Lancashire and South Cumbria Integrated Care Board

Integrated Care Board

Date of meeting	5 July 2023
Title of paper	Report of the Chief Executive
Presented by	Kevin Lavery, Chief Executive
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Agenda item	5
Confidential	No

Executive summary

This report provides an opportunity to reflect on a year since the establishment of the ICB, focusing on the importance of strong leadership that will be required to lead the organisation through a challenging recovery and transformation programme.

A key part of ensuring the ICB's success is to achieve the right balance between what happens at place and what happens across the system, and this report introduces the proposal for a place integration deal and the opportunities that are opened up by delegating to our places. The report also provides an update on the Integrated Care Strategy and specialised commissioning.

Recommendations

The Lancashire and South Cumbria Integrated Care Board are requested to note the updates provided.

Which Strategic Objective/s does the report contribute to		**Tick**
1	Improve quality, including safety, clinical outcomes, and patient experience	✓
2	To equalise opportunities and clinical outcomes across the area	✓
3	Make working in Lancashire and South Cumbria an attractive and desirable option for existing and potential employees	✓
4	Meet financial targets and deliver improved productivity	✓
5	Meet national and locally determined performance standards and targets	✓
6	To develop and implement ambitious, deliverable strategies	✓

Implications

	Yes	**No**	**N/A**	**Comments**
Associated risks			✓	
Are associated risks detailed on the ICB Risk Register?			✓	
Financial Implications			✓	

Where paper has been discussed (list other committees/forums that have discussed this paper)

Meeting	Date	Outcomes
n/a	n/a	n/a

Conflicts of interest associated with this report
Not applicable

Impact assessments				
	Yes	**No**	**N/A**	**Comments**
Quality impact assessment completed			✓	
Equality impact assessment completed			✓	
Data privacy impact assessment completed			✓	

Report authorised by:	Kevin Lavery, Chief Executive

Integrated Care Board – 5 July 2023

Report of the Chief Executive

1. Introduction

"Rough waters are truer tests of leadership. In calm water, every ship has a good captain." - Swedish proverb

1.1 As we reflect on one year since the establishment of the ICB, there are three key areas to focus on:

1. Leadership is about facing up to challenges.
2. Improvement is a constant process.
3. Delivery is key.

1.2 Being a leader is not easy. Of course, working within a challenged health organisation, decision making comes with the territory. However, it goes beyond that; it should not be easy to be a good leader. It is about facing up to challenges, getting out of your comfort zone, recognising that something is not working and having the courage to change it.

1.3 It is too easy to avoid the difficult decisions and just enjoy the trappings of power. I saw that clearly in local government during the austerity crisis. Some leaders stood up and faced up to the issues, whilst others did not – and instead hoped they would go away. This had real impact on local communities and some suffered more than they needed to as a result of a lack of leadership.

1.4 We face major challenges in health and care on a similar scale to those faced by local government in austerity. The challenge is not going to go away, and as leaders we will need to be brave in the difficult decisions that we will face over the coming years. It will be an uncomfortable experience if we are going to achieve a real step change across the system.

1.5 We also cannot take our eye off the ball. Focusing on a small number of priorities and getting them right is vital to our success but we also have to be on a continuous journey of making sure that what we are doing is making a difference.

1.6 To make progress, as leaders we have to make the most of the opportunities we have now and in doing so, we will reach a point where we can go even further.

1.7 We need to continually review the good, the bad and the ugly; reset and identify the opportunities to improve. An essential part of leadership is setting and managing expectations. Transformation programmes can often be oversold and do not meet the original expectations which can lead to a perception of failure, despite the improvements that have been made. In this context it is important

that we under-promise and over-deliver.

1.8 Which brings me to the final point that delivering improvements, consistently, is the real goal in all of this. As an organisation that enables change and supports system-thinking, our ICB must still focus on the delivery. As a board we have a duty to make sure that our priorities are met and our communities are served.

2. Integration at place

2.1 If there is one difficult decision that we made in the last year that we should commend, it was the decision that we took as a board in our first business meeting to realign the place boundaries.

2.2 Before our ICB was established, we had eight Clinical Commissioning Groups (CCGs) working across five places based on hospital catchments, and those places were not coterminous with our principle local authorities, so it would have been nigh impossible to integrate health and care. Lancashire County Council for example were in five place-based partnerships. Integration would have been too hard.

2.3 It was a tough decision to make so early in the establishment of a new organisation with a newly-formed board, but recognising the need and having the courage to make the change has built a strong foundation for much of the integration work that has taken place since.

