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, 27 July 2022 at 9.30am at the Health Innovation Campus, Health Innovation One, Sir John Fisher Drive, Lancaster University, Lancaster

	Name	Job Title
Members	David Flory	Chair
	Professor Ebrahim Adia	Designate Non-Executive Member
	Jim Birrell	Non-Executive Member
	Sheena Cumiskey	Non-Executive Member
	Roy Fisher	Non-Executive Member
	Dr Geoff Jolliffe	Partner Member – Primary Medical Services
	Kevin Lavery	Chief Executive
	Dr David Levy	Medical Director
	Kevin McGee	Partner Member – Trust / Foundation Trust (Acute and Community Services)
	Professor Jane O'Brien	Non-Executive Member
	Professor Sarah O'Brien	Chief Nurse
	Samantha Proffitt	Chief Finance Officer
	Angie Ridgwell	Partner Member – Local Authorities
Participants	David Blacklock	Chief Executive Officer - Healthwatch
	Debbie Corcoran	Public Involvement and Engagement Advisory Committee Chair
	Tracy Hopkins	Chief Executive Officer – Citizens Advice, Blackpool representing Voluntary, Community, Faith and Social Enterprise sector
In attendance	Debra Atkinson	Head of Corporate Business
	Pam Bowling	Corporate Office Team Leader (minute taker)
	Jane Scattergood	Covid19 Vaccination SRO and Director of Nursing & Quality Fylde Coast *(for agenda item 9)*
	Joe Hannett	Partnerships Manager at Community Futures *(for agenda item 9)*
	Dr Sakthi Karunanithi	Director of Public Health, Lancashire County Council *(for agenda item 9)*
	Dr David Wrigley	Vice-Chairman Morecambe Bay LMC *(for agenda item 9)*

Apologies for Absence	Caroline Donovan	Partner Member – Trust / Foundation Trust (Mental Health)
	James Fleet	Participant and Chief People Officer

Item	Note
14/22	**Welcome and Introductions** The Chair, David Flory, declared the meeting open and quorate and welcomed two new participants, Tracy Hopkins, Chief Executive Officer of Citizens Advice, Blackpool, representing the Voluntary, Community, Faith and Social Enterprise Sector and David Blacklock, Chief Executive Officer, representing Healthwatch. A Director of Public Health and a Director of Adult and Care Services were yet to be appointed as additional participants on the Board.
15/22	**Apologies for Absence** Apologies for absence had been received from Caroline Donovan and James Fleet
16/22	**Declarations of Interest** Angie Ridgwell made a declaration of interest in relation to Item 7 – Continuing Healthcare – Local Authority settlement proposal, in her role as the Chief Executive of one of the Local Authorities referenced. The Chair determined that Angie would not take part in the discussion other than to offer factual or positional information.
17/22	**Establishing the Integrated Care Board, system diagnostic: Inherited risks and issues, strategic aims and early priorities for the Integrated Care Board** Kevin Lavery introduced the paper and explained that the Integrated Care Board (ICB) had been established at the height of a global health crisis and health outcomes were worsening and inequalities deteriorating. The task facing the Integrated Care Board was to convert this crisis into opportunity and over the course of the last three months, the Chief Executive and ICB Executive Directors had undertaken a 'system diagnostic' process which had identified risks and issues inherited by the new organisation. The challenges facing the ICB were summarised under three headings: major structural challenges, system challenges and tactical challenges and the Executives were proposing that the ICB be guided by four strategic aims: • improve outcomes in population health and healthcare; • tackle inequalities in outcomes, experience and access; • enhance productivity and value for money; • help the NHS support broader social and economic development. Furthermore, a systematic and phased approach to setting priorities was recommended. The Executive team was devising a strategy to take the organisation forward through its first year of operation – focusing on ambitious objectives, realistic expectations and a small number of key priorities. The major themes which were emerging through the analysis of inherited challenges and key priorities were described in the paper. Over January to March 2023, it was expected that this work would culminate in the production of a 10-year plan and a 3-year budget. It was further proposed to adopt three phases of activity: a Stabilisation phase of

