Lancashire and South Cumbria Integrated Care Board

Integrated Care Board

Date of meeting	**02 November 2022**
Title of paper	Chief Executive's Board Report
Presented by	Kevin Lavery, Chief Executive Officer, Integrated Care Board
Author	Lisa Roberts, Business Manager and Executive Team lead contributors
Agenda item	Item 5
Confidential	No

Purpose of the paper

This paper provides the Chief Executive Officer (CEO) with the forum to update Board members on actions since the last board and highlight emerging issues and key areas of focus, to ensure Board members are sighted on the business of the ICB and its wider operating environment.

Executive summary

This report focuses on seven issues that are pertinent to stabilisation and recovery of the Lancashire and South Cumbria Integrated Care Board:

1. Cancer performance
2. Trust performance
3. Budget and system productivity
4. ICB finances
5. Operating model for the ICB and Provider Collaboration Board
6. The LSC Integrated Care Partnership
7. Winter pressures

Appendix A provides the Board with a revised Board Forward Plan, with a focus on the remainder of 2022/23 and quarter one of 2023/24.

Recommendations

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

Governance and reporting (list other forums that have discussed this paper)

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

Conflicts of interest identified

Not applicable

Implications

If yes, please provide a brief risk description and reference number	**Yes**	**No**	**N/A**	**Comments**
Quality impact assessment completed			x	
Equality impact assessment completed			x	
Data Privacy impact assessment completed			x	
Financial impact assessment completed			x	
Associated risks			x	
Are associated risks detailed on the ICB Risk Register?			x	

Report authorised by:	Kevin Lavery Chief Executive

Integrated Care Board - 02 November 2022

Chief Executive's Board Report

1. INTRODUCTION

1.1 The Chair and Executive Team met with the northwest Regional Senior Team on 14 October for our first quarterly assurance meeting. The meeting went well. The Regional Director is generally pleased with progress and supports the work we have commissioned on the operating model. The main concerns are delivering this year's budget and performance against cancer targets.

1.2 I want to bring attention to the strategy that the Board agreed at its first business meeting on 27 July. This included three phases - stabilise, recover, and transform. These three phases are not strictly sequential but the early years of the ICB needs to be focussed on the first two phases. Central to the stabilise phase is coping with winter pressures well, completing the transition to the new ICB, delivering a very challenging budget, and improving Trust performance, recognising that most trusts are inadequate or in need of improvement. Recovery involves moving to good performance and addressing the challenge of care in the community. Our health system is looking after frail elderly people, many of whom would be better supported at home and in the community.

1.3 My report touches on seven issues that are pertinent to stabilisation and recovery; cancer performance, the overall performance of our Trusts, delivering the budget and improving productivity, the ICB's finances, our operating framework, the Integrated Care Partnership (ICP), and winter pressures.

2. CANCER PERFORMANCE

2.1 We have a major problem on cancer performance. Generally, Lancashire and South Cumbria is the best performer on most service metrics in the North West, except for cancer. The target is 85% of referrals to have definitive treatment within 62 days for all cancer types. Currently, provider performance is 52.36% which is well below target, and the rate is deteriorating. Lancashire Teaching Hospitals (LTH) and East Lancs Hospital Trust (ELHT) are the two biggest providers with significant cancer backlogs for patients waiting over 62 days. A recovery plan has been completed for ELHT and one is being developed for LTH. We will bring a deep dive on Cancer performance and a composite recovery plan to the December Board.

3. TRUST PERFORMANCE

3.1 University Hospitals of Morecambe Bay (UHMB) is System Oversight Framework (SOF) 4, 'inadequate' with Blackpool Teaching Hospitals (BTH), LTH and Lancashire and South Cumbria Foundation Trust (LSCFT) SOF 3, 'in need of improvement'. ELHT and the North West Ambulance Services (NWAS) are SOF 2, 'good'. As a result, the Lancashire and South Cumbria system is rated overall as SOF 3. This is completely unacceptable for the residents of Lancashire and South Cumbria.

