NHS
Lancashire and South Cumbria
Integrated Care Board

Subject to ratification at the next meeting

Minutes of the meeting of the Integrated Care Board held on Wednesday, 12 October 2022 at 9.30am at the Health Innovation Campus, Health Innovation One, Sir John Fisher Drive, Lancaster University, Lancaster

Part 1

	Name	Job Title
Members	David Flory	Chair
	Jim Birrell	Non-Executive Member
	Sheena Cumiskey	Non-Executive Member
	Roy Fisher	Non-Executive Member
	Professor Ebrahim Adia	Non-Executive Member
	Professor Jane O'Brien	Non-Executive Member
	Kevin Lavery	Chief Executive
	Dr David Levy	Medical Director
	Professor Sarah O'Brien	Chief Nurse
	Samantha Proffitt	Chief Finance Officer
	Kevin McGee	Partner Member – Trust / Foundation Trust (Acute and Community Services)
	Chris Oliver	Partner Member – Trust / Foundation Trust (Mental Health)
	Dr Geoff Jolliffe	Partner Member – Primary Medical Services
	Angie Ridgwell	Partner Member – Local Authorities
Participants	James Fleet	Chief People Officer
	Maggie Oldham	Designate Chief Planning, Performance and Strategy Officer
	David Blacklock	Chief Executive Officer - Healthwatch
	Debbie Corcoran	Public Involvement and Engagement Advisory Committee Chair
	Tracy Hopkins	Voluntary, Community, Faith and Social Enterprise Sector
	John Readman	Director of Adult and Social Care (left during 44/22/returned during 46/22)
	Abdul Razaq	Director of Public Health
In attendance	Debra Atkinson	Company Secretary / Director of Corporate Governance
	Louise Talbot	Corporate Governance Manager (minute taker)

Item	Note
38/22	**Welcome and Introductions** The Chair, David Flory, declared the meeting open and quorate and welcomed everybody. A particular welcome was conveyed to Chris Oliver, Interim Chief Executive Officer at NHS Lancashire and South Cumbria Foundation Trust (LSCFT), as a partner member (taken over from Caroline Donovan) and, John Readman, Director of Adult and Care Services, as a participant. Members were advised that Craig Harris, observing, would be joining the ICB in November as Chief of Health and Care Integration.
39/22	**Apologies for Absence** None received.
40/22	**Declarations of Interest** There were no declarations of interest relating to items on the agenda. The Chair requested that should there be any conflicts that arise during the meeting, to advise him accordingly.
41/22	**Minutes of the last meeting held on 7 September 2022, actions and matters arising** **RESOLVED: That subject to two amendments advised prior to the meeting, the minutes of the last meeting held on 7 September 2022 be approved as a correct record.** **Action log:** **Proposal for a comprehensive Stroke Centre for North Mersey and West Lancashire –** David Levy advised that Lancashire and South Cumbria (LSC) Integrated Care Board (ICB) had its meeting before Cheshire and Mersey ICB had had their meeting, therefore, it had only recently been confirmed that there had been a slight change in service. It was agreed that they would monitor the change in flow of patients. From a Lancashire Teaching Hospitals aspect, Kevin McGee advised that there was still concern operationally that it could increase the numbers through the hyper-acute site and there would need to be continued monitoring of numbers. If there was an increase, conversations would need to be held about managing the position. The impact on services would be carefully monitored. **Primary Care Deep Dive** – David Levy advised that an action from the previous minutes be added to the action log relating to the Board receiving information in respect of a primary care deep dive. It was anticipated that a response to the Fuller report, working with multi-disciplinary teams would be submitted to the December meeting of the Board.

42/22	**Patient Story** David Flory informed members that it was the first Board meeting at which a patient story/experience would be heard commenting that whilst recognising the challenge that, whilst the ICB does not directly provide care it remains very rooted in issues that patients, carers, families and communities face on a day to day basis. There were a number of ways in which to undertake this through public and patient involvement and the idea that focus on a patient case study at each Board meeting was welcomed. Sarah O'Brien welcomed the first of this regular item to the Board. She thanked the communications and engagement team for putting together the video and a set of patient stories in going forward. The first story was from Anoushka, a patient and a care worker in Lancashire and South Cumbria who shared her experience of contracting Covid, the impact that long Covid has had on her, experience of using the virtual ward and whilst she had received support in some areas, also highlighting the gaps in services. Sarah commented that whilst there is recognition of the challenges going into winter and the increase in Covid rates, it was a timely reminder of the impact of a physical illness and on mental wellbeing. Following the story, Sarah commented that it was very clear of the impact that Covid had had on Anoushka. In terms of support, there appeared to be difficulties in accessing her GP and there may be a need for wider community sector and voluntary sector support. As winter was approaching, it was a timely reminder for people to have their Covid and flu vaccinations. It was recognised that long Covid does have a significant effect on people's lives and consideration would need to be given as to how different types of support are put in place. Whilst Anoushka had a compassionate employer, for other's adjustments may not be made. There was also a recognition of the financial impact on people if they are unable to work due to long Covid. Sarah commented that it was a good illustration of the virtual ward and stressed the need to encourage the public that phone calls or digital appointments can be made. She conveyed her thanks to Anoushka for sharing her story and experience. David Levy commented that it had been recognised that long Covid can relate to a number of conditions and affects more women than men, generally in their 30s. Within Lancashire and South Cumbria, a long Covid service had been set up (approximately 18 months ago) and through commissioning of the service, long Covid clinics have been rolled out and run by hospitals. David explained that diagnosis was made by exclusion and help is provided to patients such as those with breathing difficulties and or have mental health problems. A lot of work had been undertaken with providers of community services over the last 12 weeks in respect of virtual wards with an option for an A&E doctor to refer patients to the virtual ward without them having to go into a hospital and can, therefore, remain at home for treatment. David Levy commended this model of service and the trajectories had been agreed anticipating over 750 beds by December 2023, currently over 100 beds. The clinicians were engaged with this facility which had previously been undertaken for respiratory conditions and frailty and was about to commence for

