Overview & Scrutiny

Health in Hackney Scrutiny Commission

All Members of the Health in Scrutiny Commission are requested to attend the meeting of the Commission to be held as follows

Wednesday 6 January 2021

7.00 pm

Until further Notice, all Council meetings will be held remotely

Contact:
Jarlath O'Connell
☎ 020 8356 3309
✉ jarlath.oconnell@hackney.gov.uk

Tim Shields
Chief Executive, London Borough of Hackney

Members: **Cllr Ben Hayhurst (Chair), Cllr Peter Snell, Cllr Deniz Oguzkanli, Cllr Emma Plouviez, Cllr Patrick Spence, Cllr Kofo David, Cllr Kam Adams and Cllr Michelle Gregory**

Agenda

ALL MEETINGS ARE OPEN TO THE PUBLIC

Hackney

Access and Information

Getting to the Town Hall

For a map of how to find the Town Hall, please visit the council's website http://www.hackney.gov.uk/contact-us.htm or contact the Overview and Scrutiny Officer using the details provided on the front cover of this agenda.

Accessibility

There are public toilets available, with wheelchair access, on the ground floor of the Town Hall.

Induction loop facilities are available in the Assembly Halls and the Council Chamber. Access for people with mobility difficulties can be obtained through the ramp on the side to the main Town Hall entrance.

Further Information about the Commission

If you would like any more information about the Scrutiny Commission, including the membership details, meeting dates and previous reviews, please visit the website or use this QR Code (accessible via phone or tablet 'app') http://www.hackney.gov.uk/individual-scrutiny-commissions-health-in-hackney.htm

Public Involvement and Recording

Scrutiny meetings are held in public, rather than being public meetings. This means that whilst residents and press are welcome to attend, they can only ask questions at the discretion of the Chair. For further information relating to public access to information, please see Part 4 of the council's constitution, available at http://www.hackney.gov.uk/l-gm-constitution.htm or by contacting Governance Services (020 8356 3503)

Rights of Press and Public to Report on Meetings

Where a meeting of the Council and its committees are open to the public, the press and public are welcome to report on meetings of the Council and its committees, through any audio, visual or written methods and may use digital

and social media providing they do not disturb the conduct of the meeting and providing that the person reporting or providing the commentary is present at the meeting.

Those wishing to film, photograph or audio record a meeting are asked to notify the Council's Monitoring Officer by noon on the day of the meeting, if possible, or any time prior to the start of the meeting or notify the Chair at the start of the meeting.

The Monitoring Officer, or the Chair of the meeting, may designate a set area from which all recording must take place at a meeting.

The Council will endeavour to provide reasonable space and seating to view, hear and record the meeting. If those intending to record a meeting require any other reasonable facilities, notice should be given to the Monitoring Officer in advance of the meeting and will only be provided if practicable to do so.

The Chair shall have discretion to regulate the behaviour of all those present recording a meeting in the interests of the efficient conduct of the meeting. Anyone acting in a disruptive manner may be required by the Chair to cease recording or may be excluded from the meeting. Disruptive behaviour may include: moving from any designated recording area; causing excessive noise; intrusive lighting; interrupting the meeting; or filming members of the public who have asked not to be filmed.

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Members:	**Cllr Ben Hayhurst (Chair)**	**Cllr Peter Snell (Vice Chair)**	**Cllr Kam Adams**
	Cllr Kofo David	**Cllr Michelle Gregory**	**Cllr Deniz Oguzkanli**
	Cllr Emma Plouviez	**Cllr Patrick Spence**	

Agenda

ALL MEETINGS ARE OPEN TO THE PUBLIC

1 Apologies for Absence (19.00)

2 Urgent Items / Order of Business (19.02)

3 Declarations of Interest (19.04)

4 **Covid-19: update from GP Confederation on vaccinations roll-out (19.05)**

5 **Covid-19: update from Public Health on test, trace, isolate (19.30)**

6 **NEL system response to national consultation on Integrated Care Systems (19.45)**

7 **Cabinet Member Question Time with Cllr Kennedy (20.15)**

8 Minutes of the previous meeting (20.50)

Hackney

9 Health in Hackney 2020/21 Work Programme (20.51)

10 Any Other Business (20.56)

Access and Information

This meeting can be viewed live on the Council's YouTube channel at https://youtu.be/euvYB3sfFms

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Hackney

Health in Hackney Scrutiny Commission 6th January 2021 **Covid-19 update from GP Confederation on vaccinations roll-out**	Item No **4**

OUTLINE

The roll out of the vaccinations programme for Covid-19 is dominating the work of the local NHS and in particular the GP Confederation.

The Chair has invited Laura Sharpe (Chief Executive, City and Hackney GP Confederation) to give a VERBAL briefing to provide and update on the progress being made.

ACTION

The Commission is requested to give consideration to the briefing.

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Covid-19 vaccination update for North East London – City and Hackney

5 January 2021

Our hospitals, urgent care and other services continue to be under incredible pressure due to **rising coronavirus rates**. We are doing everything we can to manage the situation, and asking everyone to do their bit and follow the new Tier 5 rules, which will help, reduce infections.

- A second Covid vaccine (from Oxford University/AstraZeneca) has now been authorised by the Medicines and Healthcare products Regulatory Agency (MHRA).
- We have started to **vaccinate care home residents and staff** in some of our bigger homes.
- Lots of people are eager to get protected, but we are asking people **not to contact the NHS** to get an appointment. When it is the right time for people to receive their vaccination, they will receive an invitation to come forward and this may be via the phone, or through a letter either from their GP or the national booking system. We are currently vaccinating JCVI priority groups 1 and 2 (residents in a care home for older adults and their carers; all those 80 years of age and over; and frontline health and social care workers). We will make announcements in social media and the local media, and update our webpage COVID-19 Vaccination programme | East London Health & Care Partnership (eastlondonhcp.nhs.uk) when we start vaccinating other priority groups (starting with over 75 year olds). At that time if there are some over 80s who have not got a vaccination appointment they should contact their GP.
- In order to **maximise the short-term impact of the vaccination programme**, the guidance on priority groups issued by the Joint Committee on Vaccination and Immunisation has been updated. This advises that there is high efficacy from the first dose of both Pfizer-BioNTech and AstraZeneca vaccines, and the UK Chief Medical Officers' have stated that delivery of the first dose to as many eligible individuals as possible should be initially prioritised over delivery of a second vaccine dose.
    - Therefore **we are contacting some people who have had their first dose of the Pfizer vaccine to delay their second dose**. Not everyone will be contacted. It depends on the different situations facing vaccination centres, the stocks of vaccine, the staff available to contact patients and other factors. *(Please note all City and Hackney residents that were vaccinated with their first dose at the Elsdale Centre, will receive their second dose as planned this week at the same location).*
    - The **first vaccine dose** gives limited protection in the first 10 days, and increases to a very good protection by day 21. It continues to provide a high level of protection from severe illness and hospitalisation in the short term. However, to achieve maximum protection the second dose remains important and everyone is urged to attend for both appointments to get the maximum level of protection. Full details on vaccine effectiveness can be found here.
    - The second dose of the Pfizer-BioNTech vaccine may be given between 3 to 12 weeks following the first dose. The second dose of the AstraZeneca vaccine may be given between 4 to 12 weeks following the first dose.
    - The second vaccine dose should be with the same vaccine as for the first dose. Switching between vaccines or missing the second dose is not advised.
    - There is no preference for either vaccine as both give very high protection against severe disease.
    - It is vital that everyone follows the **national guidance**. While the vaccine will reduce your chance of becoming seriously ill it does not give 100% protection and we do not yet know whether it will stop you from catching and passing on the virus. National guidance will continue to be reviewed by the Government and updated when appropriate. Please find the latest guidance here.

Please do not fall for scams. The NHS will never ask you for your bank details

A range of information including patient information leaflets, guidance and frequently asked questions about the vaccine is available on our website, and videos explaining the vaccine in Sylheti, Gujarati, Tamil, Urdu and Punjabi are also available to share here. This page is updated regularly.

Public bulletin: Across north east London, we produce a regular public bulletin to share our resources, help keep local people informed about health and care services; and provide information on how they can stay well and keep safe.

City and Hackney specific update

- 975 vaccines done at Elsdale street hub week of 14th Dec; second batch of 975 for second dose being delivered 5th Jan (patients aged 80+ plus priority healthcare staff who previously received their first dose in Dec). Elsdale will then close as a vaccination location.
- A new purpose built vaccination hub at Bocking Street is going through a mandated readiness assessment – it is expected that this site will be approved by the national team on 7th Jan and for it to receive its first lot of vaccines between 13th and 15th Jan – this will be 975 Pfizer, 400 AZ and another 75 Pfizer for care homes. These vaccines will again be used on those that fall into Cohort 1 and 2 where appropriate (see JCVI guidance above).
- Another purpose built vaccination hub at John Scott Health Centre is also being set up – hoping to start vaccinating week of 18th Jan
- We have also started vaccinating care home residents and staff (if remaining vaccine available):
    - Acorn Lodge completed on 30th Dec
    - Beis Pinchos and Fradel Lodge taking place 6th Jan
    - Homerton will be vaccinating Mary Seacole (date TBC)
    - Planning for remaining homes has started
- Homerton due to receive AZ to start vaccinating staff predominantly but also some patients
- Mass vaccination sites, (including at Westfield, Stratford) in the pipeline (confirmed date TBC but expected late Jan)

Hackney

Health in Hackney Scrutiny Commission 6th January 2021 **Covid-19 update from Public Health on test, trace and isolate**	Item No **5**

OUTLINE

The Commission has been receiving updates at each meeting from Public Health on the latest number of cases and trends for Covid-19 in the borough and on the progress being made locally with the test, trace and isolate programme.

The Chair has asked Dr Sandra Husbands (Director of Public Health for City and Hackney) to provide a VERBAL update. There will be a presentation on the latest figures at the meeting.

ACTION

The Commission is requested to give consideration to the briefing.

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COVID-19 update to the Hackney Scrutiny Commission

6 January 2021

Dr Sandra Husbands
Director of Public Health
City and Hackney Public Health

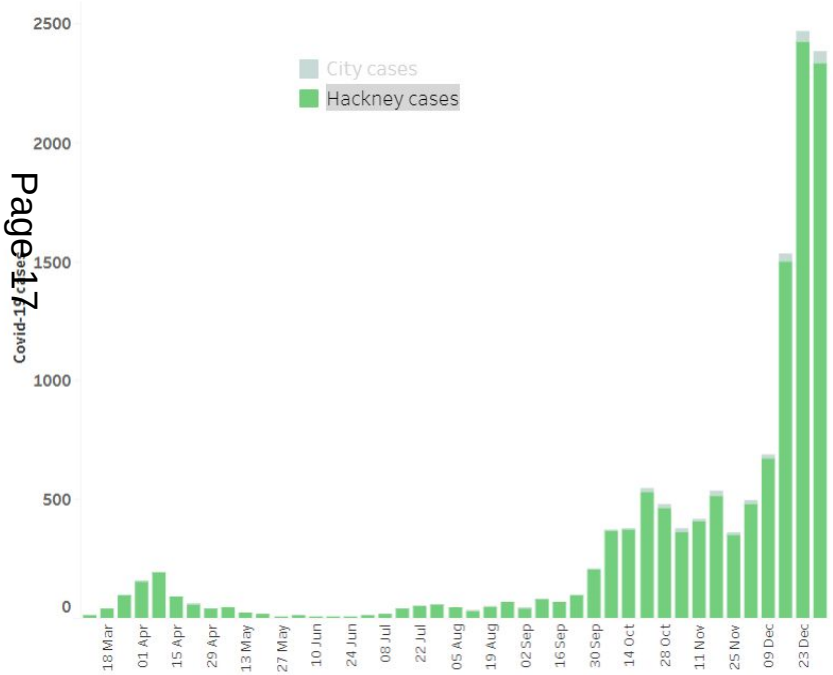
Key messages

- Due to the rising number of COVID-19 cases, deaths and an increasing pressure on the NHS, a national lockdown has been imposed from 6 January until at least mid-February.
- Hackney COVID-19 incidence rate as well as the test positivity rate has risen sharply throughout December.
- Most worryingly, the rates among the older residents have increased significantly in the past weeks.
- These factors have led to an increase in COVID-related hospital admissions and the critical care at the Homerton Hospital is now at full capacity.
- Testing capacity in Hackney has improved significantly and there is now lateral flow testing as well as the PCR testing available.
- Local contact tracing work continues to improve the overall success rates in reaching COVID-positive residents.
- A new IT system is being developed in order to facilitate case and outbreak management.

