable programmes to reduce risk and improve health outcomes
- Ensure information on risks and prevention is culturally competent and accessible to all
- Accelerate efforts to target culturally competent health promotion and disease prevention programmes
- Engage, as default, with local authority and third sector partners

Health Inequalities Impact Assessment

- Equality Health Impact Assessments should be conducted for service changes & new care pathways
- As a priority 111 First; total triage in general practice; digitally enabled mental health and virtual outpatients should be tested for achieving a positive impact on health inequalities with reviews and actions published by 31.03.21
- For each, systems should assess empirically how the blend of different 'channels' of engagement has affected different population groups and put in place mitigations to address any issues

Data Recording and Monitoring

- All NHS organisations to review quality and accuracy of data on patient ethnicity and ensure data recorded for all patients by 31.12.20
- Retrospectively updating and completing the Covid Hospital Episode Surveillance System (CHESS) is essential
- Mandatory recording of ethnicity in all clinical databases across hospital, primary care, specialised commissioning and mental health/IAPT
- All NHS organisations must use this data to plan service provision and to monitor the impact on inequalities taking swift action to rectify inequalities which are identified

Feedback from NHSEI on Lancashire and South Cumbria ICS action on health inequalities (phase 3 planning)

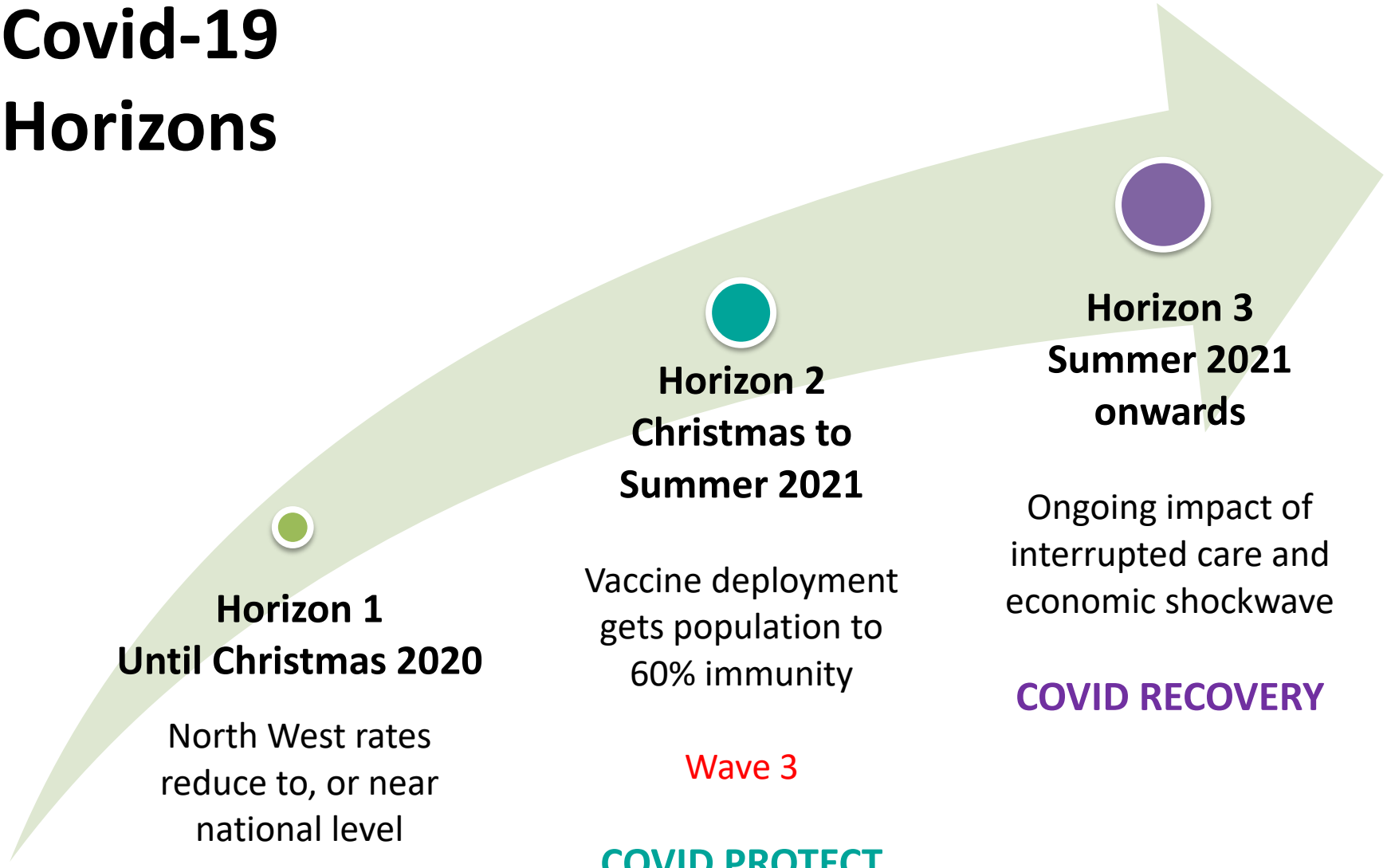
Strengths

- *ICS and partners recognize the areas where they need to improve and are developing their approaches to addressing health inequalities*
- *Good action plans are in place which will unfold and positively impact in the months ahead.*
- *Excellent winter plans are in place and risk stratification is being used across* primary care data sets
- *A systematic approach to addressing the NW Risk Reduction Framework incorporating all actions within the identified 5 priorities*
- *Use of data sets to target local interventions are in development*
- *Completing equality impact assessments*

Areas for Improvement

- *Strengthen collaborative leadership across the regions to address health inequalities*
- *Work in localities by using more place based and neighbourhood based approaches*
- *Equality impact assessments need to cover health inequalities*
- *Identify HI leads at practice level in primary care to target engagement and support*
- *Clarification on whether data sets are routinely collating equality data*
- *Strengthen narrative on long term conditions and by protected characteristics and deprivation*
- *More on digital exclusion and impact on widening inequalities*
- *Further develop more meaningful relationships that translate into more collaborative action on economic prosperity of communities, housing, climate change/environment - wider determinants*
- *More work required to identify mental and emotional wellbeing needs earlier*

Covid-19 Horizons



Horizon 1
Until Christmas 2020

North West rates reduce to, or near national level

COVID RESPONSE

Horizon 2
Christmas to Summer 2021

Vaccine deployment gets population to 60% immunity

Wave 3

COVID PROTECT

Horizon 3
Summer 2021 onwards

Ongoing impact of interrupted care and economic shockwave

COVID RECOVERY

Addressing health inequalities through Covid Horizons

Horizon 1

Until Christmas 2020

North West rates reduce to, or near national level

COVID RESPONSE

Cohort	**Targeted** Those with and at most risk of Covid-19
Issues faced	• High community transmission in deprived and BAME communities • Adverse impacts for people aged 65, BAME, learning disabilities • Low compliance with/understanding of guidance • Interrupted care impact from Wave 1 and Wave 2 • Inequalities and vulnerabilities will be exacerbated through service stand down and economic shock • Digital exclusion, particularly for deprived and elderly • Increasing demands on social care as families and carers struggle
Key actions	• Mobilise Covid responses targeted to most vulnerable, including integrated community care models • Use system levers to generate Covid responses, eg. capacity released through modified QOF • Ensure service changes (stepping up and down) are assessed for impact on health inequalities, vulnerable groups and digital inclusion (**NB mandated for 111 First; total triage in general practice; digitally enabled mental health and virtual outpatients**) • Workforce risk assessments and support enhanced for those at greater risk • Co-produce culturally competent engagement and communications to ensure messages reach target groups • Concerted effort to improve uptake of the flu vaccination in underrepresented 'at risk' groups • Deploy Call to Action to areas most at risk due to deprivation or high BAME population

Addressing health inequalities through Covid Horizons

Horizon 2

Christmas to Summer 2021

Vaccine deployment gets population to 60% immunity

Wave 3

COVID PROTECT

Cohort	**Enhanced** Those most at risk from Covid-19 plus those most at risk from interrupted care
Issues faced	• Managing transmission rates in deprived and BAME communities • Vaccine deployment to those least likely to engage and most at risk • Deconditioning of physical and mental health due to interrupted care and isolation • Family resilience undermined, food insecurity increased, likely continued increase in domestic abuse, children at risk and safeguarding concerns • Impact of Christmas gatherings likely to be felt at end January • On-going digital exclusion widening inequalities around accessibility
Key actions	• Vaccine deployment responsive to vulnerable and deprived groups, with community engagement to encourage uptake • Starting urgent review of LTC management, prioritising vulnerable groups eg. BAME, LD or over 65 with long term condition • Increased emphasis on tackling modifiable risk factors, particularly through Call to Action, consider also actions to support digital inclusion • Working with local authorities and VCFSE to wrap around wellbeing support as well as targeted work in primary care

Start now for longer term impact

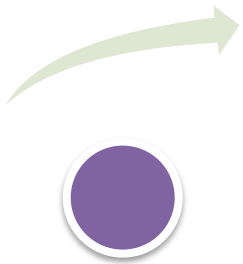
Embed Population Health Management

NHS Anchor Institution Model – grounded in ICPs with local authorities

Develop and publish health inequalities action plans by 31st March 2021 -

System reform must embed commitment to and articulate actions to deliver on health inequalities

Addressing health inequalities through Covid Horizons



Horizon 3

Summer 2021 onwards

Ongoing impact of interrupted care and economic shockwave

COVID RECOVERY

Cohort	**Whole population** A combination of targeted and universal provision to respond to inequalities
Issues faced	• Poor economic wellbeing and increasing food poverty • Mental wellbeing and resilience, incl. post traumatic stress for workforce and population and potential increase in alcoholism and substance addiction • Pre-pandemic child health, was poor and deteriorating - adverse trends in poverty, education, employment and mental health now exacerbated
Key actions	• Embed socially vulnerable children as a focus of PHM approach to ensure recovery planning supports children and families • Integrate on-going support models with local authority and VCFSE service delivery, particularly on employment support, debt management and food poverty support • Wholescale review of LTC management plans, particularly for those most vulnerable • Extending focus of PHM to strategic cohorts (anticipatory care, where PHM pilots started) • Fully embed assurance on addressing health inequalities and use this to identify areas for priority intervention • Sustained approach to and investment in, culturally competent engagement and embed community participatory research in all service planning • Resourcing and Investment Strategy is in place which ensures PHM data drives workforce profiling, deployment and investment

Embedding action and assurance on health inequalities at every layer and through every strategy

System

- National legislative proposals embedding delivery on health outcomes
- Health Inequalities within ICS System Assurance Framework progress to be monitored by ICS Board and System Leaders Executive
- Nominated leadership in place
- Population Health Management cell to oversee delivery
- ICS Anchor Institution Charter

Place

- Common ICP narrative - embodies role in improving health outcomes and reducing inequalities
- ICP maturity matrix to embed health inequalities role
- Self-assessment against Phase 3 actions
- Organisations working towards anchor status and collaborating on social value for the local economy

Neighbour hood

- Primary Care Networks to manage risk stratified population cohorts with local authority and VCFSE partners – joining up civic and community assets
- Ambition is for long term condition management to move to predictive model

Person

- Call to Action - social movement and behaviour change, focus on deprivation, BAME, LD, homelessness, etc
- Patient Activation
- Digital and health literacy

Next Steps – For consideration and discussion

In the short term, all organisations/systems must assure themselves they are undertaking the requirements of the Phase 3 guidance and North West Community Risk Reduction Framework and look to identify areas for improvement or where support is required.

The ICS must also continue to prioritise the investment in and continued development of the Population Health Management programme and Call to Action, as both of these approaches deliver on a number of the actions required.

In the longer term, to achieve real benefit from our work, a systematic approach will be needed that embeds a focus on addressing inequalities throughout all our processes, from project planning, inequalities impact assessments to funding formula and commissioning for improved outcomes.

We need to quickly establish common ground with our local authorities on health inequalities, to coordinate our efforts jointly and link into wider partnerships, such as the Lancashire Enterprise Partnership. In order to establish a catalyst for action on health inequalities, initial discussions have generated the concept of conducting a deep dive on inequalities during 2021, to understand the true impact Covid has had and ensure actions are taken by each part of our infrastructure. The establishment of a L&SC Health Inequalities Commission, similar to Fairness Commissions conducted by some local authorities, would take an independent, cross-sector view on the tangible things that can and need to be done to drive improvement. A number of actions are proposed which would take forward this work:

- Engagement, on behalf of the ICS, with all local authority chief executives and leaders to start conversations and scope the potential for a L&SC Health Inequalities Commission and linkages to/ownership by the three Health and Wellbeing Boards
- Establishment of a Health Inequalities Summit in March, which will provide data and insight, from all sectors, on the damage Covid-19 has done to our communities and serve as a call to arms for change – this will formally launch the Health Inequalities Commission
- Delivery of the Commission through April-June, with recommendations being delivered by July 2021
- Delivery against the recommendations will be monitored by the Commission and the ICS Board

We are required to capture our intentions in the form of health inequalities action plan by 31st March 2021, the establishment of this Commission will be a key focus of the plan, with the recommendations forming part of the revised action plan by the end of the Summer.