2.4 We knew it was the right thing to do and that we would never be able to truly integrate without this step. But it was not easy. We knew it would affect our ability to make fast progress with the places. We had challenges from our colleagues in primary care. Those that had been working in the former place footprints felt a connection to those places that was hard to shift away from.

2.5 It did slow us down initially; it took until December to get our full leadership team in place. Since then, we have begun to move forward and we are now really gathering pace.

2.6 It is because of the brave decision that we made in July last year that we have been able to make two other significant decisions already at our board meetings; the transaction between Lancashire and South Cumbria NHS Foundation Trust (LSCFT) and East Lancashire Hospitals NHS Trust (ELHT) for community services in Blackburn with Darwen; and the roll out of integrated neighbourhood teams over the next two years.

2.7 As part of today's papers, there is another big decision around the place integration deal. We are presented with a major delegation programme over a two-to-three-year period, and the decision opens up the opportunity to go even further.

2.8 This moves us towards the idea of a small, slim, strategic centre with most of the action happening in place and with our providers, and most people working in the ICB at those more local levels. As the delegation programme develops,

we will need to revisit that vision of a small, slim, strategic centre and make sure that what remains at the centre of the ICB is fit for purpose.

2.9 As a board, we need to appreciate that this is a huge change for the ICB. It will be a major challenge in terms of financial delegation, and in terms of leadership and culture for our staff. The other challenge is that we have a number of services that are fragile and fragmented, with significant variation in delivery arrangements, funding levels and service standards across Lancashire and South Cumbria. This is not going to be for the faint hearted and it certainly will not be plain sailing.

2.10 The place integration deal is one of the enablers for us to achieve greater integration with our local authority partners and has the full support of our local authority chief executives, who we brought together for a half day workshop in early June to look at the proposed arrangements for place integration and the opportunities to go further and faster.

2.11 The workshop was a great opportunity to reset our intentions to integrate further and for me there are three big things to consider here.

2.12 Firstly, how we can remotely monitor patients, in ‘virtual’ beds. We have done well as a system in this, and we have plans in place for rapid expansion of our virtual wards. The important part about this is not the expansion of beds. It is how we make sure that the people in those beds are the ones that need it the most. We must carefully target patients who are at risk of going into hospital, or those that are currently in hospital with moderate health needs that could be managed at home. We also have a low technology offer across the four hospital virtual ward systems. Increasing the level of technology, for example with wearable technology, could help us to move further and faster on this too.

2.13 Secondly, the Jean Bishop Integrated Care Centre in Hull is a great model of admission avoidance, providing a central hub for NHS, social care, voluntary, fire and rescue services to work collaboratively to keep thousands of frail and elderly people fit, out of hospital and living independently at home or in their care setting.

2.14 Following an initial assessment in their own home or care setting, each patient is seen at the Jean Bishop centre by a clinician (either a GP with an extended role in frailty, a consultant community geriatrician or an advanced nurse practitioner), a physiotherapist, social worker, voluntary services worker and other specialists. There are also diagnostics facilities, which enable healthcare staff to carry out blood tests, x-rays and in the near future CT scans as required.

2.15 At the end of their visit, each patient receives their care plan, knowing they have been listened to by healthcare professionals who have the time to listen and identify what is important to each patient, and reassured their plan will be implemented and monitored.

2.16 Between April 2019 and September 2022, the Jean Bishop Integrated Care Centre contributed to a 13.6% reduction in emergency hospital attendances for patients aged over 80. Over the same period there was a 17.6% reduction in emergency department attendances for patients in care homes. Following its success, the service has now been rolled out to cover the East Riding of Yorkshire.

2.17 It is a fully integrated centre and, rightly so, has received national attention as an example of good practice, not least from the Secretary of State for Health and Social Care in his keynote speech at the NHS ConfedExpo. We are just starting to look at whether we can do something similar in our patch, and one area in particular that we are looking at is Cumbria.

2.18 The third area was the opportunity to use NHS and local authority resources better between us. We already have the Better Care Fund, so why do we not utilise that more to target the right priorities within that fund, to receive a maximum return for minimum investment? Using our shared resources as efficiently as possible gives us the opportunity to free up some of our capital spend to be used on frontline services. The possibilities are impressive, and exciting if we get this right.

3. System transformation and recovery

3.1 We are one of 14 systems in England that has confirmed that we will end the year with a budget deficit, having been one of the original five ICBs that had forecasted this outcome. We are grateful to NHS England for recognising our circumstances and the work that we have been doing, with the approval of a multi-year approach to tackling our financial deficit.

3.2 However, we know that finance is just the symptom of an underlying issue; in this case it is how we are configured and how we do things round here. As I have said before, we are in a crisis, but there are some amazing opportunities that we need to take advantage of.