Hackney

The number of COVID-19 cases in Hackney started to increase from October, in December there was a sharp rise in new cases

New Hackney COVID-19 cases by week, up to 30 December

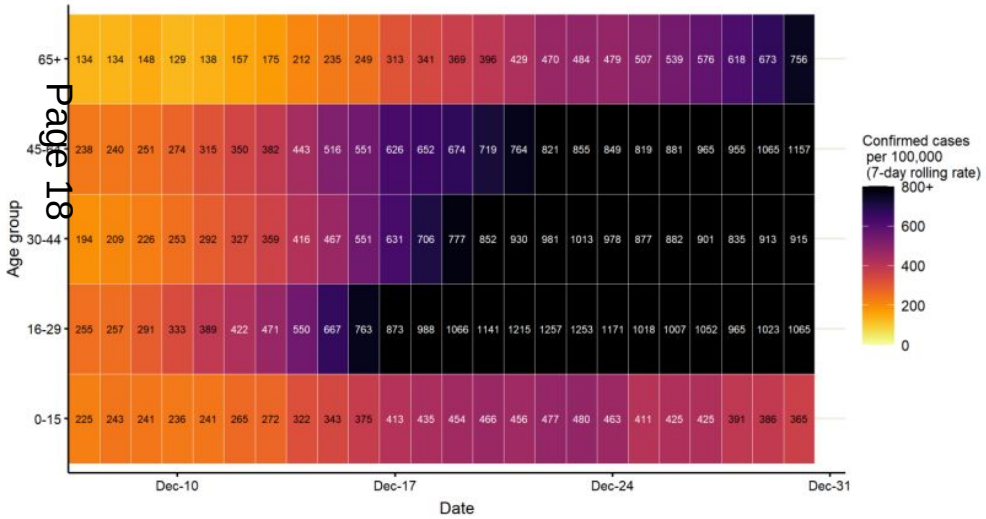


- The number of new COVID-19 cases has risen sharply in the past week coinciding with the emergence of the new, more infectious, variant of the virus.
- It is estimated that in London around 70% of all cases can now be attributed to the new variant.
- The test positivity rate has also increased significantly in the last weeks with a current rate of about 25%.
- Hackney incidence rate is now over 800 per 100,000 population which is lower than the overall London rate of around 900 per 100,000.
- The testing rates have been increasing throughout December, but there was a drop of around 50% in testing rates during the Christmas period.
- The current testing rate is around 3,800 per 100,000.

Data source: Public Health England. Most recent days subject to reporting delay.

A sharp increase in incidence rate has been recorded for all age groups in the last month

COVID-19 incidence rate by age in Hackney (7 to 30 December)



- The incidence rates in all age groups have increased significantly compared with the rates at the beginning of December:
  - Under 16: 386 vs. 220 per 100,000 respectively (up 75%)
  - 16-29: 1,023 vs. 250 (up 309%)
  - 30-44: 912 vs. 168 (up 443%)
  - 45-64: 1,065 vs. 229 (up 365%)
  - 65+: 673 vs. 129 per 100,000 respectively (up 422%)
- The increase in rates among the older age groups is worrying as these are our most vulnerable residents.

Data source: Public Health England. Most recent days subject to reporting delay.

Increase in COVID-19 cases has resulted in an increasing number of hospital admissions, NHS staff absences and COVID-19 deaths

Homerton Hospital general and critical COVID-19 bed occupancy and COVID-related staff absences

Latest Value	Weekly Change	Weekly Change (%)
50%	6.8%	16%

Latest Value	Weekly Change	Weekly Change (%)
47%	1.5%	3%

NOTE: N/A is shown if the % change cannot be

Latest Value	Weekly Change	Weekly Change (%)
108	-40	-27%

- Since the beginning of October and up to 18 of December, 36 residents died from COVID-19.
- It is likely that future weeks will bring more deaths in line with the increasing incidence among older residents and the rising number of COVID patients in critical care.
- In the week up to 31 of December, there were 184 COVID-19 patients at the Homerton Hospital with 23 in critical care.
- Critical care beds at Homerton are near full capacity.
- The number of hospital beds occupied by COVID-19 positive patients has been increasing steeply throughout December.

Data source: NEL Leading Indicators Dashboard.

Overview of testing channels in Hackney

Aims and Purpose of Testing

DIAGNOSIS Confirmation of diagnosis in clinical management (such as in hospitals)

DETECTION Identification of cases of COVID-19 for purposes of specific action to prevent viral spread

SURVEILLANCE Determine circulating disease levels and inform policy decisions for population health measures

PILOTING Asymptomatic testing to: find cases; protect vulnerable people; enable economic/social activity

Overview of testing channels in Hackney

Pillar 1 - PCR Tests in PHE, NHS, LAMP Tests

Symptomatic patients
Symptomatic NHS frontline staff and household members
Support outbreak situations
Asymptomatic patients to support resumption of elective care, inpatient care and discharge planning

Pillar 2 - PCR Mass Symptomatic Testing and regular testing

Book online or call 119
2 Mobile Testing Units
Hackney Marshes and Egerton Road.
2 MTUs in schools before Christmas in collaboration with military personnel.
3 Local Test Stations (LTS') open 7 days a week from 8am to 8pm.
Home Test Kits
CQC Care Homes and Domiciliary Workers
GP Surgeries and Satellites.

Pillar 2 - Community Rapid Asymptomatic Testing

The roll out of Lateral Flow Tests in schools and smaller pilots in settings such as housing for people with learning disabilities

1 Rapid Test Centre: 18 Edwards Lane, Stoke Newington, open 7 days a week, 10am to 7pm.

More rapid test centres planned prioritising essential workers and early years settings

Areas of future focus - Symptomatic and Asymptomatic Testing

Accessible, timely testing and isolation of **symptomatic cases** makes the largest contribution towards reducing onward transmission. Maximising the accessibility and take up of PCR swab testing remains a key priority. Offering timely and adequate support to those who face financial, medical or psychosocial difficulties in self-isolating.

More work needs to be done to **understand factors associated with testing uptake**, to inform actions focused on maximising symptomatic testing.

Test turnaround times have improved across all channels and must **continue to be optimised.**

Mobilise **asymptomatic Community Testing** across the city, in response to exponential epidemic growth. To deploy scaled up testing of asymptomatic individuals in a way that best suits and responds to the needs of Hackney's communities, to gain insight into where rapid testing supports the end to end process of testing, tracing and isolating - such as for essential workers

Local Contact Tracing

- The NHS Test and Trace system started operating on the 28 of May. This is supplemented by local contact tracing, which was implemented 22nd September 2020. This is a 7 day service.
- Cases which fail to be contacted by the national team are followed up locally. To date, over **1,500 cases** have been transferred to our local team, and around 43% are successfully completed. This takes the success rate across City and Hackney to around **85% to 90%** most weeks.
- The team consists of EHOs in the City of London, and trained individuals from Hackney customer service centre. The service is overseen by the public health team, and is supported by Public Health England.
- A new IT system ***Here to Help*** **is in development** to facilitate case and outbreak management which will be shared across the City and Hackney. This system ties together several elements of our Coronavirus response - shielding, welfare, helpline and contact tracing.
- In Hackney, **daily case reviews have been implemented**, with cases assessed jointly by the tracing team, Environmental Health, and Public Health. These identify issues of concern that require follow up.
- We are developing a **training framework** based on experience of contact tracers to date, learning from colleagues in other local authorities, and material from PHE

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Hackney

Health in Hackney Scrutiny Commission 6th January 2021 **North East London system response to the national consultation on Integrated Care Systems**	Item No **6**

OUTLINE

On 26 November NHS England launched a consultation on the next steps for Integrated Care Systems in England. It closes on 8 Jan 2021. City and Hackney's Integrated Care Board Members are contributing to a single formal response from the NEL system.

NHS England is asking respondents to choose one of two possible options for enshrining ICSs in legislation, without triggering a distracting (their words) top-down re-organisation:

Option 1: a statutory committee model with an Accountable Officer that binds together current statutory organisations.

Option 2: a statutory corporate NHS body model that additionally brings CCG statutory functions into the ICS. (their preferred option)

Attached please find:

1.) *Integrated Care – next steps to building strong and effective Integrated Care Systems across England* – the consultation document from NHSE
2.) East London Health and Care Partnership's summary of the proposals and comments on implications and next steps, which went to the December meeting of City & Hackney ICB
3.) A briefing to City and Hackney's ICBs on the transitional governance plans from January (for their Dec meeting)
4.) NHS Providers produced a briefing on 26 Nov setting out their own position on the changes

Invited for this item are the Chair and MD or City and Hackney CCG and the Cabinet Member for Health, Social Care and Leisure

ACTION

The Commission is requested to give consideration to the briefing and make any recommendations as necessary to the Cabinet Member.

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Integrating care

Next steps to building strong and effective integrated care systems across England

Contents

Introduction

This document builds on previous publications that set out proposals for legislative reform and is primarily focused on the operational direction of travel. It opens up a discussion with the NHS and its partners about how ICSs could be embedded in legislation or guidance. Decisions on legislation will of course then be for Government and Parliament to make.

This builds on the route map set out in the *NHS Long Term Plan*, for health and care joined up locally around people's needs. It signals a renewed ambition for how we can support **greater collaboration** between partners in health and care systems to help accelerate progress in meeting our most critical health and care challenges.

It details how systems and their constituent organisations will accelerate **collaborative ways of working** in future, considering the key components of an effective integrated care system (ICS) and reflecting what a range of local leaders have told us about their experiences during the past two years, including the immediate and long-term challenges presented by the COVID-19 pandemic.

These are significant new steps towards the ambition set out in the *NHS Long Term Plan*, building on the experience of the earliest ICSs and other areas. Our challenge now is to spread their experience to every part of England. From April 2021 this will require all parts of our health and care system to work together as Integrated Care Systems, involving:

- Stronger **partnerships in local places** between the NHS, local government and others with a more central role for primary care in providing joined-up care;
- **Provider organisations** being asked to step forward in formal collaborative arrangements that allow them to operate at scale; and
- Developing strategic **commissioning** through systems with a focus on population health outcomes;
- The use of **digital and data** to drive system working, connect health and care providers, improve outcomes and put the citizen at the heart of their own care.

This document also describes options for giving ICSs a firmer footing in **legislation** likely to take affect from April 2022 (subject to Parliamentary decision). These proposals sit alongside other recommendations aimed at removing legislative barriers to integration across health bodies and with social care, to help deliver better care and outcomes for patients through collaboration, and to join up national leadership more formally. NHS England and NHS Improvement are inviting views

on these proposed options from all interested individuals and organisations by Friday 8 January.

It builds on, and should be read alongside, the commitments and ambitions set out in the *NHS Long Term Plan* (2019), *Breaking Down Barriers to Better Health and Care (2019)* and *Designing ICSs in England* (2019), and our *recommendations to Government and Parliament for legislative change (2019)*.

1. Purpose

1.1. The NHS belongs to us all[1] and any changes to it must bring clear improvements for our health and care. Since 2018, integrated care systems (ICSs) have begun doing just this, enabling NHS organisations, local councils, frontline professionals and others to join forces to plan and provide around residents' needs as locally as possible.

1.2. By doing this, they have driven a 'bottom-up' response to the big health and care challenges that we and other countries across the world face and have made a real difference to people's lives. They have improved health, developed better and more seamless services and ensured public resources are used where they can have the greatest impact.