Recommendations for ICS Board

The ICS Board is recommended to endorse the following:

1. That all organisations/systems undertake a short self-assessment against the requirements of the Phase 3 guidance and North West Community Risk Reduction Framework and look to identify areas for improvement or where support is required – relevant capacity within organisations will be needed to complete this
2. That the ICS Board and Out of Hospital Cell prioritise the investment in and continued development of the Population Health Management programme and Call to Action
3. The establishment of a L&SC Health Inequalities Commission to take an independent, cross-sector view on the tangible things that can and need to be done to drive improvement on health inequalities
4. That the following actions be undertaken, overseen by Dr Julie Higgins:
    - Engagement, on behalf of the ICS, with all local authority chief executives and leaders to start conversations and scope the potential for a L&SC Health Inequalities Commission and linkages to/ownership by the three Health and Wellbeing Boards
    - Establishment of a Health Inequalities Summit in March/April and development of background work to support
    - Delivery of the Commission through April-June, with recommendations from the Commission being delivered by July 2021
5. That the ICS Board commit to freeing up capacity from within their organisations to support the leadership and development of the Health Inequalities Commission, when the full scope has been identified and agreed with local authority leaders
6. That the ICS Board commit to delivering the recommendations of the Commission and reporting to the ICS on the progress against delivering these
7. That the ICS Board will support the establishment of an ICS health inequalities action plan by 31st March 2021

For further information or discussion please contact

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Item 9

NHS
Lancashire & South Cumbria
NHS Foundation Trust

Lancashire &South Cumbria Mental Health Demand During the Covid Pandemic

Caroline Donovan, CEO

We are LSCft

Summary

NHS
Lancashire & South Cumbria
NHS Foundation Trust

- Usual **access** pathways **have been disrupted** by Covid and social restrictions, but levels of need have not reduced
- Traditional access routes via GP have become constrained – especially for new presentations, so innovation needed to grow access routes, especially **self-referral**
  - Signs of growth of self-referral via Urgent Referral **(Crisis) Line**
- When referrals are presenting, there is **greater acuity**
- Demand growth is particularly focused on **severe mental illness** (CMHT & EIS) and acuity (Home Treatment Teams and Inpatient Admission)
- Demand for **CAMHs** has grown significantly since 2016. In 2020 growth despite referral suppression due to Covid

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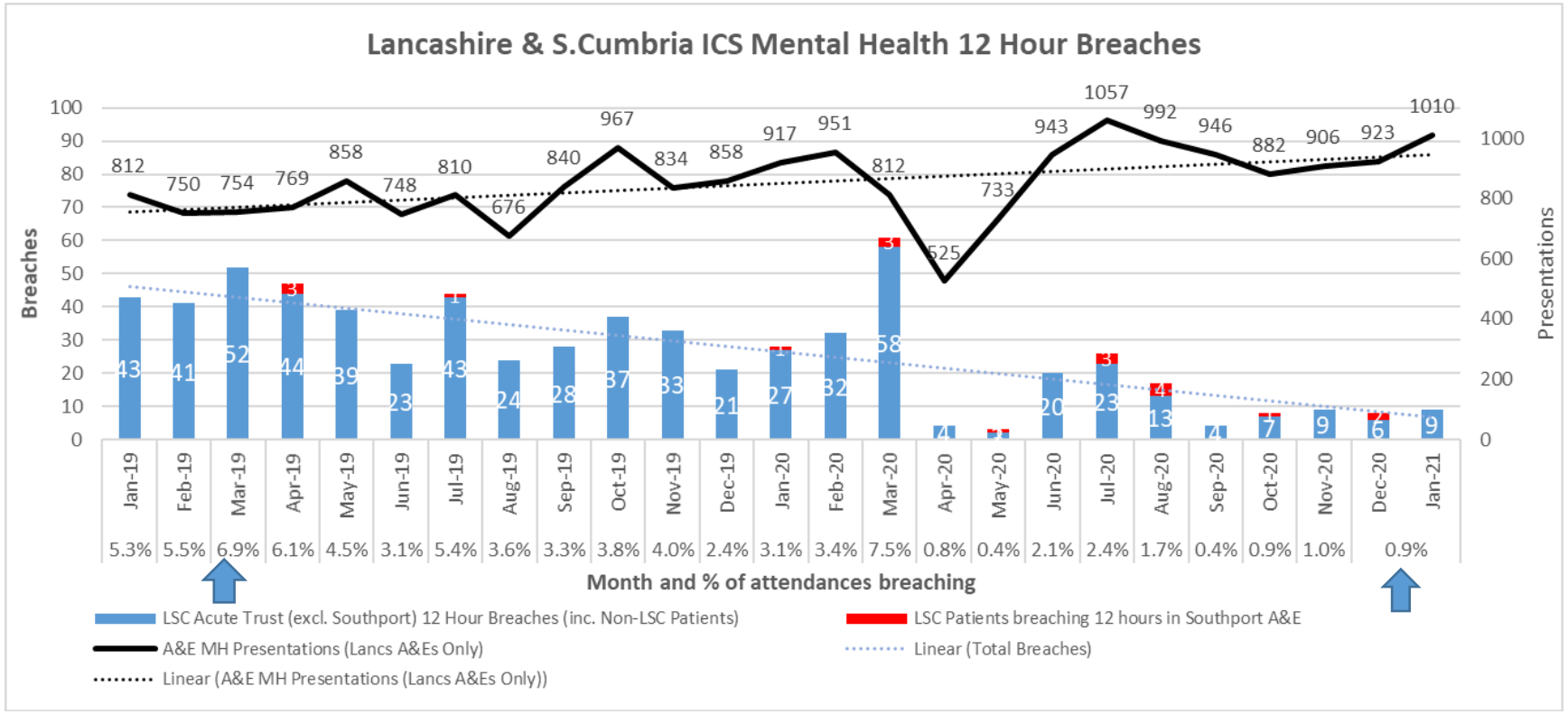
Demand: A&E

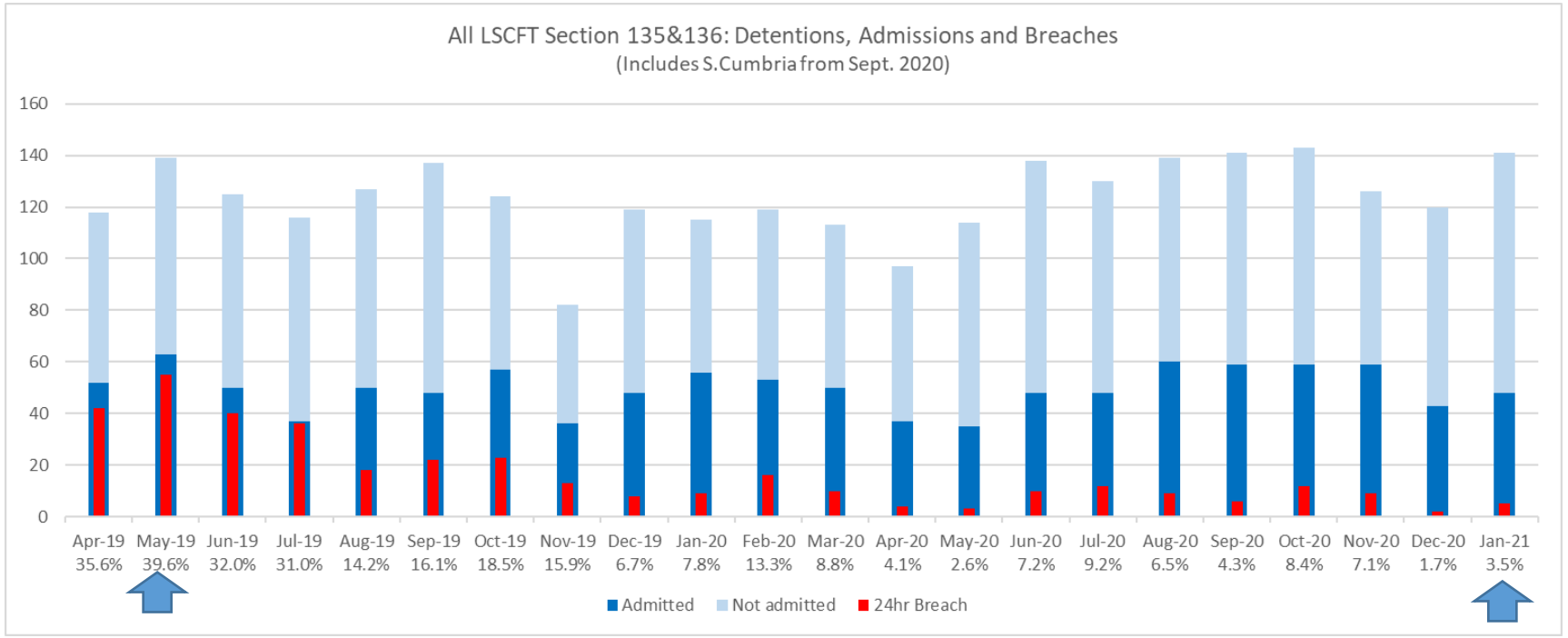
Lancashire & South Cumbria NHS Foundation Trust



- Clear dip in demand March – May 2020 during lockdown 1 with post-Lockdown surge in June & July 2020
- Sustained demand from July onwards: indicative of both higher acuity and potentially pathway issues into services (presenting in crisis, self-referral via Home Treatment Team)
- Monthly breach rate reduced c**87%** in spite of c**34%** increase in demand

Demand During Covid: s136

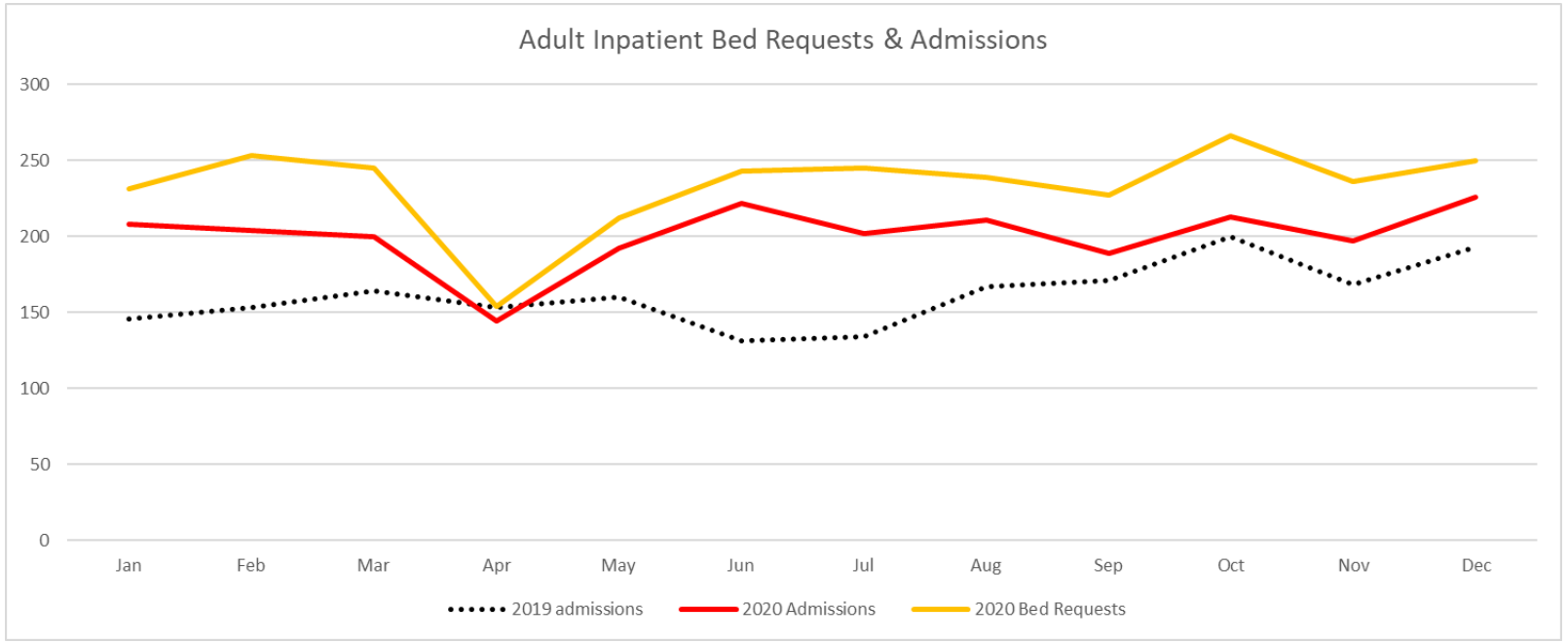
Lancashire & South Cumbria NHS Foundation Trust



- Monthly breach rate reduced **c91%**
- New IRS model planned to reduce demand on s136 detentions

Demand During Covid: Inpatients

Lancashire & South Cumbria NHS Foundation Trust



Adult Acute Admission Rate: Lancashire

	2019/20	Dec-20	Change
National average	18.2	16.2	-11%
COV039	14.9	19.3	30%

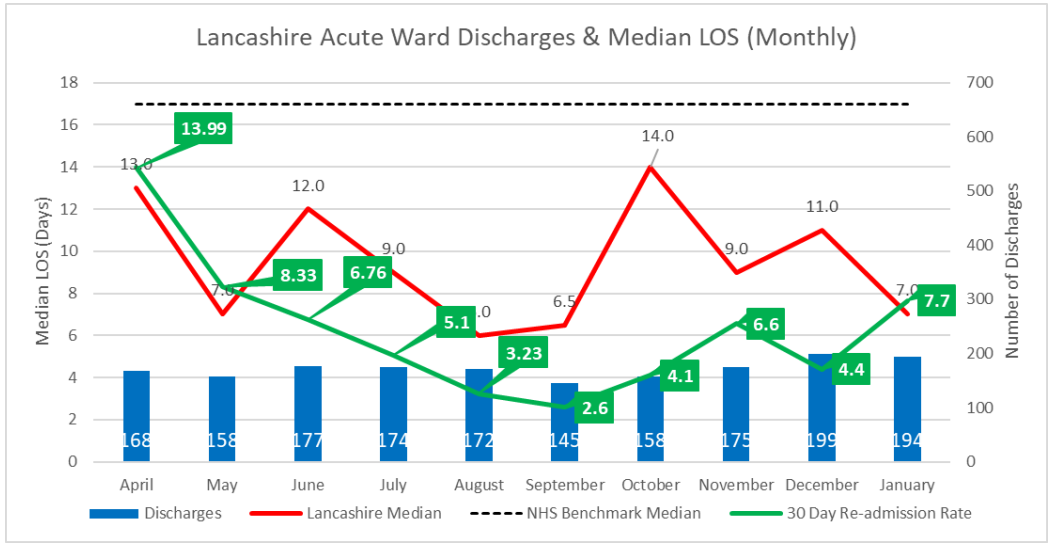
Adult Acute Admission Rate: South Cumbria

