Approved 5 May 2021

Minutes of a Formal Meeting of the ICS Board Held on Wednesday, 3 March 2021 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
Kevin McGee	Chief Executive	Blackpool Teaching Hospitals NHS Foundation Trust/East Lancashire Hospitals NHS Trust
Geoff Jolliffe	Clinical Chair	Morecambe Bay CCG
Graham Burgess	Chair	NHS Blackburn with Darwen CCG
Roy Fisher	Chair	NHS Blackpool CCG
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	Lancashire and South Cumbria ICS
Ian Cherry	Non-Executive Director	Lancashire and South Cumbria ICS
Isla Wilson	Non-Executive Director	Lancashire and South Cumbria ICS
Peter Armer	VCFS Representative	Voluntary Community Faith Sector
Claire Heneghan	Chief Nurse	NHS West Lancashire CCG
Fleur Carney	Regional Mental Health Lead	NHS England/Improvement
In Attendance		
Vanessa Wilson	Programme Director Women and Children's Services	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
Rebecca Malin	Programme Director	Lancashire Teaching Hospitals NHS Foundation Trust
Rebecca Higgs	Business Manager to Dr Amanda Doyle	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	Andy Humphreys
Tricia Whiteside	Paul Faulkner
Cllr Peter Moss	Natalie Lee
James Lee	Jenny Hurley

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. **Apologies -** Apologies had been received from Jackie Moran, Director of Integration and Transformation, West Lancashire CCG.
2.	**Declarations of Interest** **RESOLVED: All members declared an interest in System Reform.**
3.	**Minutes of Previous Formal ICS Board Meeting** **3 February 2021 –** The minutes of the meeting held on 3 February 2021 were agreed as an accurate record. **Matters arising -** Financial strategy and vaccine update are on today's agenda. A more considered look at long waits for elective recovery would be reported at the next meeting, as actions become clearer. **2 December 2020 –** The minutes of the meeting held on 2 December 2020 were agreed as an accurate record.
4.	**Key Updates/Messages** • **Vaccination Programme Progress –** Amanda Doyle (AD) reported the vaccination programme in Lancashire and South Cumbria to have delivered vaccination to more than 91% of the over 65-year old cohort, soon to be moving to the clinical vulnerable cohort and over 60-year olds. More than 580,000 doses had been administered to date, with continued focus on hard to reach and people displaying hesitancy, including some health and care staff and BAME

	communities. There had been nationally focussed attention on the BAME group; in Lancashire and South Cumbria the LRF continued to work with communities. Second dose planning was underway, following a delay to administer after 12 weeks of receiving the initial vaccine. Significant increases in supply were expected, with the need to ensure capacity to administer on stand-by. Across Lancashire and South Cumbria, the 7 large scale vaccination sites, alongside primary care sites and hospital hubs were felt to be well placed to continue and complete the vaccination programme. • **Operational Pressures -** An operating model for the Chorley Emergency Department had been worked up, with plans to step up opening hours and delivery over the next few weeks. Kevin McGee (KM) explained that from an acute trust perspective, as infection rates begin to fall, COVID positive numbers would start to fall in the hospital. Consequently, hospitals were working hard to flip capacity from COVID to general use to support restoration, however, this causes operational issues as wards need cleaning, etc, reducing capacity. Critical care remained stretched; standing up Priority 2 (P2) work would result in more patients requiring critical care. Acute trusts were working carefully and cautiously with the Critical Care Network. Hospital support through other local hospitals had been exemplary throughout this period. During the past 2 weeks, A&E had been under pressure, due to staffing issues and 'flipping wards' (between Covid/non-Covid for example), compromising flow through organisations. Performance had increased over the past few days; A&E performance continued to be monitored. Ambulance handover performance remained good. Focus continued from the acute perspective on the balance from normal winter pressures coupled with gains in terms of restoration. The restoration of P2 patients had been positive to date. The Chair recognised the phenomenal effort in undertaking the restoration process; Primary Care Network teams and hospital teams had given a monumental effort on progress made, and all were thanked for the extraordinary lengths made to maintain the vaccination programme. **RESOLVED: ICS Board members noted the update to the vaccination programme and current operational pressures.**
Future System	
5 and 12.	**System Financial Recovery Plan** Amanda Doyle (AD) highlighted significant challenges in restoring a sustainable system over the next 2-3 years, to ensure resources were used in the most effective way for the Lancashire and South Cumbria population. AD highlighted that the financial recovery plan was a whole system issue, to deliver the best use of resources available. AD would Chair a proposed Financial Improvement Board to ensure focus across the system. **Current Financial Report -** Gary Raphael (GR) spoke to a previously circulated report highlighting month 10 financial performance for the Lancashire and South Cumbria system. The current financial performance forecasted by 31 March 2021 would be £54.7m, below the deficit financial envelope of £61m by the end of the financial year. There was recognition that the North West had a longer period of high Covid demand than other parts of the Country during 2020. This year had been complicated with late notifications for capital approvals for some trusts; it was not possible for trusts to start capital schemes prior to receiving approvals, resulting in delays to the original start dates. As it is not possible to carry forward to future years slippage against this year's capital budgets, there will be a £14m call against next year's capital funds that we as a system had not previously planned for. The revenue to capital transfers reported in the finance paper were to