	actions required in the next 12-18 months; a Recovery phase of actions required in the next 1-3 years; and a Transformation phase – actions to progress in years 4-7. In order that the Board retain oversight on these major priority areas it was confirmed that regular reports on progress, risks and issues would be provided, as set out in a formal work plan which was presented within the paper. Members discussed the report and supported the direction of travel. Comments were made by the Partner Members about the importance of 'effective partnerships' and ensuring that key priorities and objectives were aligned to those of partner organisations. The need to work in partnership on domiciliary care and intermediate beds was also highlighted. Reference was made to the need to work with, and be guided by, the population and a request that the balanced scorecard include performance in terms of patient and public involvement. Other comments were made emphasising the importance of transformation, tackling inequalities and workforce transformation. Concern was expressed over the pushback of the timescales for the development of a 'lead provider' model for mental health services and the delegation of budgets to place partnerships and a timeline for this was requested. In response Kevin Lavery explained that the ICB was not yet in a state of readiness to hand over the lead provider model and Lancashire and South Cumbria NHS Trust were not ready to take it on. In terms of delegated budgets, this would take effect from April 2024, although the ability to delegate would come in from April 2023. The Chair highlighted the dynamic environment in which the Board was operating and the need to be agile to respond to new and unexpected situations whilst keeping focussed on the strategic position. **RESOLVED:** • **That the Board discussed the challenges facing the new Integrated Care Board and wider Integrated Care System.** • **That the Board endorsed the strategic aims and early priorities which are proposed for the ICB.** • **That the Board noted that action plans are now being developed under the direction of the Executive Team to address these priorities.** • **That the Board agree to receive regular progress reports on the strategic priorities as part of a board workplan of business.**
18/22	**Proposal for a Comprehensive Stroke Centre for North Mersey and West Lancashire** David Levy presented the proposal for a Comprehensive Stroke Centre to be established to serve the populations of Knowsley, Liverpool, Sefton and West Lancashire. It was noted that the responsibility for commissioner decision-making would be with the Cheshire and Merseyside Integrated Care Board (ICB) and with the Lancashire and South Cumbria (LSC) ICB due to the proposal impacting on hyper acute stroke services for the population of West Lancashire. David highlighted the following key points from the report. The proposed model of care

would mean that suspected acute stroke patients would be taken to a new single comprehensive stroke centre, which would be co-located with acute neurosurgical and stroke thrombectomy services. The preferred clinical model that emerged from an options appraisal process was for a centralised Comprehensive Stroke Centre on the Aintree Hospital site. Lancashire and South Cumbria will require assurance that this proposed change will not have a significant impact on hyper-acute stroke activity into Preston Hospital from patients who would have previously presented at Southport and Ormskirk Hospital. One of the clinical standards is that 90% of patients should be directly admitted to a specialist stroke unit. The report provided a number of scenarios which demonstrated that the proposal would not increase activity to a level that impacted on the delivery of safe hyper acute stroke services in Lancashire but David emphasised the need to review these scenarios carefully. A final business case had been approved by the Trust Boards within the scope of the proposal and the cost was noted to significantly higher than the costs in the pre-consultation business case. The budget had been incorporated into Cheshire and Merseyside financial plans. Lancashire and South Cumbria had included £250k revenue costs in its plans.

Members discussed the content of the paper and expressed their support for the proposal. Kevin McGee expressed some concern about the impact on Lancashire Teaching Hospitals and the need to monitor this on a daily basis. Comments were made about the public consultation exercise and a request that patient and public involvement continue with the development of the model of care and that patients using the service be listened to and adjustments and adaptations be made accordingly.

A question was asked if there was a levelling of services and David Levy responded that there may be a need to invest in some services. Additional information from the SNAP audit would be available later in the year and discussions had taken place with the stroke network about any weaknesses.

The Chair confirmed the Board's support for the proposals subject to the following actions:

(1) Kevin Lavery to follow up with counterparts in Cheshire and Mersey about how this works for Lancashire and South Cumbria and what the commitment entails as this is a substantial investment; and
(2) To monitor the impact on Lancashire Teaching Hospitals.