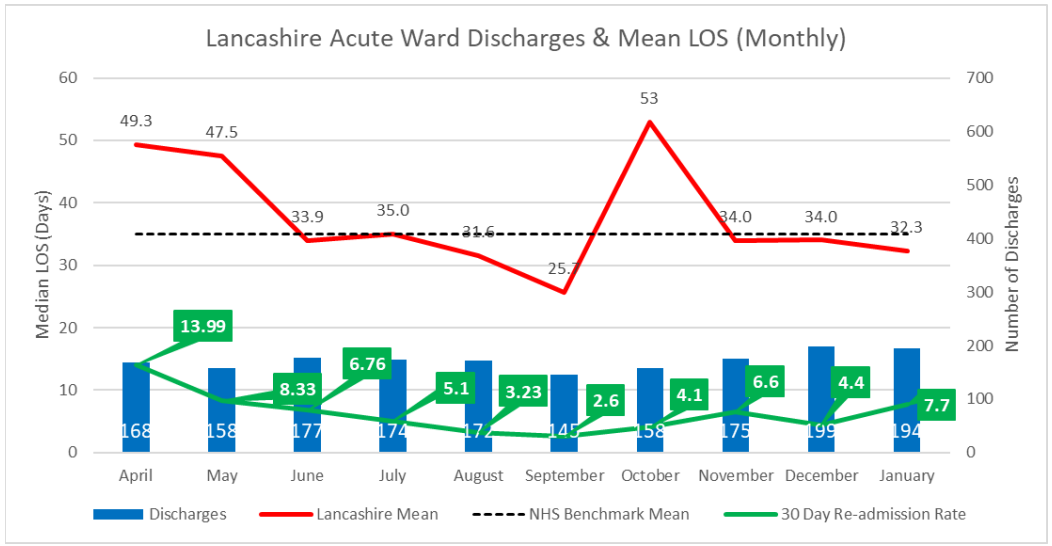
	2019/20	Dec-20	Change
National average	18.2	16.2	-11%
COV129	14.9	14.2	-5%

- Admissions eased only to the previous year's level during Lockdown 1
- Benchmarking identified a **30% increase in Trust acute admissions** per 100k population in Lancashire against a national decline of 11%.

Demand During Covid: Length of Stay

Lancashire & South Cumbria NHS Foundation Trust





- Median Length of Stay in Lancashire LOS reflects the general performance of the acute mental health inpatient pathway
- The Median LOS in Lancashire is **significantly below** the NHS Benchmark
- Lancashire Mean LOS has **decreased 32%** in last 12 months

Adult Acute Mean LOS excluding leave: Lancashire

	2019/20	Dec-20	Change
National average	34.7	33.1	-5%
COV039	42.2	28.7	-32%

Adult Acute Mean LOS excluding leave: South Cumbria

	2019/20	Dec-20	Change
National average	34.7	33.1	-5%
COV129	39.4	41.0	4%

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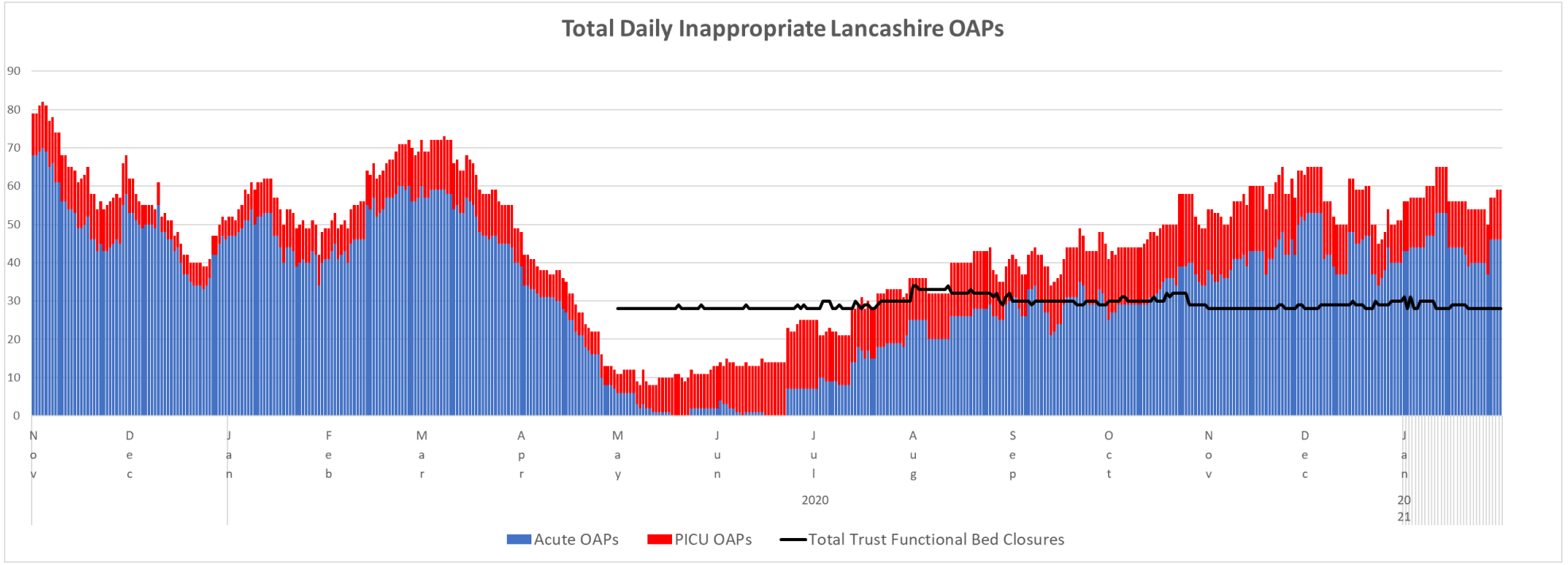
Out of Area Placements

Lancashire & South Cumbria NHS Foundation Trust



- Unprecedented demand has had a clear pressure on bed capacity, though this has been mitigated through reduced Length of Stay and lower numbers of stranded patients
- Closure of 28 LSCFT acute mental health beds to enable social distancing on wards has meant a reduction in capacity and has required additional OAP use to accommodate this demand

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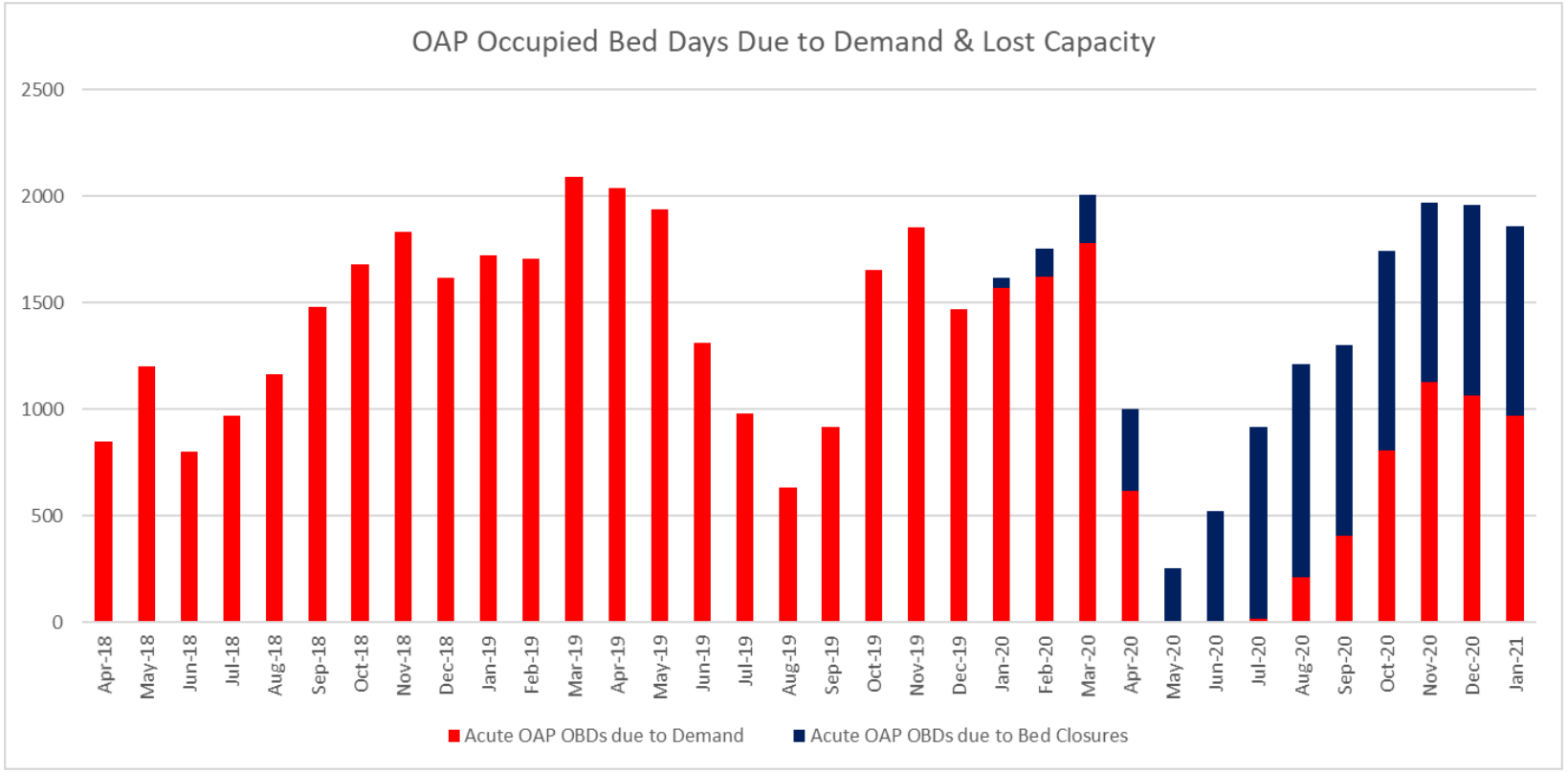
Out of Area Placements

Lancashire & South Cumbria NHS Foundation Trust



- A small number of beds were closed at the beginning of 2020 for estates works, but more significant and longer-term closures were needed from March onwards to enable IPC standards
- This has increased dependency on OAP placements as a result of lost capacity
- When comparing OAP use in Jan 2019 to Jan 2021 there has been a decrease of 44% when excluding IPC related beds

