NHS
Lancashire and South Cumbria
Integrated Care Board

Subject to approval at the next meeting

Minutes of a Meeting of the Integrated Care Board Held in Public on Wednesday, 15 January 2025 at 1.00pm in the Lune Meeting Room, ICB Offices, Level 3 Christ Church Precinct, County Hall, Preston, PR1 8XB

Part 1

	Name	Job Title
Members	Emma Woollett	Chair
	Roy Fisher	Deputy Chair/Non-Executive Member
	Kevin Lavery	Chief Executive
	Jim Birrell	Non-Executive Member
	Debbie Corcoran	Non-Executive Member
	Sheena Cumiskey	Non-Executive Member
	Professor Sarah O'Brien	Chief Nursing Officer
	Dr David Levy	Medical Director
	Dr Julie Colclough	Partner Member – Primary Care
	Aaron Cummins	Partner Member – Trust/Foundation Trust – Acute and Community Services
	Chris Oliver	Partner Member – Trust/Foundation Trust – Mental Health
	Denise Park	Partner Member – Local Authorities
Nominated Deputy	Andrew Harrison	Director of Finance - Deputising as Chief Finance Officer
Participants	Professor Craig Harris	Chief Operating Officer
	Asim Patel	Chief Digital Officer
	Dr Sakthi Karunanithi	Director of Public Health, Lancashire County Council
	Debbie Eyitayo	Chief People Officer
	David Blacklock	Healthwatch Chief Executive
	Victoria Gent	Director of Childres's Services (Blackpool)
	Neil Greaves	Director of Communications and Engagement
In attendance	Debra Atkinson	Company Secretary/Director of Corporate Governance
	Davina Upson	Board Secretary and Governance Manager
	Kirsty Hollis	Associate Director and Business Partner to the Chief Executive

Ref	Item
01/25	**<u>Welcome and Introductions</u>** The Chair, Emma Woolett, welcomed everybody to the Board meeting and thanked those observing, either in person or via the live steam, for their interest in the business of the Integrated Care Board (ICB). She informed that a focus of the meeting would relate to the acute clinical vision for Lancashire and South Cumbria and the ambition to reduce health inequalities for our residents.

	It was noted that one question had been received from a member of the public in relation to thrombectomy services which directly pertained to the agenda (Item 12c - Committee Escalation and Assurance Reports: Quality Committee) and this question would be referred to during the discussion. The Chair advised that the Board would commence with a patient story. Members would hear from a resident of East Lancashire describing her experience of care for her husband, who sadly died from terminal cancer, and her experiences as an older person who lived alone. The patient story highlighted the importance of end-of-life care.
02/25	**<u>Apologies for Absence/Quoracy of Meeting</u>** Apologies for absence had been received from Sam Proffitt, Chief Finance Officer and Deputy Chief Executive and Professor Jane O'Brien, Non-Executive member, Cath Whalley, Director of Adult Services (Westmorland and Furness) and regular participants Tracy Hopkins, Chief Executive Officer – Citizens Advice, Blackpool representing Voluntary, Community, Faith and Social Enterprise sector. It was noted that Andrew Harrison, Director of Finance was deputising on behalf of Sam Proffitt. The meeting was quorate.
03/25	**<u>Declarations of Interest</u>** The Chair noted that no declarations of interest had been advised of prior to the meeting but requested that should these arise during discussion that these were advised of. D Park advised that she would be providing an update to the register of interests which related to her taking on a trustee position at Blackburn Rovers Community Trust in November 2024. **RESOLVED: That there were no declarations of interest raised which related to the business items on the agenda. The Chair would be advised of any conflicts that arise during the meeting as appropriate.** **Board Register of Interests -** Noted.
04/25	**<u>Minutes of the Board Meeting Held on 13 November 2024, Matters Arising and Action Log</u>** **RESOLVED: That the minutes of the meeting held on 13 November 2024 be approved as a correct record.** **Matters Arising and Action Log –** All actions have proposals to address, and it was agreed that these were closed.
05/ 25	**<u>Patient Story/Citizen's Voice</u>** S O'Brien introduced the patient story and expressed thanks to Mrs A (a resident of East Lancashire) for sharing her experience, noting that Mrs A had made an approach to the ICB during an engagement event. S O'Brien recognised that whilst there were many positive experiences of direct care, there were also some challenges with the variation in services and lack of joined-up communication. This story was particularly relevant to the agenda items on clinical services reconfiguration and health inequalities. It highlighted the need to focus on reducing health inequalities when considering service change to improve outcomes and ensure an exemplary experience of care.

	The Board welcomed the patient story. While there was good feedback on the end-of-life care which had been provided in this case, the Board recognised that there is too much variance in the offer across Lancashire and South Cumbria and stressed the importance of ensuring consistency. It was also recognised that whilst there were significant enhancements which could be made through the implementation of the digital agenda there was also a degree of nervousness about digital care highlighted throughout the story. This nervousness should be reflected in digital developments to ensure that any advancements are person centred and nobody is digitally excluded. A Patel provided assurances regarding the ambition to have a single digital system across all providers which would assist with the number of correspondences being issued. **RESOLVED: That the ICB Board note the patient story.**
06/25	**Chair's Report** The Chair commented on the ICB being in intervention for financial delivery and what this meant in the context of the Board agenda for this meeting. She noted that the ICB and the system had agreed a significant deficit plan with NHSE and were not delivering against that plan. An inability to deliver on spending plans meant that there could be no confidence about delivering the Clinical Vision later in the agenda either. She stressed the need to build a delivery culture across the system and that this would increase confidence in our ability to achieve quality, financial, and strategic development. The support provided from the intervention process would be used to embed a culture of delivery that will ensure the system achieves its plans to reduce the deficit and will provide a platform to deliver the vision for healthcare articulated in today's papers. The Chair commented that this would require immense vigilance from the board to scrutinise plans and challenge for greater delivery, and to triangulate across performance and quality to ensure all areas were covered. She highlighted that the most cost-effective services were generally the highest quality ones. The Chair emphasised the need to maintain commitment to long-term transformation in line with the local vision to lead the system to deliver the plan set out, as this was the only way to address the inequalities of care, improve the experience of patients, and live within our means. As Chair, she committed to ensure that colleagues had the space and time to do what was required, including having a clear focus on the key issues over the coming months. **RESOLVED: That the ICB Board note the report.**
07/25	**Report of the Chief Executive** K Lavery commented that 39 out of 42 Integrated Care Systems had been placed into the intervention and investigation programme from NHS England, advising that Lancashire and South Cumbria ICB were in the formal stage of the process. He advised Price Waterhouse Coopers (PwC) had been appointed to work with the system, to focus to improve the year end position and review the 2025/26 budget to ensure the deficit reduction. He advised the support had been welcomed and colleagues would work closely with PwC recognising this as an opportunity to improve the position. He further commented on the New Hospitals programme and confirmed that University Hospitals of Morecambe Bay and Lancashire Teaching Hospitals had acquired sites, subject to a consultation process. He recognised the significant milestone this purchase represented for the system, noting that Lancashire and South Cumbria had not received the level of investment afforded to other systems. **RESOLVED: That the ICB Board note the report.**