	end of life care and paediatrics. The cardiac doctors were also keen to take it forward. David further commented that it was an excellent new model of caring for patients at home who do not necessarily have to be in hospital and that patients can also be discharged sooner. Maggie Oldham highlighted the challenges for staff which had also been drawn out and she referred to the performance report which showed that sickness absence was increasing across Lancashire and South Cumbria. Whilst the absences mainly related to mental health and musculo-skeletal issues, the effects of long Covid were also impacting on our workforce. She was unable to provide more detail at the current time in terms of actions being taken to reach out to staff who are affected in this way however, upon talking to members of her team and as part of her induction, the financial impacts on people who have long Covid were being felt very acutely across the breadth of the patch which may impact as we go through winter. Consideration may need to be given at building in aggregated figures in respect of the vaccination programme however, she felt that more needed to be undertaken for staff in preparation for winter. Chris Oliver stressed the importance of promoting the resilience hub and as a provider they provide timely care. He referred to David Levy's point relating to the increase in the demand for the long Covid service and the integration of both mental health and physical health. David Flory also stressed the importance of the ICB listening as to how those services come together. Abdul Razaq referred to the Covid Oversight Board, chaired by Jane Scattergood and gave assurance to the ICB of the data presented to that Board and discussions that take place around health inequalities. David Flory referred to statistical information/ratios in respect of the differences of uptake in Covid vaccinations in different ethnic communities commenting on the startling differences across those communities. He asked Kevin Lavery to bring more detailed information to a future meeting. Abdul commented that there were a range of services available and a lot of work was taking place in respect of the spring booster. It was recognised that there had been a slight reduction in uptake from the communities referred to work and continued to promote messages, eg, offering free transport. Kevin McGee commented that they were seeing social and complex needs more regularly across the system and expressed the need to be mindful of the impact in the longer term. In respect of virtual wards, he advised that they had been commended locally for having the service in place commenting that they should be used as avoidance of admittance. It was important to continue to work with primary care and from a social care perspective. James Fleet referred to the point made by Maggie in respect of staff sickness absence which came through in the patient story. He advised that there is high comparable areas of sickness absence across provider organisations and at its first meeting, the ICB People Board was very much aware of this issue. James explained that there was a lot of good work taking place looking at scaling the wellbeing and occupational health service. He was working with HR directors who monitor the position weekly and it was one of the four main priorities that the People Board is focusing on.

	Ebrahim Adia made reference to the interaction with patients and practitioners and sought clarification as to whether GPs and primary care staff were aware of long Covid and knew where to refer to. David Levy advised that multi-disciplinary teams carry out an initial assessment and it was recognised that long Covid can have multiple impacts. Patients have access to physiotherapists, psychologists and other services and stressed the importance of ensuring that tests are carried tests out in order that patients are referred to the right services. David Blacklock commented that Jane Scattergood had commissioned Healthwatch to review what was preventing communities coming forward, looking at over 25 BAME groups. He suggested that it would be helpful if the information could be presented to a future Board meeting and this was noted. **RESOLVED: That the Board welcomed the patient story as a regular item on the agenda.**
43/22	**Chief Executive's Report** The Chief Executive Officer, Kevin Lavery, presented his report to the Board which provided an update on areas of progress since the previous meeting along with emerging issues and key areas of focus. Kevin commented on the leadership challenges and pressures being faced which were truly immense however, he recognised that any option could be considered, and the leadership task was to convert that challenge into an opportunity. He highlighted four issues: **Bank and agency –** There was currently a high spend in this area at just over 40% of the NHS cap which was rising month on month. In addition to funding, it was related to patient safety and risks with this level of agency staff. More work needed to be undertaken to address this and it was recognised that there is a nervousness within Trusts in terms of quality, using private sector partners and decisions having to be made quickly to address urgent problems. Kevin was pleased to inform the Board that a procurement had recently commenced and it was important that there is a system-wide single approach, one evaluation, one recommendation and one decision. James Fleet was co-ordinating the procurement with Kevin Moynes from the provider collaborative. Kevin advised that there will be an ask of the Board to make decisions going forward with back to back agreements with Trusts via Chief Executive delegations at Trust level and reporting to their Boards accordingly. Kevin had asked Sam Proffitt to look at how payment mechanisms would work with private sector partners in respect of monthly payments to Trusts. It demonstrated the need for the provider collaborative to have a way of making collective decisions either via a committee in common, a joint committee or similar. It also demonstrated some of the cultural challenges being faced as we move forward. **Operating model for the ICB** – The challenges were recognised including health outcomes, challenging performance, difficult fiscal outlook, the pandemic and the effects of long Covid. In respect of system pressures, there needed to be clarity on the operating model for our system. Kevin explained that one area holding us back was who does what within the wider system, the role of the ICB along with levers and

processes. There would need to be clarity over the role of the Provider Collaborative Board (PCB) and arrangements that would need to be put in place in order to have a high performing system. Kevin advised that they were currently in the process of bringing in an individual who has a lot of health experience at both provider and commissioning level who would be meeting with all members of the ICB Board, Chairs and Chief Executives of provider Trusts, regional and central colleagues. KPMG had been engaged to work with NHS England (NHSE) to look at the operating model for NHSE and regionally which would dovetail with the ICB's operating model. It was anticipated that a report would be submitted to the December meeting of the Board. A similar exercise would need to be undertaken in respect of place in due course with place leaders in terms of their responsibilities with a clear intention of devolvement going forward.

Finance – It was recognised that the system was facing unprecedented challenges. As the pandemic continued alongside this, we were seeing were record numbers of patients in hospital with Covid and also effects of long Covid, concerns regarding flu in winter, the backlog in operations, the sharp growth in long term conditions including a sharp growth in patients with multiple long-term conditions, a challenging winter and the cost of living crisis, all of which will be us for a long time.