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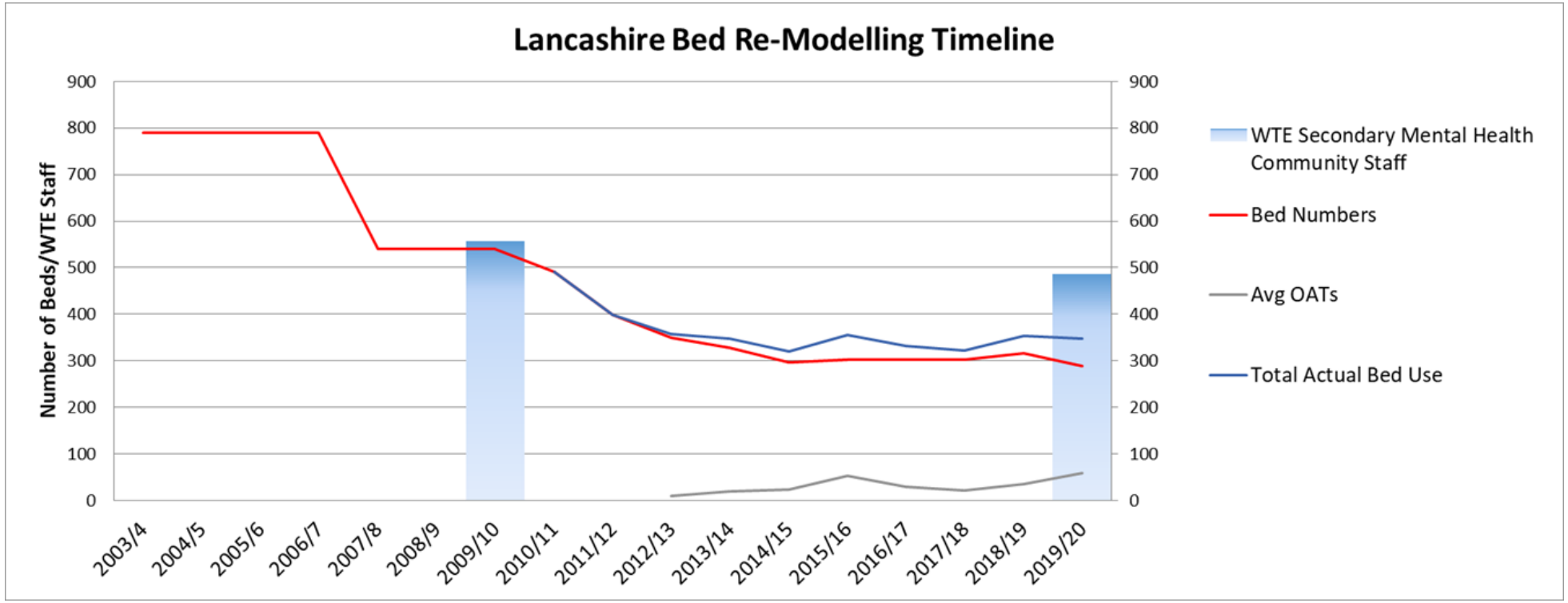
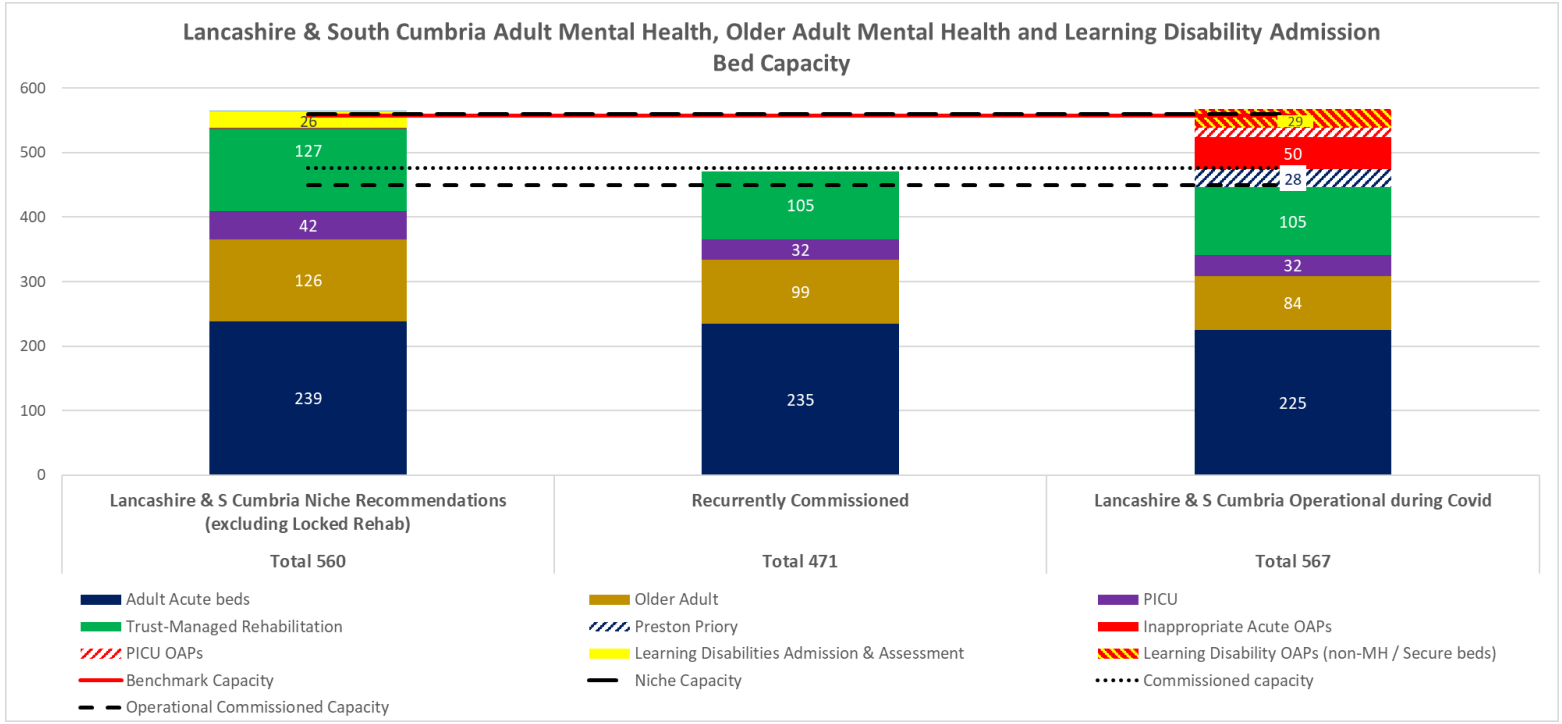
Bed Capacity in Lancashire

Lancashire & South Cumbria NHS Foundation Trust



- NOTE: 13 further beds closed as part of final reconfiguration November 2018

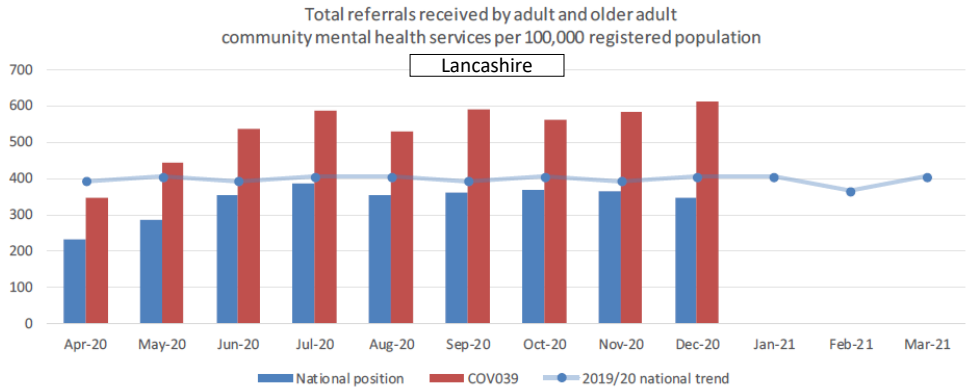
Bed capacity deficit

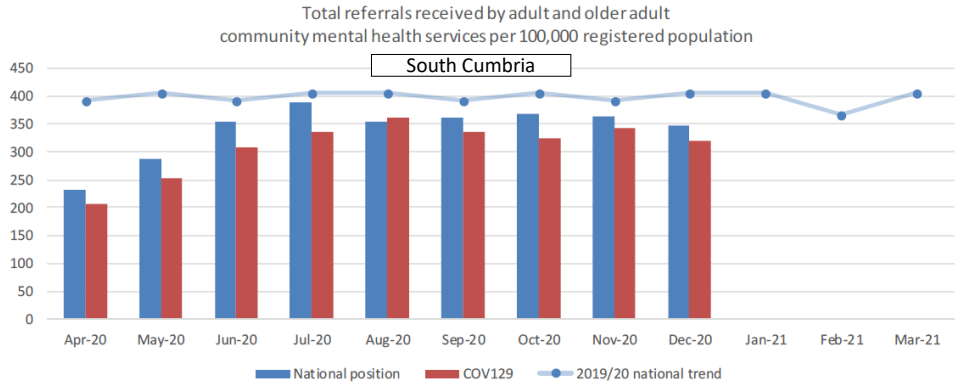


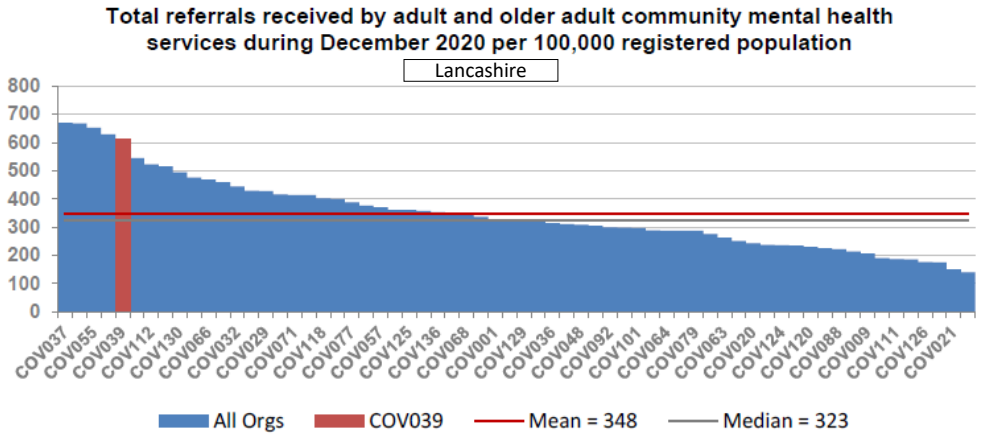
- Niche Consultancy recommended that, based on current and likely future demand, the 560 beds are required across Adult, Older Adult and Learning Disability provision (excluding very specialist Locked Rehabilitation provision and Secure LD provision)
- This is comparable to the NHS Benchmark capacity of 558 beds for a population size of Lancashire & South Cumbria
- Current commissioned capacity (including independent sector Long-Term Complex Care and High Dependency) is 471 beds
- Covid-related IPC measures have reduced available commissioned bed capacity to 446
- **This is a gap of 89 beds after the dormitory work has been completed.**

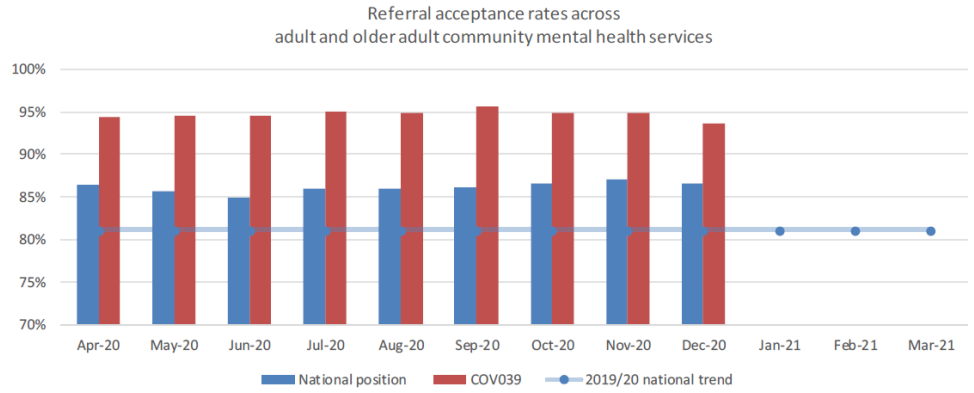
Community services Benchmarking

Lancashire & South Cumbria NHS Foundation Trust









- In December 2020 Lancashire referrals were **75% above** the NHS Benchmark, the fifth highest rate nationally
- Acceptance rates are also above the NHS Benchmark, with 94% of Lancashire referrals accepted compared to the Benchmark 87%

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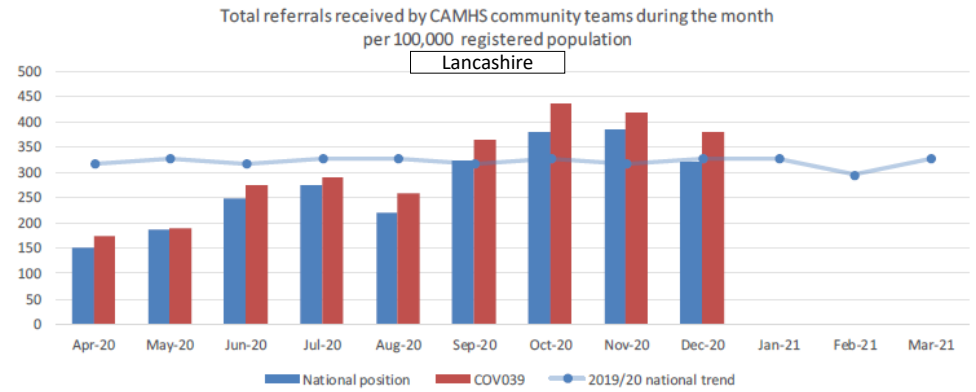
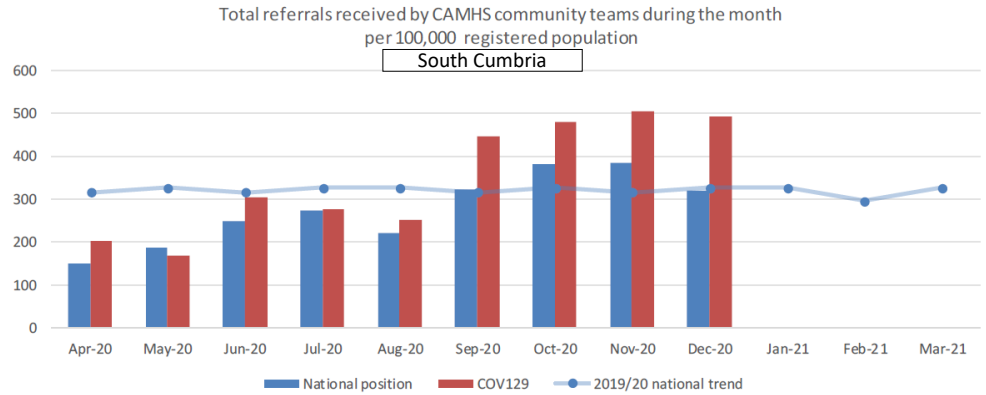
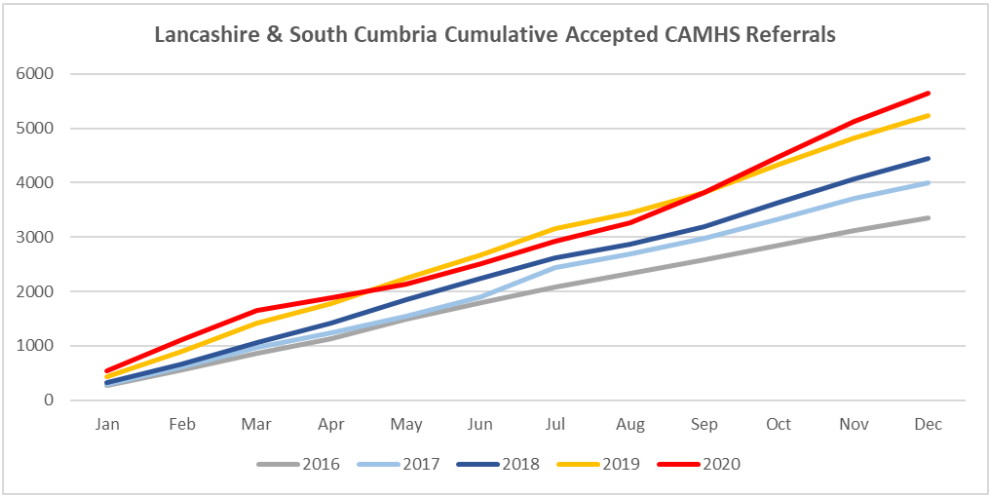
CAMHS Benchmarking