	adjust for items charged to revenue earlier in the year and trusts were looking for the ICS Board's support for the £8.5m transfers. GR made some contextual points to provide a link to the next item on the agenda. He explained that in this current financial year Lancashire and South Cumbria had received an extra £340m for COVID and other funding, above and beyond notified allocations. An extra £215m had been spent this year on staffing, compared to the 2019/20 outturn. However, in future years the same level of funding would not be expected. There was uncertainty when the extra funding would cease and whether the Treasury would accept that all new measures for infection prevention control would continue. **RESOLVED: ICS Board members:-** - **Noted the updates to the financial position and** - **Supported the revenue capital transfer of expenditure.** **Financial Recovery** – GR emphasised that the development of the governance arrangements identified in the previously circulated paper had been subject to considerable discussion among the Finance Directors, who were in agreement that proposals for financial recovery, a Board and an improvement programme, should take this work forward. However, they were mindful that discussions about the service changes necessary for us to become a more cost-effective system felt uncomfortable at this stage, as we were only just coming out of our emergency response to COVID. GR asked members to consider:- • A longer-term approach proposed for financial recovery, led by the Financial Recovery Board, senior clinicians and supported by finance colleagues • A set of short-term measures that had been identified in addition to existing CIP/QIPP plans. £163m savings had originally been planned across CCGs and trusts in 2020/21 to reach our original starting plan of a £280m deficit for 2020/21. However, in his report a recommendation had been made for the system to aim for a £200m savings target in 2021/22, £37m more than that planned for 2020/21. This was to meet the requirement discussed at previous board meetings that we must aim to achieve a higher level of savings from now onwards compared to previous years in order to improve our financial standing • Without radical action the financial position of the system would continue to deteriorate. The experience of COVID had shown success in system working and leveraging the benefits of system working should manifest across cost effectiveness too. For the 2021/22 financial year we should aim to get a premium on cost effectiveness through system working • The likelihood of additional resources to help with the recovery programme. Were it to be allocated on a population basis Lancashire and South Cumbria's share of the national recovery fund of £1bn would be around £35m (3.5%). North West Finance Directors were looking to bid for more than this figure due to the North West's experience of COVID being for a much longer period than other parts of the country, with the consequential adverse impact on our ability to recover elective activity levels. Discussion with members included the following points:- • Members agreed that the financial recovery plan be a whole system issue to resolve, involving clinicians, operational directors, and primary care colleagues • Positive views regarding the Accountable Officer leading the programme • Members were keen to see detail on the process to assess proposals put forward, ensuring pressures were not pushed from one part of a service to another, resulting in an increase in inequalities, etc