Kevin commented that difficult decisions had already been made in respect of finances in July however, the position had worsened and the challenges continued. He advised that insufficient recurring savings were being delivered, cash balances had been used in the early months and a number of recurring savings were being pushed back in the financial year. Kevin advised that if we do not deliver on the recurring savings in 2023/24, there will be real challenges. A six-month forecast was being undertaken following which, a report would be submitted to the Board in respect of the risks relating to the year-end financial position. There would need to be a review of what can be done to arrest a worsening position; recommendations would be submitted to the November meeting of the Board. Radical and urgent action would need to take place, looking at staffing across the system and whether consideration be given to a freeze on vacancies, look at a mutually agreed redundancy scheme, contractors, consultants, balances across Trusts and review capital schemes.

It was recognised that progress had been made in elective care which was performing better than the other two ICBs in the north west however, consideration would need to be given as to whether enough was being undertaken to speed up diagnostics and treatments and whether there were opportunities to improve efficiencies.

Kevin was mindful of the current financial year and stressed the importance of not losing sight of the medium term which would be when the ICB would make a difference and a group of transformation projects were taking shape and he was confident they will make a difference in years two and three. A leader would be in place from November for a shared services platform across the system. Procurement was underway for bank and agency staff and a discharge and flow project relating to the hospital and the community had been formed. A number of specific projects were also moving forward in respect of Finney House and domiciliary care. Kevin commented that some transformational projects were starting to come together however, more work was required, eg, clinical integration and the 'Get it Right First Time' programme.

	Kevin advised that following meetings with the Executives, discussions would be held with place-based leaders and local government colleagues, in particular about the hospital admission and discharge and wider community services. It was recognised that the geography was very different in terms of supply and demand. He referred to the following: **Domiciliary care** – A huge shortage of supply both nationally and across the region. Northumbria Care in North Tyneside was the first organisation to be CQC registered to provide domiciliary care. Whilst it may not be the right model for Lancashire and South Cumbria taking into differing needs across the area, the innovation and boldness was very much admired. A similar process would need to be undertaken in full partnership between health and local governments, upskilling the care workforce, with better pay and thus providing more value to their patients. Kevin suggested that it could be a branch of primary care as well as providing domiciliary care. He commented that it could be a public sector venture rather than being outsourced and would need to be undertaken very carefully without destabilising services. It would also need to be part of the ICB's 10-year plan. **Physical Community Health Services -** Currently funded across Lancashire and South Cumbria, there were varied models, varied funding levels and different providers across the ICB. Kevin advised that East Lancashire has a good model in place delivered by a high performing team resulting in the best outcomes, they have the lowest level of not meeting medical criteria to reside in the hospital by some margin. The model would need to be rolled out further across Blackburn with Darwen then Central and West Lancashire with a view to looking at Morecambe Bay and Blackpool where they have the model however, it was not working as well as East Lancashire. Kevin referred to the budgetary position and when discussing the draft budget, full and frank discussions had been held with Trusts across Lancashire and South Cumbria. One of the most challenging was at LSCFT as it had not had a deficit in comparison to other Trusts. During August there was a big planning gap at the Trust however, good progress was being made under Chris Oliver's leadership. A specialist Turnaround Director had been appointed to work with the Trust's Executives. Kevin referred to the Integrated Care Partnership (ICP); the first meeting was held on 30 September 2022 which was a community wide partnership that extended well beyond the health sector. Both Kevin and Geoff Jolliffe were representatives on the ICP. Kevin commented that there were good foundations in Lancashire and South Cumbria and the ICP was very much needed in terms of health outcomes and widening inequalities. There were well developed and mature Health and Wellbeing Boards in place with good needs assessments across the region and there was also a good pilot ICS in place which had a real push on population health. The partnership agreed that they would keep it simple in the first year but recognising that there needed to be a draft strategy in place by the end of December to build on the good foundations of the Health and Wellbeing Boards and to select a small number of areas to take forward. The ICB would then be required to respond to the strategy in its 10-year plan and 3-year budget in 2023/24. Debbie Corcoran welcomed the report and in particular made reference to the focus within the performance report commenting on the detailed discussion at the previous meeting around the information and data that the Board would wish to see and helping

	them with decision making. Whilst noting the update in respect of a Board development workshop in December and a revised performance report to be submitted to the February meeting of the Board, she questioned whether four months for the Board to have sight of a revised report was too long. Debbie sought assurance that improvements would be made in the meantime pending the newly developed report. Maggie Oldham advised that significant work needed to be undertaken as to how data is looked at, a lot of which was not owned by the ICB; the Commissioning Support Unit (CSU) provides the business intelligence support for performance data. The timescale in which the Board report was required did not allow sufficient time to extrapolate the information via the mechanisms in place however, further work had been undertaken in month with the national 'Making Date Count' team Maggie advised that as there would not be a Board business meeting in January, February was the first opportunity thatan Integrated Performance Report (IPR) could be presented. It was commented that there might be a requirement to hold the workshop in January rather than December. Maggie advised that a Task and Finish Group had been in place since July that had looked at ways of improving the report to date and she welcomed a Non-Executive Member to work with the group. She recognised the challenges, advising that they were working at pace to provide meaningful data and trends. Jane O'Brien referred to the challenges and opportunities and asked whether something could be taken forward that sets the tone around hope and innovation and could effect change thus creating a culture where people can have a say and input, also in terms of the People Strategy. Kevin Lavery advised that a staff award scheme would be introduced and the staff survey was currently underway although it was acknowledged that staff had faced uncertainty over the last few months which may affect the results which would be addressed. A leadership development programme would be rolled out across the ICB and also work was taking place in developing a programme for the system. John Readman endorsed the comments regarding domiciliary care advising that there was a connected group of the four Directors of Adult Social Services (DASS) with relevant colleagues and he would take the lead with colleagues in taking it forward across the ICB area but recognising the different needs and look at where they might focus particular innovation. He agreed that there was good learning from the North Tyneside model. Jim Birrell referred to the integrated care system and the integrated care partnership also in respect of the discussion to be held relating to the Health Equities Commission (HEC) which will have a different set of priorities. Whilst there will be a requirement for the ICB Board to agree the integrated care strategy, acknowledging that the integrated care partnership will have a set of priorities, he sought clarification as to why there would be different sets of priorities and approaches which could be confusing. Kevin Lavery advised that the HEC would be part of what we do as a system, rather than in isolation and would need to be considered alongside the 10-year plan and 3-year budgets. He referred to the ICB plan and budget commenting that we would need to be selective in going forward. There would be a requirement to respond to the integrated care partnership which will determine its own strategy, and the ICB will be required to respond to. Kevin further advised that it was all