3.2 Currently, UHMB and BTH are both subject to performance improvement arrangements led by NHS England (NHSE). Both have improvement boards chaired by the Region. Morecambe Bay also have a full-time NHSE improvement director.

3.3 Under the new arrangements the ICB is the lead agency for oversight and support for performance improvement for trusts in need of improvement. We will prioritise this responsibility and work with our trusts to accelerate improvement programmes. There has been some talk of moving to a group structure. This cannot happen with poorly performing trusts. We need a comprehensive and strategic approach to performance management under the leadership of Maggie Oldham. Maggie has the perfect background to fulfil this role having been a high-profile turnaround CEO for NHSE.

3.4 Our approach will involve bringing together comprehensive and tailored packages of support and accountability requirements for each trust. This will involve some structural changes, the use of specialist Improvement Directors, leadership development, organisational development, senior team mentoring and rigorous monitoring.

3.5 We are reaching a significant milestone for Morecambe Bay. NHSE will be reviewing the SOF status early next year and a decision on whether they move to SOF 3 by April/May next year. The ICB's view and recommendation will be instrumental in that decision. It is essential that a move to SOF 3 is sustainable and that together UHMB and the ICB can swiftly progress to SOF 2. As a result, we are in discussions with UHMB to agree a support and accountability package to progress the trust to SOF 2 within 18-24 months. This will include a specialist improvement director to replace the NHSE improvement director on the exit from SOF 4. This director will be jointly appointed by UHMB and the ICB and will report directly to the Trust CEO.

3.6 We will also develop closer working with LTH, tailored to the UHMB improvement programme. So, we will be looking to see some sharing of key positions to secure efficiencies and enable both trusts to recruit and retain quality senior staff. We will also be looking for both UHMB and LTH to be early movers on a range of programmes - bank and agency, common platform, and investment in community care to improve discharge and flow. A full report on the Morecambe Bay package will come to the ICB early in the new year and we will ensure the recommendation has the support of UHMB, LTH and the Region.

3.7 We will soon begin discussions with LSCFT, BTH and LTH to develop similar packages for consideration by the ICB. We already have some elements in place with LSCFT, an improvement director, top team monitoring and financial support. So, it is likely that LSCFT will be able to move at the greatest speed, perhaps a 6 to 9month programme to reach SOF 2.

4. BUDGET AND SYSTEM PRODUCTIVITY

4.1 We have a separate paper on finance and transformation. So, I'm not going to get into the detail, but what I will add that our system faces unprecedented challenges. We are still in a pandemic, our hospitals have record patients with

Covid, Long COVID is emerging as a major challenge, concerns about flu, a backlog in operations and a sharp growth in long term conditions. All of this makes for an extremely challenging winter with a cost-of-living crisis; and these conditions are likely to be around for years to come. As a Board, we made some tough decisions in July, yet our financial position has worsened in the face of these unprecedented challenges. We are not delivering enough recurring savings and the current financial forecasts look better than the reality because cash balances have been used in the early months, with the recurring savings planned towards the end of the year. We know that next year will be exceedingly challenging.

4.2 As we are about to finalise our six-month forecasts, it is timely that we also do a fundamental re-evaluation of the risks around the year-end position. It is time to ask ourselves, can we do even more to arrest the worsening position? We need a "get well plan" and will bring our recommendations to the next Board. This challenge will need everyone in the system to envisage that we are a single organisation with a fast-deteriorating financial outlook that requires radical and urgent action. What would you do in that situation? We would look at an all-system vacancy freeze and consider running costs and potential schemes such as the NHS Mutually Agreed Resignation Scheme (MARS), review all contractors and consultancies engaged within the system, review balances and capital schemes in all of the Trusts; look at elective care and how to speed up diagnostics and treatment, improve efficiency, theatre optimisation and outpatients.

4.3 The key issue though is not losing focus on the medium term. That is what will show whether the ICB is making a difference and adding value for the citizens of Lancashire and South Cumbria. We have a group of transformation projects that offer the real possibility of significant recurring savings; shared services/common platform, bank and agency staffing and discharge and flow with specific projects around Finney House and investments in domiciliary care.