RESOLVED:

- **That the Board note the update on the proposal and the major service reconfiguration process followed;**
- **That the Board note the impact of this proposal on residents of West Lancashire and the negligible impact on hyper acute stroke services in Lancashire but to monitor the impact on Lancashire Teaching Hospitals;**
- **That the Board approve the proposal for the establishment of a North Mersey comprehensive stroke centre for hyper-acute services for the population of North Mersey and West Lancashire with the proviso that further dialogue is undertaken to agree any financial implications for LSC ICB**

19/22	**Continuing Healthcare: Local Authority settlement proposal** Kevin Lavery introduced the item highlighting that this was an area ripe for integration and expressed his thanks to Sarah O'Brien and colleagues from Cumbria County Council who had worked together to reach a financial settlement on the historical dispute regarding delayed or incomplete assessments for CHC eligibility. Sarah O'Brien presented the paper and highlighted that the ICB has a statutory responsibility for CHC and therefore it is important to establish an effective service across Lancashire. There are challenges and risks associated which need addressing as a priority. Sarah referred to the historical dispute between seven of the eight pre-existing CCGs and three Local Authorities and asked for approval of a financial settlement. Sarah drew attention to a challenge relating to the backlog of reviews and an inherited key risk of compliance against the ICB quality indicator of 'eligibility decisions with 28 days'. In addition, there are varied models for delivery in Lancashire and South Cumbria with Blackpool having an integrated 'in house' service and other areas commissioning a service from Midlands and Lancashire Commissioning Support Unit, and a variation in performance across the service, Blackpool having performed better in the past. Two ongoing pieces of work were firstly, to seek extra resource to assist with the backlog of reviews and secondly, to review the model of CHC going forward. Roy Fisher suggested that a report be brought back to the Board on the proposals for a new model for delivery. He was familiar with the Blackpool model which worked closely with the Local Authority including joint posts and pooled budgets and had significant investment in the service. The future service model needed to be efficient and effective. Board members supported approval of the financial settlement and expressed their appreciation to Sarah O'Brien for her work on achieving a settlement which was a positive outcome for the ICB at its first Board business meeting. However, it was felt important for the Board to keep a watching brief on progress on this issue periodically. Sheena Cumiskey advised that one of the key areas for the ICB Quality Committee is to oversee CHC and therefore the Committee will provide this oversight and report to the Board via the Quality Committee Chair's report. Jane O'Brien commented that as integrated working and commissioning are key functions of the ICB, it would be helpful for the Board if insight and lessons learned from the intelligence gained by working with partners, were extracted and shared with the Board at some point. David Blacklock referred to this being an opportunity to listen to the views of patients who receive these services and use that intelligence in terms of the future direction of the service. Sarah O'Brien expressed her appreciation to Lennie Sahota, who worked alongside Sarah, on behalf of Cumbria County Council and the other Local Authorities involved in the matter, to reach the settlement. **RESOLVED:** • **That the Board note the contents of the report and risks associated with**