1.3. These achievements have happened despite persistent complexity and fragmentation. This document describes how we will simplify support to local leaders in systems, making it easier for them to achieve their ambitions. Our proposals are designed to serve four fundamental purposes:

- improving population health and healthcare;
- tackling unequal outcomes and access;
- enhancing productivity and value for money; and
- helping the NHS to support broader social and economic development.

1.4. The *NHS Long Term Plan* set out a widely supported route map to tackle our greatest health challenges, from improving cancer care to transforming mental health, from giving young people a healthy start in life to closing the gaps in health inequalities in communities, and enabling people to look after their own health and wellbeing.

1.5. The COVID-19 pandemic has given the NHS and its partners their biggest challenge of the past 70 years, shining a light on the most successful approaches to protecting health and treating disease. Vulnerable people need support that is joined up across councils, NHS, care and voluntary organisations; all based on a common understanding of the risks different people face. Similarly, no hospital could rise to the challenge alone, and new pathways have rapidly developed across multiple providers that enable and protect capacity for urgent non-COVID care.

1.6. This has all been backed up by mutual aid agreements, including with local councils, and shared learning to better understand effective response. It has

[1] https://www.gov.uk/government/publications/the-nhs-constitution-for-england

required openness in data sharing, commitment to collaboration in the interests of patients and communities, and agile collective decision-making.

1.7. The significant challenges that face health and care as we recover from the pandemic make it even more important to have strong and thriving systems for the medium term. Important changes were driven by emergency response but must be hard-wired into our future working so that the gains of 2020 can endure. DHSC's 'Busting Bureaucracy: Empowering frontline staff by reducing excess bureaucracy in the health and care system in England' report, published on the 24th November 2020, describes in detail some of these important areas of change. The report found that there are many sources of excess bureaucracy and that these are often exacerbated by duplicative or disproportionate assurance systems and poorly integrated systems at a national, regional and local level. The report also acknowledges that the more levels of hierarchy in a system, the more likely it is that bureaucracy will exist and grow. ICS' therefore have the potential to reduce bureaucracy through increased collaboration, leaner oversight through streamlined assurance structures and smarter data-sharing agreements.

1.8. To deliver the core aims and purposes set out above, we will need to devolve more functions and resources from national and regional levels to local systems, to develop effective models for joined-up working at "place", ensure we are taking advantage of the transformative potential of digital and data, and to embed a central role for providers collaborating across bigger footprints for better and more efficient outcomes. The aim is a progressively deepening relationship between the NHS and local authorities, including on health improvement and wellbeing.

1.9. This reflects three important observations, building on the *NHS Long Term Plan*'s vision of health and care joined up locally around people's needs:

- **decisions taken closer to the communities** they affect are likely to lead to better outcomes;
- **collaboration between partners in a place** across health, care services, public health, and voluntary sector can overcome competing objectives and separate funding flows to help address health inequalities, improve outcomes, and deliver joined-up, efficient services for people; and
- **collaboration between providers** (ambulance, hospital and mental health) across larger geographic footprints is likely to be more effective than competition in sustaining high quality care, tackling unequal access to services, and enhancing productivity.

1.10. This takes forward what leaders from a range of systems have told us about their experiences during the past two years.

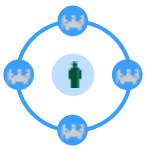
Devolution of functions and resources

1.11. Joining up delivery is not enough on its own. In many areas, we can shift national or regional resources and decision-making so that these are closer to the people they serve. For example, it will make sense to plan, commission and organise certain specialised services at ICS level, and to devolve a greater share of primary care funding and improvement resource to this more local level.

1.12. ICSs also need to be able to ensure collectively that they are addressing the right priorities for their residents and using their collective resources wisely. They will need to work together across partners to determine:

- **distribution of financial resources** to places and sectors that is targeted at areas of greatest need and tackling inequalities;
- **improvement and transformation resource** that can be used flexibly to address system priorities;
- **operational delivery** arrangements that are based on collective accountability between partners;
- **workforce planning, commissioning and development** to ensure that our people and teams are supported and able to lead fulfilling and balanced lives;
- **emergency planning and response** to join up action at times of greatest need; and
- the use of **digital and data** to drive system working and improved outcomes.

"Place": an important building block for health and care integration



1.13. For most people their day-to-day care and support needs will be expressed and met locally in the place where they live. An important building block for the future health and care system is therefore at '**place**.'

1.14. For most areas, this will mean long-established local authority boundaries (at which joint strategic needs assessments and health and wellbeing strategies are made). But the right size may vary for different areas, for example reflecting where meaningful local communities exist and what makes sense to all partners. Within each place, services are joined up through primary care networks (PCNs) integrating care in neighbourhoods.

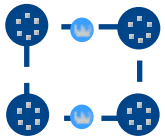
1.15. Our ambition is to create an **offer to the local population of each place**, to ensure that in that place everyone is able to:

- access clear advice on **staying well**;
- access a range of **preventative services**;
- access **simple, joined-up care and treatment** when they need it;
- access digital services (with non-digital alternatives) that put the citizen at the heart of their own care;
- access proactive support to keep as well as possible, where they are **vulnerable or at high risk**; and to
- expect the NHS, through its employment, training, procurement and volunteering activities, and as a major estate owner to play a full part in **social and economic development** and **environmental sustainability**.

1.16. This offer will be met through providers of primary care, community health and mental health services, social care and support, community diagnostics and urgent and emergency care working together with meaningful delegated budgets to join up services. It will also allow important links to be made to other public or voluntary services that have a big impact on residents' day-to-day health, such as by improving local skills and employment or by ensuring high-quality housing.

1.17. Delivery will be through NHS providers, local government, primary care and the voluntary sector working together in each place in ICSs, built around primary care networks (PCNs) in neighbourhoods.

Developing provider collaboration at scale



1.18. At some times, many people will have more complex or acute needs, requiring specialist expertise which can only be planned and organised effectively over a larger area than 'place'. This may be because concentrating skills and resources in bigger sites improves quality or reduces waiting times; because it is harder to predict what smaller populations will need; or because scale working can make better use of public resources.

1.19. Because of this, some services such as hospital, specialist mental health and ambulance needs to be organised through **provider collaboration** that operates at a whole-ICS footprint – or more widely where required.

1.20. We want to create an **offer that all people served by an ICS** are able to:

- access a full range of high-quality acute hospital, mental health and ambulance services; and
- experience fair access to these services, based on need and not factors such as geography, race or socio-economic background.

1.21. We also need to harness the involvement, ownership and innovation of clinicians, working together to design more integrated patient pathways horizontally across providers and vertically within local place-based partnerships.

2. Putting this into practice

2.1. There are many good examples of recent system working that have improved outcomes and productivity, and helped to address inequalities. But COVID has made the case for a step up in scope and ambition. NHS and local government are increasingly pressing for a more driven and comprehensive roll out of system working.

2.2. So, in this section we set out a series of practical changes which will need to be in place by April 2022 at the latest, to make a consistent transition to system working focused on further devolution to systems, greater partnership working at place and closer collaboration between providers on a larger footprint. The main themes are:

1. Provider collaboratives
2. Place-based partnerships
3. Clinical and professional leadership
4. Governance and accountability
5. Financial framework
6. Data and digital
7. Regulation and oversight
8. How commissioning will change

2.3. We will support preparatory work during 2021/22 with further guidance for systems and in the NHS Operational Planning Guidance for 2021/22.

Provider collaboratives

2.4. Provider organisations will play an **active and strong leadership role** in systems. Through their mandated representation in ICS leadership and decision-making, they will help to set system priorities and allocate resources.

2.5. **Providers will join up services across systems.** Many of the challenges that systems face cannot be solved by any one organisation, or by any one provider. Joining up the provision of services will happen in two main ways:

- **within places** (for example, between primary, community, local acute, and social care, or within and between primary care networks) through place-based partnerships as described above ('vertical integration'); and

- **between places** at scale where similar types of provider organisation share common goals such as reducing unwarranted variation, transforming services, providing mutual aid through a formal provider collaborative arrangement ('horizontal integration' – for example, through an alliance or a mental health provider collaborative).

2.6. **All NHS provider trusts will be expected to be part of a provider collaborative**. These will vary in scale and scope, but all providers must be able to take on responsibility for acting in the interests of the population served by their respective system(s) by entering into one or more formal collaboratives to work with their partners on specific functions.

2.7. This greater co-ordination between providers at scale can support:

- higher quality and more sustainable services;
- reduction of unwarranted variation in clinical practice and outcomes;
- reduction of health inequalities, with fair and equal access across sites;
- better workforce planning; and
- more effective use of resources, including clinical support and corporate services.

2.8. For provider organisations operating across a large footprint or for those working with smaller systems, they are likely to create **provider collaboratives that span multiple systems** to provide an effective scale to carry out their role.

2.9. For ambulance trusts specifically we would expect collaboration and integration at the right scale to take place. This should operate at scale to plan resources and join up with specialist providers, and at a more local level in places where focused on the delivery and redesign with other partners of urgent and emergency care pathways.

2.10. We want to spread and build on good work of this type already under way. The partnerships that support this collaboration (such as provider alliances) often take place on a different footprint to ICS boundaries. This should continue where clinically appropriate, with NHS England and NHS Improvement helping to ensure consistent and coherent approaches across systems, especially for smaller partnerships.

2.11. Local flexibility will be important but providers in every system, through partnership or any new collaborative arrangements, must be able to:

- deliver relevant programmes on behalf of all partners in the system;
- agree proposals developed by clinical and operational networks, and implement resulting changes (such as implementing standard

operating procedures to support agreed practice; designating services to ensure their sustainability; or wider service reconfiguration);

- challenge and hold each other to account through agreed systems, processes and ways of working, e.g. an open-book approach to finances/planning;
- enact mutual aid arrangements to enhance resilience, for example by collectively managing waiting lists across the system.

2.12. In some systems, larger providers may also choose to use their scale to host functions on behalf of other system partners.

2.13. NHS England and NHS Improvement will set out further guidance in early 2021, describing a number of potential models for provider collaboratives, based on those that have been established in some parts of the country, including looser federations and more consolidated forms.

2.14. We know that providers are already making progress towards effective, collaborative working arrangements despite the constraints of relevant legislation and frameworks. Indeed, many crucial features of strong system working – such as trust between partners, good leadership and effective ways of working – cannot be legislated for.

But we recognise that these could be supported by changes to legislation, including the introduction of a 'triple aim' duty for all NHS providers to help align priorities, and the establishment of ICSs as statutory bodies with the capacity to support population-based decision-making and to direct resources to improve service provision. Our recommendations for this are set out in part 3.

2.15. Systems will continue to play an increasingly important role in developing multidisciplinary leadership and talent, coordinating approaches to recruiting, retaining and looking after staff, developing an agile workforce and making best use of individual staff skills, experience and contribution.

2.16. From April 2022, this will include:

- developing and supporting a 'one workforce' strategy in line with the NHS People Plan and the People Promise, to improve the experience of working in the NHS for everyone;
- contributing to a vibrant local labour market, with support from partner organisations and other major local employers, including the care home sector and education and skills providers.
- enabling employees to have rewarding career pathways that span the entire system, by creating employment models, workforce sharing arrangements and passporting or accreditation systems that enable

their workforce to be deployed at different sites and organisations across (and beyond) the system, and sharing practical tools to support agile and flexible working;

- valuing diversity and developing a workforce and leadership which is representative of the population it serves; and
- supporting organisational and leadership development at all levels, including talent management. This should encompass investment in, and the development of improvement expertise.

Place-based partnerships

2.17. In many places, there are already **strong and effective place-based partnerships** between sectors. Every area is different, but common characteristics of the most successful are the full involvement of all partners who contribute to the place's health and care; an important role for local councils (often through joint appointments or shared budgets); a leading role for clinical primary care leaders through primary care networks; and a clear, strategic relationship with health and wellbeing boards.