4.4 These projects have dedicated leadership, resources, and emerging plans. As a system, we are currently spending over 40% above the NHS cap on bank and agency staffing and it is steadily rising, month by month. This is not just about money; it is about patient safety and the risks are high. We are out to procurement and expect to have a recommendation for the Board to consider in December. We have recruited a manager to lead the common platform work with extensive experience of shared services and outsourcing. Then, we have a group of projects – Getting if Right First Time (GIRFT), Clinical Integration - that are developing but need to be converted into properly resourced, focused projects with strong leadership.

4.5 Lastly, we have some emerging ideas whose time is coming, these relate to the connection between the front and back door of the hospital and the wider community. The first of these is domiciliary care, as we have a shortage of supply. In North Tyneside we have seen the launch of Northumbria Care, the first NHS organisation to be Care Quality Commission (CQC) registered to provide domiciliary care. It is probably not quite the right model for us, but the innovation and boldness is admirable.

4.6 We need to be just as bold as Northumbria Care, but we need to develop our own model or models. Whatever we do must be in full partnership with local government. We already have some in-house operations that could be built on and perhaps play a wider system role, that creates a new player or players in domiciliary care which would up-skills care workers to perform basic medical tests such as taking bloods and blood pressure. Any new venture or expansion would need to be developed with care to avoid destabilising the fragile care market, to expand not transfer care capacity and to bring a new dimension. In effect, providing domiciliary care and becoming an extension of primary care. This is an area where our new places really could earn their spurs. We have had discussions with the local authority CEOs, and we have agreed to bring together our place leaders and Directors of Adult Social Care to develop a proposal for consideration by the ICB as part of its 10-year plan.

4.7 The second area is physical community health services. We have varied models, funding levels and providers across the ICB area and one of the key areas of transformation over the next three to five years will be to transform Primary, Community, and Intermediate Care services. One of LSCs high performers is ELHTs integrated model, delivered by a high performing team. It is a significant contributory factor to the low numbers of patients not meeting medical criteria to reside, consistently reported by ELHT, by far the lowest in our system. We will look at all the models, resourcing levels and providers with a view to levelling-up across the region, addressing gaps and achieving consistency, in addition to looking at innovative workforce models and new ways of working to secure necessary additional capacity.

4.8 This is a real opportunity to roll out a high performing service across the ICB area. It will take time and will involve some difficult challenges with procurement needed, a levelling up of resources, integration issues with acute trusts. West Lancashire will need careful consideration because the acute trust lies in Mersey and Cheshire ICB and is the subject of a merger with St Helens and Knowsley Teaching Hospitals. LSCFT will also need careful thought as they currently provide community services in Blackburn with Darwen and Central Lancashire, which means there are cross subsidies from community services to mental health services which will need careful handling. There are also some mental health services provided by acute trusts which may be better transferred into LSCFT.

4.9 The third area is virtual wards where we have a two-year grant funded programme with NHSE which will see 746 virtual ward beds by December 2023. This will make a material difference to bed capacity within our system. We previously had the lowest number of virtual ward beds in the region, but we are making the best progress, are ahead of schedule and are securing by far the highest levels of utilisation of the virtual beds. Given this early success we should be looking for opportunities to expand and build on this. We will come back to the Board in the new year with a comprehensive proposal for the development of community health and care services, as part of our 10-year Plan.

5. ICB FINANCES

5.1 The ICB itself is a contributor to the current financial deficit. A £20m deficit from the CCGs at the end of quarter one was another major contributing factor. We are also facing very serious pressures on continuing healthcare. The Executive Team are reviewing a package of measures to address the high level of risk which includes further controls on recruitment, adjustments to the contract with the CSU, a review of all contract renewals this year, a review of all grant-funded programmes, plus considering running costs and exploring schemes such as the NHS MARS as referred to in section 4.

5.2 The establishment of an ICB Finance Committee is well underway, with an initial session planned in early November to consider its Terms of Reference and how this committee will provide regular assurance updates to the Board. It is expected that the inaugural meeting of the committee will be held in late November/Early December.