	CHC. • **That the Board approve the proposed financial settlement of £8.037 million with the three Local Authorities**
20/22	**Fuller Stocktake Report** David Levy presented the report and outlined the recommendations from the Fuller Stocktake Report 'Next steps for the development of integrated primary care neighbourhoods' published in May 2022. The paper provided a brief system commentary for each recommendation, listed below, and proposed an approach to the development of a Fuller Stocktake Delivery Plan across Lancashire and South Cumbria. a) Develop a single system-wide approach to managing integrated urgent care to guarantee same-day care for patients and a more sustainable model for practices b) Enable all Primary Care Networks (PCNs) to evolve into integrated neighbourhood teams; c) Co-design and put in place the appropriate infrastructure and support for all neighbourhood teams; d) Develop a primary care forum or network at system level; e) Embed primary care workforce as an integral part of system thinking, planning and delivery; f) Develop a system-wide estates plan to support fit-for-purpose buildings for neighbourhood and place teams delivering integrated primary care; g) Create a clear development plan to support the sustainability of primary care and translate the framework provided by *Next steps for integrated primary care* into reality, across all neighbourhoods h) Work alongside local people and communities. It was noted that a six-step approach to the development of a delivery plan is proposed which will form part of an ICB Primary Care Strategy that will return to Board in November 2022. The Fuller Report and its recommendations had been well received and a recent primary care stocktake workshop was well attended by over 100 people. Geoff Jolliffe welcomed the Fuller Report adding that there is a need to consider the context as it did not address certain national issues in primary care or recognise all the good that is being done in primary care across the country. The approach outlined by taking on local opinion to inform a delivery plan was welcomed along with a primary care forum at system level. Roy Fisher highlighted the importance of integrated working at neighbourhood level and of having a one-stop shop for patients to access services and be signposted to other welfare services. Tracy Hopkins recommended the integration of VCFSE with primary care networks and that the voluntary sector could support with some of the estate issues being experienced in primary care. Whilst the Fuller Report has VCFSE running through it, Tracy suggested that more of this collaboration be included within the paper as there are many examples of where the voluntary sector is embedded within primary care, delivering services hand in hand. Having this infrastructure around a practice can also

	be of benefit in encouraging recruitment of GPs to the area. Ebrahim Adia highlighted the fragility of primary care and the potential risk this poses for the whole health and social care system. A solution to workforce issues is multi-disciplinary teams, however, Ebrahim emphasised that as new models of delivery are developed there is a need to work alongside patients and communities to avoid breeding dissatisfaction. Kevin McGee welcomed the paper in particular the delivery planning approach in section 3.2 and the associated timeframe. Kevin highlighted the need for a rounded view of what good looks like and that the development of a primary care strategy has to sit alongside other strategies, ie acute and community. Jane O'Brien encouraged the application of a health inequalities lens and referred to intelligence available from the work with the Health Equities Commission about effective engagement to feed into these workshops. Angie Ridgwell highlighted the importance of this Report for the residents and patients as primary care is the first point of contact and the need to make sure that this is seen as part of the whole system. Local authority front line staff are an important part of the primary care system and there is lots of data available that can help to drive this work forward. Debbie Corcoran suggested looking at intelligence that is already available as well having patients and the public round the table and engaged via Patient Participation Groups. Sam Proffitt referred to a role for the ICB in pulling together this planning and strategy and connecting with partners to make sure it is comprehensive and not done in isolation. The Chair invited David Wrigley to contribute his views to the discussion. David highlighted the following three areas within primary care for the Board to focus on: workforce, including pension issues; workload; and a lack of investment in premises. Sam Proffitt confirmed that the ICB has an estates infrastructure strategy and noted the need for a focus on primary care premises issues. David Levy thanked colleagues for their helpful comments which will fed back to the primary care team. It was recognised that Fuller is much broader than primary care alone and of the need to share ideas from across the system, involving patients. It was confirmed that the Executive Team will pick up how the primary care strategy best fits within the overall ICB strategy to ensure it is coherent. **The Board:** • **Noted the contents of the report.** • **Approved the proposed delivery planning approach.** • **Agreed to receive a further report in November 2022.**

