Lancashire and South Cumbria Integrated Care Board

Approved 29 January 2024

# Minutes of the ICB Finance and Performance Committee Held on Monday, 18 December 2023 at 2.00pm by MS Teams

| Name | Job Title | Organisation |
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| **Members** | | |
| Roy Fisher (from item 7) | Chair/Non-Executive Member | L&SC ICB |
| Jim Birrell | Non-Executive Member | L&SC ICB |
| Sam Proffitt | Chief Finance Officer | L&SC ICB |
| Asim Patel | Chief Digital Officer | L&SC ICB |
| Katherine Disley | Director of Operational Finance | L&SC ICB |
| Stephen Downs | Director of Strategic Finance | L&SC ICB |
| Andrew Harrison | Director of Place and Programme Finance | L&SC ICB |
| Debra Atkinson | Company Secretary/Director of Corporate Governance | L&SC ICB |
| Maggie Oldham | Chief of Transformation and Recovery | L&SC ICB |
| Kathryn Lord (representing Sarah O'Brien) | Director of Quality Assurance and Safety | L&SC ICB |
| **Attendees** | | |
| Craig Harris (from item 9) | Chief Operating Officer | L&SC ICB |
| Glenn Mather | Associate Director of Performance and Assurance | L&SC ICB |
| Sandra Lishman | Committee and Governance Officer | L&SC ICB |

| Item No | Item | Action |
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| 1. | **Welcome and Introductions**<br><br>J Birrell chaired the initial part of the meeting explaining that R Fisher had been unexpectedly delayed. Members and attendees were thanked for joining and members were made aware that the meeting would not be quorate until R Fisher had joined the meeting. | |
| 2. | **Apologies for Absence**<br><br>Apologies for absence had been received from Debbie Corcoran, Sarah O'Brien and Roger Parr. | |
| 3. | **Declarations of Interest**<br><br>**(a) Finance and Performance Committee Register of Interests –** Noted.<br><br>**RESOLVED: There were no declarations of interest relating to items on the agenda. Members were asked that if at any point during the meeting a conflict arose, to declare at that time.** | |

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| **4.** | **(a) <u>Minutes of the Meeting held on 27 November 2023 and Matters Arising</u>**<br><br>Members highlighted the following errors within the minutes:-<br>- For clarification, page 5, 3rd paragraph, the first sentence should read 'S O'Brien raised concern for 2024/25 due to no continuing healthcare clinical re-commissioning plan'.<br>- Correction, page 7, 2nd bullet point, should read 'Total patients waiting to start consultant led treatments had grown by around 10,000 per month since February'.<br>- It was agreed not to record when members leave the meeting room briefly, unless relevant to quoracy of the meeting. 'Jim Birrell left the meeting room' to be removed as only left for a brief moment.<br>- Correction, page 8, item 9, A Harris to be changed to A Harrison.<br><br>**RESOLVED: That subject to the amendments to be made, the committee approved the minutes of the meeting held on 27 November 2023.**<br><br>**(b) <u>Action Log</u>**<br><br>The action log was reviewed and the following discussed:-<br><br>1. **Draft Terms of Reference** – Conversation between David Flory and Committee Chairs had taken place around a month previous. S O'Brien co-opted as a clinical representative member to ensure clinical input at meetings. Agreed to close action.<br><br>2. **Performance highlight report: position and plans for improvement** – Agreed to close action.<br><br>3. **Review of performance indicators –** Not yet due.<br><br>4. **Trajectory mapping –** Flow chart being worked up.<br><br>5. **System Recovery and Transformation Board update –** Flow chart being worked up.<br><br>6. **Representative from the national team to attend a Finance and Performance Committee meeting –** It had been arranged that Christopher Green, NHS England, attend the committee meeting on 29 January 2024.<br><br>7. **Membership – Terms of Reference** – Agreed to close action.<br><br>8. **Action Log – Performance Report –** Not yet due.<br><br>9. **Assurance Plan –** Not yet due.<br><br>10. **Performance High Impact Indicators –** Agreed to close action.<br><br>11. **Performance Report –** Agreed to close action. | |