Lancashire & South Cumbria NHS Foundation Trust



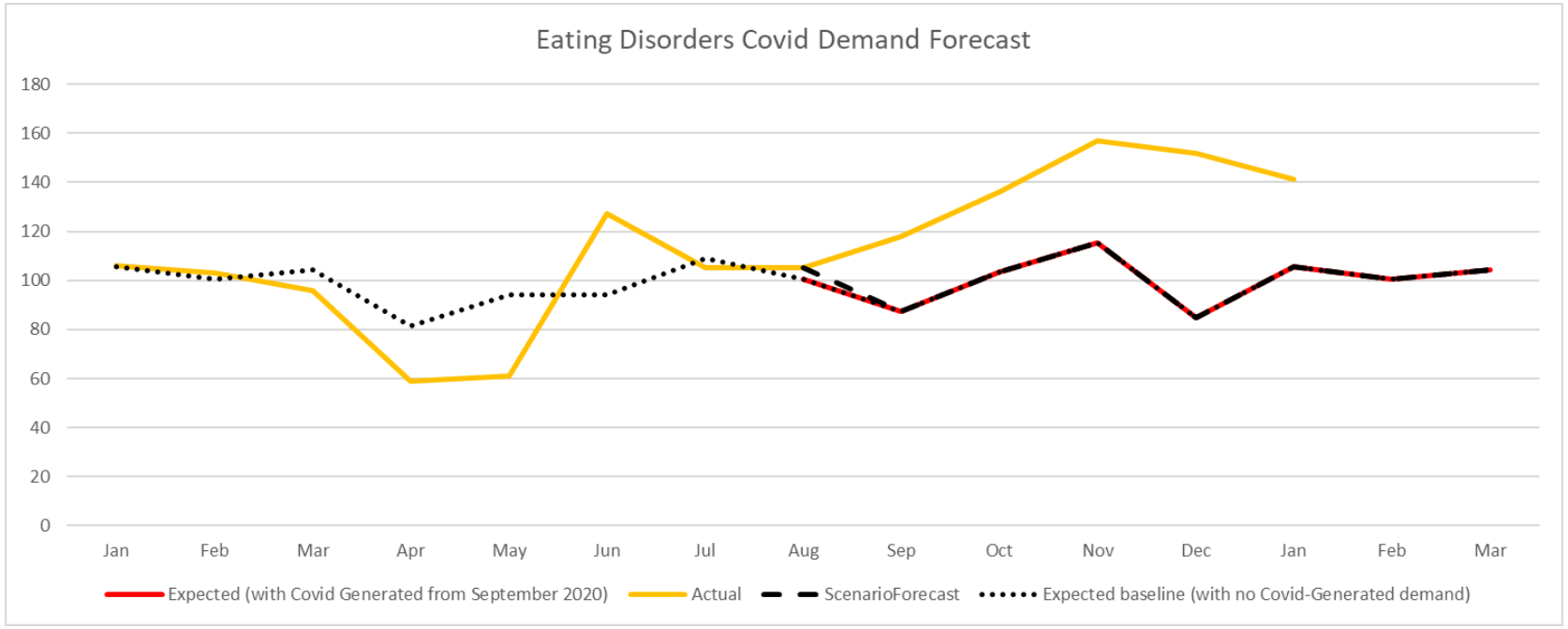


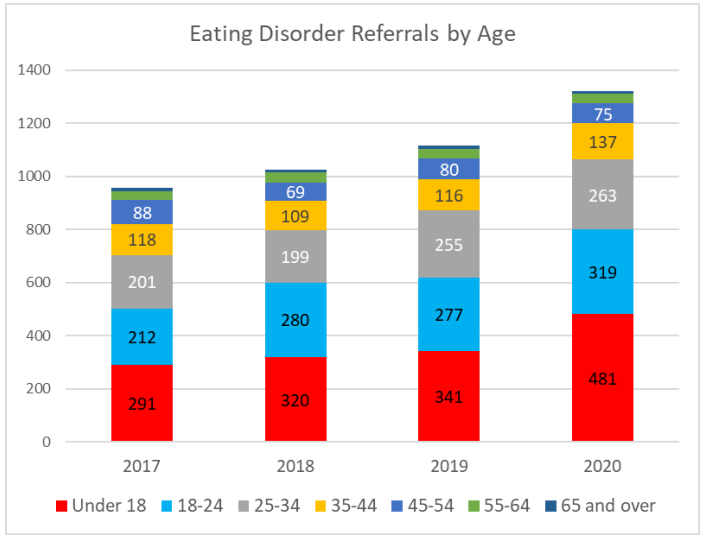


- Lancashire & South Cumbria CAMHS referrals have been above the national Benchmarked rate since April 2020, and above the 2019 Benchmark since September
- Lancashire & South Cumbria CAMHS referrals and acceptance rates have increased year-on-year
- Demand growth has been **68.6%** from 2016

Demand During Covid: All Age Eating Disorders

Lancashire & South Cumbria NHS Foundation Trust





- Early 2020 demand for Eating Disorders Services was at comparable levels to 2019
- **41.6% more accepted referrals** June-December 2020 compared to same period in 2019
- Demand in 2020 was 162% higher than commissioned capacity
- Total referrals in 2020 were 38.4% higher than in 2017
- In the same period, referrals of under 18s **increased by 65%**

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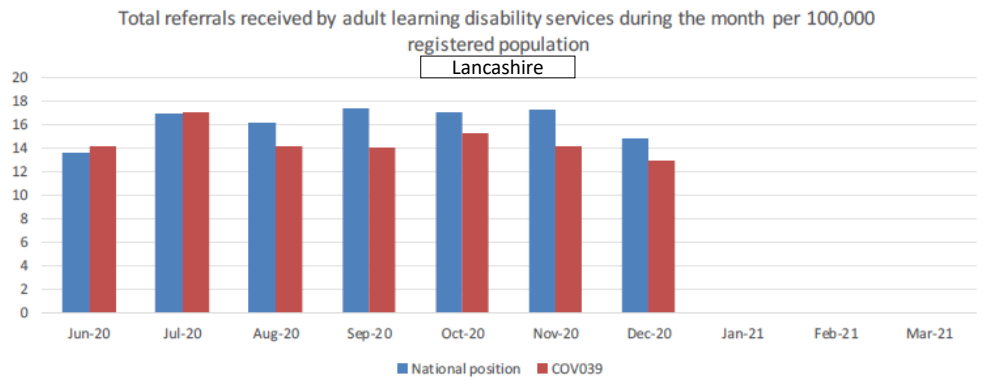
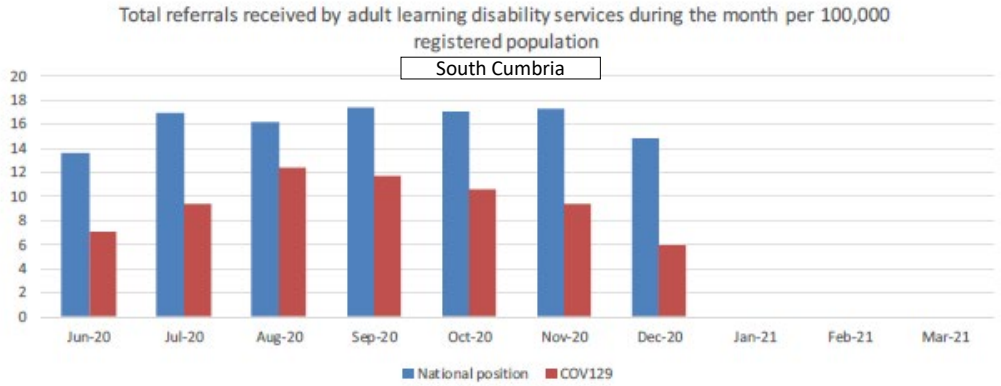
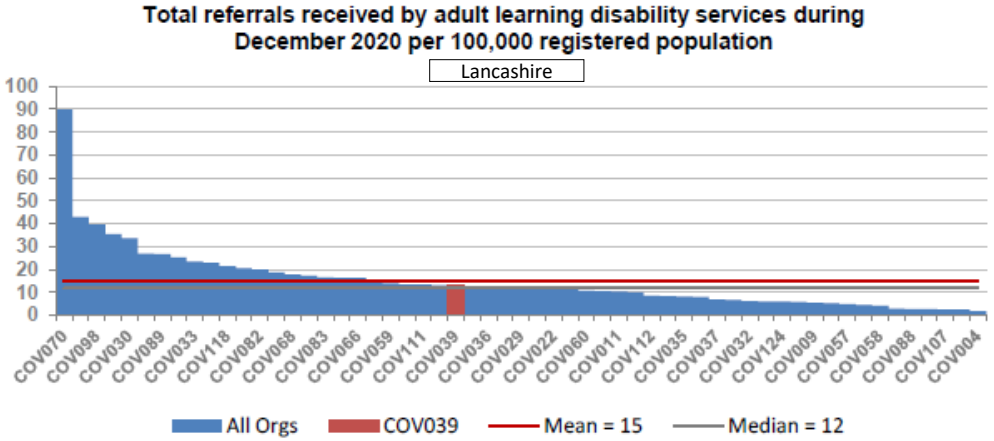
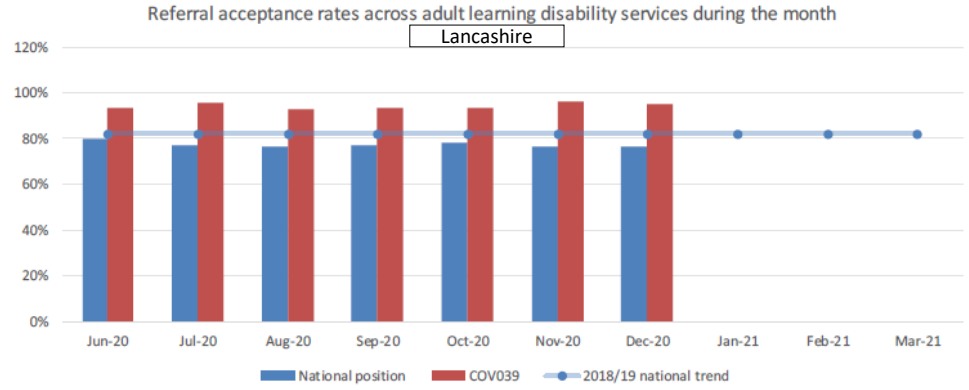
Adult LD Benchmarking





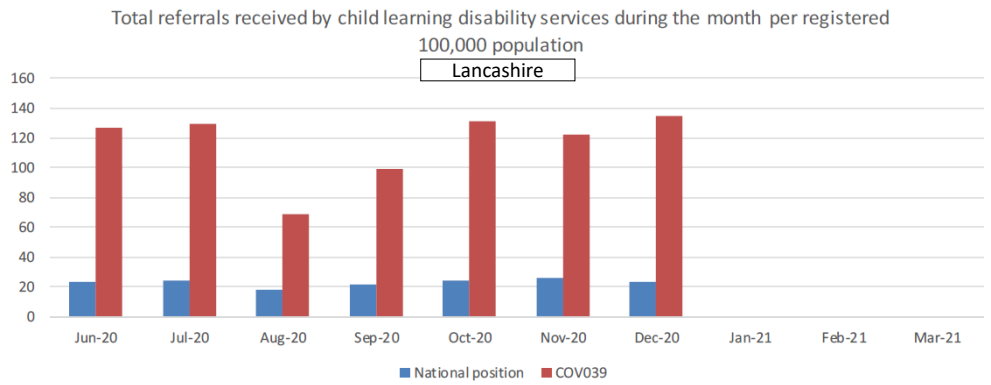


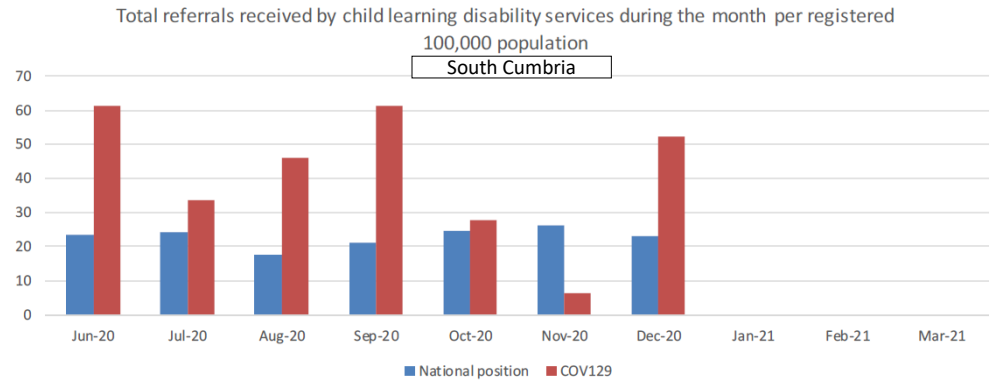


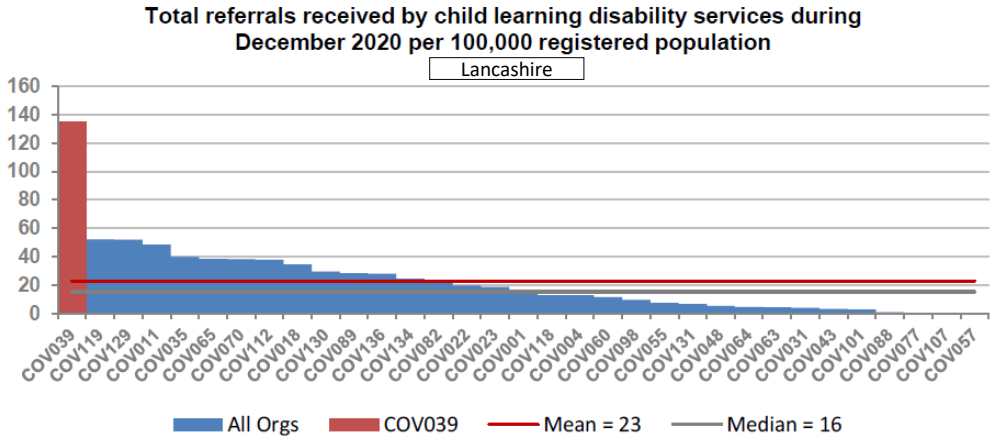
- Referral rates into Adult Learning Disability Services have been below the NHS Benchmark in Lancashire and, more notably, South Cumbria
- However, it is also notable that referral acceptance rates are higher within Lancashire compared to the NHS Benchmark