	• To understand the mechanism by which changes over a number of years could be managed, including non-recurring spending to enable recurring savings in future years • Concern was raised regarding making progress in-year due to former experience of transforming the way we work, i.e. timescale was not appropriate • Financial Improvement Board would be key to identifying system working opportunities • Voluntary sector was keen to work with Julie Higgins' team on population health management and Lancashire and South Cumbria Foundation Trust • Financial recovery would need to be developed in terms of the longer-term approach and be realistic in terms of what could be achieved in terms of transformation • Opportunity to re-think priority programme to improve quality whilst delivering efficiency • Concern about extraordinary patient demand; national policy is about growth and new activity, not existing demand - consideration would need to be given as part of the system programme • The need to recognise as organisations and local leadership at place, that there were many opportunities for efficiency indicated by model hospital, 'getting it right first time' or similar • Need to demonstrate what could be delivered quickly in 2021/22 • Whilst the Finance Improvement Board would be important to co-ordinate proposals, the approach to reprioritising programmes may reframe some work being undertaken and some proposals may need pared back or declined • Reconfiguration of services would require engagement with Overview and Scrutiny Committees; conversations should held sooner rather than later • Inequalities agenda should be a focus as part of the long-term recovery element. At a meeting yesterday, Dr Owen Williams, Chief Executive Officer, Calderdale and Huddersfield NHS Foundation Trust presented some interesting perspectives to Lancashire Teaching Hospitals Trust Board. The provider trusts operate as a group of providers and had reached agreement about areas to focus on around recovery/restoration, including some of the real issues with inequalities in their agenda; it was thought this type of work would be picked up as part of the provider collaboration work in Lancashire and South Cumbria and would need to be looked at from the outset • Digital processes based on risk should be looked at to replace current analogue processes, saving money whilst providing people with better services. AD emphasised that in order for the system to become financially sustainable it would need to look at how to most effectively use the £3.5bn we spend in total, rather than how to save money on the margins. We must look at how to use the money allocated for the best of health and clinical outcomes for patients. The system would need to look at what would be required in the future and what would be a sensible use of resources going forward. Organisations were asked to consider what would need to be worked on together to take this forward, resulting in a better position. Kevin McGee (KM) said that from a Trust perspective this would prove a challenge. Trusts had been used to delivering at least 3% cost efficiency; however, this had previously contained significant levels of non-recurring measures, which had compounded the problem we now have. The challenge faced was how to make the system more efficient, taking out recurrent costs. KG was in support of the proposed processes, however, questioned the reality as 80% of the cost base was staffing. Consolidation of staff/services would need to be looked at differently in future. Difficult decisions would have to be made and the cost base reduced by taking out cost on staffing.

	GR responded that the system partners holding each other to account is crucial; senior leaders would be required to sign up to this, however, if one partner was unable to reach the expectation at a particular time, the system as a whole should be able to compensate. GR continued that the programme was being scoped as one that would ensure improved cost effectiveness from changes to the way that services are delivered. He did consider whether we should name it the system improvement programme, however, this would confuse it with the existing System Improvement Programme already in place in areas where quality issues are being addressed. It was noted that regardless of what pressures exist currently, the system was over committed. GR emphasised that as a system we should look to national non-recurring funding for recovery of elective care. Members acknowledged the financial arrangements expected for Quarter 1 next year with hints of the approach continuing into Q2. GR mentioned that if it were not possible to implement some schemes during the first quarter or half of 2021/22 because of the rolled forward funding arrangements, the point from which full year savings could be measured for those schemes would need to be agreed. The Chair summarised the discussion - organisations would hold each other to account and deliver what had been committed to, to ensure our recovery programme is moving in the right direction. Colleagues' proposals must be sustainable and transformative. He drew attention to Appendix 1 in the paper and emphasised the importance of the principles therein. **RESOLVED: The ICS Board members:-** - **Noted the aggregated pre-Covid starting financial position of the ICS's NHS organisations, as reported in the annual draft planning returns from March 2020** - **Approved the establishment of a System Financial Improvement Board, chaired by the ICS Chief Officer. This would 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** - **Supported the convening of the Investment Committee and would look for early confirmation that the rules underpinning investment and spending decisions were validated, agreed and applied** - **Noted 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 had been developed in the background more recently** - **Set an ambitious savings target of 5% or £200m for the system for 2021/22, noting that attribution of targets to specific sectors or ICPs would need to be determined during the forthcoming planning process** - **Agreed that the system-wide schemes and the amounts identified in the report, and/or other alternatives that may arise from subsequent discussions, be developed in the next two months to enable implementation from early 2021/22** - **Ensure efficiencies and cost reductions driven by changes in practice over the past 12 months were identified and embedded in current practice and a similar rapid improvement process be adopted for 2021/22.**
6.	**New Hospitals Programme** Rebecca Malin (RM) provided a monthly update on the New Hospitals Programme, highlighting the following key points:- • Communications and engagement had been developed both internally and externally. Timing on launching the communications would be dependent on final agreement from