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| | 12. **Committee Remit –** Not yet due.<br><br>13. **Review of Risk ICB-008 System Financial Sustainability** – D Atkinson confirmed the risk been updated. Agreed to close action.<br><br>14. **LSC Provider Collaboration Board Minutes –** Agreed to close action.<br><br>15. **Performance Report – Children and Young People –** Ongoing.<br><br>16. **Dying Well –** Outcome from discussion with Executive Team awaited. | |
| **5.** | **<u>Key Messages and Overview of Agenda</u>**<br><br>S Proffitt advised the committee of the key messages and overview of the agenda including:-<br><br>- The likely position in the system was around £250m deficit<br>- The ICB had submitted a plan at the start of year with £80m deficit<br>- At month 8, the actual deficit was £172m (ICB £50m, providers £122m)<br>- A plan was resubmitted to NHS England to achieve £198m by year end<br>- During the month, the following had impacted the forecast position:-<br>• The national and regional budgets for AARS and public health had been withdrawn, resulting in the worsened position of £12.5m<br>• Pressures had increased due to overperformance on the acute contract mainly due to high-cost drugs, impacting £8.1m<br>• Budget challenges around cancer and population health had not been agreed, totalling £9.3m, which continued to be challenged<br>• Further risks with planned industrial action and winter.<br><br>There were a variety of actions that could be taken to reach the wider system £198m, of which £49m was the ICBs) forecast deficit, however, none were guaranteed. These were currently being looked at.<br><br>S Proffitt reported that at month 8, providers were at £122m deficit, £32m off plan and the forecast had not changed. Industrial action continued to impact, by £16m year to date. Providers had started the year with CIPs of £190m plus £72m of extra stretch and £20m OAPs. CIP schemes were generally being delivered and schemes had increased by £15m since month 7. The full year forecast of £149m was £79m above plan.<br><br>In summary, the likely year end position was c£250m deficit. More work was required to achieve the £198m revised deficit plan. Several mitigations had been identified to bring the current ICB likely forecast down to £70m by year end, against a target of £49m. The current provider trajectory was £180m, however, improvement would need to be delivered to reach the target of £149m deficit. The forecast included a recharge to the local authorities for the historic transforming care packages and without this, the ICB forecast was assessed at £100m.<br><br>S Proffitt continued that it would be important that an agreement was reached for with local authorities for transforming care packages, both in year and historic, to meet the forecast deficit. C Harris was undertaking a lot of work around commissioning and a letter to take 10% out of contracts had been sent to Trusts. Working with Trusts, a clear process would be put in place as to how this could be achieved.<br><br>Concern was raised regarding the time delay in implementing a vacancy freeze, that | |

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| | had been agreed a couple of months ago.<br><br>Members were made aware that there was £50m inflation pressures and industrial action had cost around £16m to date. The Lancashire and South Cumbria system had been allocated £90m to manage all pressures in the system. £800m had been provided nationally to resolve all pressures, which was shared between systems on the number of clinical posts.<br><br>**RESOLVED: The Finance and Performance Committee note the key messages and overview.** | |
| ***The agenda was taken out of order.*** | | |
| **7.** | **<u>ICB Finance Report – Month 8</u>**<br><br>It was explained that given the timeline of when the financial position had been finalised, headlines would be provided for the month 8 position.<br><br>K Disley spoke to a presentation reporting that at month 8, the ICB was reporting a year to date deficit position of £50.4m against a break-even plan and was forecasting to deliver its planned full year £0.5m surplus position, which included the assumption that the current residual risk was mitigated in full. The position continued to be driven by prior and in-year cost pressures and undelivered QIPP/mitigation plans. A full review of the residual risk had been undertaken as part of a replanning exercise, with £70.3m being identified, driving the current reported deficit position.<br><br>Continuing healthcare had started to stabilise and the inflation element was being maintained. Unvalidated data showed an increase in provider high cost drugs, which should be included in the fixed contract - work would take place with provider and business intelligence colleagues to understand what was driving this performance and ensure due process was being followed.<br><br>As part of the re-planning exercise, a full review of residual risk had been undertaken during month 8.<br><br>An overview of the income and expenditure was shared, highlighting the trajectory on the year to date and the forecast variance, confirming that the trajectory had started to become more stable.<br><br>***Roy Fisher joined the meeting. The meeting was now quorate.***<br><br>£38.8m of additional allocations had been received in month. £19.2m had been received for national support funding, £10.9m for ERF allocations, along with £8.7m for small SDF schemes/increase in POD allocations. These elements had been factored into the position.<br><br>The forecast was to achieve the efficiency plan, with the £0.5m surplus position.<br><br>The ICB Board had recently looked at gross risk fo £291m, which had increased by £8.1m in month 8 due to the forecast variable acute contract overperformance in contracts. Further validation of this would be undertaken in month 9 to confirm the pressure. | |