3.3 If we had a blank sheet of paper, we would not plan to have seven elective care centres, six A&Es, five separate and expensive sets of support services. We would not plan to spend over £300 million on temporary staff at premium rates and spend two thirds of our money on treating illness, and one third on care and community.

3.4 The solutions are pretty obvious; we need a major clinical productivity and reconfiguration programme with single clinical networks, increasingly moving to single sites so that ultimately we have two or three elective sites. We need major non-clinical reconfiguration with a single platform for shared services and the collaboration bank.

3.5 Although the answers are obvious, they are not easy to do. Again, this links back to strong leadership and making difficult decisions. In recognition of the importance and enormity of the system recovery and transformation work,

Maggie Oldham is taking the lead on this portfolio.

3.6 To free Maggie up to focus fully on recovery and transformation, we have made some changes to the portfolios of other members of our executive team. Chief nurse, Sarah O'Brien, and medical director, David Levy, will also be freed up to support as clinical leads, which will be a vital part of the clinical productivity and reconfiguration.

3.7 Most of Maggie's functions, along with some of David's and Sarah's, will move to Craig Harris, who will be responsible for urgent and emergency care, mental health, primary care and emergency preparedness, resilience and response (EPRR). The expectation is that with these new functions, Craig will play a much bigger role in consolidating commissioning, which has been fragmented due to legacy arrangements from the eight CCGs.

3.8 We have embarked on a month of intensive work to kickstart the recovery and transformation programme and the paper in part two of the board meeting presents the results of this intense review and provides a baseline for the programme.

3.9 We also launched a second mutually agreed resignation scheme for ICB staff. Feedback from staff side representatives has identified a small number of staff that did not feel they were well enough informed of the future of the organisation to make a decision about the scheme during the first round. We are not expecting large numbers of applications and the approvals process will be carefully managed to ensure that we retain the stability of our teams.

3.10 We need to recognise that we have a very challenging agenda here, reconfiguration is not for faint hearted and will be high risk, which again links back to the need for robust leadership. That is why we need a dedicated team for this. We are going to keep this at the forefront of our decision-making; it is going to be biggest issue that dominates our agenda in the coming years.

4. Lancashire and South Cumbria Integrated Care Partnership (ICP)

4.1 The ICP continues to support the development and maturity of our place-based partnerships, which are often best placed to act on the wider determinants of health. The ICP has made good progress in building a shared purpose across the whole system; to support people to live healthier and more independent lives longer, through our Integrated Care Strategy.

4.2 We must tackle the most complicated issues affecting people's health and wellbeing together, we know that many of these problems can only be solved through better integration and working together with our communities. ICB board members endorsed the draft strategy at the 29 March meeting and can now find the full strategy document on the ICP's website.

4.3 It is intended for use by the public, partners, our places and wider organisations within the Lancashire and South Cumbria system. Both the full strategy and summary version were approved by the Lancashire and South Cumbria

Integrated Care Partnership on 17 April 2023 and can now be formally adopted by the ICB board.

4.4 The partnership itself also continues to develop, since it formed in the summer of 2022, so the Terms of Reference (ToR) have also been updated to reflect the move to a more formal and established stage in the partnership's existence. Board members are also asked to endorse the updated ToR, which can be found on the Lancashire County Council website.

5. Specialised commissioning transfer

5.1 NHS England will be delegating a major portion of specialised commissioning to ICBs from next year. The new arrangements will be set up in shadow form during 2023-24, scheduled to go live on 1 April 2024.

5.2 It has been agreed that Lancashire and South Cumbria ICB will host the North West specialist commissioning hub.

5.3 The inaugural meeting of the North West Specialised Services Committee (NWSSC) met on 1 June 2023. The purpose of this committee is to provide a forum for NHS England and the three North West ICBs (Greater Manchester, Cheshire and Merseyside and Lancashire and South Cumbria) to collaboratively make decisions on the planning and delivery of the joint specialised services, to improve health and care outcomes and reduce health inequalities. The draft ToR for the committee were received and endorsed by the board in May and the final version can now be found on the ICB website.

5.4 This joint committee will support ICBs taking on full delegated commissioning responsibility and will provide Lancashire and South Cumbria ICB a greater level of involvement in the commissioning of specialised services to better align and transform pathways of care around the needs of local populations. Future meetings will focus on the identified transformation priorities as well as the financial plan.

5.5 It is important to note here that we do not want to simply devolve the hub to the three ICBs and then do everything in the same way it had been done by NHS England. The rationale behind this transfer is to do things differently and better. One of the big opportunities will be further devolution of specialised commissioning and integration with the work of the ICBs. There will be opportunities to move work upstream and reduce the demand for specialised commissioning and this is best done at ICB level, rather than at a national level.