21/22	**Place-based Partnerships: Recommendations following the review** The Chair introduced the paper which described the outcomes of a review of the five current Lancashire and South Cumbria Placed Based Partnerships (PBP) and proposed to reconfigure and align boundaries with local government footprints to allow for deeper integration and joining up of care for our citizens. The Chair welcomed the diversity and breadth of contribution to the engagement exercise and welcomed Jane Scattergood, Dr David Wrigley, Dr Sakthi Karunanithi and Joe Hannett to the table to add to the discussion. The Chair noted receipt of an open letter from GPs which had been circulated to Board members prior to the meeting as requested. Jane Scattergood presented the paper and highlighted that this was a significant piece of engagement activity done rapidly. Partner agencies were supportive of the proposals however General Practice had significant concerns. Should the Board approve the proposal, a number of recommendations for implementation were suggested for consideration. Sakthi Karunanithi, speaking on behalf of a local government perspective, commented that local government has a significant role in creating the conditions for people to thrive in and given the need to integrate services and address inequalities being one of the primary aims of the emerging ICBs, strengthening local authority formal collaboration was a must. Agreeing place-based footprints was not seen as a problem to be solved but a polarity to be managed and the existing footprints were focused towards acute patient flow. Dr Karunanithi concluded that this strategic shift of strengthening local authority collaboration was important, whilst not losing a strengthening of clinical collaboration in the system towards more prevention and addressing inequalities. Joe Hannett, representing the view of Central Lancashire Leader Partnership, framed the response by initially describing the reasons for getting involved in the development of the ICS and what their experience had been. Joe then summarised the feedback to the review from the partnership. A single place board is attractive, however, there was concern over the size of each place, some populations would be between 100,000 to 150,000 and another 1.5m, and concern that low incidence issues would be lost and smaller groups would not feature in system thinking. There was concern that partners could divert away from what needs to be done in turning the curve on health inequity, poverty, loneliness, deprivation and getting to a preventative health and care system. In their opinion, the current boundaries of ICS/ICPs/PCNs were established to suit the NHS not to underpin partnerships. In the LSC voluntary sector there was an appreciation of the rationale for the place review and any concerns were contextual to members. They felt there was a need to review and re-engineer culture across all partners to release control and pooled budgets and recruit and reward for the behaviours needed. Finally, Joe concluded that the ICS is about partnership and needs leadership, intention, nurture, resource and system design/thinking. Dr David Wrigley, GP Partner at Ash Tree House and Vice-Chair of the Morecambe Bay LMC welcomed the opportunity to contribute to the review on behalf of 1200 GPs across the ICB along with other staff in General Practices. David expressed disappointment at the paper given this was a momentus decision and that an open

	letter had been written signed by 89 local GPs, consultants and healthcare leaders. David commented that the current 5 places made sense in the geography and history of local communities and years of fruitful relationships built up were at risk of being dismantled by this decision. David felt there was no clear justification for the place to be based on local authority upper tier boundaries. It was suggested that the Board be given choices and that a review of the ICB's objectives be undertaken along with the risks and opportunities that the current configuration presents. A set of options to achieve the objectives should then be provided with new governance and partnership arrangements, along with an engagement exercise. Dr Wrigley added that the Board should consider that this review had been done rapidly and it would add bureaucracy. It was suggested that the current geographical boundaries should remain, with a renewed commitment to working more closely with upper tier authorities. Finally, Dr Wrigley urged a reconsideration of the proposal and a meaningful engagement process. Kevin Lavery thanked Jane Scattergood for her work on the review. Kevin advised that he had commissioned the review as the strategic intent emerging from the Board was to strengthen community services, look at the determinants of health, and find opportunities for integrating health and care much better, recognising that Lancashire and South Cumbria have limited experience of this. Also, there were deeper levels of integration and co-terminous boundaries across the whole of the North of England expect for LSC. The review was not about the boundaries; it was about how to drive deeper integration and get more of a handle on the determinants of health which largely lie outside of the health service. Kevin emphasised that this is not a one size fits all model and the need to recognise double devolution. It is not about everything operating at place-based level, where appropriate integrated teams should be operating at the neighbourhood level as described in the Fuller Report. Kevin concluded that the current system is not working with too many people arriving at A&E that should not be there and hundreds of beds across the system occupied by people who should not be in hospital. The system faces significant challenges that require more integration between health and care. Sarah O'Brien shared her experience of working as a CCG Accountable Officer in an integrated care system outside of Lancashire and South Cumbria. Sarah also acknowledged the concerns described by Dr Wrigley and the importance of working with primary care to address them. Sarah's experience was of close integration with local government with integrated teams and pooled budgets. Sarah referred to highly publicised evidence of better outcomes and therefore expressed her support of a move to co-terminosity. The ICB and Local Authorities had shared areas of responsibility and therefore presented opportunities to work in an integrated way. There were also opportunities for developing better outcomes for children and young people by working more closely as a health partner. The challenges posed in terms of hospital footprints are understood however a very small number of residents use the services of an acute hospital. In order to support acute and primary care there is a need for a system working in an effective and efficient way based on how the wider community and wider community partners help our population to live their lives in a healthy way. In conclusion Sarah highlighted the importance of building strong deep relationships between health and local government by co-location and co-working and the need to make a decision on this in order to move forward on the work that is

needed.