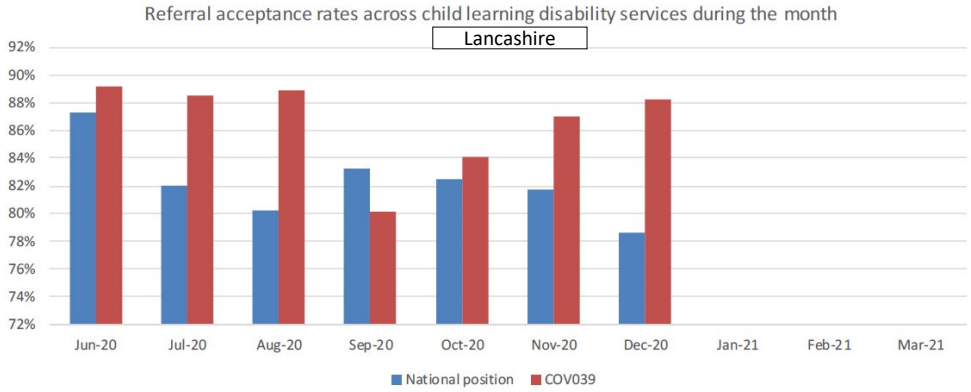
Children's LD Benchmarking

Lancashire & South Cumbria NHS Foundation Trust









- Referral rates into Children's Learning Disability Services have been notably above NHS Benchmark in Lancashire and South Cumbria
- Acceptance rates also above the NHS Benchmark
- NB – some Children with Autism are included which would not necessary be nationally

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LSC Psychological Resilience Hub

NHS Lancashire & South Cumbria NHS Foundation Trust

LSC Resilience Hub

Sector	Referrals to end Jan
Health Care	96
Local Authority	8
Blue Light Services	5
Other	10
TOTAL	118

- Online self referral screening tool live from December 2020 with **33%** of total referrals received in **January 2020**
- Majority referrals between ages 30-45 females
- High percentage of staff from nursing and health care assistant roles.
- Collaboration agreed with Critical Care Network in January 2020
- Range of promotional materials available to support staff in accessing resources, support

Workplace Trauma Support & Team Resilience

Contact	Numbers
Team Resilience sessions	25
Individual staff engaged	350
WTS Trainers trained	169

- People trained to reach between 10 and 30 peers with support, advice and guidance
- 27 teams trained in WTS from 1 acute hospital trust
- Large number of sessions arranged with range of organisations in Q1 and Q2 2021

Resilience Hub Support for the psychological impact of Covid-19

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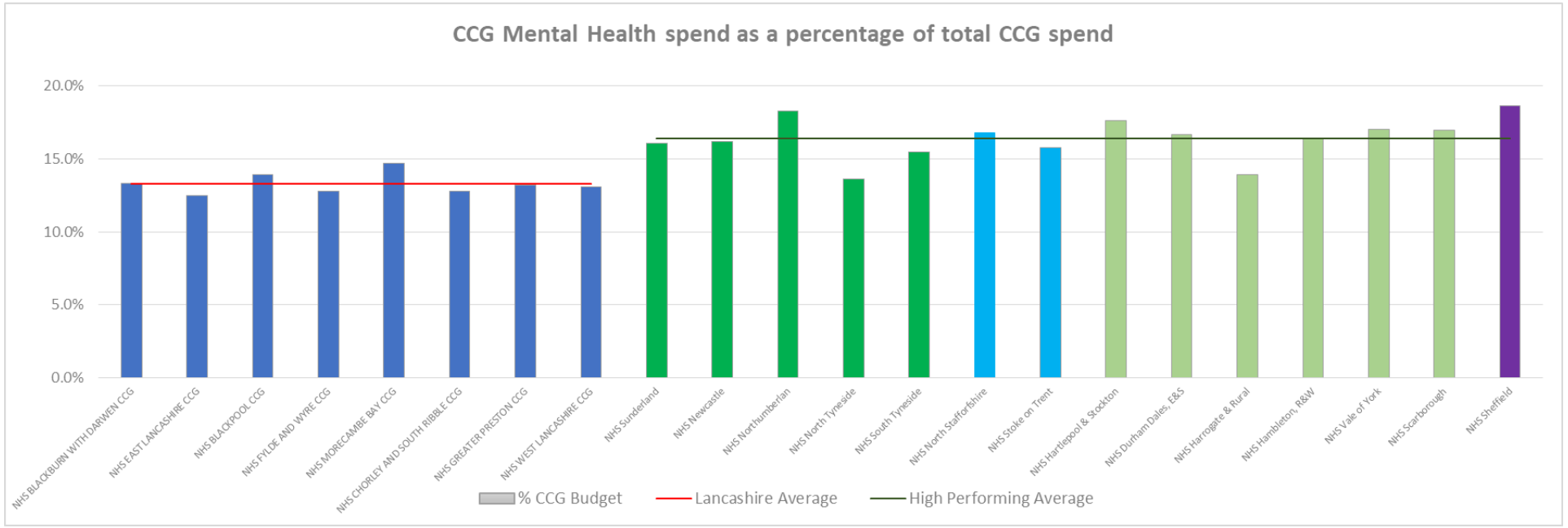
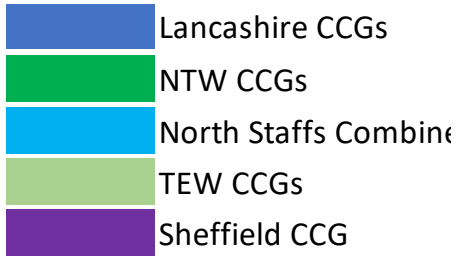
CCG Proportionate Mental Health Investment

Lancashire & South Cumbria NHS Foundation Trust





- Average Lancashire CCG spend is c13%
- Average CCG spend in high performing Mental Health Trust localities is c16% of total CCG spend
- 'The proportion of CCG spend on MH is lower than comparable sites with similar deprivation profiles in the Midlands and North West (15%)' – **Clifford Mann, National Clinical Advisor (A&E)**
- Lancashire additional spend at **16% = c£70m**
- Lancashire additional spend at **15% = c£40m**

Next Steps

NHS
Lancashire & South Cumbria
NHS Foundation Trust

Strategy:

- Develop an ICS partnership strategy for all age Mental Health and Learning Disability & Autism
- Bed redesign model integral to the new strategy
- Focus more on prevention and community resilience with partners – Local Authorities, Primary Care, Voluntary Sector and NHS Trusts

Bed Capacity:

- Work in partnership with NW Trusts to release additional private sector capacity enabling OAPs closer to home
- Dormitory ward redesign in Blackburn and Kendal
- Plans to open Wesham in early 2022
- Whalley site negotiations
- Provision of Learning Disability beds in ICS footprint working with national team

Community Transformation

- Mental Health Investment Standard (MHIS)
- Community / Primary Care redesign
- Implementation of the ICP level Integrated Response Service (IRS)
- CAMHS redesign
- Mental Health Urgent Access Centers (MHUACs)
- Eating Disorder Services

We are LSCft

ICS Board

Title of Paper	The Ockenden Report (10.12.20) and Clinical Quality Assurance for Maternity Services		
Date of Meeting	Wednesday 3rd March 2021	Agenda Item	10

Lead Author	Vanessa Wilson Programme Director Women and Children's Services	
Contributors		
Purpose of the Report	Please tick as appropriate	
	For Information	Yes
	For Discussion	Yes
	For Decision	
Executive Summary	The paper seeks to inform the Integrated Care System (ICS) Board about The Ockenden review, commissioned by the Department of Health in 2017 which reviews maternity services at the Shrewsbury and Telford Hospital NHS Trust. The first report from the review was published on 10th December 2020; the second report will be published later in 2021. The report not only outlines the immediate and essential actions for the Trust under review but also actions required of maternity services in all Trusts across England. The paper also documents the required future responsibilities for the LSC Maternity and Newborn Alliance Board (previously the Local Maternity System Board) to be responsible for Perinatal Clinical Quality Assurance, as the maternity arm of the ICS, along with its existing transformation role. In order to comply with recommendations and ensure a robust response investment is required in the Maternity System infrastructure in order to fulfil the new responsibilities.	
Recommendations	The ICS Board is asked to note the content of the paper with regard to: a) Providing assurance regarding the local maternity providers against Urgent and Essential recommendations of the Ockenden Report. b) The evolving role of the Local Maternity System as the maternity arm of the ICS with growing functionality for clinical quality assurance. c) The appointment of a Director of Midwifery for the system.	
Next Steps	Appointment of the Director of Midwifery	

Healthier Lancashire & South Cumbria

ICS Board

	Establish the Local Perinatal Quality Oversight Group, reporting arrangements and SOP for escalation.		
Equality Impact & Risk Assessment Completed	Yes	No	**Not Applicable**
Patient and Public Engagement Completed	Yes	No	**Not Applicable**
Financial Implications	**Yes**	No	Not Applicable
Risk Identified	**Yes**		No
If Yes : Risk	Risk on programme risk register A lack of a clear governance framework for the new QS reporting / assurance requirements (roles and responsibilities at CCG / LMS level compared to Regional level) will lead to confusion across the system, duplication of reporting and gaps in knowledge at LMS level re: local picture		
Report Authorised by:	Better Births Executive Team		

Report to Lancashire and South Cumbria

Integrated Care System Board

Paper Title	The Ockenden Report (10.12.20) and Clinical Quality Assurance for Maternity Services
Paper Author	Vanessa Wilson (Programme Director Women and Children's Services)
Meeting(s)	ICS Executive Team Monday 1st February System Leadership Executive Wednesday 17th February ICS Board meeting Wednesday 3rd March

Executive Summary

The paper seeks to inform the Integrated Care System (ICS) Board about The Ockenden review, commissioned by the Department of Health in 2017 which reviews maternity services at the Shrewsbury and Telford Hospital NHS Trust.

The first report from the review was published on 10th December 2020; the second report will be published later in 2021. The report not only outlines the immediate and essential actions for the Trust under review but also actions required of maternity services in all Trusts across England.

The paper also documents the required future responsibilities for the LSC Maternity and Newborn Alliance Board (previously the Local Maternity System Board) to be responsible for Perinatal Clinical Quality Assurance, as the maternity arm of the ICS, along with its existing transformation role.

In order to comply with recommendations and ensure a robust response investment is required in the Maternity System infrastructure in order to fulfil the new responsibilities.

Key Issues / Proposal

1.0 At the start of the review process it was planned to consider 23 cases this has since risen to 1,862, the majority of incidents occurring between the years 2000 to 2019. The interim report follows the completion of 250 reviews.

2.0 The 27 Local Actions for Learning outlined in the report are framed around four categories:

- general maternity care
- maternal deaths
- obstetric anaesthesia

- neonatal care

3.0 Learning From Previous National Reports

3.1 The review found that many important recommendations from previous national maternity reviews and local investigations, which might have made a significant difference to the safety of mothers and babies receiving care at the Trust, had either not been implemented or the implementation had failed to create the intended effect of improving maternity care.

4.0 Main Findings

- Lack of kindness and compassion
- Concerns of families about their care dismissed, inappropriate language in medical records, face to face and in complaint responses. Women blamed for their loss.
- Poor risk assessments and not reassessed at each contact.
- Poor standards of foetal heart rate monitoring.
- Lack of informed decision making and consent by women about choices in their care and place of birth.
- Poor escalation of development of risks and emergencies, leading to delay in transfer or appropriate medical care. Midwife to obstetrician, junior medical staff to obstetrician.
- Poor Consultant Obstetric oversight of high risk pregnancies.
- Failure to learn from incidents.
- Inappropriate use of oxytocin during labour
- Inappropriate use of forceps
- Reluctance to perform caesarean sections when indicated
- Poor bereavement care, including poor communication & lack of memory making
- Lack of compassion & understanding of senior medical staff

5.0 Immediate and Essential Actions – Maternity

5.1 Enhanced Safety

a) A plan to implement the Perinatal Clinical Quality Surveillance Model

b) All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB

c) Enhancing safety by partnership working between trusts to investigate and share learning from serious incidents;

5.2 Listening to Women and their Families

a) Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services

b) In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard.

c) Listening to women and families by having independent advocates on boards

5.3 Staff Training and working together

a) Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.

b) The report is clear that joint multi-disciplinary training is vital. Working together to provide the highest standard of care for babies and families

c) Confirmation that funding allocated for maternity staff training is ringfenced and any CNST Maternity Incentive Scheme (MIS) refund is used exclusively for improving maternity safety.