	underpinned by joint working and that the ICP would need to be realistic about what is required. The HEC would need to be built into the core of the ICP strategy following which a review of the priorities would be undertaken for the 10-year plan and the 3-year budgets. Kevin McGee welcomed the report and made particular reference to the discussion relating to bank and agency and the overall budgetary position which were intrinsically linked. In respect of the work relating to bank and agency, whilst it had been challenging, a positive step forward was being taken. Kevin explained that it would give us control as to how we use bank and agency however, it will not tell us why we use it. There was too much capacity open in the system, therefore, a requirement to employ staff at very high rates through bank and agency. As at that day, there were approximately 450/460 unfunded beds across the system. There was a requirement to look at the causes and symptoms of the issue and that health and social care would need to work in a different way to ensure patients were in the right place and did not have to use hospital beds when there is no requirement for them to do so. It would then have an impact on overall transformation, how staff are used, how capacity is used and will help to reduce unfunded bed numbers. Kevin advised that the 450/460 beds equate to 15-17 wards, the size of a small district general hospital – each ward costing approximately £3-4m to run. He stressed the importance of focusing on causes of bank and agency as opposed to trying to get the grip and control, he envisaged that the fundamental root of the issues would be borne out following which, improvements would be made in respect of performance, safety, staff morale thus reducing the need for staff to be spread over a number of areas. Kevin welcomed the focus in order to address and resolve the issues. Geoff Jolliffe referred to 'Getting it Right First Time' (GIRFT) within the report and welcomed the point about the individual. He stressed the importance of 'getting your job right' which was critical in people taking personal responsibility. David Levy had collectively agreed with the Medical Directors of Trusts to focus on four priorities during 2022/23 and agreed a level of ambition and a team to take forward the work, some of which had commenced. He also stressed the importance regarding the interface with primary and secondary care and outlined the work being taken forward. James Fleet commented on the financial position and the work referred to by Kevin McGee and Chris Oliver recognising there was scalability and lessons to learn. Whilst very early, some areas of work had gone well; there had been some dedicated resource and very critical challenge from outside the organisation which was necessary. It was supercharged from a clinical perspective and the Medical Director and James had had discussions also with the turnaround specialist. It was acknowledged that LSCFT had very strong clinically led programmes developing and emerging. He welcomed the fact that efficiency programmes were being developed by a medic and a medical leader rather than a finance director which was very powerful and straddled the important world of care, quality and efficiency. Chris Oliver recognised that LSCFT had not had a good history of recurrent cost improvement and the pandemic had amplified this over the last two years. He advised that work had been taking place with the recovery Director over the last three weeks meeting with operational teams. It was anticipated that the programme of current delivery would be finalised over the next week along with routine cost control and

financial grip. He stressed the importance of the clinical thread and everybody taking ownership which was key and to continue with quality improvements which needed to be on a sustainable financial foundation; this was the message they were taking forward across the Trust.

Sarah O'Brien provided reassurance in developing the integrated performance report advising that a work was taking place in the background. She referred to the recent meeting of the Quality Committee which received continuing healthcare data also workforce data that had been submitted to the People Board. Sarah also advised that teams have information in areas such as SEND, learning disabilities and mental health. Work was taking place but the challenge was how to collate and submit to the Board.

Roy Fisher welcomed the report from Kevin Lavery and commented on Fylde Coast Medical Services (FCMS) which has innovative approaches in reaching out to communities, eg, a bus around the Fylde Coast to give Covid vaccinations. In respect of the ICP strategy, both he and James attended the Blackpool Health and Wellbeing Board and discussion was held about having a health and wellbeing strategy for that Board. It was important that strategies were aligned and it was about having one aligned integrated strategy and taking forward a medical and social care model. At the meeting they discussed who should develop the strategy, also referring to the ICB strategy. Roy stressed the importance of bringing the strategies together into one place.

Kevin Lavery referred to FCMS which was carrying out a wide range of contracts across the country. He referred to the upper quartile performers in the system that the ICB could work with and had tasked Jane Cass, in the partnership team, to look at high performers in the system with a view to working with them in the future. Kevin also advised that the FCMS contracts were annual and he would welcome a long term partnership with them as it would allow them to focus funding on the front line rather than the bureaucracy of renewals. It would also give them greater certainty as a social enterprise to be able to recruit on a longer-term basis. Kevin commented that there were opportunities for the voluntary sector in going forward, it was a win/win and was not all about more money but about more certainty.

Angie Ridgwell referred to the comments made by Jim in respect of the health equities commission (HEC). She commented that local authorities co-design the ICP with Kevin Lavery and colleagues and they see the HEC as another stream of evidence running alongside the evidence base they already have which would then influence the integrated care strategy which would be set in the broader context looking at population health, financial constraints and technical and innovative opportunities. It would in turn come back to the ICB when looking at allocating resources and delivery of the strategy through both the place-based partnerships and other organisations already established. Angie also referred to the Lancashire 2050 plan and it was noted that the HEC evidence would also sit alongside other areas. She suggested that a conversation be held at the Board about the Lancashire 2050 plan which would go out to consultation and stressed the importance of engaging with as many stakeholders as possible.