08/25	**<u>Board Assurance Framework</u>** D Atkinson advised the circulated paper presented an update on the controls in place, the main sources of assurance in support of the achievement of the ICB's core aims/objectives and activity undertaken in Quarters 2 and 3 for the principal risks held on the Board Assurance Framework (BAF). It was noted that the Assurance Framework played a key role in informing the production of the Chief Executive's Annual Governance Statement (Annual Report). D Atkinson advised: - There had been one increase in a risk score (BAF-002) from 12 to 15 in quarter 3, which related to an increase in national attention and visibility of ICBs duties to tackle inequalities and increase prevention following the Darzi Quality Committee; however, the impact of current financial challenges was impacting on the ability to deliver against key programmes of work. - A request for closure of BAF-010. - The risk relating to the ICB and system financial plan had been fully reviewed and updated. A Harrison advised that due to the fast-moving pace through intervention that that this risk would be continually monitored and updated. - Mitigating actions for each risk were aligned to the executive delivery plan which was referenced in section 2. - In accordance with the ICB's Risk Management Policy, operational risks which score "20" or higher were also included within the report. There were two risks highlighted, (ICB-029: Neurodevelopment pathways across Lancashire and South Cumbria and ICB-026: ICB's ability to meet its statutory Send responsibilities), which were held on the Operational Risk Register (ORR). - The positive outcome of Mersey Internal Audit Agency's (MIAAs) phase 1 review of the ICB's Assurance Framework undertaken in November 2024, which concluded that the BAF had significantly improved since the previous review in 2023/24. - Following the review of the outcome of the committee review, which was includes in the chairs report, it was noted that there would be a full realignment of the BAF depending on outcomes of the committee arrangements. The Chair commented that whilst the corporate governance team were responsible for the structure of the BAF, each area of risk had a lead executive and requested that members pose any questions to the executive owner of the risk. S O'Brien commented on the two risks related to neurodevelopment pathways and Special Educational Needs and Disabilities (SEND) and formally advised a SEND inspection had taken place during December 2024 in Lancashire, and the final report, along with the action plan, would be presented to the board. She advised that the risks had been reflected within the SEND inspection. D Park commented that the Local Authority were statutory partners for Special Educational Needs and Disabilities (SEND) and noted the importance to continue to collaborate to support vulnerable and young people effectively. J Birrell queried the reason behind closing BAF-010, as there remained an ongoing requirement to move forward in this underdeveloped area. C Harris explained the closure was related to how the risk was originally written and the risk needed to be captured differently. It was noted that an alternative risk would be included in the next iteration of the BAF when this is submitted to Board.

	Dr S Karunanithi referenced the increase in the risk score for BAF-002 concerning the duty to reduce health inequalities. He emphasised the need to maintain focus and consider what actions were necessary to stabilise and reduce this risk. The Chair expressed her interest in understanding the rationale behind the increase in risk. D Levy noted that the risk reflected the current population health situation with a degree of challenges sitting outside of the health sector environment and highlighted the significant financial challenges faced by the population. He commented on the work being undertaken, which would be discussed later in the agenda and through an additional paper to Board in March 2025, there was hope the risk level could be reduced. K Lavery commented on the need to reflect on the external environmental challenges that would increase inequalities. However, the focus should be on what actions were being taken to reduce the risk of health inequalities, which was a statutory duty of the ICB. He cited admission avoidance as an example of an action that would improve the situation. It was suggested the risk be reviewed in terms of the general climate and the organisation's approach to make a difference. C Oliver reflected that Lancashire and South Cumbria NHS Foundation Trust (LSCFT) were taking their health inequalities action plan and strategy for formal board approval, and all providers would have a similar document, suggesting a review against what providers were undertaking with the overarching work from the ICB, which may assist to address gaps. He provided an example that LSCFT was looking into the possibility of extending their WiFi into communities at no extra cost during the review of the Trusts digital infrastructure, this extension could provide some deprived areas with access to WiFi connections. The Chair requested that the paper which would be submitted to March 2025 Board should include a re-assessment of the health inequalities risk score (BAF-002) and overlay some work which was being undertaken with providers and partners. **Action: D Levy** ***(Action Log)*** **RESOLVED: That the ICB Board:** • **Note the contents of the report and the activity undertaken in Quarters 2 and 3 in relation to the principal risks held on the BAF** • **Review the BAF and the full entries provided in Appendix 1** • **Approve the changes to those risks highlighted under section 3.2 with the exception of BAF-002 and BAF-010 (*see below)** • **Note the risks held on the ORR that are scored "20" or higher** • **Note the positive outcome of the MIAA review of the Assurance Framework** • **Note the next steps to support the development of the BAF for 2025/26** • ***Note that a re-assessment of risk BAF-002 and an overlay with provider and partner work would be undertaken** • ***Note that an alternative risk would be drafted for inclusion in the BAF**
09/25	**<u>Improving health and care in Lancashire and South Cumbria: Clinical Vision</u>** D Levy spoke to the circulated report and presentation which provided detail of the ICB's vision for improving health and care in Lancashire and South Cumbria. The vision was to have a high quality, community-centred health and care system by 2035, with an emphasis on prevention, wellbeing and healthy communities rather than solely on a specific health issue and/or clinical

visit of a patient. This would be underpinned by a clinical vision and progress towards a 2030 Roadmap for delivering transformation in Lancashire and South Cumbria
He highlighted:

- A national 10-year plan was awaited, noting that there would be a move from acute care to primary care settings for health care, move from treatment to prevention and a move from analogue to digital.
- A blueprint had been developed for the acute sector (excluding mental health) with an emerging programme for a community transformation strategy also being developed.
- Several commissioning intentions had been developed from the blueprint which had been shared with providers.
- A workshop for LSC 2030 took place in November 2024.
- The focus of the priorities for the next 3 months was highlighted to ensure readiness for April 2025, with a focus on identifying patients who are frail to ensure that advanced care plans were available, consider the development of a locally enhanced service for primary care to ensure a consistent offer and further develop a community rehabilitation model.

The Chair acknowledged the significance of this work and recognised that members had had a number of opportunities to engage in the development of the vision. She emphasised the need for engagement and decision-making, and recognised this was a significant moment for the acute part of the system, commenting on the importance of tying this work to all other parts of the system, both NHS and non-NHS.

A Cummins supported the work on the vision and roadmap which had been developed and commented this provided clarity to patients and colleagues on the next phase of the plans. He emphasised the need to focus on timelines and stressed the pressure to articulate the impact of these plans in 2025/26 on quality. It was agreed that fewer but more impactful priorities were needed, and there was a need to move quickly to get delivery plans approved before April 2025.

A Cummins asked whether there was an understanding of what would prevent the success in certain areas, stressing the importance of governance and decision-making. He referenced the statement in the circulated papers regarding the project being delivered by one Trust and stressed a cross-provider leadership team would be necessary to build a cohort of community clinical leadership. He requested that a risk-sharing or financial framework be developed this quarter, as risks in one area could prevent delivery.

D Levy agreed with the comments from A Cummins, particularly on the need for a focus in a few areas, advising that a productive meeting had taken place with Lancashire Teaching Hospitals Chief Executive regarding the granular detail relating to One LSC for pathology. D Levy recognised that whilst a service may be led by one Trust there would be an impact seen across the system.

The Chair commented on the balance required between delivery and strategic thinking. Given the intervention the system was in, a new strategic powerhouse would not be established. However, there was a need to find a way to drive through what was required next year. It was agreed that the discussion surrounding A Cummin's points relating to Governance, risk sharing and what was required for next year were taken offline and reported back to the next Board meeting in March 2025, alongside Commissioning Intentions.

Action: D Levy/C Harris ***(Emailed action)***

Dr S Karunanithi commented that having a vision was positive, however he raised concerns about the realism of delivering priorities in the next three months, and he asked what would count as success for the board to be assured of delivery. Secondly, he queried the need to consider the public narrative, which currently focused mainly on demand. D Levy explained that the next three months would be used to work up the proposals; they would not commence

	immediately, with the aim to commence these plans from April 2025. He also highlighted the importance of public engagement and the use of digital technology to avoid attendance at hospitals. N Greaves advised that the public narrative in the paper set out the vision and challenges. He also reflected on conversations which had been held over the last few months (September to December 2024 through a series of engagement events) and work on perception which had helped to shape this work. It was noted that patient stories formed the heart of this engagement, and these were starting to influence and shape the transformation work. D Corcoran noted the circulated report captured the themes and feedback from the last quarter and a request from the Public Involvement and Engagement Advisory Committee was to ensure that learning was embedded throughout the transformation programme. She recognised that ongoing engagement was necessary to ensure continued success and provide continued oversight and assurances as to what was being undertaken to address concerns raised. J Colclough stressed the importance of providing clear and consistent communication and not using conflicting language, especially when patients felt they had been attributed a label such as 'frail', which would help to alleviate fears for the patient population. K Lavery acknowledged this report marked the beginning of a significant journey to address inequalities, patient safety, quality and value for money. He noted the approach would be incremental, focusing on a few areas at a time and adjusting governance as required to enable the delivery. He highlighted the importance of regularly reviewing in line with the Commissioning Intentions to provide a better experience at home for patients and that this would release capacity in hospitals. It was agreed to provide a further update on improving health and care in Lancashire and South Cumbria - Clinical Vision, to the March 2025 Board, recognising the requirement to potentially have an update at each Board meeting. **RESOLVED: That the ICB Board:** • **Note the vision for improving health and care in Lancashire and South Cumbria** • **Note the progress for developing a clinical vision to support transformation and service reconfiguration which improves health and care for residents of Lancashire and South Cumbria** • **To receive a further update at March 2025 Board.**
10/25	**<u>Reducing Health Inequalities</u>** D Levy advised the circulated paper provided an opportunity for the Board to consider the ICB's statutory duties to reduce inequalities in access and outcomes for the resident population of Lancashire and South Cumbria. He advised of the background which highlighted that LSC was home to some of the most severe inequalities in the country. Further to a workshop taking place at the Board Seminar session held in December 2024, support was sought from the Board for the organisation to develop and commit to several high-level goals and a whole-organisational approach to improving the health of the population and tackling health inequalities. D Levy advised that some of the actions were for the NHS to take, with others to be delivered in conjunction with wider partners in the Integrated Care System. He advised that it was intended that a further paper would be submitted to the Board in March 2025. D Levy referenced the audacious goals which were contained within the paper, namely:

- Improvement of healthy life expectancy by 10% in the most disadvantaged 10% of wards in the next 5 year
- Decrease non-elective admissions by 20% in the 20% most disadvantaged in by March 2027
- Improvement of key health outcomes for children by 10% in the most disadvantaged 10% of wards in 5 years.