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| | Mitigations identified during the replanning exercise amounted to £208.7m, resulting in a residual risk of £83m. The month 8 reassessment of deliverablity reduced the impact to £165.5m, resulting in a residual risk of £134.3m. Additional mitigations had been identified to reduce the residual risk as at month 9.<br><br>**RESOLVED: That the Finance and Performance Committee note the report.** | |
| **11.** | **<u>Business Sustainability Group Update</u>**<br><br>A Harrison presented a report providing feedback on the Business and Sustainability Group meetings held in November and December and the process of the re-submission of financial plans for the second half of the year. Meetings had been held with prescribing, primary care, urgent and elective care, cancer and mental health leads to firm up expectations and plans regarding the further use of system development funding (SDF) and other allocations in supporting the overall delivery challenge facing the ICB. Increased QIPP was now being forecasted. It was highlighted that prescribing colleagues had suggested that increased access to a specialist workforce would help expedite some of the work required to progress - managers were asked to look at what was required. It was thought there were people already employed in the system, not focused in this area, who could assist.<br><br>*Primary care* – There was a further offer of savings with a large underspend of SDF and other complicated funding. A further couple of areas had been identified that could be taken forward including holding back cloud based telephony, however, individual practices were already meeting with teams to arrange implementation.<br><br>*Urgent care* – Urgent care leads had agreed not to spend all of the urgent care money in the system, however, there was still a risk.<br><br>*Elective* – Data resolution, resulting in £2.7m improvement in the independent sector, had been taken out. It had been clarified that this achieved elective recovery fund status – this had now been recovered from the centre and was included in figures. There was risk with the elective recovery position at East Lancashire Hospitals Trust as the data had not yet been validated.<br><br>*Cancer* – £400,000 slippage had been listed from the cancer programme which had been deemed not to put patients at risk.<br><br>*Mental health* – It had been agreed not to overspend on the mental health investment standard, which had previously been a concern – monitoring would continue.<br><br>Forecasts also reviewed included winter spend, additional mental health scrutiny on posts not yet recruited to, areas of primary care underperformance, further slippage in hypothecated primary care funding, expectations of year end primary care achievement payments, receipt of Elective Recovery Fund payments to cover Independent Sector overspends, and some expectation of provider improvements.<br><br>A team had been put together to try and accelerate evidence based intervention so providers would benefit or stop the activity taking place and recover costs of anything paid over in contracts, etc.<br><br>A Harrison continued that the everyone in the organisation should be focused on the intent behind reducing the run rate, in a safe and appropriate manner. | |