	the Department of Health and Social Care • Plans for the New Hospitals Programme Summit would continue to be worked through and colleagues from all organisations would be invited to the Summit • Clinical leaders were essential to lead on this work to ensure sustainability. 25 clinical leaders had been appointed across all disciplines within Lancashire and South Cumbria, to date • Review of outputs would continue, as thinking was developed to ensure there were no gaps • Several workshops had been held relating to the Case for Change, to shape why the new hospital was needed in the region. Workshops were well attended, with representatives including clinicians, wider workforce, governance experts, etc • First draft of the Case for Change was published internally last week; currently out for review and comment. Graham Burgess (GB) reflected positivity that the draft case for change identified a number of problems delivering services across a widespread and deprived area and for patients accessing hospitals. However, the case for change had not identified the problems of people **not** accessing services and therefore no solutions had been put forward for these aspects. He felt this should be emphasised together with solutions, to ensure the community could be positive about the proposals. Ian Cherry had suggested it would be useful to work backwards from the drop-dead date, rather than forwards in activity plans; RM agreed to contact Ian outside of this meeting to work through the Gantt chart. **ACTION: R MALIN** RM would be presenting an update and 'forward look' at the next Joint Committee of CCGs (JCCCG) meeting. The deadline for the first capital business case is 1 March 2022; a series of key milestones would be required prior to this date which would be discussed at the JCCCG meeting. The scheme would require public consultation, which would add time into the process. The scheme focussed on Preston and Lancaster, with the driver being the poor condition of the estate at Lancaster and Preston hospitals; an early decision had been taken for this programme to be progressed as a whole system, focussing on the transformation of services across Lancashire and South Cumbria. Focus should remain on the hospitals element; however, the scheme would need to be able to articulate what else would transform in the system to enable the new hospitals facilities to be successful. This would be built on within the Case for Change, with patient representative involvement. Aaron Cummins confirmed that the business case would require a strong steer to ensure it was kept as simple as possible, being tight and focussed. Whilst there were ICS issues around delivering population health/wider strategies, it was highlighted that this business case could not relate to all issues. The Chair summarised that much work would need to be undertaken within the next few weeks and months, whilst remaining aligned and focussed on finalising a compelling Case for Change. The ICS Board would continue to require regular monthly updates on the option appraisal and business case processes as they are developed. **RESOLVED: The ICS Board noted the contents of the report.**
7.	**System Reform**