The Chair acknowledged there were further aspirations and specific areas to be addressed which would require metrics to be included within the submission to the March 2025 Board.

Dr S Karunanithi praised the excellent work which included significant engagement having been undertaken with partners. He emphasised the requirement to be as specific as possible regarding the opportunities given the limitations of the next financial year. He also highlighted the idea of tracking spend on prevention, as mentioned in the Darzi report, and stressed that this should be seen as a whole budget for the Integrated Care Board (ICB) and not 1% of a team's budget allocated to prevention. The Chair acknowledged the financial pressures and noted that carving out a sum of money, which might go towards administrative costs, was not an attractive option. However, framing it as ensuring that 1% of every penny spent is dedicated to prevention presented a more compelling narrative. A Cummins commented on this approach which would require flexibility in the financial framework to address the 3-5 year longer term health inequalities strategy, which would require further discussion and underpinned this critical piece of work.

A Cummins stated that he would be guided by colleagues on the focus areas, and stressed the importance of having a position regarding what this would mean for capacity, demand and provision of care for providers, requesting that this be mapped through to show a material shift in demand and capacity through a system programme management approach.

A Patel commented on the comments from Dr S Karunanithi that it was challenging to describe a risk until outcomes had been measured and suggested that a focus should be more on capacity, resources and metrics. This clarity would help determine whether an impact had been made which would lend itself to a better board level conversation.

S O'Brien welcomed the paper and acknowledged the excellent discussion which took place in December 2024 with an agreement to focus on key areas to undertake these well. She made a plea to connect with other areas of work where there was already work being undertaken on this agenda, such as mortality and Learning Disabilities (LD), which are the most vulnerable groups with health inequalities. Collaboration with these teams could provide additional support and ensure a more comprehensive approach. V Gent supported this plea.

D Levy stressed the importance of ensuing that system partners were involved in the discussion and to agree the metrics for measuring impact, advising he was meeting with directors of public health to commence these discussions.

V Gent commented that although the population of Blackpool was in significant need of help, people may not always come forward for assistance. She suggested focusing on reaching into marginalised communities through co-production. D Levy advised that coproduction would be incorporated into the proposals, particularly in areas with significant levels of deprivation.

It was agreed that the recommendations contained within the paper would be further developed into detailed proposals for consideration by the Board at its meeting in March 2025.

	RESOLVED: That the ICB Board: • **Endorse the intention to develop high level goals and plans for delivery of the ICB's duty to reduce health inequalities for the consideration of the Board by March 2025** • **Note that further work is now underway to develop a roadmap including the proposed high-level goals, realistic deliverables, metrics and milestones. This work will involve colleagues from across the ICB, Public Health and other relevant partners.** • **Confirm that the ICB's approach to operational planning in 2025/26 will make explicit reference to the duty to tackle health inequalities, identifying action across the whole ICB in 2025/26 and signalling medium and longer term actions.** • **Support further work within the ICB to consider the capacity and capability of the organisation to deliver the work including addressing the need for intelligence and insights, for example to provide predictive modelling and modelling of impact.** • **Endorse the work to develop a phased, multi-year delivery plan to have fully implemented a revised financial allocation methodology by 2030, as one of the key enablers to the delivery of the ICB's health equity goals. An initial step towards this in 25/26 is the plan to move towards more needs-based funding for Primary Care** • **Endorse the plan in 25/26 to establish a baseline of prevention spend across the ICB with a view to increasing the prevention budget by 1% per annum.**
11/25	**<u>System Recovery Investigation and Intervention – Next Steps</u>** K Lavery commented on the deterioration of the financial position in October and November 2024. This resulted from back-ended efficiency saving programs not being delivered within the timeframe expected. Secondly, a firebreak on recruitment had been agreed with PA Consulting which had also slipped and not delivered the anticipated savings. He further advised that three of the Trusts in Lancashire and South Cumbria accounted for 80% of the off-plan figure, advising that turnaround directors would be appointed to provide support to these Trusts. It was noted that a significant element of the support from Price Waterhouse Coopers was to address the 2025/26 planning, noting the planning guidance had not yet been received from NHS England which was now expected in February 2025. K Lavery advised of the areas of focus for the ICB: to reduce the level of high-risk QIPP by having tighter control of spend in All Age Continuing Care which was being supported by a turnaround team. Also, for commissioning for 2025/26 to have higher levels of grip and control, and to work as a system to take decisions regarding the services which are commissioned. A Cummins noted the importance of recognising the scale of the challenges faced as a system and what decision needed to be made. He commented this was not just related to pushing hard at the Cost Improvement Program (CIP) but rather a wholesale restructure of the health and care services which were provided. From the provider perspective, he advised discussions had taken place through the Provider Collaborative Board (PCB) during November and December 2024 which focused on the approach to financial recovery, with one or two trusts doing well which then impacted on managing cost controls and delivery commitment, resulting in a commitment to ensure all Trusts followed the same protocol on planning, budget management and delivery, with good support being provided by Simon Worthington. A Cummins further highlighted the need for an honest discussion when the draft plans were received to ensure an appropriate level of check and challenge and peer review ahead of the