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| | Jim commented that in future reports, the committee required to see progress made and areas where Trusts, or impetus from the committee, would help to take this work forward.<br><br>**RESOLVED: That the committee note the Business Sustainability Group update report.** | |
| **8.** | **<u>Provider Position – Month 8</u>**<br><br>S Downs spoke to a presentation providing updated highlights to the provider position. The year to date position at month 8 was a deficit of £121.7m, a £4m deterioration from month 7 and £32.2m worse than plan. The slides showed comparison of what would need to happen to reach the £149.5m deficit, and what Trust's need to do if their position was pro-rata. The majority of Trusts were tracking their position, however, it was noted that Blackpool Teaching Hospitals had the largest year to date varience. The Trust was confident they could meet the deficit by deploying a lot of non-recurrent measures – the ICB would track this closely. East Lancashire Hospitals Trust activity position was explained as issues continued with uploading the ERF data - there was uncertainty as to what the performance position was and the Trust had a lot of uncoded activity, along with other activity that had not been recorded. The position was highlighted as a risk and a further meeting was planned with NHS England on Thursday where the position would be flagged. It was noted that this could not become an ICB cost pressure.<br><br>*Cash* **-** Providers had reported that they would require £120m of cash support this year, which would attract interest.<br><br>*CIP Position* - A slide was shown with the full-year impact of the CIP position, and S Downs highlighted that for a number of providers, the full year impact was larger than the in-year impact. East Lancashire Hospitals Trust had recognised they were an outlier and were currently reviewing figures.<br><br>*WTE Projections* - There was a lot of focus on head count growth in the Lancashire system with over a 7000 increase in whole time equivalents (wte) since the pandemic hit, with 60% of the increase being non-clinical workforce. NHS England had challenged asking what the system was doing to reduce the head count between now and the year end. East Lancashire Hospitals head count continued to grow, however, it was viewed that they could deliver this year's number with the head count increase as funding was mainly non-recurrent. NHS England required an updated position in January 2024. Both NWAS and Lancashire Care Trust head count were increasing, however, NWAS' was through UEC investment in frontline services and 111 and Lancashire Care's was due to more beds being opened.<br><br>*Capital* - It was emerging that Lancashire Teaching Hospitals were behind on their medical assessment unit scheme – the ICB would discuss this with the acute trust tomorrow. Blackpool Teaching Hosiptals had £7m of EPR digital capital and Morecambe Bay had £4m. At present, the procurement was on hold and the ICB was discussing with NHS England whether this could be rephased in the absence of a business plan. All capital in the system outside of the envelope that was directly awarded to providers, ie, digital, UEC, was monitored separately with providers, not forming part of the ICBs overall control total.<br><br>*Agency* – Figures showed £22m overspend year to date, with £14m in nursing and £8m in medical. This would equate to £34m at year end, compared to £116m spend last year. Discussion was being held with NHS England around what the system was doing | |

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| | to influence the whole time equivalent on agency. Blackpool Teaching Hospitals and Lancashire Teaching Hospitals continued to be significantly over levels required.<br><br>S Downs raised concern in relation to the East Lancashire Hospitals data and whether this would be on plan when it was successfully uploaded to NHS England. There was likely to be data quality issues due to the scale of the EPR implementation.<br><br>R Fisher asked that detail on capital that had been awarded directly to Acute Trusts be shared in a future report to this meeting. In respone to a member's question around the Blackpool Teaching Hospitals position, at a recent Improvement and Assurance Group (IAG) meeting it was recognised the biggest challenge was for Blackpool Teaching Hospitals to reach the £24m deficit by the end of the financial year. Discussion had been held regarding the outturn position and high agency rates, and the Trust had commented that they felt the position would be delivered as not all of the recovery had been reflected on the forecast. 50% of consultants within medicine were locums. NHS England had challenged all Trust's at their individual IAG meetings. S Proffitt added that NHS England showed concern where the whole time equivalents were being reduced, and how trusts were ensuring the run rate was reducing to reach recurrent delivery. It was noted that the assurance meetings had been put together well, however, were long and difficult meetings. M Oldham continued that the IAG meetings in December were the first chance to describe the full nature of the position to NHS England with the provider trusts. New models of care and the acceleration of some of these programmes would be reported on the system recovery and transformation board item, later in this meeting. K Lord confirmed that there were long-term locums in the stroke department at Blackpool Teaching Hospitals. All escalation areas at Blackpool Teaching Hospitals were closed a few months ago which had caused pressure in flow, however, the trust had been operating under OPEL level 2 and as of today it was thought this had escalated to an OPEL 3, yet to be clarified. All wards were boarding at least 2 or 3 patients, meaning there was no bed space and these patients were not in the head count for those units, resulting in a very tough position. Although escalation areas may not be there, pressure across units was high. Chief nurses across Lancashire, working with Greater Manchester and Cheshire and Mersey, were looking at what was deemed acceptable.<br><br>**RESOLVED: That the Finance and Performance Committee note the report.** | **SD** |
| **6.** | **<u>Provider Assurance Summary</u>**<br><br>Due to the Improvement and Assurance Group (IAG) meetings being held on 13/14 December and the timeframe to this meeting, M Oldham provided a verbal update to members summarising assurance with provider organisations. Due to the current system financial position and the opportunity to update providers on the national and regional meeting held on 1 December, Nikhil Khashu, NHS England North West Regional Director of Finance, joined some of the IAG meetings. N Khashu provided really good comments at the meetings including around the triangulation of workforce from where we were pre-covid to now, and on the growth that was still being experienced in some of the providers since March 2023. At the meetings, discussion was held with providers around the importance of accurate triangulation between workforce numbers and the prediction, stressing to all that a further return had been submitted to NHS England a week after the meeting held on 1 December. The next return was due in January and whilst workforce numbers and spend had risen, double counting or counting agency costs must not be included in the overall workforce number. Clarity was required as to whether it was a substantive run rate for workforce increase or agency costs. More work would be undertaken around workforce. Financial | |

