NHS
Kernow
Clinical Commissioning Group

GB2122/076

Governing Body

Summary sheet

Date of meeting: 5 October 2021
For: Public session (Part 1)
For: Decision

Agenda item: Chair's report
Author(s): Dr Paul Cook, chair
Presented by: Dr Paul Cook, chair

Executive summary

Since mid-August Mrs Kate Shields has joined us as the CCG chief executive and accountable officer and has spent time getting to know us better as individuals and as an organisation. I am really pleased to welcome her here more formally at the Governing Body and we are feeling the positive influences and her fresh approaches already.

In addition to welcoming Kate, this report also covers the following areas:

- System pressures
- Health and care bill and integrated care system (ICS) update
- Cornwall Pride event
- Working with people and communities - ICS guidance released

Governing Body (GB) members are asked to confirm their commitment to the 10 principles outlined in the ICS guidance (see **Appendix 1**) and recommend their approval to ICS partners and the new integrated care board (ICB) which is expected to replace NHS Kernow in April 2022.

Recommendations and specific action the governing body needs to take at the meeting

1. Note the contents of the report.
2. Confirm their commitment to the ten principles contained within Appendix 1 and recommend their approval to system partners.

System pressures more waxing than waning

In the interval since the last GB meeting we have seen summer come and go and the focus is back to winter pressures. Unfortunately summer and winter are feeling much the same. We have had a system wide letter to everyone about the sustained 'rising tide' of pressure in our health and social care system and we have experienced or seen the bottlenecks in parts of our delivery of care. Services are working at full throttle and increased demand has led to an increased response. Despite colleagues in all sectors working harder and longer, there is a sense at times of feeling overwhelmed.

On top of this there has been a sustained campaign in the National Press for GPs to see their patients face to face. This deep misunderstanding has gone largely unchallenged apart from by those it criticises who have had to find even more time and energy to defend their position to their patients. I could write a large piece on this but I encourage you to read perspectives from our LMC (Local Medical Committee) https://www.kernowlmc.co.uk/general-practice-in-cornwall-on-brink-of-a-crisis/ and the BMA (Brtish Medical Association) https://www.bma.org.uk/media/4629/21092021-bma-to-secretary-of-state-for-health.pdf where this complex and unhelpful situation is explained with clarity. This is then juxtaposed against the National GP Survey which shows significant satisfaction with General Practice in Cornwall and the Isles of Scilly. However, there is no doubt that some areas of our county can appear better than others at delivering care but some areas have much more of a challenge than others.

We are increasingly aware of our local health outcomes and I am pleased to support the report being presented later from our Director of Public Health which leaves three impressions with me: the unstinting expertise and leadership through the pandemic from the public health team, the strengthened spotlight on the effect of health inequalities and a refreshed importance of the wider determinants of health having much more influence over our wellbeing and life expectancy than just pure healthcare provision. In the past 3 months an approach to help address these concerns has been invigorated through the development of a program of population health management which looks at data-driven insights being used to inform the planning and delivery of care and improve health and wellbeing outcomes. The understanding of our data informs our strategies at a local and county level. In making the discrepancies or inequalities visible we are then forced to make a conscious decision to either accept or change the status quo.

This brings me to the issue of resource and we hear through the Governing Body how the circa £1 billion allocation is spent and what we see as a result. I think we concentrate on the areas of biggest pressure or failure and rightly so, but we also recognise our restrictions in workforce and geography. We have the responsibility to manage our resources through complex processes and levels of decision making that make informed judgements about where to apply resource. This doesn't always work smoothly and we can see later in the agenda an example of how significant rapid 'system' decision making caused undue upset through a lack of communication over the temporary minor injury unit closure. Additionally I can also attest to my time has been consumed about issues concerning routine earwax removal. How do we prioritise our resource?

In August 1980 the Black report https://en.wikipedia.org/wiki/Black_Report on 'Inequalities in Health' was published and in 2010 the Marmot Review https://www.parliament.uk/globalassets/documents/fair-society-healthy-lives-full-report.pdf was published with a 10 year review completed last year. We are looking nationally at the same issues for over 40 years and something needs to change. Our local report describes many variations and as an uncomfortable example, there can be a 12yr difference on life expectancy depending on where you are born in Cornwall and the Isles of Scilly or a significant increase in difference if you have a particular type of severe mental health illness or learning disability. This is not an inequality limited to our county and is reflected in national data in communities throughout England.

So, we have money (?enough), workforce (not enough and under strain) and we have variance in life expectancy and health outcomes depending primarily on socio-economic circumstances. We have an increase in normal demand and also in regard to a backlog of need. We are still experiencing the continual effects of the pandemic and we witness variance in experience and outcomes depending on age, sex, race, weight, long-term conditions, socio-economic background. How do we move the resource to a more equitable footing? How do we level up when it may mean that some people feel they are being levelled down? What do we start doing or more importantly what do we stop doing with the resources we currently have?