	next phase. He recognised this would not alter the dial on delivery, but the collaborative approach would improve accountability and more oversight on core delivery. The Chair queried when the check and challenge work would take place through the PCB and whether this was prior to Board submissions. A Cummins advised the first draft plans were due next Wednesday, and through February and March, there would be peer check and challenge sessions before finalising which would not dilute the role of the board. D Park recognised the financial pressures and made a further plea for collaborative efforts to address the challenges in the health and care system to effectively manage the pressures and sustain effective working relationships. Dr S Karunanithi noted that from the public's perspective, there was a requirement to be more proactive with communities to ensure they were on board with the changes thereby mitigating the element of surprise, which was crucial. There was also a need to be specific and clear in communication about what these changes meant for the population of Lancashire and South Cumbria. The Chair added that the proposed clinical reconfiguration aligned with what patients were expressing they wish to happen and confirmed the commitment to ensure that communication was at the forefront of the proposals. K Lavery recognised the number of opportunities which had been identified to address the variations in quality and value for money, recognising that a focus on reducing the number of frail patients in hospitals and modernising outdated technology was essential. The Chair emphasised the importance of delivering on these opportunities to make significant improvements and ensure better outcomes for patients. **RESOLVED: That the ICB Board note the content of this report, the current level of financial risk and the approach to mitigating this, both in the short-term and long-term.**
12/25	**<u>Committee Escalation and Assurance Report</u>** The Board received a summary of key matters, issues and risks discussed since the last report to the Board on 13 November 2024 to alert, advise and assure the Board. The summary report also highlighted any issues or items referred or escalated to other committees of the Board. Minutes approved by the committees to date were presented to the Board to provide assurance that the committees had met in accordance with their terms of reference and to advise the Board of business transacted at their meetings. **<u>Public Involvement and Engagement Advisory Committee – 18 December 2024</u>** D Corcoran highlighted the following from the report commenting no alerts had been made. **Advise:** Your health. Your future. Your say.': It was noted the ICB's commissioning intentions and 2030 Roadmap programme would consider public insight and perceptions, to form a set of 'you said, we've listened' statements in terms of commissioning intentions and to be fed back to the public **Assure:** Engagement in priority wards – population health improvement: Committee reviewed the work undertaken with continued systematic multi-agency work in place-based areas and demonstration of engagement and involvement adding impact.

Assure: Shaping Care Together and New Hospitals Programme - The committee had received an update and assurances surrounding the consultations on service transformation and were able to offer feedback.

Primary Care Commissioning Committee – 25 November 2024 and 20 December 2024

D Corcoran commented that the summaries provided the detail of discussions and actions taken and was happy to take any questions on these.

Quality Committee – 20 November 2024 and 18 December 2024

S Cumiskey referred to the alerts within the report as follows from 20 November 2024:

- **Maternity:** The LMNS had noted a 'cluster of neonatal deaths' at one trust and a review is underway to ascertain if there is any cause for concern.

- **Patient Safety:** Committee alerted to 2 Never Events and a death in Accident and Emergency and had been reported in line with PSIRF. ICB Quality visits regarding UEC due to start before the end of November in line with NHSE recent request regarding safety in urgent care.

- **Mechanical Thrombectomy:** Committee received an update given the high level of patient safety risk in this clinical pathway. The gap in provision and patient safety risk remained and discussions were ongoing between the trust, ICB and NHSE to find a solution. A question had been received from a member of the public and S Cumiskey provided a commitment that this would be responded to.

- **Histopathology:** There had been a significant backlog of histopathology tests at one Trust with some evidence of patient harm. A Rapid quality review had been undertaken involving system colleagues, and mitigations have been put in place to manage the risks. However, some actions remain outstanding, and assurance is required that clinical prioritisation is occurring to ensure that histopathology blocs for people on the 2-week pathway are being analysed quicker through the backlog.

S Cumiskey referred to the alerts within the report as follows from 18 December 2024:

- **Children & Young People & SEND:** Committee had been alerted to three key areas of risk: Waiting times across Neurodevelopment pathways for children remain very long. A statutory inspection for Lancashire has just completed and the formal report in January will flag waiting times and timeliness of EHCPs as an area of concern for the ICB. There is a gap in dysphagia support for children over 5 years in Central Lancashire, whilst some mitigations are in place the long run impact on children is unclear and a risk. The length of Occupational Therapy waits at one provider is causing concern. S Cumiskey noted the requirement for a system response to the pathway.

- **Patient Safety:** Primary Care PSIRF guidance is now published BUT delivery across primary care will require a step change in practice and this has not been included in the contract so committee alerted to the risk that many GP practices will not deliver the PSIRF without funding.

J Birrell acknowledged the detailed information provided and reflected on the occurrence of never events, which were happening at a rate of two per week. He queried how the system can ensure that providers address these issues. S Cumiskey explained the importance of understanding how the ICB Quality Committee operates, by seeking assurance from Trusts on

patient safety, effectiveness, and experience is understood. The team worked closely with Trusts to understand why the risks are emerging, how they are being mitigated, and to track the impact of work undertaken. She further noted the work of the Improvement and Assurance Groups (IAGs) would focuses on assurance.

S O'Brien reminded members that as commissioners of the system, there was a duty to oversee the quality of commissioned services, and the ICB Quality Committee provided invaluable insights in highlighting areas where assurance was not sufficient. S O'Brien explained that a dedicated quality team worked with the Trusts and smaller providers as well as primary care quality. She noted that a team member sat on the Trusts quality committees and on also attended the mortality review meetings which provide a level of assurance. It was noted that nationally there had been an increase in never events.

Further assurance was provided that any issues could be escalated through the IAG's and any ongoing quality concerns were also addressed through a regional Quality Surveillance Group. In December 2024, the Quality Committee triple A advised that the ICB had self-assessed based on National Quality Board (NQB) guidance and developed a quality governance framework for the ICB, which had been shared with providers. She also advised of the quality indicators which are within contracts and require evidence submission, which was checked by the quality team.

A Cummins noted that Trusts were ultimately responsible for their own governance and acknowledged that a number of never events were relatable to human error. He highlighted that mutual aid had been provided to the Trust who was struggling with histopathology, which should reduce the exposure to harm highlighted in the report.

D Levy acknowledged the processes which were in place to manage the never events, recognising the presence of the ICB at Trusts' Quality Committees as part of the decision-making process as being is crucial. He commented that through escalations, rapid quality reviews had taken place, which appeared an effective way to obtain system assistance, as demonstrated recently with the histopathology review. It was also noted that the IAGs had been noted by regional colleagues as being an effective way of managing quality outcomes at Trusts and it had been clear that quality should remain on the agendas for these meetings.