	David Flory recognised the differently defined roles and different responsibilities however, he commented that the outcome would be to align priorities and resources. He was very confident of the joint working in going forward but recognised the risks identified during the discussion. **RESOLVED: That the Board note the report.**
44/22	**Finance Progress Report** Sam Proffitt presented the report on the month 5 financial performance for the Lancashire and South Cumbria system. The report covered revenue and capital positions, delivery against efficiency targets and an update on progress against mitigating financial risk. It was noted that at the end of August (month 5), the ICB was reporting a deficit of £52.6m which was £35.1m off the expected plan position. The variance against the plan presented a large movement from £12.4m at month 4 to £35.1m at month 5 which was largely due to a required change to the plan for the ICB enacted nationally rather than a deterioration in month. It was noted that whilst Covid was very much present, there had been a 57% reduction in the Covid budget for 2022/23 which equated to approximately £100m. Also with staff sickness, Sam referred to the patient story commenting on the social care issues however, the leadership challenge was to address both and achieve the target. Sam referred to three key focus areas as a team, a Board and as a system: • **Short term** – To undertake as much action as possible to achieve a balanced position and to meet targets. • **Medium term** - Programmes of work, flow work was key, how do we shut down temporary unfunded capacity whilst recognising what is needed in the system and to look at alternatives. Other areas, discussed earlier in the meeting in respect of bank and agency, elective recovery along with clinical and corporate work. • **Longer term** – How to turn the medium-term programmes into more transformational work to drive out the long-term financial savings. Sam referred to the £35.1m off plan of which £19m related to the ICB and was the first three months of the CCGs existing in April to June 2022 where cost improvement plans were not in place but there were, and continue to be a number of pressures in packages of care. She explained however, that the budget had been profiled in 12ths so there was some catching up required. She advised that there was a plan and the need to balance at ICB level. In respect of the £60m off plan for providers, Sam advised that it reflected the level of cost improvement plans (CIPs). A current concern related to the level of CIPs that were non-recurrent and that the expected aim was that 60% of CIPs should be recurrent however, it was only at 10%. She expressed concern at the high level of risk and the affect it will have on the recurrent position moving into 2023/24 which needed to be addressed. Following the discussion held earlier in the meeting, Sam would produce a report that will describe the work being undertaken to address the issues. She advised that a

	forensic review would be undertaken in month 6 and the team was working with Trusts with clear deadlines of the current position, associated risks and opportunities to be taken forward. Dedicated senior finance colleagues were leading on individual programmes of work. In respect of assurance, Sam advised that monthly meetings were taking place with Trust Directors of Finance and she stressed the importance of the Board understanding the plans and having them in place. With regard to the financial pressures, Sam advised that whilst she can discuss with finance colleagues at provider Trusts, there needed to be a wider discussion and at the quarterly assurance meetings, and that Maggie would attend going forward to pick up the wider performance agenda. Sam advised that two pieces of work had been undertaken in respect of where the pressures were, the first of which related to LSCFT where the model was working well and to consider if it should be used at other organisations. The other related to a deep dive into Morecambe Bay as they have the biggest planning risk and whilst it had reduced, still remained. Also to look at their CIPs acknowledging that they were improving on recurrent CIPs which was something that was required from all organisations. It was noted that it was important to take every effort in order to achieve a balanced position at year end and to ensure continued focus on the recurrent position. Sheena Cumiskey reflected on the discussion held, in particular treating what we do across the system as one organisation. It was acknowledged that there was an increasing need from the population which was driving a number of issues including financial costs. She asked whether there was a requirement to address need and how to use resources to carry them out together. Whilst it was important to look at the positions of individual organisations, it was also important to understand how resources were being used, how effectively they were being used and consideration of integrated opportunities. A starting point would be about how people live their lives in their own communities and Sheena referred to the excellent work being undertaken by third sector organisations meeting that need in a very different way and then how it is taken through in everything we do. Sam welcomed the comments made and her ambition was to ensure the funding was in the right place using population health and the allocation formula effectively and not continuing to look at individual organisations but to look at it collectively for the population. In the short term, Sam advised that work was taking place on the financial framework and how it can be undertaken effectively which will take time. *John Readman left the meeting temporarily.* Sam referred to transformational work which would need to be considered and explained that they would be looking at the 3-year budget at the end of December which would need to underpin the 10-year plan and within that, there will be major transformational change, therefore, it was important that that the money flowed through. When talking about a financial strategy and plan, it was important to discuss

	investment and disinvestment to ensure funding was in the right place. Sarah O'Brien referred to the quarterly assurance meetings commenting that it was important to bring lead clinicians into those discussions from both the ICB and within the provider organisations. David Flory posed a question to Chris Oliver and Kevin McGee in particular, commenting that we had moved through the changes in the finance regime and had a contradiction when we look at the books, ie, a significant overcommitment in terms of recurring expenditure and at the same time there were big cash balances at the Trusts which was a product of the regime. His fear was the availability of significant cash balances in the balance sheet which was a liability not an asset and there could be a perception of delaying difficult decisions. He asked how the matter could be addressed. Kevin McGee did not believe it was currently a factor commenting that each individual provider Board was focused on retaining the balance in keeping things safe in the short term with the all the pressures identified and the performance issues and making sure we undertake recurrent transformation which will drive out costs. He explained that there was a real focus within each of the individual providers and reiterated that the primary driver of the cost base was the bed base currently open as it drives the staff required to be employed to manage those beds. Kevin commented that whilst there are patients in those beds who should be cared for elsewhere, there is unfunded capacity open, therefore, there was a requirement to understand the cause of the issues being face. If the system can work together and attempt to move back to the current bed base, it would drive out a large proportion of the costs in the system and would allow the reduction in the use of bank and agency that then has flow issues in terms of quality and safety. Kevin advised that they were currently in excess of 98% occupancy rates in the system commenting that working with Sam, Kevin Lavery and across the system, was to have the recurrent plans so that when we come out of winter into spring, the excess capacity can be closed down very quickly within the system and the costs removed. Kevin commented that there was a real focus within providers around this and they understand the need to deliver recurrent cost savings, there was an absolute focus on other areas, having discussed 'Getting it Right First Time', model hospital, theatre efficiencies and it was important to drive them all through at the same time. Kevin felt that there was a real focus in trying to drive out the costs. It was a timing issue about how we move through winter and how the recurrent plans are put in place to take out excess and unfunded capacity. David Flory referred to a comment made by Angie Ridgwell about the consequences to the system of an overspend. Kevin Lavery made reference to Julian Kelly, Chief Finance Officer of NHSE who was currently holding weekly meetings with other ICBs and he stressed the importance of owning the agenda advising that in the longer term, ie, months rather than years, there would be a requirement to determine the right operating models, be clear on the direction of travel, expectations and consequences. Sam advised that in advance of the operating model being finalised, the Directors of Finance across the system would be meeting to ascertain what the operating assurance piece will look like and she welcomed the suggestion of building clinicians into that process.