2.18. The place leader on behalf of the NHS, as set out above, will work with partners such as the local authority and voluntary sector in an inclusive, transparent and collaborative way. They will have four main roles:

- to support and develop primary care networks (PCNs) which join up primary and community services across local neighbourhoods;
- to simplify, modernise and join up health and care (including through technology and by joining up primary and secondary care where appropriate);
- to understand and identify – using population health management techniques and other intelligence – people and families at risk of being left behind and to organise proactive support for them; and
- to coordinate the local contribution to health, social and economic development to prevent future risks to ill-health within different population groups.

2.19. Systems should ensure that each place has **appropriate resources, autonomy and decision-making capabilities** to discharge these roles effectively, within a clear but flexible accountability framework that enables collaboration around funding and financial accountability, commissioning and risk management. This could include places taking on delegated budgets.

2.20. Partnerships within local places are important. Primary care networks in neighbourhoods and thriving community networks are also provider collaboratives, and for integration to be successful we will need primary care

working with community, mental health, the voluntary sector and social care as close to where people live as possible.

2.21. The exact division of responsibilities between system and place should be based on the principle of subsidiarity – with the system taking responsibility only for things where there is a clear need to work on a larger footprint, as agreed with local places.

The NHS's offer to local government

2.22. We will work much more closely with local government and the voluntary sector at place, to ensure local priorities for improved health and care outcomes are met by the NHS becoming a more effective partner in the planning, design and delivery of care. This will ensure residents feel well supported, with their needs clearly understood; and with services designed and delivered in the most effective and efficient way for each place.

2.23. As ICSs are established and evolve, this will create opportunities to further strengthen partnership working between local government, the NHS, public health and social care. Where partnership working is truly embedded and matured, the ability to accelerate place-based arrangements for local decision-making and use of available resources, such as delegated functions and funding, maximises the collective impact that can be achieved for the benefit of residents and communities.

Clinical and professional leadership

2.24. Clinical and other frontline staff have led the way in working across professional and institutional boundaries, and they need to be supported to continue to play a significant leadership role through systems. ICSs should embed **system-wide clinical and professional leadership** through their partnership board and other governance arrangements, including **primary care network** representation.

2.25. **Primary care clinical leadership** takes place through critical leadership roles including:

- Clinical directors, general practitioners and other clinicians and professionals in primary care networks (PCNs), who build partnerships in **neighbourhoods** spanning general practice, community and mental health care, social care, pharmacy, dentistry, optometry and the voluntary sector.
- Clinical leaders representing primary care in **place-based partnerships** that bring together the primary care provider leadership role in federations and group models

- A primary care perspective at system level.

2.26. **Specialist clinical leadership** across secondary and tertiary services must also be embedded in systems. Existing **clinical networks** at system, regional and national level have important roles advising on the most appropriate models and standards of care, in particular making decisions about clinical pathways and clinically-led service change. System-wide clinical leadership at an ICS and provider collaborative footprint through clinical networks should:

- be able to carry out clinical service strategy reviews on behalf of the ICS;
- develop proposals and recommendations that can be discussed and agreed at wider decision-making forums; and
- include colleagues from different professional backgrounds and from different settings across primary care, acute, community and mental health care.

2.27. **Wider clinical and professional leadership** should also ensure a strong voice for the wide range of skills and experience across systems. From nursing to social care, from allied health professionals to high street dentists, optometrists and pharmacists, and the full range of specialisms and care settings, people should receive services designed and organised to reflect the expertise of those who provide their care.

Governance and public accountability

2.28. Systems have told us from recent experience that good partnership working must be underpinned by mutually-agreed governance arrangements, clear collective decision-making processes and transparent information-sharing.

2.29. In the *NHS Long Term Plan* and *NHS planning and contracting guidance for 2020/21*, we described a set of consistent operating arrangements that all systems should put in place by 2021/22. These included:

- system-wide governance arrangements (including a system partnership board with NHS, local councils and other partners represented) to enable a collective model of responsibility and decision-making;
- quality governance arrangements, notably a quality lead and quality group in systems, focused on assurance, planning and improvement;
- a leadership model for the system, including an ICS leader with sufficient capacity and a chair appointed in line with NHSEI guidance; and
- agreed ways of working with respect to financial governance and collaboration.

2.30. ICSs now need to put in place firmer governance and decision-making arrangements for 2021/22, to reflect their growing roles and responsibilities. With the below consistent framework, these should be flexible to match local needs.

2.31. As part of this, each system should define:

- **'place' leadership** arrangements. These should consistently involve:
    i. every locally determined 'place' in the system operating a partnership with joined-up decision-making arrangements for defined functions;
    ii. the partnership involving, at a minimum, primary care provider leadership, local authorities, including Director of Public Health and providers of community and mental health services and Healthwatch;
    iii. agreed joint decision-making arrangements with local government; and
    iv. representation on the ICS board.

  They may flexibly define:

    i. the configuration, size and boundaries of places which should reflect meaningful communities and scale for the responsibilities of the place partnership;
    ii. additional membership of each place partnership that is likely to include acute providers, ambulance trusts, the voluntary sector and other partners;
    iii. the precise governance and decision-making arrangements that exist within each place; and
    iv. their voting arrangements on the ICS board.

- **provider collaborative leadership** arrangements for providers of more specialist services in acute and mental health care. These should consistently involve:
    i. every such provider in a system operating as part of one or more agreed provider collaboratives with joined up decision-making arrangements for defined functions;
    ii. provider collaboratives represented on the appropriate ICS board(s).

  They may flexibly define:

    i. the scale and scope of provider collaboratives. For smaller systems, provider collaboratives are likely to span multiple systems and to be represented on the board of each. These arrangements should reflect a meaningful scale for their responsibilities;

ii. the precise membership of each collaborative (acute providers, specialist providers, ambulance trusts at an appropriate footprint, mental health providers);

iii. the precise governance and decision-making arrangements that exist within each collaborative; and

iv. their voting arrangements on the ICS board.

- **individual organisation** accountability within the system governance framework. This will consistently involve:

  i. the responsibility and accountability of the individual provider organisations for their current range of formal and statutory responsibilities (which are unchanged); and

  ii. the accountability relationship between the provider organisation and all place-based partnerships and provider collaboratives of which it is a member.

  It may flexibly define:

  iii. Any lead provider responsibility that the organisation holds on behalf of a place partnership or a provider collaborative.

2.32. Integrated care systems draw their strength from the effectiveness of their constituent parts. Their governance should seek to minimise levels of decision-making and should set out defined responsibilities of organisations, partnerships at place, provider collaboratives and the core ICS role. Each ICS should seek to ensure that all the relevant bodies feel ownership and involvement in the ICS.

2.33. The local test for these governance arrangements is whether they enable joined-up work around a shared purpose. Provider collaboratives and place-based partnerships should enable peer support and constructive challenge between partners delivering services and accelerate partners' collective ability to improve services in line with agreed priorities.

2.34. The greater development of working at place will in many areas provide an opportunity to align decision-making with local government, including integrated commissioning arrangements for health and social care, and local responsiveness through health and wellbeing boards. There is no one way to do this, but all systems should consider how the devolution of functions and capabilities to systems and places can be supported by robust governance arrangements.

2.35. ICS governance is currently based on voluntary arrangements and is therefore dependent on goodwill and mutual co-operation. There are also legal constraints on the ability of organisations in an ICS to make decisions jointly. We have previously made a number of recommendations for legislative change to Government and Parliament to increase flexibility in decision making by enabling decision making joint committees of both

commissioners and providers and also committees of Providers. Section 3 of this document captures these options and also describes our thinking on clarifying arrangements for an ICS.

2.36. Many systems have shown great ways to involve and take account of the views and priorities of local residents and those who use services, as a 'golden thread' running through everything they do. During 21/22, every ICS should work to develop systematic arrangements to involve lay and resident voices and the voluntary sector in its governance structures, building on the collective expertise of partners and making use of pre-existing assets and forums such as Healthwatch and citizen's panels.

2.37. In particular, governance in ICSs should involve all system partners in the development of service change proposals, and in consulting and engaging with local people and relevant parts of local government (such as with overview and scrutiny committees and wider elected members) on these. It should appropriately involve elected councillors, and other local politicians such as metro mayors where relevant, and reflect transparency in wider decision-making.

2.38. Each system should also be able to show how it uses public involvement and insight to inform decision-making, using tools such as citizens' panels, local health champions, and co-production with people with lived experience. Systems should make particular efforts to understand and talk to people who have historically been excluded.

Financial framework

2.39. In order that the collective leadership of each ICS has the best possible opportunity to invest in and deliver joined-up, more preventative care, tailored to local people's needs, we will increasingly **organise the finances of the NHS at ICS level** and put **allocative decisions in the hands of local leaders**. We are clear that we want ICSs to be key bodies for financial accountability and financial governance arrangements will need to reflect that. NHSEI will update guidance to reflect these changes.

2.40. That means that we will **create a 'single pot**,' which brings together current CCG commissioning budgets, primary care budgets, the majority of specialised commissioning spend, the budgets for certain other directly commissioned services, central support or sustainability funding and nationally-held transformation funding that is allocated to systems.

2.41. ICS leaders, working with provider collaboratives, must have the freedom – and indeed the duty – to distribute those resources in line with national rules such as the mental health, and the primary and community services investment guarantees and locally-agreed strategies for health and care, for example targeting investment in line with locally-agreed health inequalities

priorities, or responding flexibly as new, more preventative services are developed and patient journeys change.

2.42. ICS leaders will also have a duty to ensure that they deploy the resources available to them in order to protect the future sustainability of local services, and to ensure that their health and care system consumes their fair share of resources allocated to it.

2.43. It also means that ICS leaders will be expected to use new freedoms to delegate significant budgets to 'place' level, which might include resources for general practice, other primary care, community services, and continuing healthcare. Similarly, through active involvement at place level, providers will have a greater say in how transformation funding is deployed. Decisions about the use of all of these budgets will usually be made at the lowest possible level, closest to those communities they serve and in partnership with their local authority. New powers will make it easier to form joint budgets with the local authority, including for public health functions.

2.44. Providers will through their role in ICS leadership have the opportunity to shape the strategic health and care priorities for the populations they serve, and new opportunities – whether through lead provider models at place level or through fully-fledged integrated care provider contractual models – to determine how services are funded and delivered, and how different bodies involved in providing joined-up care work together.

2.45. We will deliver on the commitment set out in the Long Term Plan to mostly move away from episodic or activity-based payment, rolling out the blended payment model for secondary care services. This will ensure that provider collaboratives have greater certainty about the resources available to them to run certain groups of services and meet the needs of particular patient groups. Any variable payments will be funded within the ICS financial envelope, targeted to support the delivery of locally-identified priorities and increasingly linked to quality and outcomes metrics. Each ICS will be expected to agree and codify how financial risk will be managed across places and between provider collaboratives.

2.46. These changes will reduce the administrative, transactional costs of the current approach to commissioning and paying for care, and release resources for the front line - including preventative measures - that can be invested in services that are planned, designed and delivered in a more strategic way at ICS level. This is just one way in which we will ensure that each ICS has to capacity and capability to take advantage of the opportunities that these new approaches offer.

2.47. Finally, we will further embed reforms to the capital regime introduced in 2019/20 and 2020/21, bringing together at ICS level responsibility for allocating capital envelopes with responsibility for allocating the revenue

budgets which fund day-to-day services. This will ensure that capital investment strategies:

- are not only coordinated between different NHS providers, but also aligned with local authorities' management of their estates and wider assets;
- reflect local judgments about the balance between competing priorities for capital expenditure; and
- give priority to those investments which support the future sustainability of local services for future generations.

2.48. We will set out in the 2021/22 planning guidance how we will support ICSs to begin operating more collective financial governance in 2021/22 and to prepare for the powers and duties set out above.

Data and Digital

2.49. Data and digital technology have played a vital role helping the NHS and care respond to the pandemic. They will be at the heart of creating effective local systems, helping local partners in health and social care work together. They can help improve productivity and patient outcomes, reduce bureaucracy, drive service transformation and stimulate improvement and research.