The Chair sought clarification on whether members felt assured by the processes described and noted that there would be a focus on the Triple A from Quality committee at the next Board meeting to ascertain whether there were assurances provided on the alerts raised today. J Birrell commented that it would be helpful to receive detail mapping out the quality governance framework in easy-to-follow steps and escalation processes. **Action: S O'Brien** ***(Action log)***

D Corcoran reflected on the systems financial position and challenges, noting that it was imperative that board were assured on quality issues as this was an area of where the level of risk which could increase.

<u>Finance and Performance Committee – 9 December 2024 and 6 January 2025</u>

R Fisher emphasised that finances were a fast-moving aspect of the ICB governance in the current climate, and stressed the importance of scrutinising the information in a timely manner, noting the information which was received in the finance report today would supersede the details in the Triple A. R Fisher provided assurances the Finance and Performance Committee had provided scrutiny. He advised that consideration was being given to altering the timings of the Finance and Performance Committee to be more aligned with Board meetings.

He recognised the commissioning and control targets for 2025/26 were reviewed by both the Executive team as well as non-executive members and noted the important principle of

	affordability. **RESOLVED: That the ICB Board:** • **Note the Alert, Advise and Assure within each committee report and approve the recommendations as listed within the report.** • **Note the summary of items or issues referred to other committees of the Board over the reporting period.** • **Note the ratified minutes of the committee meetings.**
13/25	**<u>Urgent and Emergency Care (UEC) Recovery and Winter Update 2024/25</u>** C Harris advised of the regular nature of this report to Board during the winter period which provided an overview and update on the various programmes of work to support UEC recovery and winter planning during 2024/2025. These include: • Current winter pressures as reported by the System Coordination Centre • UEC recovery plan 2024/25 national ambitions and performance • UEC improvement plans • Current status of the UEC capacity investment funding for 2024/25 • Key risks for UEC. C Harris expressed thanks to all staff across Primary, Community and Acute care in relation to the support and management of the difficult winter period to date. He advised the pressures were highlighted through a number of Trusts being in Operational Pressures Escalation Levels (OPEL) 4 which was noted as being the highest level. Given this, there were a number of actions which had to be taken including stopping some outpatient services and cancelling of annual leave. He highlighted some of the pressures which included a critical incident at a Trust which had required a system response, an increase in cases of flu which had been recorded as being four times higher than the previously recorded three weeks, an increase in ambulance handover delays and the Mental Health system also being under pressure and declaring OPEL 4 in early December 2024 due to some high clinical risks. C Harris advised that in response to OPEL 4 being declared, several actions had been implemented which were highlighted within the paper and included additional evening operational meetings and daytime calls, local escalation calls convened with partners to initiate key actions and tactical responses to reduce operational pressures and maximise hospital discharges, with all providers being requested to review their major incident plans. He further commented on the four-hour target of 78% of patients being seen within 4 hours. Up to November 2024 this had remained static at 77.5% but it had since slipped to 76.1% replicating the position last year. The Category 2 ambulance response times had also slipped to 25 minutes 39 seconds at the end of 2024. The Chair conveyed formal thanks to all parties and staff involved in supporting the system throughout the winter period to maintain performance. C Oliver questioned whether, given the pressures in the system, it would be beneficial to examine the trends in discharge-ready patients and collaborate with partner organisations to reduce the number of patients who no longer required acute care. C Harris welcomed this suggestion and advised of a discharge strategic oversight group, which was nationally mandated and had produced a report on flow which was agreed would be valuable to be included in a future update to the board. **Action: C Harris** ***(emailed action)*** J Colclough alerted members that throughout Primary Care pressures were also experienced and noted this was not reflected within the report to Board. C Harris recognised this and

	advised of an ongoing piece of work which allowed practices to self-assess. He committed to work on a solution, with an inclusion in future reports of the headlines from primary care which was agreed would enhance the reports. **Action: C Harris** ***(emailed action)*** D Blacklock sought clarification regarding how the public were engaged with when services were under pressure, what guidance was offered and the impact of this. C Harris provided assurances that there were comprehensive proactive approaches to communication, including working with Trusts if there were 'hot spots' in the system to provide reminders to the public regarding alternatives including the 111 service and Pharmacy First. N Greaves highlighted the extensive work being undertaken across communication teams, including partnerships with local authorities and working with local communities, to build connections. He did recognise that monitoring the impact was challenging. The Chair queried whether the NHS App could be utilised further, recognising this would not be appropriate for all service users. J Colclough advised of the option to manage the messages which patients receive through the App. The Chair acknowledged the significant work and achievements which had been made under immense pressure. However, she asked about the delivery of the changes contained within the Urgent and Emergency Care (UEC) plan and queried about the timing of the implementation of these. C Harris advised the delivery of the changes was planned to continue into the next financial year, noting that whilst some stabilisation had been noted in Q3 and Q4 there had not been traction on improvements. He commented the plans would need refreshing. The UEC plan had replaced the requirement to have a separate winter plan, and there would be an ongoing year on year improvement plan which would be linked to patient flow, access, responsiveness, discharges, and under pinned by affordability. A Cummins emphasised the need for a distinction between the winter plan (which Trusts had developed over a number of years) and the general UEC improvement plan. He requested that component parts (resources and impact expectations) were built into the delivery plans to assist with performance and financial sustainability. Confirmation was provided the detail would be submitted to the March 2025 Board as part of commissioning intentions. Dr S Karunanithi referred to the reduction of uptake of the flu vaccination amongst the workforce which would require a focus to understand how to do more as a system to prevent flu outbreaks through winter planning. He also commented on the fragmentation of the access to obtaining flu vaccinations via pharmacies and primary care and the difficulties which had been noted regarding making appointments. **RESOLVED: That the ICB Board note the content of the report and receive assurances that oversight of progress and all associated requirements continue via place UEC Delivery Boards and the Lancashire and South Cumbria Strategic System Oversight Board for UEC and Flow.**
14/25	**<u>Finance Report – Month 8</u>** A Harrison spoke to the circulated finance report and highlighted: - The Integrated Care System (ICS) submitted its final 2024/25 plan in June 2024, setting out a system deficit of £175m and accepting the NHSE system control total. - As at the 30 November 2024 (month 8) the system was £62.7m behind plan with a reported £94.9m deficit. The ICB was reporting a year-to-date deficit of £7.0m with the remaining £55.7m variance from plan associated with the acute provider Trusts. - Delivery of the agreed plan was dependent on the release of £530.8m of efficiency savings, £260.8m for provider trusts and £270.0m for the ICB. - As at the 30 November 2024, Provider Trusts had a shortfall of £37.7m on the year-to-date delivery of efficiency savings. The high risk in the system related to a significant number of