5.4 Managing complex pregnancy

a) All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.

b) Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres.

5.5 Risk Assessment throughout pregnancy

a) A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance

5.6 Monitoring Fetal Wellbeing

a) Implement the saving babies' lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.

5.7 Informed Consent

a) Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website.

b) Women need to have accurate information to make informed choices to enable informed consent

6.0 L&SC Ockenden Assurance

6.1 This report builds upon the paper 'Future Quality Assurance functions of Local Maternity Systems.

6.2 To date provider trusts have been asked to undertake 2 assurance reviews against the 7 Essential and Immediate recommendations of the Ockenden Report.

6.3 Both of these submissions have been through a peer review process and signed off by the Maternity Alliance Board prior to submission to regional Chief Midwife and the Regional Surveillance and Concerns Group. . The latest submissions were Monday 15th February.

6.4 Areas for action by Trusts include:

- Appointment of an independent maternity advocate at each trust – awaiting national role profile
- Appointment of Obstetrics Lead for fetal monitoring – new role requiring resources

- Non digital information available to parents about choices during pregnancy – EIA to be undertaken on written materials
- Audits being undertaken to evidence conversations and risk assessments are occurring as required.
- Compliance with Birth Rate + staffing model
- Submission of all Serious Incidents to the Maternity Alliance Board along with other data to allow for their new function – process being established to commence in April 2021.

6.5 There has also been an assurance review required by the Maternity Alliance, as the maternity arm of the ICS, regarding their compliance with Ockenden recommendations.

6.6 Areas for action by the Alliance include:

- Establishing a local Quality Assurance forum that will feed into the Alliance Board and the proposed ICS Quality and Performance Committee
- Appointing a senior midwife to lead on quality assurance and a governance lead as currently the required skills and competences are not in the team.
- Establish an escalation SOP and reporting programme for Trusts to provide relevant information both qualitative and quantitative

7.0 Midwifery Workforce and Leadership

7.1 Ockenden assurance also asks about midwifery workforce and leadership.

7.2 Currently within Lancashire and South Cumbria there are no dedicated Directors of Midwifery and none of the Chief Nurses are dual qualified as a midwife.

7.3 The recommendation from the Royal College of Midwifery which is endorsed in Ockenden is that each Trust which provides maternity care should have a Director of Midwifery. This would clearly be ideal but also aspirational hence the proposal, which was supported by SLE, to appoint a Director of Midwifery for the system in the first instance who would support the HoMs and CNs and provide leadership to the Clinical Quality Assurance work of the Alliance Board.

8.0 Future Arrangements

8.1 As well as, and because of, the recommendations of the Ockenden review there is going to be enhanced scrutiny of maternity services through the new surveillance forums at a regional level that will put demand on systems to produce and review intelligence, both quantitative and qualitative, to assure of service safety and quality.

8.2 As the maternity arm of the ICS the Alliance will take on a more formal role in perinatal clinical quality oversight alongside transformation and improvement activity.

8.3 Principle 2 within 'Implementing a revised perinatal quality surveillance model' (December 2020) states that the LMS will support the ICS to oversee perinatal clinical quality by:

- Ensuring an appropriately experienced and senior representative of the LMS (provider or commissioner with a clinical background) is a member of the ICS chaired Local Quality Surveillance Group
- Leading on the production of a local quality dashboard which brings together hard and soft intelligence and ensuring it is discussed regularly at meetings of the Local Surveillance Group.
- Taking timely and proportionate action to address any concerns identified and building this into local transformation plans. The onus should be on trusts to share responsibility for making improvements, making use of strengths in individual trusts.
- Reporting concerns to the Regional Chief Midwife and Lead Obstetrician and regional quality committees, where necessary with a request for additional support.

8.4 The actions above in 4.6 will support the achievement of these recommendations.

8.5 Within LSC due to our close working with the North West Clinical Network and being embedded within the ICS (many other LMSs are not in this position) the LMS is in a strong position to take on the new responsibilities with a robust quantitative maternity dashboard already in existence.

Implications / Impact

Quality • Yes	**Compliance** • Yes	**Other Workstream** • Yes joint working potential with existing LMS
Finance • Yes	**Legal** • No	**Wider ICS** • Yes
Workforce • Yes	**Equality & Diversity** • Yes	**Outside ICS** • Yes – regional level reporting into regional surveillance board.

Recommendations

The ICS Board is asked to note the content of the paper with regard to:

a) Providing assurance regarding the local maternity providers against Urgent and Essential recommendations of the Ockenden Report.

b) The evolving role of the Local Maternity System as the maternity arm of the ICS with growing functionality for clinical quality assurance.

c) The appointment of a Director of Midwifery for the system.

Appendix A

https://www.england.nhs.uk/wp-content/uploads/2020/12/implementing-a-revised-perinatal-quality-surveillance-model.pdf

Appendix B

Summary of proposed changes to the Maternity Quality Model – see page 7

Healthier Lancashire & South Cumbria

	Existing Model	New Model	How this will be achieved
Trust	Locally led by frontline and board safety champions with variable levels of oversight for maternity and neonatal safety.	A formal mechanism for sharing safety insights between frontline and the Board Safety champion.	CNST MIS Action 9
	Variable understanding of maternity safety at Board level.	Strengthened oversight for maternity and neonatal safety at Board level	Revised guidance, a Toolkit; development of a Board level set of measures.
	Maternity issues reflected at Board ad hoc	Quarterly Board review of maternity and neonatal safety	CNST MIS Action 9; CQC Inspection process
Local	CCG monitoring quality of maternity care. Oversight for SI's. Assurance through Clinical Quality risk groups.	CCG representation on system level (ICS) quality boards. ICS to Chair.	Revised national model for quality surveillance requires all system level quality groups to report on maternity.
	LMSs have responsibility for transformation; measuring the quality of services; ensuring learning across the LMS and beyond.	LMSs to be supported to take a formal role in maternity and neonatal quality oversight, alongside transformation and QI.	Formal requirement set out within revised LMS deliverables - 2020
	Variation in representation for maternity at local QSG	LMS representation on local quality group	Revised national model for quality requires LMS representation in new quality model
Regional	Quality oversight led by DoN and Chief Nurse working with CCG/ICS through a quality governance committee/group.	Regional Chief Midwives with a leadership role in quality and safety reporting to the Regional Chief Nurse and linked to Programme Boards.	A revised framework for regional oversight for maternity quality; supporting ICS/LMS roles; clear governance, and responsibilities.
	Variable extent to which maternity care, data and intelligence from maternity and neonates are reviewed, unless a quality concern arises.	Bring together insights from regional reps from a range of organisations (HSIB, CQC, RCOG, NHSE/I, RCM; MVP; NHSR, MBRRACE-UK).	New quality models to include Regional Chief Nurse and Lead Obstetrician with access to or bringing insights from a range of organisations/information
	Variation in use of dashboards and metrics to reliably inform quality outcomes.	Specified requirement for quality boards/groups to include maternity representation. Intel should be considered as part of overall Trust intelligence. A range of measures to inform the quality of maternity and neonatal services	Revised national guidance on system oversight structures to be issued in the autumn. ReChMid/obstetrician to represent maternity. A new regional reporting tool
National	Regional QSG's report into Exec Quality group. NHSR led Early Notification Maternity Safety Surveillance and Concerns group with membership from a range of national orgs with insights into maternity.	CMidO and NCD join as members of EQB escalating relevant maternity/neonatal concerns for review. Leadership to transfer to NHSE/I (Autumn 2020). To be chaired by CMidO and NCD enabling insights to be brought to EQB.	Revised national model for quality includes CMidO and NCD as members of EQB and as chairs of the National Maternity Safety Surveillance and Concerns Group.

ICS Board

Date of Meeting	3 March 2021
Title of Paper	ICS Finance Report
Presented By	Gary Raphael, ICS Executive Lead for Finance
Author	Elaine Collier, ICS Head of Finance
Agenda Item	12
Confidential	No

Purpose of the Paper
For noting.
Executive summary
This paper reports on the month 10 financial performance for the L&SC system. It covers the revenue and capital positions of all L&SC partners and the position on ICS central functions.
Recommendations
The Board is asked to **note** the updates to the financial position and **support** the recommendations to action a revenue to capital transfer of expenditure as reported in paragraph 13.

Governance and Reporting
(List other forums that have discussed the issues in this paper)

Meeting	Date	Outcome
None		

Conflicts of Interest Identified
Not applicable

Implications						
Quality Impact Assessment Completed	**Yes**	☐	**No**	☐	**N/A**	☒
Equality Impact Assessment Completed	**Yes**	☐	**No**	☐	**N/A**	☒
Privacy Impact Assessment Completed	**Yes**	☐	**No**	☐	**N/A**	☒
Financial Impact Assessment Completed	**Yes**	☒	**No**	☐	**N/A**	☐
Associated Risks	**Yes**	☒	**No**	☐	**N/A**	☐
Are Associated Risk Detailed on the ICS Risk Register?	**Yes**	☐	**No**	☒	**N/A**	☐
If Yes, Please Provide a Risk Description and Reference Number	They are detailed in this report					

Financial Report

Introduction

1. This paper reports on the month 10 financial performance for L&SC partners and ICS central functions.

Financial Performance

2. As indicated in previous reports, we are now being monitored against the fixed financial envelope that has been assigned to the L&SC system for months 7 to 12. The tables below reflect the system's performance against the latest formal submission of our phase 3 financial plan figures which indicated a £90.7m deficit over and above our envelope.

3. Table 1 below shows the summary financial position for the L&SC system by commissioner and provider sectors at the end of month 10, January 2021. The system is currently reporting a year-to-date underspend of £16.5m against plan and is forecasting a £23m underspend against plan for year-end.

4. However, since this plan was submitted, the system was asked to further improve its forecast. Whilst these tables report against the latest formal plan that exists in organisations financial systems, we have included a table in paragraph 10 to show how performance looks compared to our revised forecast target.

5. The reported numbers below assume that we will receive additional national funding. Our partner organisations are no longer able to claim top up payments but we still expect some costs will attract additional national funding over and above our financial envelope. These are reported against the "COVID-19 Reimbursement – M7-12" lines below and at month 10 these costs equate to £16.6m in CCGs for the Hospital Discharge Programme and £7.1m in trusts for testing, mass vaccination, etc. Should these claims not be validated, this will deteriorate our financial position.

Table 1 – L&SC summary financial position as at the end of month 10, January 2021:

L&SC - M10						
	Year-to-date			Forecast Outturn		
	Plan	Actual	Under/(over) spend	Plan	FOT	Under/(over) spend
	£m	£m	£m	£m	£m	£m
CCG financial position	(127.4)	(143.9)	(16.4)	(127.4)	(154.3)	(26.9)
CCG Retrospective Top Up - M1-6	127.4	127.4	0.0	127.4	127.4	0.0
COVID-19 Reimbursement - M7-12	0.0	16.6	16.6	0.0	27.8	27.8
Commissioner Total	**(0.0)**	**0.2**	**0.2**	**0.0**	**0.9**	**0.9**
Trust Income excl Top Up	2,289.7	2,295.4	5.8	2,797.2	2,815.2	18.0
Pay	(1,753.7)	(1,746.0)	7.7	(2,124.6)	(2,134.6)	(10.0)
Non Pay	(802.2)	(804.0)	(1.9)	(970.9)	(970.3)	0.6
Non Operating Items	(33.7)	(32.3)	1.4	(39.9)	(39.1)	0.8
Trust Top Up - M1-6	247.5	243.7	(3.8)	247.5	243.7	(3.8)
COVID-19 Reimbursement - M7-12	0.0	7.1	7.1	0.0	16.5	16.5
Provider Total	**(52.4)**	**(36.1)**	**16.3**	**(90.7)**	**(68.6)**	**22.1**
L&SC Total	**(52.4)**	**(35.9)**	**16.5**	**(90.7)**	**(67.6)**	**23.0**

6. For the final version of the plan, the SLE agreed that L&SC should adopt a tactical approach to balance CCG positions and show the financial gap against trusts. Taking this approach has led to providers holding what effectively is an ICP system deficit.

7. Table 2 below reports on the ICP performance against the planned deficit / financial gap. This shows the £16.5m year-to-date underspend against plan by ICP. All ICP areas are currently reporting an improved year-to-date position compared to their plan, and most are forecasting that the improvement will continue to year end, with an underspend of £23m being forecast against plan for year-end.