2.50. But digital maturity and data quality is variable across the health and care. Data has too often been held in siloes, meaning that clinicians and care professionals do not have easy access to all of the information that could be useful in caring for their patients and service users.

2.51. To fulfil the potential of digital and data to improve patient outcomes and drive collaborative working, systems will need to:

(1) build smart digital and data foundations
(2) connect health and care services
(3) use digital and data to transform care
(4) put the citizen at the centre of their care

Build smart digital and data foundations

- Have clear **board accountability** for data and digital, including a member of the ICS Partnership Board being a named SRO.
- Have a system-wide **digital transformation plan.** This should outline the three year journey to digitally-driven, citizen-centred care, and the benefits that digital and data will realise for the system and its citizens.

- Build the **digital and data literacy** of the whole workforce as well as specific digital skills such as user research and service design.

- Invest in the **infrastructure** needed to deliver on the transformation plan. This will include **shared contracts and platforms** to increase resiliency, digitise operational services and create efficiencies, from shared data centres to common EPRs.

Connect health and care services

- Develop or join a **shared care record** joining data safely across all health and social care settings, both to improve direct care for individual patients and service users, and to underpin population health and effective system management.
- Build the tools to allow **collaborative working** and frictionless movement of staff across organisational boundaries, including shared booking and referral management, task sharing, radiology reporting and pathology networks.
- Follow **nationally defined standards** for digital and data to enable integration and interoperability, including in the data architecture and design.

Use digital and data to transform care

- Use digital technology to **reimagine care pathways**, joining up care across boundaries and improving outcomes.

- Develop shared **cross-system intelligence and analytical functions** that use information to improve decision-making at every level, including:

    - actionable insight for frontline teams;
    - near-real time actionable intelligence and robust data (financial, performance, quality, outcomes);
    - system-wide workforce, finance, quality and performance planning;
    - the capacity and skills needed for population health management.
- Ensure **transparency of information** about interventions and the outcomes they produce, to drive more responsive coordination of services, better decision-making and improved research.

Put the citizen at the centre of their care

- Develop a road map for **citizen-centred digital channels** and services, including access to personalised advice on staying well, access to their own data, and triage to appropriate health and care services.

- Roll out **remote monitoring** to allow citizens to stay safe at home for longer, using digital tools to help them manage long-term conditions.

- We want to build on the experience of data sharing during COVID so that data is shared, wherever it can and should be. This will inform the upcoming Department of Health and Social Care Data Strategy. While this will be mainly about embedding a culture of sharing data with appropriate safeguards, we would support legislative change that clarifies that sharing data for the benefit of the whole health and care system is a key duty and responsibility of all health and adult social care organisations. This will require a more flexible legislative framework than currently exists to support further evolution and empower local systems to lead and drive that agenda.

Regulation and oversight

2.52. We have consistently heard that regulation needs to adapt, with more support from national regulators for systems as well as the individual organisations within them, and a shift in emphasis to reflect the importance of partnership working to improve population health.

2.53. Regulation best supports our ambitions where it enables systems and the organisations within them to make change happen. This means a focus on how effective local arrangements are at implementing better pathways, maximising use of collective capacity and resources, and acting in partnership to achieve joint financial and performance standards.

2.54. We have already taken steps to bring together NHS England and NHS Improvement to provide a single, clear voice to the system and our legislative proposals haven't changed – this merger should be formalised in future legislation.

2.55. As a formally merged body, NHS England will of course remain answerable to Parliament and to the Secretary of State for Health and Social Care for NHS performance, finance and healthcare transformation. There will need to be appropriate mechanisms in law to ensure that the newly merged body is responsive and accountable. We envisage Parliament using the legislation to specify the Secretary of State's legal powers of direction in respect of NHS England in a transparent way that nevertheless protects clinical and operational independence.

2.56. There are a further practical steps that we can take to support systems:

- working with the CQC to seek to embed a requirement for strong participation in ICS and provider collaborative arrangements in the "Well Led" assessment;
- issuing guidance under the NHS provider licence that good governance for NHS providers includes a duty to collaborate; and
- ensuring foundation trust directors' and governors' duties to the public support system working.

2.57. We expect to see greater adoption of system- and place- level measurements, which might include reporting some performance data such as patient treatment lists at system level. Next year, we will introduce new measures and metrics to support this, including an 'integration index' for use by all systems.

2.58. The future **System Oversight Framework** will set consistent expectations of systems and their constituent organisations and match accountability for results with improvement support, as appropriate.

2.59. This approach will recognise the enhanced role of systems. It will identify where ICSs and organisations may benefit from, or require, support to help them meet standards in a sustainable way and will provide an objective basis for decisions about when and how NHSEI will intervene in cases where there are serious problems or risks.

The proposed future Intensive Recovery Support Programme will give support to the most challenged systems (in terms of quality and/or finance) to tackle their key challenges. This will enable intervention in response to CQC findings or where other regulatory action is required. This approach enables improvement action and targeted support either at organisation/provider level (with system support) or across a whole system where required and may extend across health and social care, accessing shared learning and good practice between systems to drive improvement.

2.60. Greater collaboration will help us to be more effective at designing and distributing services across a local system, in line with agreed health and care priorities and within the resources available. However there remains an important role for patient choice, including choice between qualified providers, providers outside the geographic bounds of the system and choice of the way in which services need to be joined up around the individual person as a resident or patient including through personal health budgets.

2.61. Our previous recommendations to government for legislation include rebalancing the focus on competition between NHS organisations by reducing the Competition and Market Authority's role in the NHS and

abolishing Monitor's role and functions in relation to enforcing competition. We also recommended regulations made under section 75 of the *Health and Social Care Act 2012* should be revoked and that the powers in primary legislation under which they are made should be repealed, and that NHS services be removed from the scope of the *Public Contracts Regulations 2015*. We have committed to engage openly on how the future procurement regime will operate subject to legislation being brought before Parliament.

How commissioning will change

2.62. Local leaders have repeatedly told us that the commissioning functions currently carried out by CCGs need to become more strategic, with a clearer focus on **population-level health outcomes** and a marked reduction in transactional and contractual exchanges within a system. This significant change of emphasis for commissioning functions means that the organisational form of CCGs will need to evolve.

2.63. The activities, capacity and resources for commissioning will change in three significant ways in the future, building on the experience of the most mature systems:

- Ensuring a single, system-wide approach to undertake **strategic commissioning**. This will discharge core ICS functions, which include:
    - assessing population health needs and planning and modelling demographic, service use and workforce changes over time;
    - planning and prioritising how to address those needs, improving all residents' health and tackling inequalities; and
    - ensuring that these priorities are funded to provide good value and health outcomes.
- Service transformation and pathway redesign need to be done differently. Provider organisations and others, through partnerships at place and in provider collaboratives, become a principal engine of transformation and should agree the future service model and structure of provision jointly through ICS governance (involving transparency and public accountability). Clinical leadership will remain a crucial part of this at all footprints.
- The greater focus on population health and outcomes in contracts and the collective system ownership of the financial envelope is a chance to apply capacity and skills in transactional commissioning and contracting with a new focus. Analytical skills within systems should be applied to better understanding how best to use resources to

improving outcomes, rather than managing contract performance between organisations.

2.64. Many commissioning functions are now **coterminous with ICS boundaries**, and this will need to be consistent across the country before April 2022. Under the legislative provisions recommended in section 3 current CCG functions would subsequently be absorbed to become core ICS business.

2.65. However, with the spread of place-based partnerships backed by devolved funding, simplified accountability, and an approach to governance appropriate to local circumstances along with further devolution of specialised commissioning activity, there will be flexibility for local areas to make full use of the local relationships and expertise currently residing in CCGs.

2.66. Systems should also agree whether individual functions are best delivered at system or at place, balancing subsidiarity with the benefits of scale working. Commissioners may, for example, work at place to complete service and outcomes reviews, allocate resources and undertake needs assessments alongside local authorities. But larger ICSs may prefer to carry out a wider range of functions in their larger places, and smaller ones to do more across the whole system.

2.67. Commissioning support units (CSUs) operate within the NHS family across England, providing services that have been independently evaluated for quality and value for money. We expect that CSUs will continue to develop as trusted delivery partners to ICSs, providing economies of scale which may include joining up with provider back office functions where appropriate and helping to shape services through a customer board arrangement.

Specialised commissioning

2.68. Specialised services are particularly important for the public and patients, with the NHS often working at the limits of science to bring the highest levels of human knowledge and skill to save lives and improve health.

2.69. The national commissioning arrangements that have been in place for these services since 2013 have played a vital role in supporting **consistent, equitable, and fast access for patients** to an ever-expanding catalogue of cutting edge technologies - genomic testing, CAR-T therapy, mechanical thrombectomy, Proton Beam Therapy and CFTR modulator therapies for patients with cystic fibrosis to name just a few.

2.70. But these national commissioning arrangements can sometime mean fragmented care pathways, misaligned incentives and missed opportunities for **upstream investment and preventative intervention**. For example, the split in commissioning responsibilities for mental health services has

potentially slowed the ambition to reduce the number of children admitted for inpatient treatment and, where they are admitted, making sure they are as close to home as possible. Bringing together the commissioning of mental health services has aligned incentives and enabled resources to be moved into upstream services, reducing over-reliance on geographically distant inpatient care.

2.71. Integrated care systems provide an opportunity to further **align the design, development and provision of specialised services with linked care** pathways, where it supports patient care, while maintaining consistent national standards and access policies across the board.

2.72. The following principles will underpin the detailed development of the proposed arrangements:

- ***Principle One: All specialised services, as prescribed in regulations, will continue to be subject to consistent national service specifications and evidence-based policies determining treatment eligibility.*** NHS England will continue to have responsibility for developing and setting these standards nationally and whoever is designated as the strategic commissioner will be expected to follow them. Over time, service specifications will need to become more outcomes focused to ensure that innovative and flexible solutions to unique system circumstances and/or opportunities can be easily adopted. But policies determining eligibility criteria for specific treatments across all specialised services will remain precise and consistently applied across the country.

- ***Principle Two: Strategic commissioning, decision making and accountability for specialised services will be led and integrated at the appropriate population level: ICS, multi-ICS or national.*** For certain specialised services, it will make sense to plan, organise and commission these at ICS level. For others, ICSs will need to come together across a larger geographic footprint to jointly plan and take joint commissioning decisions. And many services, such as those in the highly specialised services portfolio, will continue to be planned and commissioned on a national footprint. Importantly, whichever level strategic commissioning occurs the national standards will apply.

- ***Principle Three: Clinical networks and provider collaborations will drive quality improvement, service change and transformation across specialised services and non-specialised services.*** Clinical networks have long been a feature of the NHS. But, during the COVID pandemic they have become critical in supporting innovation and system wide collaboration. Looking ahead they will be supported to drive clinically-led change and service improvement with even greater

accountability for tackling inequalities and for improving population health.

- ***Principle Four: Funding of specialised services will shift from provider-based allocations to population-based budgets, supporting the connection of services back to 'place'.*** We are considering from April 2021 allocating budgets on a population basis at regional level and are considering the best basis for allocating funding and will provide further information in due course. In this first year, adjustments will then be made to neutralise any changes in financial flows and ensure stability. We intend to publish a needs-based allocation formula, before using it to inform allocations against an agreed pace of change in future years. A needs-based allocations formula will further strengthen the focus on tackling inequalities and unwarranted variation.

3. Legislative proposals

3.1. The detailed policy work described above will be necessary to deliver our vision but will not by itself be sufficient. While legislation is only part of the answer, the existing legislation (*the National Health Service Act 2006 and the Health and Social Care Act 2012* does not present a sufficiently firm foundation for system working.

3.2. In September 2019, NHSEI made a number of recommendations for an NHS Bill[2]. These aimed to remove current legislative barriers to integration across health and social care bodies, foster collaboration, and more formally join up national leadership in support of the ambitions outlined above.