Jane O'Brien asked for a deeper flavour of the broader range of discussions that had taken place and the extent to which the good things are not lost. Jane Scattergood responded that one of the universal messages was the value of the district councils and the value of neighbourhoods and to further relationships with smaller footprints. With regard to concerns about the geography, scale and size of LCC as a single place, the review proposed three Delivery Units within Lancashire county - East Lancashire, Central including West Lancashire and a North or coastal – Fylde and Wyre, Lancaster area. There was some concern around the Westmorland and Furness footprint, a new unitary authority which comes into being at the beginning of April. Other messages were around a structure that makes the organisations able to hold each other to account in a meaningful way on the joint ambition for integration and action on inequalities and public health. There is also a piece of work to be done around care pathways and the development of a Clinical and Care Professional Leadership Framework.

Angie Ridgwell commented on the need to ensure effective operational delivery and have the right strategic framework. Local government is a robust partner that lives within its means financially with some areas for improvement and can work in partnership to delivery efficient and effective services prioritising within a financial envelope. Pooling budgets and resources will be a fundamental solution and will reduce bureaucracy. Local government has shared priorities of prevention, population health, reducing inequalities and providing good care. By dividing up Lancashire into three Delivery Units of Central, North and East, enables manageable geographical footprints and to make warranted distinction in services and prioritisation of resources. It was confirmed that the District Councils fit within these three Delivery Units.

Geoff Jolliffe acknowledged that this was a difficult decision and recognised the points made by Dr Wrigley and clinical colleagues. Dr Jolliffe added that this proposal is about achieving what is most important and in his role as a Board member, he supported the proposal. The most pressing issue is care provision which needs to be addressed. This creates a problem for secondary care in terms of people in hospital who should not be there and a recognition that the current geographies have not solved these issues. Clinicians and managers should be asked to work across the whole system in what is the best possible model, boundaries should not matter. Dr Jolliffe acknowledged relationships have been built up but clinicians can still work together and work across boundaries where it makes sense to do so. The most relevant context will be system-led working in areas such as stroke and cancer, work on delivering better care in the community and deliver our ambitions around population health and resolving health inequalities in place. Finally, Dr Jolliffe suggested that as this is an interim year there is a re-evaluation in six months to review what has worked and what needs changing.

Jim Birrell advised that he supported the proposal but sought assurance that the good working relationships that were in place would not be fractured as a consequence of adopting this process. Jim also supported the point made that the arrangements need to be flexible and adapt to developments over the coming 12/24/36 months.