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| | figures had been discussed earlier in this meeting, however, there was further work to be undertaken in this area to clarify granular detail.<br><br>Members expressed their surprise that workforce information was difficult to extract. M Oldham responded that the ICB received the information, however, confidence level in the data was low. The focus was to funnel the data further and there was variation in confidence of reporting of the Trusts. S Downs continued that providers report headcount (wte) on a monthly basis by bank, agency and substantive employees. There was also variation in the way Trust's report headcount, which was being worked through. 66% of the wte was in non-clinical workforce, suggesting that headcount could be reduced that would not have a direct impact on safety. Some of the biggest percentage increase in staff were in bands 8 and 9. M Oldham continued that from the work of the recovery support programme, where organisations had acute shortages nationally, more skilled people had been brought in to compensate and supplement for risk that could be seen. In summary, an evidence based conversation with this committee or regulators could not be held at this time in the granular, detailed way that was required. Messages must be sensitively handled to ensure staff did not misinterpret. Each provider currently recruited to its own operating model and although banding on posts was subject to agenda for change, banding may carry a different weighting due to slight nuances to posts in each organisation, creating migration of staff when posts were advertised. Non-clinical posts deemed to be critical continued to be approved by organsations in relation to their operating model.<br><br>This was the first cycle of IAG meetings where granular financial exploration had been held at the meetings, which had created rigorous debate.<br><br>The greatest risk heard through all trusts was the pressures of flow, partly due to winter acceleration. When escalation wards were open and patients were also being boarded, it was often impossible to get extra staff as the bank and agency were already providing staff to cover the escalation. When these wards were closed, and boarding was taking place, wards continued to look to go out to agency staff as there was high level of risk in these areas. Recently, research had been published that tried to validate risk associated to patient harm in trusts that were boarding, however, the Royal College of Medicine were encouraging boarding in as this took away the risk consolidated in the urgent and emergency care pathways. Research now showed that rather than having patients in urgent and emergency care with risk, there was now greater risk with these additional patients on a ward. This was expected to become significant this winter as the acuity on wards caused high level of sickness in some orgnasations with associated stress. The message from all organisations was that it was thought the greatest pressure this winter was around how urgent and emergency care was handled.<br><br>J Birrell expressed that committee discussion on 'winter' would need to be held in the near future.<br><br>**RESOLVED: That members note the verbal update.** | **SL** |
| **12.** | **<u>System Recovery and Transformation Update</u>**<br><br>M Oldham updated members, providing the committee with an update on the system recovery and transformation programme. Messages from each programme would be reported to the System Recovery and Transformation Board at it's meeting on 19 December. The report had been circulated to members with the meeting papers. An error was highlighted within the meeting report that had previously been circulated to members - the MIAA undertook a 'commissioned piece of work' (not an audit) to validate | |