3.3. Recommendations included:

- rebalancing the focus on **competition** between NHS organisations by reducing the Competition and Markets Authority's role in the NHS and abolishing Monitor's role and functions in relation to enforcing competition;
- simplifying **procurement** rules by scrapping section 75 of the 2012 Act and remove the commissioning of NHS healthcare services from the jurisdiction of the Public Contracts Regulations 2015;
- providing increased flexibilities on **tariff**;
- reintroducing the ability to establish **new NHS trusts** to support the creation of integrated care providers;
- ensuring a more coordinated approach to planning **capital investment**, through the possibility of introducing FT capital spend limits;
- the ability to establish decision-making **joint committees** of commissioners and NHS providers and between NHS providers;
- enabling **collaborative commissioning** between NHS bodies – it is currently easier in legislative terms for NHS bodies and local authorities to work together than NHS bodies;
- a new "**triple aim**" duty for all NHS organisations of 'better health for the whole population, better quality care for all patients and financially sustainable services for the taxpayer; and

2 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/875711/The_government_s_2020-2021_mandate_to_NHS_England_and_NHS_Improvement.pdf

- **merging NHS England and NHS Improvement** – formalising the work already done to bring the organisations together.

3.4. These recommendations were strongly supported and backed across the health and social care sector[3]. We believe these proposals still stand.

3.5. One of the key considerations in our recommendations was how, and to what extent, ICSs should be put on a statutory footing. Responses to our engagement were ultimately mixed – balancing the relatively early stage of development of some ICSs against a desire to enable further progress and to put ICSs on a firmer footing.

3.6. At the time, we proposed a new statutory underpinning to establish ICS boards through voluntary joint committees, an entity through which members could delegate their organisational functions to its members to take a collective decision. This approach ensured support to those systems working collectively already and a future approach to those systems at an earlier stage of development.

3.7. Many respondents to our engagement and specifically Parliament's Health and Social Care Select Committee raised a number of questions as to whether a voluntary approach would be effective in driving system working. There was particular focus on those areas at an earlier stage of their development and whether a voluntary model offered sufficient clarity of accountability for health outcomes and financial balance both to parliament and more directly to the public.

3.8. The response of the NHS and its partners to COVID-19 and a further year of ICS development has increased the appetite for statutory "clarity" for ICSs and the organisations within them. With an NHS Bill included in the last Queen's Speech, we believe the opportunity is now to achieve clarity and establish a "future-proofed" legislative basis for ICSs that accelerates their ability to deliver our vision for integrated care.

3.9. We believe there are two possible options for enshrining ICSs in legislation, without triggering a distracting top-down re-organisation:

Option 1: a statutory committee model with an Accountable Officer that binds together current statutory organisations.

Option 2: a statutory corporate NHS body model that additionally brings CCG statutory functions into the ICS.

[3] https://www.aomrc.org.uk/wp-content/uploads/2019/09/190926_Support_letter_NHS_legislation_-proposals.pdf

3.10. Both models share a number of features – broad membership and joint decision-making (including, as a minimum, representatives from commissioners; acute, community and primary care providers; and local authorities); responsibility for owning and driving forward the system plan; operating within and in accordance with the triple aim duty; and a lead role in relating to the centre.

Option 1 – a statutory ICS Board/ Joint Committee with an Accountable Officer

3.11. This option is closer to our original proposal. It would establish a mandatory, rather than voluntary, statutory ICS Board through the mechanism of a joint committee and enable NHS commissioners, providers and local authorities to take decisions collectively.

3.12. Unlike previously proposed versions of this model it would have a system Accountable Officer, chosen from the CEOs/AOs of the Board's mandatory members. This Accountable Officer would not replace individual organisation AOs/CEOs but would be recognised in legislation and would have duties in relation to delivery of the Board's functions. There would be a duty for the Board to agree and deliver a system plan and all members would have an explicit duty to comply with it.

3.13. In accordance with our stated ambition, there would be one aligned CCG only per ICS footprint under this model, and new powers would allow that CCGs are able to delegate many of its population health functions to providers.

3.14. This option retains individual organisational duties and autonomy and relies upon collective responsibility. Intervention against individual NHS organisations (not working in the best interests of the system) would continue to be enhanced through the new triple aim duty and a new duty to comply with the ICS plan.

3.15. The new Accountable Officer role would have duties to seek to agree the system plan and seek to ensure it is delivered and to some extent offer clarity of leadership. However, current accountability structures for CCG and providers would remain.

3.16. There remain potential downsides to this model. In effect, many of the questions raised through our engagement in 2019 about accountability and clarity of leadership would remain. While the addition of an Accountable Officer strengthens this model, there remains less obvious responsibility for patient outcomes or financial matters. Having an ICS Accountable Officer alongside a CCG Accountable Officer may in some cases confuse rather than clarify accountability. The CCG governing body and GP membership is

also retained, and it is questionable whether these are sufficiently diverse arrangements to fulfil the different role required of CCGs in ICSs.

3.17. Furthermore, many may not consider this model to be the “end state” for ICSs and opportunities for primary legislative change are relatively rare. There are therefore strong arguments to go further when considering how the health and care system might evolve over the next ten years and more.

Option 2 – a statutory ICS body

3.18. In this option, ICSs would be established as NHS bodies partly by “re-purposing” CCGs and would – among other duties – take on the commissioning functions of CCGs. Additional functions would be conferred and existing functions modified to produce a new framework of duties and powers.

3.19. The CCG governing body and GP membership model would be replaced by a board consisting of representatives from the system partners. As a minimum it would include representatives of NHS providers, primary care and local government alongside a Chair, a Chief Executive and a Chief Financial Officer. The ICS body should be able to appoint such other members as it deems appropriate allowing for maximum flexibility for systems to shape their membership to suit the needs of their populations. The power of individual organisational veto would be removed. The ICS Chief Executive would be a full-time Accounting Officer role, which would help strengthen lines of accountability and be a key leadership role in ensuring the system delivers.

3.20. The ICS’s primary duty would be to secure the effective provision of health services to meet the needs of the system population, working in collaboration with partner organisations. It would have the flexibility to make arrangements with providers through contracts or by delegating responsibility for arranging specified services to one or more providers.

3.21. This model would deliver a clearer structure for an ICS and avoids the risk of complicated workarounds to deliver our vision for ICSs. Although there would be a representative for primary care on the Board, there would no longer be a conflict of interests with the current GP-led CCG model (created by the 2012 Act) and it could be possible to allocate combined population-level primary care, community health services and specialised services population budgets to ICS.

3.22. Many commissioning functions for which NHSE is currently responsible could, for the most part, be transferred or delegated to the ICS body, but with the ability to form joint committees as proposed through our original recommendations, with NHSE, if and where appropriate.

3.23. Through greater provider involvement, it could also reduce some of the transactional burdens of the current contracting processes. There would be powers for the ICS to delegate responsibility for arranging some services to providers, to create much greater scope for provider collaboration to use whole-population budgets to drive care pathway transformation.

Our approach

3.24. Either model would be sufficiently permissive in legislation to allow different systems to shape how they operate and how best and most appropriately deliver patient care and outcomes support at place.

3.25. Under either model we would want local government to be an integral, key player in the ICS. Both models offer a basis for planning and shaping services across healthcare, social care, prevention and the wider determinants of health. Both would allow for the delegation of functions and money to place-based statutory committees involving NHS bodies and local government. Both would enable NHS and local government to exploit existing flexibilities to pool functions and funds.

3.26. While both models would drive increased system collaboration and achieve our vision and our aims for ICSs in the immediate term, we believe Option 2 is a model that offers greater long term clarity in terms of system leadership and accountability. It also provides a clearer statutory vehicle for deepening integration across health and local government over time. It also provides enhanced flexibility for systems to decide who and how best to deliver services by both taking on additional commissioning functions from NHS England but also deciding with system colleagues (providers and local councils) where and how best service provision should take place.

3.27. Should these proposals be developed further and proposed by Government as future legislation, we would expect a full assessment of the impact of these proposals on equalities and public and parliamentary engagement and scrutiny as is appropriate.

Questions

Q. Do you agree that giving ICSs a statutory footing from 2022, alongside other legislative proposals, provides the right foundation for the NHS over the next decade?

Q. Do you agree that option 2 offers a model that provides greater incentive for collaboration alongside clarity of accountability across systems, to Parliament and most importantly, to patients?

Q. Do you agree that, other than mandatory participation of NHS bodies and Local Authorities, membership should be sufficiently permissive to allow systems to shape their own governance arrangements to best suit their populations needs?

Q. Do you agree, subject to appropriate safeguards and where appropriate, that services currently commissioned by NHSE should be either transferred or delegated to ICS bodies?

4. Implications and next steps

4.1. The ambitious changes set out here are founded on the conviction that collaboration will be a more effective mechanism for transformation against long term population health priorities and also for driving sustainable operational performance against the immediate challenges on quality, access, finance and delivery of outcomes that make difference to people's experience of services today.

4.2. International evidence points to this being the case as across the world health systems change to pursue integration as the means of meeting health needs and improving health outcomes. We have seen this reinforced through our experiences in tackling COVID-19.

4.3. The rapid changes in digital technology adoption, mutual cooperation and capacity management, provision of joined up support to the most vulnerable that have been essential in the immediate response to the pandemic have only been possible through partners working together to implement rapid change as they focus on a shared purpose.

4.4. As we embed the ways of working set out above, partners in every system will be able to take more effective, immediate operational action on:

- managing acute healthcare performance challenges and marshalling collective resource around clear priorities, through provider collaboratives;
- tackling unwarranted variation in service quality, access and performance through transparent data with peer review and support arrangements organised by provider collaboratives;
- using data to understand capacity utilisation across provider collaboratives, equalising access (tackling inequality across the system footprint) and equalising pressures on individual organisations.

The NHS England and NHS Improvement's operating model

4.5. NHSEI will support systems to adopt improvement and learning methodologies and approaches which will enable them to improve services for patients, tackle unwarranted variation and develop cultures of continuous improvement.

4.6. This will be underpinned by a comprehensive support offer which includes:

- access to our national transformation programmes for outpatients and diagnostics;
- support to tackle unwarranted variation and increase productivity (in partnership with the Getting it Right First Time programme);
- the data they need to drive improvement, accessed through the 'model health system';
- the resources and guidance that they need to build improvement capability; and
- assistance from our emergency and electivity intensive support teams (dependent on need).

4.7. Much of this support offer will be made available to systems through regional improvement hubs, which will ensure that improvement resource supports local capacity- and capability-building. Systems will then able to flexibly and rapidly deploy the support into place partnerships and provider collaboratives.

4.8. NHSEI developed a joint operating model during 2019, with input from senior NHS leaders including those in systems and regions, as well as frontline staff and other stakeholders. This resulted in a description of the different ways NHSEI will operate in future, underpinned by a set of principles including subsidiarity, and a set of 'levers of value' that NHSEI can use at national and regional level to support systems.

4.9. NHSEI will continue to develop this operating model to support the vision set out above, and any legislative changes. This will include further evolving how we interact with systems nationally and regionally; and ensuring that its functions are arranged in a way that support and embed system working to deliver our priorities.

4.10. The new operating environment will mean:

- increased freedoms and responsibilities for ICSs, including greater responsibility for system development and performance, as well as greater autonomy regarding assurance.
- the primary interaction between NHSEI and systems will be between regions and the collective ICS leadership, with limited cause for national functions to directly intervene with individual providers within systems.
- as systems take on whole population budgets they will increasingly determine how resource is to be used to 'move the dial' on outcomes, inequalities, productivity and wider social and economic development

against their specific health challenges and population health priorities.

- NHSEI regional teams will become ‘thinner’ as we move direct commissioning responsibility out to systems (individually and collectively). They will increasingly continue to enable systems to take on greater autonomy, working with them to identify their individual development priorities and support needs.

Transition

4.11. The experience of the earliest ICSs shows that great leadership is critical to success and can come from any part of the health and care system. But, to be effective, it must be felt right across, and draw on the talents of leaders from every part of, a system.