	Andrew Bennett (AB) introduced his paper updating members on the range of activities taking place to implement the ICS' System Reform Plan. Action was taking place following the national publication of a Government White Paper 'Integration and innovation: working together to improve health and social care for all', which contains proposals to place ICS's onto a statutory footing by April 2022. It was envisaged that 2021/22 would be very much a transitional year. Further national guidance was expected in the next few months to help guide the approach. A parliamentary process would then be expected to take place, with further guidance expected in the autumn. The focus for the Board is evolution of the ICS as a statutory NHS body and the plans for a wider NHS/care partnership. Consideration would need to be given to the implications for the system. The ICS Development Oversight Group would start to meet from 9 March 2021, taking an overview of the programme and looking at the statutory issues. The 'white paper' asks to transfer many of the Strategic Commissioning Committee functions into an ICS statutory body from April 2022. 8 CCG Governing Bodies had recently accepted proposals to build on this role over the next few months. The latest position with ICPs was a critical part of the 'white paper', the importance of place-based partnerships was highlighted, with further development work taking place in March/April; an update would be provided at the May meeting of the ICS Board. **ACTION: A BENNETT** Legislation would not be required now to enable the Council and the ICS to work better together; issues were already being identified to bring forward where appropriate. A Government proposal for consultation in Cumbria was expected to take place shortly; an ICS draft response would be brought to the next ICS Board meeting. **ACTION: A BENNETT** The Chair stated that our focus was to have a very successful system, improving health and access to services. A system would need to be built that would deal effectively, efficiently and openly with all challenges faced and new challenges that come along. This could only be achieved if all organisations work together, are engaged and contribute as we develop. The Chair conveyed his appreciation of CCG leadership, having taken this through CCG Governing Bodies in the last couple of weeks. Roy Fisher (RF) highlighted that a huge amount of partnership working would be required to enable this work to get through Boards; Boards must understand the message, direction of travel and way forward. ICP development would need to move at pace, working together in this transition year. Geoff Joliffe (GJ) stated that the ICP Development Group continued to be an important part of the reform process and that the whole purpose of the reform agenda was about services being better than they were before. The Group had been tasked to bring system reform to the attention of primary care and this was part of the wider process to engage local government and primary care in a more meaningful way. Shaun Turner felt that the partnership was now in a much better position for system reform than in the past. It was moving in the right direction with much having been achieved. He emphasised that we must move away from merely pushing costs around the system, as all organisations are under the same objectives. It was agreed that further updates would be provided to the ICS Board in April/May 2021.

	RESOLVED: The ICS Board:- - **Discussed the implications of the White Paper for the current System Reform programme in Lancashire and South Cumbria** - **Noted the update on on the range of activities taking place to implement the ICS' System Reform Plan.**
8.	**Embedding Action on Health Inequalities – Proposals for Lancashire and South Cumbria Approach** Julie Higgins (JH) explained that the paper circulated to members prior to this meeting had been written in December prior to the latest White Paper being received, therefore, some of the dates required review. Recent discussion had been held regarding the importance of prevention, health inequalities in restoration and how the provider collaborative could undertake that work. Members were aware of the significant health inequalities in Lancashire and South Cumbria compared to other parts of country. The paper set out the NHS ask on health inequalities and proposed a stepped approach to health inequalities moving into restoration, building a programme on population health management and health inequalities. Our Region had previously reviewed the action on health inequalities to be rated as green. A key component of the NHS England/Improvement dashboard is health inequalities, therefore, this would form part of the regional assessment of ICSs. The process of reviewing work in ICPs had proved invaluable and had identified issues about which we had not previously been sighted, eg, processes in the breast screening programme that may have exacerbated health inequalities, which had recently been reviewed by the cancer network. A phased approach on health inequalities/population management had been discussed by boards around 6 months previously, when it was agreed to prioritise finance for these areas. It had also been proposed to Boards to set up a Health Inequalities Commission, which would build on the Fairness Commissions, previously led by Local Authorities and enable our respective agendas to be brought together. JH explained that it would be possible for the relevant leads in the 5 ICPs in Lancashire and South Cumbria to come together as a system resource for this part of our agenda, however, they would also need to meet requirements in ICPs. A large part of the evidence base detailing the experiences of local people in neighbourhoods would come through ICPs. JH confirmed that the Institute of Health Inequity had agreed to support the proposed process. A task and finish group was being looked at to take this work forward. SEED and the local health partnership were looking to bring in funds to help with the economic parts of the business on the Health Inequalities Commission, which would help to shape the NHS contribution to the economy in Lancashire and South Cumbria. COVID vulnerable work with the VCFS had continued and conversations had been initiated with Directors of Public Health about how to align endeavour with local authorities and how to bring the intelligence functionality further; JH was in the process of speaking with Local Authority Chief Executive Officers about this work. Isla Wilson (IW) said that there was a need to respond to the national agenda alongside the local specifics being reported. It was important that all organisations commit to reviewing the data coming through and taking this forward, as system reform is worked through. Mike Wedgeworth (MW) raised the question as to how this would fit into the context of the White Paper when we already have an integrated care system. Concern was raised as to whether the commission may take energy, enthusiasm, and hard work away from creating a health and care partnership. Work was already underway to meet legislative requirements and establish effective partnerships.

