Approved 3 March 2021

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)), Claire Heneghan (Chief Nurse, West Lancashire CCG) 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

- 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	