4.12. These systems have developed a new style of behaviour, which makes the most of the leadership teams of all constituent organisations and empowers frontline leaders. System leaders have impact through a collaborative and distributive leadership style that operates across boundaries, leading for communities.

4.13. This shared approach to leadership is based on qualities such as openness and transparency, honesty and integrity, a genuine belief in common goals and an ability to build consensus.

4.14. ICSs need to be of sufficient size to carry out their ‘at scale’ activities effectively, while having sufficiently strong links into local communities at a much more local level in places and neighbourhoods.

4.15. Pragmatically we are supporting ICSs through to April 2022 at their current size and scale, but we recognise that smaller systems will need to join up functions, particularly for provider collaboration. We will support the ability for ICSs to more formally combine as they take on new roles where this is supported locally.

4.16. We will work with systems to ensure that they have arrangements in place to take on enhanced roles from April 2022. We will set out a roadmap for this transition that gives assurance over system readiness for new functions as these become statutory.

4.17. We know that under either legislative proposal we need to ensure that we support our staff during organisational change by minimising uncertainty and limiting employment changes. We are therefore seeking to provide stability of employment while enabling a rapid development of role functions and purpose for all our teams, particularly in CCGs directly impacted by legislative Option 2.

4.18. We want to take a different approach to this transition; one that is characterised by care for our people and no distraction from the 'day job': the critical challenges of recovery and tackling population health.

4.19. **Stable employment:** As CCG functions move into new bodies we will make a 'continued employment promise' for staff carrying out commissioning functions. We will preserve terms and conditions to the new organisations (even if not required by law) to help provide stability and to remove uncertainty.

4.20. **New roles and functions:** For many commissioning functions the work will move to a new organisation and will then evolve over time to focus on system priorities and ways of working. The priority will be the continuation of the good work being carried out by the current group of staff and we will promote best practice in engaging, consulting and supporting the workforce during a carefully planned transition, minimising disruption to staff.

4.21. Other functions will be more directly impacted, principally the most senior leaders in CCGs (chief officers and other governing body / board members). ICSs need to have the right talent in roles leading in systems.

4.22. Our commitment is:

- not to make significant changes to roles below the most senior leadership roles;
- to minimise impact of organisational change on current staff during both phases (in paragraphs 4.19 and 4.20 above) by focusing on continuation of existing good work through the transition and not amending terms and conditions; and
- offer opportunities for continued employment up to March 2022 for all those who wish to play a part in the future.

Next steps

4.23. We expect that every system will be ready to operate as an ICS from April 2021, in line with the timetable set out in the *NHS Long Term Plan*. To prepare for this, we expect that each system will, by this time, agree with its region the functions or activities it must prioritise (such as in service transformation or population health management) to effectively discharge its core roles in 2021/22 as set out in this paper.

4.24. All ICSs should also agree a sustainable model for resourcing these collective functions or activities in the long term across their constituent organisations.

4.25. To support all of the above, all systems should agree development plans with their NHSEI regional director that clearly set out:

- **By April 2021:** how they continue to meet the current consistent operating arrangements for ICSs and further planning requirements for the next phase of the COVID-19 response
- **By September 2021:** implementation plans for their future roles as outlined above, that will need to adapt to take into account legislative developments.

4.26. Throughout the rest of 2020, the Department of Health and Social Care and NHSEI will continue to lead conversations with different types of health and care organisations, local councils, people who use and work in services, and those who represent them, to understand their priorities for further policy and legislative change.

4.27. The legislative proposals set out in this document takes us beyond our original legislative recommendations to the government. We are therefore **keen to seek views on these proposed options from all interested individuals and organisations**. These views will help inform our future system design work and that of government should they take forward our recommendations in a future Bill.

4.28. Please submit your response to this address: www.engage.england.nhs.uk/survey/building-a-strong-integrated-care-system

4.29. Alternatively you can also contact england.legislation@nhs.net or write with any feedback to NHS England, PO Box 16738, Redditch, B97 9PT by Friday 8 January.

4.30. For more information about how health and care is changing, please visit: www.england.nhs.uk/integratedcare and sign up to our regular e-bulletin at: www.england.nhs.uk/email-bulletins/integrated-care-bulletin

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East London Health & Care Partnership

The next steps to building strong and effective integrated care systems across England – a summary

NHSE/I November 2020v1.3

Executive Summary

The document signals a renewed ambition for how we can support greater collaboration between partners in health and care systems to help accelerate progress in meeting our most critical health and care challenges. It is based on the experience of the earliest ICSs and wide input from colleagues across the NHS, local government and wider partners.

- Our proposals are designed to serve four fundamental purposes:
- improving population health and healthcare
- tackling unequal outcomes and access
- enhancing productivity and value for money
- helping the NHS to support broader social and economic development

Executive Summary

In practice this means that from April 2021 all parts of our health and care system will be working together as integrated care systems, involving:

- stronger **partnerships in local places** between the NHS, local government and others, with a more central role for primary care in providing joined-up care
- **provider organisations** being asked to step forward in formal collaborative arrangements that allow them to operate at scale
- developing **strategic commissioning** through systems and a focus on population health outcomes
- the use of **digital and data** to drive system working, connect health and care providers, improve outcomes and put the citizen at the heart of their own care.

In addition to setting out expectations for how integrated care systems will work from April 2021, the document also describes options for giving ICSs a firmer footing in legislation likely to take effect from April 2022 (subject to parliamentary decision).

NEL ICS Exec will submit a response to NHSE (england.legislation@nhs.net) on 8 January after hearing from local stakeholders by 4 January 2021 (nel-ics.pmo@nhs.net)

Background

It builds on the commitments and ambitions set out in:

- NHS Long Term Plan (2019)
- Breaking Down Barriers to Better Health and Care (2019)
- Designing ICSs in England (2019)
- Recommendations to Government and Parliament for legislative change (2019)

Flagstones of development are:

- Improved partnership and collaboration
- Formulising partnership arrangements
- Focus on population health
- Use of digital and data

Build on LTP observations

- Decisions closer to communities lead to better outcomes
- Collaboration at place level can overcome competing priorities
- Collaboration between providers more likely to improve quality, access and productivity

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Purpose

- Remove legislative barriers that hinder partnerships
- Enhance or facilitate a bottom up approach to health and social care
- Work from larger footprints while devolving decision making

Priorities

- **Cancer**
- **Transforming mental health**
- **Tackling inequalities**
- **Meet the Covid-19 challenge** (mutual aid demonstrates the power of collaboration)

Integrated Care Systems

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Partners will work together to determine:

- Distribution of financial resources
- Improvement and transformation
- Operational delivery arrangements
- Commissioning development and workforce planning
- Emergency planning and response
- Use of digital data
- Draw strength from its constituent parts

“Place” - a building block for ICSs

- Provide staying well advice
- Preventative services
- Joined up care and treatment
- Access to digital services
- Proactive support to the vulnerable
- Estates – plays a part in social/economic sustainability

Practical steps

1. **Provider collaborative:** Join up working at scale and placed based. Coordinated. Local flexibility. Workforce plan
2. **Placed based partnerships:** Primary care link to Health & Wellbeing Boards. Local understanding and identity. Principle of subsidiarity (Primary Care, Mental Health, Comm/Vol, Community Health Services)
3. **Clinical & professional leadership:** Embed system wide clinical leadership, through PCNetworks, neighbourhoods and partnership boards
4. **Governance & accountability**: ICS Governance to include Comm/vol sector. Establish placed based and provider collaborative clinical leadership.

Practical steps

5. **Financial framework:** A Single pot. Local leaders making allocating decisions. New powers for joint budgets and blended tariffs.
6. **Data and digital:** Connectivity. Smart data & digital foundations. Citizens at the centre. Transform and build tech infrastructure.
7. **Regulation and oversight:** New integration index performance data. System oversight framework to come
8. **Commissioning change:** Reduced competition. Population level outcomes. Key tasks – assess, prioritise, plan, measure, transformation, agree at scale provision. CSUs to continue their role

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Specialist commissioning principles

- Stay consistent to national service specifications
- To be led at ICS or multi ICS level
- Clinical networks and provider collaboration to drive improvements
- Shift from provider to population allocations

Legislative proposals to:

- reduce competition
- simplify procurement
- improve capital investment coordination
- establish ICS trusts
- create joint provider and commissioner committees
- merge NHS England and Improvement
- embed the “Triple Aim”
  - Better health for the whole population
  - Better quality of care
  - Financial sustainability for the tax payer

Two options to avoid top down, ‘distracting’ re-organisation

East London Health & Care Partnership

1) Statutory ICS Board/Joint Committee with an with accountable officer

- Establish a mandatory ICS board
- Explicitly duty for all members (CEOs) to deliver the system plan
- Retains individual organisation duties & outcomes
- ICS AO selected from member AO/CEOs and not replace individual AO/CEOs
- Replies on collective responsibility
- Responsibilities still not clear – ok as a transitional model?

2) Statutory Corporate NHS Body Model – NHSE/I preferred

- Re-purposed NHS body to undertake CCG duties
- Requires agreed framework of duties and powers
- ICS AO would be a full time role
- No Organisational powers of veto
- Less conflicts of interest
- Better for long term ambition and vision?

Staff Stability

Stable employment: As CCG functions move into new bodies we will make a ‘continued employment promise’ for staff carrying out commissioning functions. Terms and conditions to the new organisations will be preserved (even if not required by law) to help provide stability and to remove uncertainty.

New roles and functions: Many commissioning functions will move to a new organisation and will then evolve over time to focus on system priorities and ways of working. The priority will be the continuation of the good work being carried out by the current group of staff and we will promote best practice in engaging, consulting and supporting the workforce during a carefully planned transition, minimising disruption to staff. *Other functions* will be more directly impacted, principally the most senior leaders in CCGs (chief officers and other governing body / board members). ICSs need to have the right talent in roles leading in systems.

NHSE commitment:

- To not make significant changes to roles below the most senior leadership roles
- To minimise impact of organisational change on current staff by focusing on continuation of existing good work through the transition and not amending terms and conditions
- To offer opportunities for continued employment up to March 2022 for all those who wish to play a part

Implications and next steps

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- Systems can already:
  - Manage acute care collaboratively
  - Tackle unwanted variation
  - Use data to tackle inequalities and share the load
- NHSE/I to provide support / tools to ICSs following internal reorganisation
- A road map to April 2022 in development
- Seek to provide employment stability
- NEL to consider local feedback process to meet NHSE 8 Jan 2021 deadline
- Be ready to operate as a single ICS from April 2021
  - By April 2021 NEL to produce a plan on how it will meet consistent operating arrangements and the next phase of the Covid response
  - By Sept 2021 an implementation plan for our future roles as outlined above, that will need to adapt to take into account legislative developments.

Your feedback

East London Health & Care Partnership

- We are keen to provide a response to NHSE/I on their proposals and would encourage feedback on your views so that we can compile our ICS response.
- We would encourage groups to discuss these proposals and let us have your views. It would be particularly helpful if discussions could take place between different partners about how they see these proposals impacted on our ability to work in a more integrated way.
- The closing date for a response to NHSE/I is 8 January 2021
- In order to compile a response and get it signed off by ICS leaders we will need any feedback no later than 4 January 2021 – However, please submit earlier if possible.
- We are keen to know which of the governance models put forward by NHSE/I you prefer: option 1 or 2 on slide 12?
- Do you have any comments on what we need to do to make our ICS work most effectively?
- What other views do you have about our emerging ICS?
- Please send your responses to nel-ics.pmo@nhs.net by 4 January at the latest

Thank You

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North east London's local authorities, NHS and community organisations working together to deliver sustainable health and care for local people.
www.eastlondonhcp.nhs.uk
Follow us on twitter @elhcp

East London Health & Care Partnership
Citizen's Panel

Join the East London Citizens' Panel and help us shape health services in north east London. Help create services that work for you and others in your area and get your voice heard.
enquiries@eastlondonhcp.nhs.uk

City & Hackney IC Operating Model & CCG Merger: Transitional Governance from January 2021

December 2020

Context

- At the Integrated Commissioning Board (ICB) meeting on 12 November the Board reviewed the output from the ICB Development Session held on 29 October. As the minutes state: both the City of London ICB and London Borough of Hackney ICB "Approved that further work now take place in order to continue to develop transitional governance arrangements and prepare further detail around these proposals for further review at a third ICB development session next year."