Kevin McGee (KM) confirmed his support for the work and asked members to consider how to link the work being undertaken regionally to make the case for additional resources. Health is the biggest employer in Lancashire and South Cumbria and, therefore, a health theme should be present in all economic strategies in relation to investment, supply chains, universities, training and workforce. This would help keep spending within Lancashire and South Cumbria, building the economy. The Marmot report refers to wider determinants of ill health, the life expectancy of people and the amount of healthy life years people enjoy.

Roy Fisher also supported this work.

Amanda Doyle (AD) highlighted the need to translate the work to specific actions using evidence to argue for a fair share of resources to reduce health inequalities. AD explained that the Commission would look at how to bring evidence and expertise together and take action as a system.

Discussion also included the following points:-

- The work broadened out the contribution which was vital to improving health and wellbeing of populations. Institutions should be asked to take a place-based approach to improving the health and wellbeing of their populations. Eileen Fairhurst indicated she had attended the first meeting of the Health Sector Boards of the Lancashire LEP last week where comments were made about the relationship between employment, work and health
- Thinking was required over the next few months about how the public would hold the ICS to account; this was not understood at this stage due to being work in progress
- Work would also be delivered by Primary Care Networks, working with the VCFS
- Pre-pandemic, discussion had begun regarding bringing Health and Wellbeing Boards together to discuss topics such as this. With work being undertaken in the local Networks and Primary Care Networks, Health and Wellbeing Boards would need to be in the centre to take this forward.

Neil Jack (NJ) commented that practical action was required and most of the areas need focus. NJ raised concern whether this would be a solution to medical problems and should not be to save NHS money but focus on supporting families to parent better, improve living conditions, etc. Any money would need to be collectively agreed as to how it would be spent, thinking about practical actions required.

JH confirmed that understanding data was important; conversations had started with Local Authority Chief Executive Officers regarding intelligence functions. The Health Inequalities Commission would galvanise and bring together important pieces of work. Evidence from the public and professionals like Marmot, would tell us what the measures were and how to make a difference. JH is involved in the Regional Health Inequalities Health Board so would take relevant comments from this meeting back to that Board. The next steps would be to strengthen population health management cells to better enable programme oversight and to set up a Task and Finish group, scope resources required and establish a Health Inequalities Commission.

RESOLVED: The ICS Board endorsed:-

- **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 would be needed to complete this**