	savings being back ended delivery of which was expected in the final quarter of the year. - The ICB had met its year-to-date target for savings. In addition, A Harrison advised of two transactions which met the criteria for special payments and required approval by the Board, advising a special payment was an item that was outside the normal range of departmental activity and was not considered when monies were voted for by Parliament. As such, these transactions were subject to greater control than other payments and were mandatory disclosures within the ICB's Annual Report and Accounts. He noted that due to the time sensitivity of the payments required executive sign off: - £550 ex gratia payment to meet the requirement of an associated Ombudsman's report following a complaint for failings in the ICB's management of a residential placement. - £4,320 ex gratia payment to compensate travel costs incurred by relatives of an ICB patient, who had been transferred out of the ICB footprint for care. J Birrell raised concerns about the financial position, particularly highlighting the significant consequences of overspending on cash flow, which was causing the system's cash to become tight and would require oversight. J Colclough raised a concern regarding the financial summary position, noting that primary care was not included as a separate line. J Birrell assured the Finance and Performance Committee received a full breakdown with the board receiving a summary position. This detail was captured in the ICB line contained within the report. The Chair acknowledged the significant amount of work and scrutiny currently being applied to the financial position, which was very tight and would continue to be monitored closely until the end of the year. **RESOLVED: That the ICB Board note the content of this report and approve the two special payments.**
15/25	**<u>Integrated Performance Report</u>** A Patel spoke to a circulated report which provided the Board with the latest position against of published performance metrics and he highlighted: - **Elective Recovery**: There had been a small reduction in the overall number of patients waiting although the number remained high (240,071). Delivery of the revised target for zero 65-week waiters by the end of December 2024 was challenged in a couple of specialties. He advised the plan for reform for elective care which was published on the 6 January 2025 provided a refocus on 18-week referral to treatment standards, noting that by March 2026 the percentage of patients waiting less than 18 weeks should stand at less than 65% and advised that currently the achievement of this standard stood at 60.8%. - **Mental Health:** The out of area placement target had been revised to the number of people in beds out of area, rather than bed days. The latest data showed there were 6 inappropriate out of area placements, slightly above plan. The interventions in place around prioritisation and focus were recognised. A Patel reflected that over the last year of reporting the performance report there had been an increase in demand compared to the previous period, which was also highlighted in the Chief Executives report to Board and noted that elective cases had increased by 13.2% compared to last year, attendances at Accident and Emergency increased by 6.4%, Cancer referrals by 11.4%. He commented on the dedication of the front-line staff in this challenging environment. A Patel further commented that during the COVID pandemic access to elective care reduced

	dramatically with the widening of health inequalities, people in deprived areas were waiting longer and he emphasised that future planning needed to review elective care to ensure that this inequality to access did not continue. R Fisher commented on the significant reduction of patients who were in hospital beds when they no longer required medical care at Barrow in Furness and requested for the detail to be shared as to how this reduction was achieved. A Cummins advised that University Hospitals of Morecambe Bay were still in excess of the target for Non-Medical Criteria to Reside patients (NMC2R), he noted that improvements had been seen in Barrow which had resulted in a material shift. This improvement had been sustained through a combination of therapies in hospitals and discharges coordinated through Place and Local Authority. However, this success had not been replicated at Royal Lancaster Infirmary, where 32% of patients were currently NMC2R. The Chair expressed a desire to understand the blockers preventing replication across the system to achieve similar improvements at the next Board. **Action: C Harris** ***(Action Log)*** S O'Brien raised concerns about the significant impact of flu on workforce sickness absence, noting the financial cost of flu on both the workforce and the population. She suggested the board should take more action to review and raise the profile of vaccination uptake for the next year, as this area of prevention could make significant savings. Dr S Karunanthi supported this suggestion and expressed willingness to work with S O'Brien on this with further discussion to the ICB board in May 2025. **Action: S O'Brien/Dr S Karunanthi** ***(Action Log)*** S Cumiskey emphasised the need to understand the drivers behind the lack of vaccination uptake and behaviours, suggesting the involvement of N Greaves and D Corcoran. A Patel noted that in January 2025 the bed occupancy at East Lancashire Hospitals NHS Trust and Blackpool Teaching Hospitals NHS Foundation Trust was the highest with these areas having the largest areas of deprivation and the poorest flu vaccination uptake. **RESOLVED: That the ICB Board note the content of the report.**
16/25	**Audit Committee Escalation report:** **<u>Audit Committee – 19 December 2024</u>** J Birrell advised of six completed audit reports which were presented to the committee. He highlighted the All Age Continuing Care report and alerted members to the outcome of Mersey Internal Audit Agency (MIAA) Quarter 2 report which included five high priority recommendations and provided assurance that these would be monitored through the ICB Quality Committee and Finance and Performance Committees: - A need to clarify the BAF risk target - Develop a clearer understanding of the drivers behind the financial variances - Determine the next steps to follow up the data analytics exercise commissioned from MIAA - Ensure there is sufficient resource to develop the in-house audit programme - Design Place-based reporting arrangements for management of reviews. **RESOLVED: That the ICB Board:** • **Note the Alert, Advise and Assure from the Audit Committee and approve the recommendations as listed within the report.** • **Note the summary of items or issues referred to other committees of the Board over the reporting period (as appropriate).** • **Note the ratified minutes of the Audit committee meetings.**