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| | the financial deficit as the ICB entered it's first year.<br><br>J Birrell commented that getting to a model of care was important as this would impact in many areas including how clinical services would be rationalised, and anything emerging from this would have impact on financial and quality aspects. He expressed that the paper was helpful to read and suggested that it would be helpful to see this work set out in a Venn diagram for easy visualisation.<br><br>M Oldham reported that a clinical configuration event had been held recently for the Provider Collaborative Board and ICB executive colleagues where there was an acknowledgement to include financial forecasting against each workstream. Headcount was being looked at within schemes, as this contributed to the clinical headcount and it was acknowledged that schemes with no return in investment or whilst improvement in performance was seen, was at the cost of the workforce.<br><br>The next System Recovery and Transformation Board meeting was scheduled to be held on 19 December 2023 where a workstream update would be provided, along with a deep dive into central services. This scheme was set to yield the most financial benefits in-year, however, had slipped considerably. Different operating models continued to recruit staff and support in the HR and finance functions had been delayed, therefore, would be accelerated into the scheme.<br><br>A Harrison commented that the Better Care Fund (BCF) as a whole was being reviewed by the out of hospital team, the ICB and local authorities, in relation to how the BCF could be more effective and dynamic around what they were delivering in terms of reductions in length of stay, avoidance of hospital admissions and the improvement of hospital discharge. A piece of work was being undertaken to re-establish key performance indicators associated with the BCF, work would ensure that the system was benefiting.<br><br>A New Models of Care Clinical Advisory Group, chaired by D Levy, had now been set up, with it's initial aim to articulate the vision and role of the clinical configuration and estate utilisation within 6 months. Members felt that achievement of this would be a major step forward for the ICB.<br><br>**RESOLVED: That the Committee note the report.** | |
| **6.** | **<u>ICB Performance Report – Month 8</u>**<br><br>A Patel introduced the item focussing on key headline metrics, as part of the second half of the year (H2) return. G Mather explained that metrics focussed in the report included urgent and emergency care, elective care and cancer. A deterioration in some of the performance targets had been seen due to the current pressures at acute trusts. Performance would be tracked against plans as they were re-submitted by provider organisations. Although performance was challenged there was some positives including average ambulance hand over times that had improved. Pockets of challenged areas had been seen, in particular in Blackpool, and winter conversations would be featured into this to support provider challenges. A&E performance was slightly below plan and below the 76% target, and it was predicted this would deteriorate over the next few months but pick up towards the end of the financial year. Virtual bed capacity had been reduced within the H2 ICB plan and occupancy levels were improving with the organisation of resource in the right place. Blackpool Teaching Hospitals and East Lancashire Hospitals were reporting that they would not meet the 65 week wait challenge by the end of March 2024, predominantly due to challenges around | |

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| | orthodontics and gynaecology. There was no requirement for ICBs to refresh their plans, therefore, zero waiters over 65 weeks remained the target.<br><br>*Cancer* – All providers had struggled across the 4 categories over recent months. Currently, providers were performing against plan for the faster diagnostic standard. However, there were elements of improvement expected over the next couple of months. Less patients were waiting over 63 days for cancer treatment, achieving the target for the end of year, the maintenance of those patients going forward was crucial.<br><br>*Elective Recovery Fund (ERF)* – East Lancashire Hospitals continued to have difficulty in reporting data into the national system due to an upgrade of the Electronic Patient Record system, resulting in the overall position being skewed for Lancashire and South Cumbria. If it was assumed that the East Lancashire Hospitals delivery plan threshold was met, the forecast outturn position for month 8 would be around 110.7% of baseline. S Downs reported that a meeting was being held with NHS England later in the week when this would be discussed further. The total risk would be unknown until the Trust was able to report accurately. Outpatient data had now started to be reported, including 65 week waiters. A Harrison explained that from a financial perspective as a system, at this stage, East Lancashire Hospitals Trust were forecasting that they would achieve their financial position, without access to ERF. Any underperformance would be due to a lack of reporting.<br><br>Members discussion included that overall on priority metrics, it seemed positive and that Trusts were on course to meet most targets this year. There was concern that virtual ward capacity was below where it was originally thought to be at this time. It was helpful to include type 1 A&E information and the total number of beds within the report. Key indicators should be monitored and reported in future reports. Concern was shown from a patient safety and quality perspective, that East Lancashire Hospitals Trust continued to be unable to report, due to new system problems being experienced. Overall, the ICB was meeting key priorities.<br><br>***C Harris joined the meeting.***<br><br>S Downs responded that other Trusts who implemented EPR had reporting difficulties. A Patel commented that 65+ week waiters would be looked at. The plan had indicated that East Lancashire Teaching Hospitals and Blackpool Teaching Hospitals were no longer submitting zero on plan. Focus was on this area as it was submitted within the revised ICB plan. Moving forward, these metrics would be highlighted to members for focus. Programmes of installing EPR had been very challenged and escalations had been received. Information had now started to flow, which would be reported to the Committee.<br><br>***K Lord left the meeting.***<br><br>**RESOLVED: That the Finance and Performance Committee note the report.** | |
| **9.** | **<u>2024/25 Financial Planning Presentation</u>**<br><br>S Downs provided the committee with an update on the planning position for 2024/25 and members were asked to note that national planning guidance was awaited. The ICB had started planning conversations with providers, assuming there was no growth, and planning for 10% less. It was felt there was a disconnect between workforce, finance and activity and this triangulation would be worked on. Provider figures were being worked through and non-recurrent/recurrent recovery actions would be looked at for the ICB. | |