	- **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** - **The establishment of a Lancashire and South Cumbria Health Inequalities Commission to take an independent, cross-sector view on the tangible things that could and need to be done to drive improvement on health inequalities** - **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 Lancashire and South Cumbria 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** - **Commitment to freeing up capacity from within their organisations to support the leadership and development of the Health Inequalities Commission, when the full scope had been identified and agreed with local authority leaders** - **Commitment to delivering the recommendations of the Commission and reporting to the ICS on the progress against delivering these** - **Supporting the establishment of an ICS health inequalities action plan by 31 March 2021.**
9.	**Mental Health Update** Caroline Donovan (CD) presented an update on current demand for mental health services, including the following highlights: • Excellent partnership working had been seen with voluntary, primary care, local authorities and police • Access pathways had been disrupted as primary care was working in a different way, being a big source of referrals, or as schools were not open in the same way, being a big referral source for children and young people • 24/7 crisis lines and self-referral lines had been set up during the pandemic. There had been increased demand in Lancashire and South Cumbria, which was not typical for the demand across the rest of England. Generally, there had been a higher acuity of patients/people accessing services, including people with severe mental illness, eating disorders, children/young people. Historical issues regarding capacity not matching demand had resulted in a challenging situation. The previous lockdown showed a reduction in people coming through the service, however, numbers had now exceeded the highest levels of demand for the last 2 years. A lot of work had been undertaken collaboratively. Despite an increase in demand, a 90% decrease in historic long waits for 12 hours in A&E had been seen. Mental Health Decision Units were open and capital had been invested to open units in some A&E Departments. Demand with people coming into the service on a Section 136 particularly impacted on police. There had been nearly 100% reduction in long-waits despite demand rising. There was a 30% increase in admission rates against an 11% decrease as the national average for England. Admissions had been higher than in 2019 and at any time and the system had received more bed requests than there were beds available. Transformation work was being taken forward, showing significant reductions in length

	of stay, a 32% reduction being achieved compared to last year, which was lower than the national average for mean and median lengths of stay. CD mentioned the historical issues in out of area placements; the ambition by 1 April 2021 was that no people should travel out of area for a bed. A 40% decrease in out of area beds had been seen, due to COVID infection prevention control. New investment in community services in the last year had been positive, hence some of the outcomes. Work had been undertaken with 'Niche' consultancy looking at the bed deficit, with a gap of around 90 beds having been identified for the system. CD reported that work was underway with the national team to secure capital for a new learning disability unit; currently there were no learning disability beds in Lancashire and South Cumbria. Higher numbers of children/young people had been seen (higher than the average demand in England) and in the last 4 years this has increased by nearly 70%. A lot of work was being undertaken around this to reduce the number. During the pandemic, there had also been an increase in people with eating disorders, particularly in the under 18 cohort. Lancashire and South Cumbria had the highest number of children with a learning disability per square mile across England, this included children with autism. A psychological resilience hub for staff across the ICS, including partners in emergency services and social care, had been invested in, to support people with psychological trauma. The proportion of mental health spending compared to the total in Lancashire and South Cumbria was 13%, compared to the national average of 15%. Next steps included:- • Commitment to developing an ICS wide all age mental health, learning disability and autism strategy, which all partners would own • The bed model to be integrated within the strategy; public and partner consultation would be required • To focus on prevention and community resilience within the wider partnership • To collaborate on a northwest basis with the private sector, to see if this year we could achieve a more intelligent use of beds • New funding to open wards that previously had to close due to being dormitories • Achieving the Mental Health Investment Standard • To work on completely transforming and re-designing the 'front door' • Planning for an integrated response service for ICPs • Redesigning CAMHS services and transforming eating disorder services; currently in process • Mental Health Urgent Access Centres. Karen Partington reported there had been significant improvement to numbers of patients waiting in the Emergency Department in Lancashire Teaching Hospitals and asked if there was any outcome data available to show what happened to people who were not able to get beds. CD responded that some patients had beds within Lancashire and South Cumbria Foundation Trust and others with the private sector. Home treatment services intensively support patients waiting for a bed. It was now exceptional to wait for beds in the system; risk is carried whilst awaiting a sustainable solution.