	RESOLVED: That the Board note the report.
45/22	**Performance Report** Maggie Oldham acknowledged the comments made earlier in the meeting and her subsequent explanations regarding the content of the current performance report. She provided an overview of the current performance support available to the ICB via the Commissioning Support Unit (CSU) which was minimal. Maggie conveyed her thanks to individuals for their continued support advising that there had been a shift in data since July and she had worked with the team to produce the report submitted to the Board. She would take the comments back to the national 'making data count' team to ascertain whether any faster progress could be made prior to February and the board workshop being planned for January. Maggie advised that the Chief Digital Officer, Asim Patel would be commencing in post on 1 November 2022 and that Asim has vast experience in producing performance score cards and working with CSU colleagues. Maggie reiterated the comments made that we do not lack ambition. She advised that we were working on a limited infrastructure on an aggregated position and staff were working hard at ground floor level, particularly in the areas where we have deprivation or under-performance where the standards needed to be improved. Maggie referred to the comments made by Sam Proffitt on the intense need to be able to work at sub-Board level on both performance and the implications on the financial position advising that there were plans to start to interrogate data during October and November outside of the Board meeting in order to be able to offer high level trends and focus on the right areas. Maggie advised that there needed to be close links with the provider collaborative Board and that there are mechanisms such as the Elective Recovery Board. She suggested that in the absence of the performance report being produced in the way they wish it to be produced, whether information from that function could be included in the December report in order to see their data more closely. Jim Birrell commented that the report was relatively bland and did not provide sufficient information that he could comment on. He suggested that drawing from performance reports from Trusts and primary care would be beneficial in order to be able to have a better picture of the current position across the area. Maggie Oldham advised that a Director of Performance had recently been appointed. She advised that a performance function would be developed and agreement would need to be made as to what would be undertaken in-house and what support would be provided by the CSU. In terms of the Making Data Count function at the department, Maggie had worked previously with them resulting in positive outcomes in terms of performance reports. She welcomed support from Jim in shaping the work being taken forward. Whilst information from individual organisations would be helpful, she commented that it can be difficult to offer triangulated aggregated information. Kevin McGee welcomed Maggie to her role commenting that her understanding and

	experience of the acute sector would help with the work in going forward. He offered to work with Maggie in bringing the reports together and stressed the importance of having the same data source that feeds into the provider and ICS reports which was vital in order that there was one version of the truth. He further commented that there was a lot of data available in the system to enable us to aggregate which would provide both benchmarked and absolute information by individual organisations. Sarah O'Brien commented that there needed to be an understanding of the variation across the patch. In particular, she drew out the metric relating to learning disability and autism health checks - amongst our most vulnerable population. There was currently an underperformance in all of the metrics relating to this, the health check being one of the most important metric in checking individuals and identifying risks. Sarah advised that it is a primary care challenge and was a challenge across the legacy CCGs prior to Covid and that it was important the ICB was sighted in this area. Learning disabilities and autism were high both on the national and local agenda. Sarah was the Executive Lead in this area and was currently establishing a team to monitor and take forward suggesting that a focused piece of work be submitted to the Board after December to have more understanding of this group of people, where services are offered and to look at performance. Geoff Jolliffe welcomed the comments from Sarah stressing the importance of looking after this particular group of vulnerable people, particularly after the pandemic. In respect of data, Geoff referred to primary care commenting that there was a huge variation in primary care and whilst it can be carried out, there needed to be an understanding as to how it is undertaken. He suggested that when looking at data to review it practice by practice and by place to place. Ebrahim Adia sought clarification as to where the work would be undertaken in respect of the ICB Board being able to influence which metrics are agreed and in terms of the assurances required. He recognised that whilst there was a selection of metrics, there was a requirement to broaden them but at the same time, not to overwhelm ourselves. There would also be a range of approaches and agreement of tolerance levels around each of the metrics. Maggie acknowledged that there was a lot of data available however, different platforms were used to extrapolate the data. She commented that because of the breadth of the organisation represented it was important to be able to review at sub-Board level to address the pertinent issues and to have a level of confidence that matters were being taken forward within the Executive functions and via committees. She stressed the importance of the workshop which would be key recognising the breadth of knowledge and experience that individuals can bring. Angie Ridgwell commented that in comparison to the previous month, her understanding was that there was a decline in performance aligned to a decline in financial performance. She sought clarification in respect of the actions being taken to address this, stressing the importance of being more cohesive. Angie further commented that whilst the balanced scorecard had since improved, social care was about acute hospitals, there needed to be a different mindset around this and the workshop was important in terms of addressing that shift. She would ask whether we recognise ourselves in the data provided and when the actions would come forward both in terms of performance and financial performance in order that support can be