5.6 There are also substantial risks in making this change, looking at the transformation agenda. We must recognise that this is a significant change; funding is currently directed to specialist institutions, for example Liverpool University Hospitals NHS Foundation Trust (LUHFT) and Manchester University NHS Foundation Trust (MFT).

5.7 From 2024, funding will be population-based through ICBs. A careful balance will therefore need to be struck between progressing the transformation agenda

and transitioning safely from the current arrangements. Further work will need to take place to understand the full financial risks and opportunities.

5.8 The added complication in the North West is that we have a number of specialist institutions in Greater Manchester and Merseyside that provide services to patients well beyond the North West. That is another significant risk that we will need to keep an eye on.

6. Hewitt review: government response

6.1 Following on from the Hewitt report published in April 2023, the government provided a response to the report within their response to the House of Commons Health and Social Care Committee's report on 'Integrated care systems: autonomy and accountability'.

6.2 The response is generally supportive of Hewitt, and there is a lot of overlap between Hewitt's report and that of the Health and Social Care Committee's, with regards to ICS oversight, national targets and the role of the Care Quality Commission (CQC).

6.3 One of the areas that was perhaps not responded to as fulsomely as I might have expected was prevention. The budget for prevention is one of the things that has been left to ICB discretion. Hewitt had recommended a one per cent real terms increase annually, but this does not feel like it goes far enough.

6.4 We need to go further and invest more, whilst recognising that this will be challenging with the financial constraints within which we are working.

6.5 Prevention is a local priority, for us as an ICB and as an Integrated Care Partnership, and we are one of a small number of ICBs that commissioned Professor Sir Michael Marmot to do a report on the issue of inequalities, who called for an increase in public health funding and increased focus on prevention from the NHS.

6.6 However, not everything requires significant extra investment. One simple area is the campaign to reduce smoking. I have agreed with the chair that we will commit to the NHS Smokefree Pledge. In signing the NHS Smokefree Pledge, organisations commit to reduce the harm caused by tobacco through implementing comprehensive smokefree policies.

6.7 To support our work in this area, the ICB is working with key partners to develop a refreshed Tobacco Free strategy for Lancashire and South Cumbria which will be presented to the board during the autumn.

6.8 The pledge document will be signed by the chair, chief executive and medical director of the ICB.

7. New Hospitals Programme

7.1 At the end of May, there was a national funding announcement which confirmed that Lancashire and South Cumbria will receive funding for two new hospitals to replace Royal Preston Hospital and Royal Lancaster Infirmary.

7.2 We are in the second tranche of funding, which on the face of it seems like a delay from 2030 to 2035. However, if we are realistic about the delivery, this involves two huge and complex projects, and there will be a lot of groundwork to complete between now and then, which we would have been unlikely to achieve within six or seven years.

7.3 The timescales will allow the necessary time for securing the land, getting the consent, carrying out a comprehensive consultation and engagement process with our staff, patients and communities, undertaking significant enabling works, working closely with local authority partners, as well as undertaking the construction of the project. This is a huge project that will take eight to ten years from start to finish. There is a long way to go; the critical issue is to secure the land. We are not in a position to be able to discuss sites as that is commercially sensitive, but we do need to secure the land as a priority.

7.4 We have also had confirmation of the budget envelopes, and that both hospitals will be new builds. This is significant as it really does allow us to build hospitals of the future, which will be premised on transforming our community services to result in a community centric health and care system, rather than being set up purely to tackle illness.

7.5 Our prime objective is that most people get care living independently at home and only go into hospital when they really have to. One of the differences we might therefore expect to see would be fewer beds.

8. NHS Parliamentary Awards

8.1 We have been shortlisted for three NHS Parliamentary Awards; improving the care and detection of oesophageal cancer in patients with Barrett's oesophagus (cytoprime); Lancashire and South Cumbria Reproductive Trauma Service (our maternal mental health service) and tackling COVID-19 vaccination hesitancy and health inequalities in underserved and seldomly heard communities. The awards ceremony take place on the same day as board, Wednesday 5 July.

8.2 The recognition that we received from 11 MPs across our patch helps to highlight the work of our staff and partners and shows appreciation from our MPs for a number of projects that are making a difference to the lives of our communities. Being nominated for awards such as these helps to demonstrate the impact that colleagues working in the ICB have for our patients and communities on a daily basis and I am keen to see more recognition for our organisation as we develop.

9. Recommendations

9.1 The Lancashire and South Cumbria Integrated Care Board is requested to note the updates provided.

Kevin Lavery

26 June 2023