	Furthermore, the VCFS had been working closely with mental health colleagues, with open two-way conversations. The VCFS had felt extremely well linked in and is working closely on the community mental health transformation programme and triage service for people in crisis. CD continued that it was planned for the Learning Disability Mental Health Strategy to work with the ICS Clinical Strategy. On 1 April 2021 there would be a move to establish a locality model; 15 new Directors had been appointed, 3 for each ICP, and as this moved into the collaborative model, primary care, voluntary sector, local authority and the police need to be working in partnership both at ICS and place level. It was recognised that a lot of improvement work had been undertaken in the system over the last two years, despite the challenges of COVID. Infection prevention control had impacted on the bed base; Lancashire and South Cumbria had been affected due to a disproportionate level of dormitory beds in the system. CD also mentioned that Blackpool had the highest admissions in the country for drugs and alcohol. As there had not been sufficient investment in mental health over the past few years, community resilience needed to be improved. Although some good work had begun, much further work was still required. A national £500m fund was planned for long term growth, to support new service developments. CD asked members to ensure we made a good case to secure our share of the funding available in 2021/22. **RESOLVED: ICS Board members noted the update.**
Assurance	
10.	**Maternity Quality Assurance/Ockenden Report** Vanessa Wilson (VW) explained that the Ockenden review had been commissioned by the Department of Health in 2017, to review maternity services at Shrewsbury and Telford Hospital NHS Trust. The first report from the review was published on 10 December 2020; the second report would be published later in 2021. The report outlined the immediate and essential actions for the Trust under review and actions required of maternity services in all trusts across England. The investigation began as a review of 26 cases, however, by the end of this report over 1,200 cases were being reviewed from families coming forward. VW noted that none of the issues identified in the review were new to maternity services. The main findings within the report included poor clinical practice and incompetence, with issues around culture and attitude, issues around kindness of staff, poor care, learning from incidents and poor bereavement care. There were 7 immediate and urgent actions that maternity providers had been asked to respond to and a number of actions the ICS had asked to include. Trusts had submitted high-level clinical quality assurance returns in December 2020 and a further assurance document on 15 February 2021. Each had been peer reviewed prior to submission. 2 trusts in Lancashire and South Cumbria had received verbal feedback to submissions. Returns showed the expectation that not all 7 essential and immediate recommendations were green at the point of submission as some were new requirements, including the appointment of an independent maternity advocate at each trust and investment in a lead obstetrician for foetal monitoring. Some escalation processes were required to be put in place; a requirement for the Local Maternity Systems Board (LMS) as the maternity arm of the ICS was to collate evidence for clinical quality assurance purposes, to ensure all serious incidents are submitted to the ICS for review. A process

	was being put in place to take effect in the next few weeks. Providers were in a good place around assurance; monitored through the LMS, with oversight of the new Maternity Board. CCGs currently hold the statutory responsibility for quality assurance in maternity services with trusts reporting serious incidents to them. Feedback was awaited from the regional team; a process would be set up around quality and safety at ICS level. Approval had been gained for the appointment of a Director of Midwifery at system level. The ICS was felt to be in a good position with an established LMS since 2017, embedded in the STP and now ICS. A maternity dashboard had been established, managed between the LMS and Clinical Network. Kevin McGee (KM) suggested that as this moved forwards links from the LMS to the Provider Collaboration Board would need to be strengthened to ensure providers could give assurance through the ICS. Amanda Doyle (AD) reported a history of significant challenges with maternity services within the system, confirming her support to a position of Director of Midwifery for the ICS, as part of clinical leadership across the system. AD would attend a meeting with the regional workforce lead to discuss future key roles within the ICS as a statutory organisation; a process would need to be agreed. Aaron Cummins reported that University Hospitals of Morecambe Bay NHS Foundation Trust was part way through completing the 5-year post Kirkup review, recognising measures that had been taken. Once completed, the Morecambe Bay experience would be shared. **RESOLVED: ICS Board members noted the content of the report with regard to:-** • **Providing assurance regarding the local maternity providers against Urgent and Essential recommendations of the Ockenden Report** • **The evolving role of the Local Maternity System as the maternity arm of the ICS with growing functionality for clinical quality assurance** • **The appointment of a Director of Midwifery for the system.**
Routine Items	
11.	**Items to forward to the next ICS Board Meeting** No items were raised at the meeting.
12.	**Financial Report** Item discussed within item 5 on the agenda.
13.	**Any Other Business** There was no other business raised.
Date and Time of the next Formal ICS Board Meeting: Wednesday 5 May 2021 – 10.00-12.30 noon, MS Teams Videoconference	