	provided to the team. David Levy commented that the conversation reflected the challenge for a performance report card in order that we can understand the data presented in such a way that there can be informed analysis of the figures. David commented that it was important we were careful where individual places data was, also taking into account the national data. David Levy commented that there were challenges with cancer which was a national issue and he made particular reference to the breast cancer two week wait. The increase in demand was of concern to the Executives and work was taking place to develop a cancer recovery plan. There were also some very fragile specialist surgical services at present and work had taken place with the regional team. David Levy also referred to out of area placements and he had had discussions with Sam Proffitt and Sheena Cumiskey. A plan would be drawn up and significant redesign work would take place. James Fleet advised there was an emerging approach being taken forward across the domains however, using the workforce domain as an example, he commented that it was important to have a single version of the truth in terms of data and information. He validates workforce data with workforce leaders across the patch and there was a rich dataset available which was in line with provider returns. James also commented that the first meeting of the People Board received a report which showed variation in terms of headline numbers and they agreed an action that wherever the variations were, dialogue would take place with providers to ascertain where the variation sits asking two questions - What action is individual provider taking picking up in respect of variation? What can we do to support them as a system? Kevin Lavery reminded the Board of the context with a system under extreme pressure and dramatic increases in need and demand for services along with a tired workforce resulting in a number of performance challenges. Whilst there was not a shortage of data, that was too much data and insight and action was required. He welcomed the work being taken forward in respect of cancer as highlighted by David Levy. Kevin further commented that a more detailed report would come back to the board on the cancer recovery plan.. Kevin commented that poor performance was taken seriously and it was noted that in comparison to the other two ICBs in the region, Lancashire and South Cumbria ICB was a quiet achiever however, there was no room for complacency. Whilst generally, Lancashire and South Cumbria was within the national average, there needed to be improvements for the population across this area. David Flory was mindful that as a Board, colleagues were supported and achievements made as a system. **RESOLVED: That the Board note the contents of the report.** **Deep Dive on Urgent and Emergency Care -** Maggie Oldham gave a presentation on a deep dive into urgent and emergency care which provided an oversight on what

	was working well, the key challenges, the key risks and actions in progress. In conclusion, the UEC had normalised working under extreme pressure and there was an expectation that the pressure would intensify during the winter period. More detailed plans were required with a commitment from all ICB partner organisations to give it priority. It was noted that a winter summit would be held in November following which, key performance indicators would be developed looking at the mechanisms in place and identifying escalations. Maggie advised that a number of requests had been made from primary care to take this forward. She conveyed her thanks to the staff in front line services for their continued support. Geoff Jolliffe commented that whilst the data showed that the number of primary care consultations were increasing, it did not highlight the length of the consultation (telephone call 10 minutes/face to face 15-20 minutes). There did not appear to be a reduction in the consultation times and the volume of work was more than the data was showing. Geoff also commented that a lot of work was being undertaken in respect of the Fuller report around primary care leadership outwith the integrated care system, ie, leadership as primary care providers coming together. He referred to a number of leadership fora including primary care networks, local medica committees and federations with a view to them coming together however, it would need to be at scale in order to make a difference. Consideration would need to be given as to what could be stopped and what they could do more of recognising that it would require a contractual basis to it. Sheena Cumiskey conveyed her thanks to people who are caring for others and held them in huge admiration. In the medium term, she suggested that consideration be given to the role of place taking a population-based response and how we bring together meeting need. She referred to integration of physical and mental health needs and referred to David Levy's comments earlier in the meeting in terms of community transformational work. Whilst it was recognised that a lot of work was taking place, she asked how we respond effectively and how people stay well. Sheena suggested looking at people's mental health needs in partnership and seeing people in a holistic way. *John Readman returned to the meeting.* Jim Birrell would wish to see a quantification of the impact on what is happening. He further commented that we were in a poor position and there needed to be more robust assurance rather than having lots of projects in place, ie, 'investing an amount of money and this is the impact'. Maggie recognised the scale of opportunity and was mindful there wasn't a PMO discipline in place. Executives had discussed the tactical elements and as we move through winter, there needed to be a focus on what needs to be undertaken in 2023/24 in order that the ICB has a strategic position going into 2024/25.

	Chris Oliver referred to physical and mental health pathways and in particular, placements in out of area which were a significant cost to the system. He welcomed the opportunity of working with Maggie in respect of the integrated care pathway. David Levy referred to flow in secondary care commenting that consideration also needed to be given in respect of flow in primary care. He advised that a primary care winter plan was being developed which he would share with Maggie and take to the workshop. The Chair commented that the intention was to have a single plan rather than a double stream. Kevin Lavery recognised the challenges but stressed the importance of remaining positive. The Board would need to address the short term then the medium term commenting that Maggie and the team were co-ordinating with Trust leaders. He would ask whether we were well organised and although achieving in some initiatives, would need to keep going. By ensuring community services continued and investments in Finney House, domiciliary care and intermediate care, it should make a huge difference in going forward. There was also a requirement to strengthen the primary care system which is where place would have a role to play in going forward. Kevin also stressed the importance of ensuring it was right across the region and that it was in our thought process. A dual approach would need to be taken through winter but also recognising the strategic changes and ensure it was joined up at place resulting in success across the system. **RESOLVED: That the Board note the update.**
46/22	**Approach and Oversight for the Urgent and Emergency Care Assurance Framework** A report was submitted to the Board in respect of the Urgent and Emergency Care (UEC) assurance framework. **RESOLVED: That the Board note:** • **The report and be assured there is a robust process for ongoing completion of the National monthly urgent and emergency care assurance framework updates and monitoring and key risks relating to it – via the surge and resilience group, accountable to Executive Leadership team.** • **That there has been robust collaborative planning to take us into this unpredictable winter with financial allocations targeted towards those issues likely to provide the best return on investment by seeking to respond to the known pressures.**
47/22	**Policies and Procedures: Emergency Preparedness, Resilience and Response (EPRR) / Business Continuity Policies** Maggie Oldham was responsible for EPRR for the ICB and an EPRR lead would be joining the organisation in November. The report explained that NHS organisations were required to prepare for and respond to incidents and disruptions which may