The evolution into an integrated care system (ICS) allows us to build on what we have learnt and to be enabled for closer working in order to enact change. We can be expertly managed, clinically led and have the golden thread of citizen engagement to try and address the needs of our population. If we really want to acknowledge the data and facts about our community then difficult decisions will continually need to be made together.

In essence, I feel this is exemplified by the following, credited to New Zealand.

(https://www.healthnavigator.org.nz/clinicians/e/equity/)

What is health equity?

The definition of health equity by the Ministry of Health is as follows:

“In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes.”

The concept acknowledges that not only are differences in health status unfair and unjust, but they are also the result of differential access to the resources necessary for people to lead healthy lives.

What does this mean?

Put simply:

- equality is treating people the same
- equity is treating people fairly
- equity is about being prepared to work differently to help people achieve the same outcomes

In this illustration the first picture shows what happens when everyone gets the same. In the second picture we can see that each person gets the support they need to see the game. The third picture shows everyone being able to watch the game without additional supports because the systemic structures and biases that cause the inequity have been removed.

Health and care bill and ICS update

As we move closer to April 2022, an ICS update will become a regular feature of each meeting to provide GB with assurance of the closedown of NHS Kernow and the safe transfer of its staff into the new ICB organisation.

Kate Shields, NHS Kernow's new accountable officer, will provide today's report.

Cornwall Pride event

Cornwall Pride took place in Newquay over the August bank holiday weekend. The LGBTQ+ employee network group and NHS Kernow's events lead attended and were supported by a variety of volunteers.

The messaging focused on Think 111 and mental health support. It was fantastic to see the Think 111 banner at the front of the Pride parade.

The public were asked what the NHS meant to them and were asked to write their responses. It is wonderful to see how much value people in the community place on the NHS. There was a positive atmosphere, and members of the public were very happy to engage.

This event was only possible by working collaboratively with system partners. We'd like to thank members of the LGBTQ+ employee network group, NHS Kernow's communication and engagement team, and the volunteers at the Royal Cornwall Hospitals NHS Trust for their support in this year's Pride. Support for these events in future is important for the network. We are already starting to plan for next year's Pride and we are looking for financial support with a small budget to support the network and its activities.

An engagement report shall shortly be published on NHS Kernow's website.

Working with people and communities - ICS guidance

At the Governing Body (GB) meeting this morning, members will receive the petition from the Launceston minor injuries unit (MIU) campaign group regarding the re-opening of the MIU as soon as possible. All organisations involved have apologised for the lack of communication regarding this decision which was due to an oversight when the decision was made outside of our normal decision making processes due to the severe emergency pressures being experienced. As can be seen at Appendix 1, recent ICS guidance was released regarding engagement with people and communities. In view of the petition, we are asking Members to confirm their commitment to the 10 principles outlined in the guidance and recommend their approval to ICS partners and the new integrated care board (ICB) which is expected to replace NHS Kernow in April 2022.

Appendix 1 – ICS Building strong integrated care systems everywhere

ICS implementation guidance on working with people and communities

The ICS design framework sets the expectation that partners in an integrated care system (ICS) should agree how to listen consistently to, and collectively act on, the experience and aspirations of local people and communities. This includes supporting people to sustain and improve their health and wellbeing, as well as involving people and communities in developing plans and priorities, and continually improving services. This guidance sets out 10 principles for how integrated care boards (ICBs) can develop their approaches to working with people and communities, and the expectations.

Key points

- A strong and effective ICS will have a deep understanding of all the people and communities it serves.
- The insights and diverse thinking of people and communities are essential to enabling ICSs to tackle health inequalities and the other challenges faced by health and care systems.
- The creation of statutory ICS arrangements brings fresh opportunities to strengthen work with people and communities, building on existing relationships, networks and activities.

Action required

- ICBs are expected to develop a system-wide strategy for engaging with people and communities by April 2022, using the 10 principles in this document as a starting point.
- ICB constitutions are expected to include principles and arrangements for how the ICB will work with people and communities.
- ICBs should work with partners across the ICS to develop arrangements for ensuring that integrated care partnerships (ICPs) and place-based partnerships have representation from local people and communities in priority-setting and decision-making forums.
- ICBs are expected to gather intelligence about the experience and aspirations of people who use care and support and have clear approaches to using these insights to inform decision-making and quality governance.

Ten principles for how ICSs work with people and communities

1. Put the voices of people and communities at the centre of decision-making and governance, at every level of the ICS.
2. Start engagement early when developing plans and feed back to people and communities how their engagement has influenced activities and decisions.
3. Understand your community's needs, experience and aspirations for health and care, using engagement to find out if change is having the desired effect.
4. Build relationships with excluded groups, especially those affected by inequalities.

5. Work with Healthwatch and the voluntary, community and social enterprise (VCSE) sector as key partners.
6. Provide clear and accessible public information about vision, plans and progress, to build understanding and trust.
7. Use community development approaches that empower people and communities, making connections to social action.
8. Use co-production, insight and engagement to achieve accountable health and care services.
9. Co-produce and redesign services and tackle system priorities in partnership with people and communities.
10. Learn from what works and build on the assets of all ICS partners – networks, relationships, activity in local places.