Kevin McGee commented that whilst there was a lot of good work taking place and

	strong relationships had been built, the current system was not working with worsening health inequalities and more medically fit for discharge patients residing in hospital. The provider collaborative supported deeper integration and co-terminosity with local government whilst recognising there would be issues to address. Kevin highlighted paragraph 4.9 of the report as summing up the discussion that had taken place at the provider collaborative around the need for wider transformation across Lancashire and South Cumbria, investment in primary care and development of a new financial framework for the system. Support was expressed for the proposal highlighting the need to focus on the future delivery model. Roy Fisher referred to the need to design a working model that will fit all the opportunities that the Board can bring adding that it was important to take on board all of the clinical comments heard. Roy had initially been concerned about the size of Lancashire place but was comforted by the response from Angie Ridgwell about the 3 delivery units. Roy offered his support for the proposal adding that in the past it had been proven that the working more closely with Local Authorities had provided a better service for patients and the public and that this proposal provided an opportunity to bring this forward at much quicker pace than with the current boundaries. Support was also expressed for a review in 6 to 9 months' time Sheena Cumiskey commented that the purpose of the ICB is about improving lives and reducing inequalities and there was a need to focus on the communities in which people live, support them to make a difference in their lives and that integration was the key to this. There was a need to learn from what has worked well in the past, focus on building on what is already there and what works well. Sheena highlighted the importance of all partners working effectively together and that she supported the proposals as they would enable this to happen. Sheena suggested that it would be worthwhile for the Board to reflect on paragraph 8.2, should the Board approve the proposal, and added her support to a review in 6 to 9 months' time. Jane O'Brien referred to the comments made today about how the proposals will improve system and partnership but also a strong desire to not lose but maintain and enhance what is already working well. Jane was keen therefore to ensure that the concerns expressed were not dismissed but heard and addressed and that an understanding was developed with colleagues to protect against unintended consequences. Jane expressed her support for the proposals and of the need to preserve what already works well. Ebrahim Adia expressed his appreciation to be able to hear the views of colleagues directly at the meeting today. Ebrahim referred to the comments made around double devolution and the need to hold on to what is working, making sure that this is universalised across the four geographical areas and then to be clear about how that strategic relationship which is fostered through co-terminosity enables good practice to flourish. David Levy referred to his experience of working in other parts of the North West with challenged systems and that it was only when the Local Authority were fully engaged that sustainable progress could be made to improve the quality of care. He felt that it was right that the focus would be on neighbourhoods and this would benefit the flow through hospitals. England's greatest inequalities are in the local area and this has to

	be improved through partnership with Local Authority colleagues. Dr Levy expressed his support to move to the four place-based partnerships, however, there was a need to gain a deeper understanding of the concerns of clinical colleagues and also supported the suggestion of a review. The Chair confirmed the Board's approval of the proposal to align the Place Based Partnerships with the local authority footprint as set out in the paper. The Chair expressed his appreciation for the excellent paper and noted the comment made by David Wrigley that it felt rushed but there was a need to make this decision one way or the other in order to work through the places for the reasons of delegation of resource allocation. The Chair noted the need to consider the recommendations for implementation set out in paragraph 8.3 of the paper and that Clinical and Care Professional Leadership Framework was an important part of taking forward implementation and an action for the Executive Team. The Chair also noted the points made about the need to review over the forthcoming period and the Chair asked the Executive Team to consider some measures and tangible examples of where the change has made a positive difference in the short, medium and into the longer term so as the board can assess the impact of the proposals. **ACTION: Executive Team** **RESOLVED:** **That the Board approved the proposal to align our Place Based Partnerships with our local authority footprints and to consider the further recommendations for implementation.**
22/22	**ICB budget 2022/23** Sam Proffitt presented the paper and set out the financial budget for the Lancashire and South Cumbria ICB for the period April 2022 to March 2023. It was explained that the LSC ICB submitted a balanced financial plan as part of the 2022-23 Operational Plan submission on 20 June 2022 which was compliant with the national 2022-23 priorities and operational planning guidance. The budget set out in the paper underpins that plan and provides detail on the system allocation, expenditure budgets, efficiency requirements and risk. The system will need to manage the risk identified within the plan through clear organisational efficiency plans and system wide schemes in order to deliver the balanced plan. The planning priorities and budget book were set out in the appendices to the paper. It was noted that this was a centralised budget, pulled together from the previous 8 CCGs and the intention in the longer term is to operate on a delegated budget basis with work ongoing on the allocation and the financial framework to allow this to be done. The following key points were highlighted: - Total system allocation in 2022-23 of £3.8bn, of which £3.5bn is recurrent - From 2022/23, the allocations' methodology seeks to move systems back towards a fair share distribution of resource. - Contracts have been rolled out from last year. - Additional elective funding of £60m to deliver 104% of 2019/20 levels of activity - Running cost envelope of £32m - Service development funds of £76m - Covid funding reduced by 57% to £74m