Table 2 – L&SC ICP summary financial position as at the end of month 10, January 2021:

SUMMARY OF FINANCIAL GAP BY ICP	Year-to-date			Forecast Outturn		
	Plan	Actual	Under/(over) spend	Plan	FOT	Under/(over) spend
	£m	£m	£m	£m	£m	£m
Central Lancashire ICP	(11.9)	(5.9)	6.1	(19.3)	(7.0)	12.3
Fylde Coast ICP	(11.9)	(11.4)	0.4	(20.6)	(19.5)	1.1
Morecambe Bay ICP	(15.9)	(8.5)	7.5	(25.0)	(18.9)	6.1
Pennine Lancashire ICP	(9.4)	(9.3)	0.1	(17.7)	(17.0)	0.7
West Lancashire MCP	0.0	0.2	0.2	(0.0)	0.9	0.9
Lancashire & South Cumbria FT	(1.4)	0.2	1.6	(4.1)	(1.8)	2.2
North West Ambulance Service	(1.9)	(1.4)	0.5	(4.0)	(4.3)	(0.3)
L&SC SYSTEM FINANCIAL GAP	**(52.4)**	**(36.1)**	**16.5**	**(90.7)**	**(67.7)**	**23.0**

8. Appendix 1 (attached) shows further detailed information on the income and expenditure trends for both commissioner and provider sectors. The trust table shows how trust performance can fluctuate due to both increasing expenditure and loss of income. The Covid response has had a particular impact on trusts being able to achieve previous income levels and whilst some of this has been reflected in the financial envelope, there is an expectation that they will recover their income levels during months 7 to 12.

Covid Related Costs

9. Tables 3 and 4 below show the Covid related costs that our partner organisations are continuing to incur. As mentioned in paragraph 5 above, the financial envelope for months 7 to 12 includes funding for all Covid related costs with the exception of some specific costs that are expected to attract additional national funding. The tables show the current costs by category of spend and by organisation, and highlights the costs that we expect to receive national funding for.

Table 3a – CCG Covid related costs by category of spend as at the end of month 10, January 2021:

CCGs - Covid Analysis	Total
	£m
Commissioning Services	84.1
Primary Care Services	12.5
Programme / Running Costs	0.0
TOTAL	**96.6**

Table 3b – CCG Covid related costs by CCG as at the end of month 10, January 2021:

CCGs - YTD Covid Related Costs	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	Total	of which - national funding expected
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	
Blackburn with Darwen CCG	0.5	0.5	0.7	0.9	0.7	0.6	0.8	0.5	0.4	0.6	6.2	1.1
Blackpool CCG	0.8	0.8	1.8	1.8	1.7	1.9	0.8	(0.6)	2.4	1.4	12.7	2.1
Chorley & South Ribble CCG	0.7	0.7	1.1	1.2	0.8	1.3	0.8	0.8	0.7	0.6	8.7	1.9
East Lancashire CCG	1.6	1.6	1.2	2.1	1.8	2.0	1.6	1.2	1.1	1.4	15.6	1.6
Fylde & Wyre CCG	0.4	0.4	1.0	1.2	1.0	1.3	0.7	(0.7)	1.4	0.8	7.5	1.5
Greater Preston CCG	0.8	0.8	2.3	1.5	5.5	3.5	1.3	1.3	1.7	2.0	20.7	3.6
Morecambe Bay CCG	1.5	1.5	1.2	2.4	2.1	1.9	1.9	2.0	2.7	1.6	18.7	3.7
West Lancashire CCG	0.3	0.3	0.5	0.8	1.4	0.8	0.3	0.8	0.5	0.8	6.5	1.1
TOTAL	**6.5**	**6.5**	**9.8**	**11.9**	**15.0**	**13.3**	**8.3**	**5.3**	**10.8**	**9.2**	**96.6**	16.6

Table 4a – Trust Covid related costs by category of spend as at the end of month 10, January 2021:

Trusts - Covid Analysis	Total
	£m
Pay	79.0
Non Pay	83.3
TOTAL	**162.3**

Table 4b – Trust Covid related costs by trust as at the end of month 10, January 2021:

Trusts - YTD Covid Related Costs	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	Total	of which - national funding expected
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	
Blackpool Teaching Hospital	3.7	3.7	2.8	(3.8)	1.1	2.5	2.1	2.4	2.0	1.2	17.7	1.5
East Lancashire Hospital	3.0	3.0	2.8	3.4	2.3	2.6	1.8	3.1	2.7	0.5	25.1	0.6
Lancashire & South Cumbria FT	2.7	2.7	2.1	1.8	1.4	2.7	1.1	1.9	1.0	4.4	21.8	1.6
Lancashire Teaching Hospital	5.0	5.0	4.5	4.6	3.4	4.5	4.5	3.6	4.1	2.8	42.0	2.7
North West Ambulance Service	3.4	3.4	3.6	2.9	2.2	3.3	2.5	3.0	2.7	3.2	30.2	0.1
Univ Hosp of Morecambe Bay	3.8	3.8	2.6	2.4	1.6	2.3	2.2	2.2	2.4	2.3	25.5	0.6
TOTAL	**21.5**	**21.5**	**18.4**	**11.3**	**12.0**	**17.9**	**14.2**	**16.2**	**14.9**	**14.4**	**162.3**	7.1

Improved Forecast Target

10. As indicated above, following the latest plan submission, additional work was required to further improve our position by £29m, giving us an improved target deficit of £61.1m. The revised plan figures in table 5 below have been manually adjusted to reflect the improved position that the system is now being monitored against so that we can show our performance against this new target. The table shows that the system is £5.5m adrift of the year-to-date target and £6.6m adrift of the forecast outturn position. However, there is still some work progressing nationally to understand the impact of increased annual leave accruals, with staff being unable to take leave due to sickness or working additional hours in the Covid response. We understand that the month 9 increases in the level of accruals would not count against our target and therefore have adjusted the latest movement from the forecast outturn figures below to show what our year-end performance would look like if this is confirmed. This shows that the system would underspend its revised plan by £6.4m.

Table 5 – L&SC ICP summary financial position as at the end of month 10, January 2021, with plan manually amended to reflect the improved forecast requirement:

SUMMARY OF FINANCIAL GAP BY ICP	Year-to-date			Forecast Outturn		
	Revised Plan	Actual	Under/(over) spend	Revised Plan	FOT	Under/(over) spend
	£m	£m	£m	£m	£m	£m
Central Lancashire ICP	(4.0)	(5.9)	(1.9)	(8.0)	(7.0)	1.0
Fylde Coast ICP	(8.7)	(11.4)	(2.8)	(17.3)	(19.5)	(2.2)
Morecambe Bay ICP	(9.2)	(8.5)	0.7	(18.3)	(18.9)	(0.6)
Pennine Lancashire ICP	(7.6)	(9.3)	(1.7)	(15.2)	(17.0)	(1.8)
West Lancashire MCP	0.0	0.2	0.2	0.0	0.9	0.9
Lancashire & South Cumbria FT	0.0	0.2	0.2	0.0	(1.8)	(1.8)
North West Ambulance Service	(1.2)	(1.4)	(0.3)	(2.3)	(4.3)	(2.0)
L&SC SYSTEM FINANCIAL GAP	**(30.6)**	**(36.1)**	**(5.5)**	**(61.1)**	**(67.7)**	**(6.6)**
adjusted for annual leave accrual movement in M09 which we understand				0.0	13.0	13.0
will not count against our target				**(61.1)**	**(54.7)**	**6.4**

Capital

11. As previously reported the ICS has a capital envelope of £138.7m for 2020/21 for our pre-Covid business as usual plans and we have worked with Trust partners during the year to refine these plans to ensure we are able to remain within this envelope. During the year a series of additional capital allocations have become available resulting in a total available resource of £234.3m. There have been two significant changes to the position reported at the last board meeting.

12. Whilst most Trusts continue to forecast achievement of these plans, the late notification of the emergency loan to Blackpool Teaching Hospital has resulted in an unavoidable slippage against the plan of c£5.6m. It has not been possible at an ICS level to offset this by increasing expenditure across other ICP areas. Indeed, despite the Trusts' commitment to maximise their capital spend there are some risks to achieving plans. Trusts continue to develop contingency plans to mitigate the risks. The £5.6m along with any other slippage will be a first call on next year's capital allocation.

13. In addition to the above, given the risks associated with achieving the revenue target it is likely that there will be a requirement for a revenue to capital transfer of expenditure. The value of this is to be finalised but could be in the region of £8.5m. In the event that this is required, and supported, this constitutes a further pressure on next year's allocation.

14. ICS and Trust colleagues are in the process of developing an investment/capital programme for next year. Trust colleagues are meeting on the 26th February to outline the requirements driven by backlog maintenance, IT and medical equipment replacement and any requirements for service and financial improvements. This will feed into the Estates and Infrastructure workshop led by ICS colleagues on 2nd March. It should be noted that the collective demands are likely to be greater than the available resources. Consequently, individual organisations, ICPs and the ICS/ Investment Committee will need to undertake prioritisation exercises to balance back to resources. In order to minimise this requirement alternative sources of funding, such as leases/commercial partnerships will be explored and recommended where the revenue impact is favourable.

ICS Central Functions

15. The table below provides an update on the financial position for central functions. The focus on the Covid response earlier in the year and the delay in some national funding being confirmed, has meant a slow start to some workstreams, resulting in a year-to-date underspend. However, we are currently working to clear significant levels of invoices against these areas and will be able to update the year-end forecast in the next report.

Table 6 – Central Functions budgets as at the end of month 10, January 2021:

ICS Central Functions	Year-to-date			Full Year Forecast		
	Budget	Actual	Under/(over) spend	Annual Budget	Forecast Outturn	Under/(over) spend
	£000	£000	£000	£000	£000	£000
ICS Core Budgets						
Clinical Portfolios	371	336	35	454	454	0
Enabling Functions	1,097	953	144	1,313	1,313	0
Executive Functions	1,791	1,391	400	2,151	2,151	0
Other Support Functions	237	237	(0)	284	284	0
	3,495	2,917	578	4,202	4,202	0
Nationally Funded Budgets	9,892	2,215	7,677	11,873	11,873	0
System Funded Budgets	446	236	210	535	535	0
TOTAL	**13,833**	**5,368**	**8,465**	**16,610**	**16,610**	**0**

Recommendation

16. The Board is asked to **note** the updates to the financial position and to **support** the revenue to capital transfer of expenditure signalled in paragraph 13.

Gary Raphael
ICS Executive Lead for Finance
24 February 2021

APPENDIX 1

CCG summary of year-to-date expenditure and forecast outturn positions:

L&SC - CCG Overview M10									
Net Expenditure		Year-to-date			Trend	Forecast Outturn			Trend
		Plan	Actual	Under/(over) spend		Plan	FOT	Under/(over) spend	
		£m	£m	£m		£m	£m	£m	
Blackburn with Darwen CCG		238.0	238.0	(0.0)	↔	291.3	291.3	0.0	↔
Blackpool CCG		429.7	429.7	0.0	↔	599.7	599.7	(0.0)	↔
Chorley & South Ribble CCG		263.1	263.1	(0.0)	↔	315.0	315.1	(0.0)	↔
East Lancashire CCG		569.2	569.2	(0.0)	↔	692.8	692.8	0.0	↔
Fylde & Wyre CCG		281.3	281.3	0.0	↔	340.7	340.7	(0.0)	↔
Greater Preston CCG		297.1	297.1	0.0	↔	355.7	355.7	(0.0)	↔
Morecambe Bay CCG		519.5	519.5	0.0	↔	626.3	626.4	(0.0)	↔
West Lancashire CCG		163.0	162.8	0.2	↑	195.7	194.7	0.9	↑
Total CCG Net Expenditure		**2,760.9**	**2,760.7**	**0.2**	↑	**3,417.2**	**3,416.3**	**0.9**	↑

NOTE

Plan figures reflect the submission on 18/11/20 in which CCGs were all at breakeven, adjusted for the outstanding retrospective top up for M7-12 Hospital Discharge Programme costs which are expected to be funded nationally.

Trust summary of year-to-date income and expenditure and forecast outturn positions:

L&SC - Trust Overview M10									
Income & Expenditure		Year-to-date			Trend	Forecast Outturn			Trend
		Plan	Actual	Under/(over) spend		Plan	FOT	Under/(over) spend	
		£m	£m	£m		£m	£m	£m	
Blackpool Teaching Hospital	Income	394.6	397.6	3.0	↑	481.1	487.0	5.9	↑
	Expenditure	450.0	453.0	(2.9)	↓	545.3	551.4	(6.1)	↓
East Lancashire Hospitals Trust	Income	461.2	461.8	0.6	↑	561.7	564.4	2.8	↑
	Expenditure	510.1	508.5	1.6	↑	618.9	621.1	(2.2)	↓
Lancashire Teaching Hospitals Trust	Income	466.4	466.6	0.2	↑	572.1	573.5	1.4	↓
	Expenditure	539.7	536.5	3.2	↑	652.8	646.3	6.5	↑
Lancashire & South Cumbria FT	Income	327.0	325.5	(1.5)	↓	398.8	402.0	3.3	↓
	Expenditure	355.6	354.1	1.5	↑	430.1	435.9	(5.8)	↑
North West Ambulance Service	Income	319.0	319.6	0.6	↑	387.7	389.0	1.3	↑
	Expenditure	338.1	338.3	(0.2)	↑	408.9	410.7	(1.8)	↔
Univ Hospitals of Morecambe Bay	Income	321.5	324.3	2.9	↑	395.8	399.3	3.5	↑
	Expenditure	396.0	391.9	4.0	↓	479.4	478.7	0.8	↑
Total Trust Income		**2,289.7**	**2,295.4**	**5.8**	↑	**2,797.2**	**2,815.2**	**18.0**	↑
Total Trust Expenditure		**2,589.6**	**2,582.3**	**7.2**	↓	**3,135.4**	**3,144.1**	**(8.7)**	↓

NOTE

Plan figures reflect the submission on 18/11/20 in which Trusts were indicating a £90m deficit against the envelope.

Trust plan figures assume that the outstanding retrospective top ups will be paid along with nationally funded schemes.