	affect their ability to continue normal functions and that may affect patient care. The ICB was designated as a Category 1 Responder under the Civil Contingencies Act 2004, which required identified organisations to prepare for, be resilient against and respond to disruptions and major incidents and must comply with EPRR Framework, the NHS strategic national framework containing principles for health emergency preparedness, resilience, and response for NHS-funded organisations in England To manage the process, NHS organisations are required to outline how they will meet their EPRR statutory and regulatory requirements. The EPRR policy and Business Continuity Policy described the process and how the ICB will meet its statutory and regulatory EPRR requirements. A workshop would be undertaken prior to the end of the calendar year looking at the ICB's designated responsibilities and working to a standard framework. In the event of a major incident happening imminently, Jim Birrell questioned if there was sufficient resource to manage/oversee the incident. David Levy advised that provision had been put in place since 1 July 2022 via an on-call system which included an ICB Executive as the strategic commander, supported by senior managers. Training had also been undertaken and everybody is supported. Feedback received was that the process was working well. Geoff Jolliffe referred to primary care and business continuity, suggesting that in the event of an incident at a GP practice that shared databases in localities would allow access to data at another practice. **RESOLVED: That the Board:** • **Approve the EPRR Policy and Business Continuity Policy.** • **Note the actions in progress and endorse the next steps in the EPRR programme.**
48/22	**Lancashire and South Cumbria Clinical Commissioning Groups: 2021/22 Annual Reports and Accounts** Sam Proffitt spoke to a circulated report which summarised the process and governance stages undertaken by Lancashire and South Cumbria (LSC) CCGs prior to disestablishment on 30 June 2022, and for the receipt and publication of respective 2021/22 Annual Report and Accounts. NHSE had provided clarification on the statutory arrangements for the presentation of CCG annual accounts to cover the period of 2021/22, in lieu of an Annual General Meeting, given that they were no longer in existence hence presented to the Board meeting held in public for noting. It was noted that each annual report and accounts was required to be published online by 30 September 2022 and as CCG websites were largely archived, the eight LSC CCG annual reports had been published on the ICB website. Sam confirmed that there had been no material changes in audit process to the accounts and each CCG had a true and fair view of its accounts. There had been an

	ask around some adjusted items which showed as an allowable deficit and in the accounts as relevant. Sam conveyed her thanks to the staff who produced the reports and was also mindful of the work undertaken during Q1 (April to June 2022). **RESOLVED: That the Board note the receipt and publication of all Lancashire and South Cumbria CCG Annual Reports and Accounts 2021/22.**
49/22	**Summary Report of Committee Business** The Board was provided with a summary of key business, decisions and progress updates for committees/groups held during September and to receive approved committee minutes. The Chair asked committee/group Chairs to provide verbal updates as follows: **Public Involvement and Advisory Engagement Committee –** Debbie Corcoran advised that a second workshop had been held and the first formal meeting of the committee would be held on 20 October 2022 with a focus on the operating model relating to the community and carers and how it will develop at place. Debbie referred to a public and engagement deep dive into the new hospitals programme. The committee would look at a draft template/structure for a public engagement and involvement assurance report and a regular public insights report which would draw together to support decision making. **People Board –** Ebrahim Adia advised that the first formal meeting of the People Board had been held on 28 September 2022 at which interesting and detailed comparative data was reviewed. Further work would be undertaken in respect of data relating to social care, primary and community care in order to have a fully integrated perspective in respect of workforce. Work would also take place in relation to emerging themes and as an ICB were we can add value and more capacity. He referred to workforce sickness absence relating to mental health commenting that a focus would need to be undertaken around this area. In respect of Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) 2022 data, an overview of action plans across each provider Trust had been reviewed. It was recognised that whilst there were similar issues, different actions were being undertaken in provider organisations and, therefore, there was a need to look at best practice around this. It was noted that the ICB's staff profile was different to the WRES data in comparison to provider organisations as the ICB did not have the same diversity. **Quality Committee –** Sheena Cumiskey advised that a preparatory session had been held in August and the first formal meeting held in September at which a representative from the Foxton Centre attended and provided individual patient stories about experiences of accessing NHS services. The Quality Committee was mindful of how it could change what we do, undertake from a population perspective and to ensure patients have a safe experience. The committee would also look more closely at being more connected in terms of the strategy and the patient safety framework. A development session would be held on 19 October 2022 to look at committee effectiveness and addressing the right areas. A workplan had been agreed which

	would be reviewed regularly. **Primary Care Contracting Group –** David Levy referred to commissioning delegation advising that discussions were taking place in respect of processes. General practice services were currently commissioned however, pharmacy, dental and optometry would be commissioned from 1 April 2023. Work continued with the regional team supporting the primary care commissioning function which would be part of the ICB. **Audit Committee –** Jim Birrell advised that the second meeting of the Audit Committee had taken place at which discussion was held regarding the work being taken forward by internal audit colleagues, the CCGs' accounts and financial sustainability. He explained that the committee could not yet provide any substance to assurance and that the committee was where it would expect it be currently. The Audit Committee welcomed the establishment of a Finance and Performance Committee and the discussion during the Board meeting had reiterated this requirement. The Chair was pleased with the progress of the committees. He advised that Roy Fisher would Chair of the Finance and Performance Committee which would be established imminently. **RESOLVED: That the Board:** • **Note the summary of discussions and key business of the committees of the Board.** • **Receive the approved minutes of the Audit Committee held on 26 July 2022.** • **Note the progress update of the Public Involvement and Engagement Advisory Committee in readiness for its inaugural meeting in October.** • **Note the establishment of the Finance and Performance Committee, to be chaired by Roy Fisher.**
50/22	**Any Other Business** There was no further business.
51/22	**Date and Time of Next Meeting** The Chair advised that discussions were taking place regarding alternative venues for Board meetings. The next meeting would be held on Wednesday, 2 November 2022 commencing at 9.30am to 12noon. Until advised further, the venue would be the Health Innovation Campus, Lancaster University, Lancaster, LA1 4AT