	- Mental Health Investment Standard provided for - Better Care Fund to continue - Provision for investment into stroke services. - Reserves/Contingencies built in - 3-year capital allocation - ICB efficiency target of 5% Jim Birrell commented that the budget appeared to be constructed in a sensible way and supported the view not to devolve budgets at this point in time. Angie Ridgwell advised that she has commissioned work in the Local Authority to look at areas for joint working, pooling of resources and to put savings back into the system. Progress on this would be brought back to the Board at the appropriate time. A discussion took place about the use of capital and that it is an ICB responsibility to execute delivery of the capital programme. This was recognised as a good opportunity to reconcile priorities in individual organisations with strategic priorities and use capital in a different way. **RESOLVED:** • **That the Board note that the Lancashire and South Cumbria ICB is statutorily responsible for ensuring its expenditure does not exceed the budget allocated from NHS England for 2022-23 and for ensuring expenditure on administrative running costs is within the specified allowance.** • **That the Board approve the budget for the period 1 April 2022 to 31 March 2023.**
23/22	**2022/23 Financial Plan** Sam Proffitt explained that the purpose of the paper was to set out the key areas of the financial plan including the risk to the delivery of a breakeven position in 2022/23 and the mitigating actions. Sam highlighted the following key areas from within the report. 2021/22 was operationally challenging and a high level of the savings achieved were delivered non-recurrently. This had impacted on the opening of the 2022/23 financial year as those savings plans were required to be delivered on a recurrent basis. The planning guidance required organisations to include a 1.1% efficiency target. In order to support a balanced plan, a 5% efficiency target has been set for all organisations. Temporary covid and hospital discharge funding had been reduced and a further planning risk of £178m has been identified driven by the need to reduce the excess and unfunded capacity in the system. Attention was drawn to three areas which would support delivery of the efficiency savings target and improve quality and reduce costs simultaneously: a sustainable workforce; clinical excellence using Right Care, Getting it Right First Time (GiRFT) and model hospital data; and corporate services opportunities. It was noted that a significant scheme is underway on efficiencies in the use of bank and agency staffing.

	Five priority schemes for the system have been identified as the focus for efficiency savings with dedicated resources and clear programme plans for delivery. Delivery against these programmes is monitored by the ICB Delivery Board, jointly chaired by Kevin Lavery and Kevin McGee. Debbie Corcoran sought assurance that equality impact assessments were being undertaken in terms of the savings programmes. In response it was confirmed that the Trusts have strong processes around quality impact assessments and equality impact assessments. Any changes will also be underpinned by robust quality improvement assessments reported through the ICB Quality Committee. Kevin McKee commented that there is a clear understanding amongst providers of the size of the financial issues faced and that normal cost efficiencies will not achieve the level of efficiencies needed to right size services. Collective decisions about where money is spent can be taken forward with the ICS and ICB Delivery Board, accepting that it will be challenging and there will be difficult decisions to be made. Ebrahim Adia referred to the need to shift to meaningful transformation programmes done at scale and to take costs out on a recurrent basis. Other comments were made about the importance of working together with a common purpose and strategic intent to change the way in which health inequalities are tackled and to improve outcomes and to understand that care is not always good and there is a need to get pathways right and improve quality and safety of care. David Levy added that in terms of improvement work, the Provider Collaborative had identified areas of activity that didn't need to take place, which would be taken forward by close working between primary and secondary care. **RESOLVED:** **That the Board note the report, the risk and the mitigating actions.**
24/22	**Report from the Audit Committee on the appointment of Internal and External Audit** Jim Birrell reported that the Audit Committee met on 26 July 2022 and approved MIAA as the ICB's Internal Auditor. The Audit Committee considered two External Audit companies and agreed to seek further information before making a final decision on the appointment. This was expected to take place within the next two weeks and before the next meeting of the Board. The Board agreed to delegate authority to the Audit Committee via a committee Chair's action to make a decision on the appointment of the External Auditors. **RESOLVED:** • **That the Board note the appointment of MIAA as the ICB's Internal Auditor.** • **That the Board delegate authority to the Audit Committee via a committee Chair's action to appoint the ICB's External Auditors which will be subsequently reported to the Audit Committee on 29 September 2022.**
25/22	**Any Other Business**

	There was no further business.
26/22	**Date and Time of Next Meeting** • Wednesday, 7 September 2022 • 9.30am to 12noon • Health Innovation Campus, Lancaster University, Lancaster, LA1 4AT