6. OPERATING MODEL FOR THE ICB AND PROVIDER COLLABOARATIVE BOARD (PCB)

6.1 We are aware health outcomes in LSC are poor, and inequalities are widening. Performance is poor, we are still in the midst of a pandemic, and we have a challenging fiscal outlook. Our system continues to be under severe pressure with record patients with COVID, a backlog of operations and a sharp increase in long term health conditions.

6.2 We need to act swiftly to address these challenges. One issue that is holding back progress is a lack of clarity over who does what. What is the operating model for our new system? What is the role of the ICB? What levers and processes are needed? What is the interface with the PCB and what is the role of the PCB itself? What arrangements do we need to encourage a high performing system that makes swift progress? I have now appointed Dame Ruth Carnall to help work through these issues with us. Ruth is perfectly qualified with 30 years plus experience in healthcare, including 20 years at CEO level in acute hospitals, mental health, and community services. She spent seven years as CEO of NHS London and is now Chair of the Kings Fund. Ruth will be approaching Board members as part of her work. She will also talk with colleagues in the trusts, the PCB, Region, and NHSE. It is likely that Ruth's report will be considered at the February Board meeting.

7. INTEGRATED CARE PARTNERSHIP

7.1 We recognise this is different to the ICB. This is a community-wide NHS, voluntary sector and Local Authority partnership that extends well beyond health. The Lancashire and South Cumbria ICP is chaired by Councillor Michael Green of Lancashire County Council. We had our second meeting of the partnership on 25 October. The partnership looks on course to agree a draft strategy by December.

8. WINTER PRESSURES

8.1 We are planning a summit in December to ensure that our plans are appropriate and that all parts of the system are fully aligned. The Chair and I will be arranging regular communications on winter performance with local MPs.

8.2 Resilience and Surge Schemes across Lancashire and South Cumbria There are 27 approved schemes in relation to the £12.95m Demand and Capacity funding that the ICB has been allocated by NHSE, of which 13 schemes are live and 14 schemes are currently being mobilised. Robust monitoring arrangements have been agreed by the ICB's Resilience and Surge Planning Group and finance team and are in the process of being implemented. The further 54 local placed-based winter schemes will be monitored using the same principles and methodology for consistency. Oversight will be provided through the Resilience and Surge Planning Group and local A&E Boards. These arrangements will also enable the ICB Board to receive regular updates on progress, risks, and the impact.

8.3 Going Further on Our Winter Resilience Plans - (Publication reference PR2090 - 19 October) - In August, NHS England set out key actions to improve operational resilience. Following further engagement with systems they have now set out a necessary expansion of these plans and additional actions noted in the table below:

New 'Actions'	When	Director Lead
• *All systems establish 24/7 System Control Centres (SCCs)*	01.12.22	S McGirr
• *Combined adult and paediatric Acute Respiratory Infection (ARI) hubs (previously RCAS hubs)*	TBC	J Mellor
• *Community – based falls response*	31.12.22	J Mellor
• *Care homes ambulance conveyance avoidance*	TBC	J Mellor
• *Supporting High Frequency Users (HFU)*	TBC	J Mellor

8.4 Risks and Mitigations - The Resilience and Surge Planning group holds a detailed overarching risk log. Individual schemes will be managed locally through local plans. High level risks are workforce; fragility of domiciliary care market; clinical and financial risks of a reduced Discharge to Assess (D2A) allocation; lack of robust Intermediate Care Services and bed pressures not meeting criteria reside (NMC2R). Additional capacity has been identified through the schemes to support and mitigate the risks. Recognising workforce is the greatest challenge.

9. BOARD WORKPLAN FOR Q3 AND Q4

9.1 Further to the Board Workplan received in July, a review has been undertaken to ensure the agenda and focus of board meeting for the remainder of 2022/23 are aligned to our priorities. This is attached at **Appendix A**.

10. RECOMMENDATIONS

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

Kevin Lavery

Chief Executive
26 October 2022