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| | S Proffitt reported that work was being undertaken on the exit run rate and further detail would be reported at the next committee meeting.<br><br>In response to points raised by members, A Harrison assured the committee that a paper would be reported to the next Business Sustainability Group, highlighting that discussions need to be held in relation to how money was allocated in the system, considering areas of inequality and referencing a presentation on the outlying financial framework. S Proffit would include reference to the outcome of the Business Sustainabilty Group discussion around allocations within the next report to the ICB Board.<br><br>**RESOLVED: That the Finance and Performance Committee note the content of the report.**<br><br>After this meeting, a paper and presentation providing an ICB benchmarking analysis, and a short presentation regarding review of the risk to quality and clinical outcomes (ICB-008) would be circulated to members for information. | **SP** |
| **10.** | **<u>ICB Commissioning Reset – Update on Progress</u>**<br><br>C Harris briefed the Committee on the progress made in the reset of the ICB's commissioning role, following a review in April 2023 and discussions held since. It was explained that in July 2023, executive responsibility for the ICB commissioning leadership became the responsibility of a single executive officer. The commissioning reset's aim was to set out a clear approach to delivery of the ICB's statutory responsibility to commission health and care services on behalf of the Lancashire and South Cumbria population. The 3 key workstreams within the programme were Commissioning Accountability Framework, commissioning and contracting processes and governance assurance and decision making. The Commissioning Accountability Framework provided an understanding to what was being commissioned, roles, remits, accountablities and responsibilities and how they can operate within the system. Commissioning and contracting processes gives a bit more detail to how this would be approached. Governance assurance and decision making, was around how the ICB operates, with an established Commissioning Resource Group reporting to ICB Executive Committee. A committee arrangement was currently being looked at. Commissioning reset looked at roles and responsibilities as a commissioning organisation, what had been adopted from CCGs and what the ICB was required to do. 2 stakeholder sessions had been held to discuss the current challenges within the commissioning work of the ICB and to agree shared solutions. C Harris confirmed that all work within the reset was linked to the ICB's strategic objectives. It was aimed that from April 2024, an integrated set of strategic partnership meetings would be set up, to discuss contracting and commissioning with providers.<br><br>A presentation was shown to members setting out the system plan in relation to aligning and delivering the system strategies. The slides had previously been discussed at a recent Executive away day, Business and Sustainability Group, Commissioning Resource Group, and would go back to the Business and Sustainability Group following today's discussion. Based on conversations in the reset, stakeholder engagement sessions and the review that had been undertaken, there was still no single plan describing the ICB's vision, how this would be delivered through implementing a financially affordable and sustainable target operating model being underpinned by the ICB's clinical strategies, whilst improving quality outcomes in line with the ICB's strategic objectives. All the plans currently were not interfaced that allowed the system, partners or ICB staff to understand where the focus and prioirities were and where resources | |