17/25	**<u>Northwest Specialised Commissioning Arrangements – 1 April 2025</u>** C Harris reminded members of the current arrangements relating to the delegated specialised commissioning services which commenced in April 2024, noting there was a Lancashire and South Cumbria specialised commissioning oversight group (co-chaired by C Harris and D Levy) and a Joint Committee across the 3 ICBs and NHSE (attended by J Birrell and C Harris). He advised of the intention to transfer the Northwest Specialised Commissioning Hub which was a shared service across the 3 ICBs. This would result in Lancashire and South Cumbria ICB being the host ICB from 1 July 2025. Members were advised of the work which was being undertaken to support this transfer including structures and transfers with a further update required to Board regarding assurances surrounding adequate staffing and resourcing. The proposed payment arrangements detailed were noted: - The ICB would receive direct allocations to commission specialised services for its population. - The NW Specialised Commissioning Hub would provide a financial management service for this allocation and the Hub would work with the ICBs to develop and agree a financial plan. - Key financial issues would be discussed and agreed through the finance sub-group and all financial decisions would be agreed in line with each ICBs financial governance for single ICB services. - For those multi-IBC services, financial decisions would be agreed via the joint commissioning committee. - The hub would monitor and report delivery of this plan into the ICBs, with the hub preparing financial schedules to support payments for specialised commissioning services. - All payments would be agreed and approved by the ICBs. C Harris advised of further delegations of an additional 25 services as of 1 April 2025 and highlighted the agreement via the Northwest Finance sub-group that from April 2025, the contracting for delegated services along with retained specialised services and other NHS England non specialised services (health and Justice, Armed Forces). He advised that work had commenced with the regional contract leads to set out an operating model to support these arrangements with the hub continuing to undertake contract negotiation and management of the specialised elements of the contract whilst minimising duplication where appropriate. C Harris advised that since the delegation agreement was finalised, further development work across the programmes had taken place, resulting in the necessity to vary the existing delegation agreements in advance of April 2025, which were detailed in the circulated paper, and required formal approval from the ICB Board. S Cumiskey raised concerns regarding the quality of the services commissioned and the delegation agreements, stressing the importance of understanding how the quality of services commissioned were managed and delegated. C Harris advised a proposal was being considered for NHS England (NHSE) to retain the quality element from a leadership perspective but delegated the team to LSC ICB. It was recognised the proposal required further discussion between C Harris and S O'Brien with the regional team due to there being concerns relating to vulnerability, risk and capacity. D Levy commented as more services came across to the ICB there was a necessity to be aware of the teams in order to provide appropriate support. The Chair wished to receive assurances that the Quality Committee was confident in the quality assurance processes prior to providing approval. C Harris advised that a significant proportion of the delegation was already in place, with small amendments to the delegation agreement

	being requested prior to the hub being transferred. He requested the delegation agreement be agreed before the hub was transferred and that further assurances on the hub arrangement be provided. S Cumiskey requested clarification surrounding mental health specialised commissioning as there were already delegations in place and she queried whether this proposal would impact on the current arrangements. C Oliver advised across the Northwest each mental health Trust was reviewing their delegation agreements and advised of the potential for changes, it was agreed for these discussions to be included in the next iteration of the specialised commissioning update/lead provider model to Board in May/June 2025 and to include the further assurances on the hub and staffing transfers. **Action: C Harris** ***(Emailed action)*** **RESOLVED: That the ICB Board:** • **Approve the variation to the Delegation Agreement set out in Appendix One with further assurances regarding the quality assurances processes for the hub to be provided in May 2025** • **Note the update on the creation of the NW Specialised Commissioning Hub Shared service within the NW region.** • **Note the proposed payment arrangements set out in paragraph 3.1.**
18/25	**Annual Review and publication of Conflicts of Interest Registers** D Atkinson advised the circulated report provided the board with an overview of the annual review which detailed activity undertaken since the last report to the board in March 2024 including key updates to the ICB's policies and procedures to ensure the statutory requirements for managing Conflicts of Interest (including gifts and hospitality) were met. The report contained an update on the ICB's arrangements for staff training in relation to the NHS England's (NHSE) online training modules for Managing Conflicts of Interests for ICB staff. As previously reported, Module 1 became mandatory for all ICB staff on 1 April 2024 as part of the ICB's core mandatory training requirements. It was highlighted that NHSE was currently working to release Modules 2 (for decision making staff) and Module 3 (for ICB chairs) and once this was released, any further updates to the ICB's policy requirements for mandatory training would be implemented. **RESOLVED: That the ICB Board:** • **Note the contents of the report** • **Approve the annual review and publication of the ICB's registers of interests** • **Note the improving position on staff compliance rates with training module 1** • **Note the release and implementation of training modules 2 and 3 once released**
19/25	**Any Other Business** There were no issues raised.
20/25	**Items for the Risk Register** **RESOLVED: That there were no items to be included on the ICB Risk Register.**
21/25	**Closing Remarks** Thanks were expressed to members of the public and colleagues who had observed the ICB

	Board meeting and to the Board members for their submitted papers and discussion. The meeting was closed.
22/25	**<u>Date, Time and Venue of Next Meeting</u>** The next meeting to be held in public would be on Wednesday, 12 March 2025, 1.00pm-4.00pm in the Lune Meeting Room, ICB Offices, Level 3 Christ Church Precinct, County Hall, Preston, PR1 8XB. The meeting closed.

Exclusion of the public:
"To resolve, that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" (Section 1(2) Public Bodies (Admission to Meetings Act 1960).