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| | would be deployed. A slide was shown highlighting how the system would interface, by strategic plans, decision making process and delivery, with the ICB strategic objectives sitting above all other strategies and plans. Carl Ashworth and the commissioning team had been working on a Prioritisation Framework that would take requirements and run through a programme, based on financial affordability, delivery and quality, improved outcomes for residents and population, routed back through a strategy and linked to strategic objectives. Prioritisation would start to distill all of the asks from plans and put them into a decision making cycle which would make strategic and system intentions. These would be underpinned by the ICB's clinical strategy and financial strategy, leading to provider CIPs needing to be in line with what the ICB wanted to commission. The plan would ensure all programmes in the ICB and the Provider Collaborative Board were aligned. The plan would be for a 1 year cycle and would be refreshed in addition to being in line with transformation across a 10 year period, for example, implementation of the New Hospitals Programme. Focus must be on the recovery agenda, but with regard to the new models of care. The plan pulls together a clear set of deliverables, who is doing what, what is being achieved, cost, pulling together interfaces and interfacing commissioning, that would report into the ICB's governance arrangements. The ICB had signalled notice to providers to change the contract for next year, looking at workforce, assumed growth, clinical services, fragile services, and estate issues. A response would be provided to NHS England by the end of January 2024, showing how financial balance would be met, providing confidence and assurance of delivery.<br><br>The Chair thanked C Harris for the work undertaken to date. C Harris confirmed that responses had been received from all providers following the ICB's commissioning intentions being sent. Contracts were being worked through as well as detailed work around £200m across the system that could not be reconciled.<br><br>J Birrell commented that this work was very challenging but was concerned that time was moving on. From the Finance and Performance Committee perspective, he suggested it would be helpful to see a plan of how this would happen in a short timescale, as much would need to be in place for 2024/25. Concern was raised around conversations being held at the end of January around the 10% reduction with providers, and that this was cutting across conversations held earlier in this meeting. C Harris responded that chief executives and executives attend the Improvement Assurance Group meetings where this letter would be discussed. Work would be concertinaed into the next 3 months, and over the next 10 years work would be undertaken on the new models of care annual hospital programme. A 10% reduction from the provider contracts would be required to ensure financial balance and it was noted that this was being worked through with individual organisations. S Proffitt expressed that overall as a system, spend would need to be reduced and this piece of work would join up with the recovery plan.<br><br>Members raised concern that 10% reduction was an enormous ask for providers. A Harrison responded that providers had been spending much less than 10% 4 years ago and although there had been cost growth, there had also been expansion of services and workforce over the last 4 years, with a significant proportion of the posts being non-clinical. This was about new spend, not cost growth. Members were asked to be mindful that the 10% would not all be asked for in year 1, and a reduction would be agreed with providers based on various components.<br><br>The Chair thanked C Harris and teams for their important work on taking commissioning further as an organisation.<br><br>**RESOLVED: That the Committee note the report.** | **CH** |

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| **13.** | **<u>System Finance Group Minutes</u>**<br><br>The draft minutes of the System Finance Group meeting held on 24 November 2023 had been previously circulated to members, for information. Concern was raised regarding the number of apologies from Finance Directors.<br><br>**RESOLVED: That the Committee note the contents of the report.** | |
| **14.** | **<u>Committee Escalation and Assurance Report to the Board</u>**<br><br>To be agreed outside of the meeting. | |
| **15.** | **<u>Items Referred to Other Committees</u>**<br><br>There were no items referred to other committees. | |
| **16.** | **<u>Any Other Business</u>**<br><br>There were no matters raised. | |
| **17.** | **<u>Items for the Risk Register</u>**<br><br>There were no items. | |
| **18.** | **<u>Reflections from the Meeting</u>**<br><br>The Chair thanked everybody for their contributions to the meeting. | |
| **19.** | **<u>Date, Time and Venue of Next Meeting</u>**<br><br>The next meeting would be held on Monday, 29 January 2024 at 1 pm in the Windermere Room, ICB Offices, County Hall, Preston. | |