- The purpose of this paper is to set out the high-level steps and the timeline for moving from City & Hackney's current governance arrangements to the governance arrangements required to underpin the new integrated care operating model within the context of a North East London (NEL) Integrated Care System, a single NEL CCG and the City & Hackney local system. Before April 2021 City & Hackney Integrated Care Partnership Board (ICPB) will receive a mandate from the NEL ICS with a devolved allocation to deliver the ICS mandate.

- Building on the discussion at the 29 October ICB Development Session***, the ICB is invited to confirm its commitment to transition from an Integrated Commissioning Board to an Integrated Care Partnership Board with revised terms of reference and a wider membership***. Both the proposed terms of reference and wider membership will be discussed at the ICB meeting on 14 January 2021

- In parallel with the transition from the ICB to the ICPB there is a requirement to establish a new Neighbourhood Health and Care Board (NH&CB) which will receive a mandate from the ICPB that takes into account national, NEL and local priorities and sets out the expectations of the local system.

- ***It is important that we receive ICB endorsement to proceed*** with the recommended governance transitional plan, from December 2020 to April 2021, because this will set the agenda and the pace for transition to the new integrated care operating model across the City & Hackney local system.

ICB is invited to confirm the transition of the ICB to the Integrated Care Partnership Board (ICPB) and the establishment of the Neighbourhood Health & Care Board (NH&CB)

Governance transition – some assumptions (1 of 2)

- From 14 January 2021 onwards the ICB should begin to meet as a “transitional” Integrated Care Partnership Board. At this meeting, business will be divided into two parts:
    - Part 1 – The normal business of the ICB
    - Part 2 – A facilitated simulated session which would:
        - Review the proposed ICPB terms of reference and membership
        - Review, discuss and comment on the draft mandate which would exist between the ICPB and the Neighbourhood Health & Care Board
        - Discuss potential content/agenda items which might be brought to the Integrated Care Partnership Board.
        - Reflect on how the meeting with a larger group has worked and any steps that could be taken to make it more effective.
- At the Transitional ICBP Board meeting, on 11 February, the ICPB should confirm its terms of reference and membership.
- In parallel, work will take place on the formation of the Neighbourhood Health & Care Board with a view to holding a first transitional NH&CB meeting in February 2021 (date to be confirmed). It is anticipated that key agenda items will be:
    - Terms of reference and membership of the NH&CB
    - Draft mandate between IPCB and NH&CB
- There will be an ICPB Development Session in March 2021 (date to be confirmed) to review progress, discuss the mandate prior to sign off and consider any improvements to the governance arrangements supporting the IC operating model. We expect signoff for the mandate to take place no later than at the ICPB and NH&CB meetings in March 2021 (dates to be confirmed).

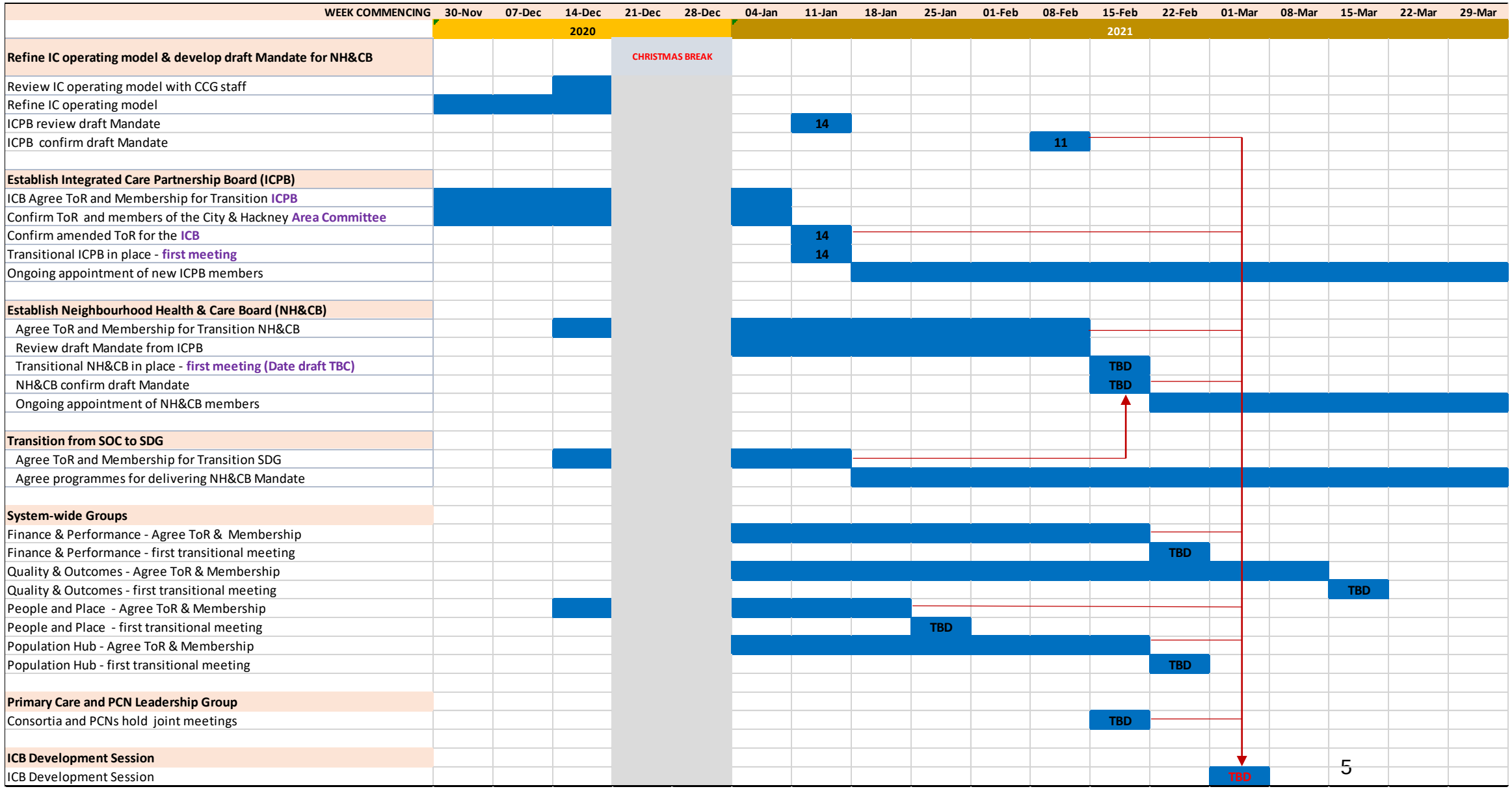
Both ICPB & NH&CB will have agreed transitional ToR and board membership before April 2021.
We expect these to be “transitional” and subject to change in the light of more information and experience

Governance transition – some assumptions (2 of 2)

- From December 2020 to end March 2021 work will take place to determine the terms of reference and membership for a number of critical system-wide groups, specifically:
    - Finance & Performance
    - Quality & Outcomes
    - People & Place
    - Population Hub
- The assumption is that all of the system-wide groups will have at least one transitional meeting before April 2021
- From February 2021 PCN Consortia and PCNs will start to meet together to map out their primary care governance and how they will work together to meet their combined responsibilities.
- Overleaf we summarise the proposed governance transition timeline to April 2021.

There will be a review point in 2021/22 to adjust the IC operating model and the groups that support the ICPB & NH&CB in order to fine-tune the City & Hackney local system

Governance – transition timeline



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On the day briefing: *Integrating care*, NHS England and NHS Improvement

Today NHS England and NHS Improvement (NHSE/I) has published *Integrating Care: Next steps to building strong and effective integrated care systems across England*. It sets out NHSE/I's view of the strategic direction of system working, including a consultation on two new proposals to put Integrated Care Systems (ICSs) on a statutory footing in the NHS Bill expected in late spring 2021. The paper was tabled and discussed at the NHSE/I board meeting on 26 November 2020.

This briefing summarises the key proposals for NHS trust and foundation trust boards, including the expanded role and functions of ICSs, the new emphasis on at-scale provider collaboratives and place-based partnerships, and the questions about legislative change that NHSE/I is inviting views on by Friday 8 January 2021. We will submit a consultation response based on member feedback – please contact georgia.butterworth@nhsproviders.org to share your views.

Key points

1. NHSE/I has published a paper setting out its view of the strategic and operational direction of system working, underpinned by detailed policy and legislative proposals. The paper is positioned to open up a discussion about how ICSs could be embedded in legislation or guidance.
2. It proposes a national plan to accelerate ICS development in 2021/22. NHSE/I will increasingly devolve more functions and resources from the national and regional teams to ICSs ahead of potential legislative change to be implemented from April 2022.
3. NHSE/I is seeking views on two options for putting ICSs on a fuller statutory footing than its original proposals (September 2019), both of which require legislative change. The first option involves creating a mandatory board/joint committee at ICS level with an Accountable Officer. The second option, which NHSE/I prefers, is a corporate NHS body at ICS level that essentially repurposes the CCG and brings its statutory functions into the ICS. In this scenario, the ICS leader would be a full-time accounting officer role.
4. The paper importantly recognises the leadership role played by providers at both system and place level. NHSE/I want to support at scale collaboration between acute, ambulance and mental health providers and place-based partnerships across community services, primary care and local

government (as well as other partners). This emphasis on providers and place provides a pragmatic approach to the next stage of development of system working that we welcome.

5 NHSE/I is now directing ICSs to firm up their governance and decision-making arrangements in 2021/22 to reflect their growing roles and responsibilities, including establishing place and provider collaborative leadership arrangements.

6 This document confirms that NHSE/I will increasingly organise NHS finances at ICS level, giving ICS leaders responsibility for allocating a 'single pot' of NHS funding for their patch.

7 It also reaffirms the shift to strategic commissioning at ICS level, with other commissioning activities moving to provider organisations/collaboratives/place-based partnerships. Further changes to the commissioning landscape are expected in the legislative proposals.

8 The 2021/22 NHS operational planning guidance will set out further detail on the implementation of all these changes next financial year. NHSE/I will also publish further supporting material for provider collaboratives in early 2021. We will continue engaging in this policy development process and the drafting of any legislative proposals.

Background

The proposals set out in this policy document represent a step change in NHSE/I's vision of system working, building on the ambitions in the *NHS Long Term Plan* (January 2019) and the lessons learned from successful collaboration during the COVID-19 response. While ICSs/STPs have been supported to evolve in a largely 'bottom up' way over the past few years, it is clear that NHSE/I now aims to standardise progress across England to embed ways of working ahead of potential legislative change to be implemented from April 2022.

The purpose of ICSs

In this paper, NHSE/I describes ICSs as having four core aims:

1. improving population health and healthcare outcomes;
2. tackling inequality of outcome and access;
3. enhancing productivity and value for money;
4. and helping the NHS to support broader social and economic development.

This builds on the 2020/21 NHS Operational Planning Guidance which defined two key roles for ICSs: system transformation and collective management of system performance. The list of functions has now expanded to include determining:

- Distribution of financial resources to places and sectors;
- Improvement and transformation resource;

- Operational delivery arrangements based on collective accountability between partners;
- Workforce planning, commissioning and leadership and talent development;
- Emergency planning and response; and
- The use of digital and data to drive system working and improved outcomes.

This list of functions represents a significant step change in the role of ICSs. NHSE/I will need to support systems to effectively discharge their new roles in 2021/22 and ensure their readiness for new functions if they become statutory. All ICSs/STPs will be expected to set out how they meet the phase four planning requirements by April 2021 and implementation plans for their future roles by September 2021. While some trusts and systems will welcome this shift of national/regional resources and decision-making to ICSs/STPs, others will want time to develop their ways of working further before taking on additional responsibilities. We will need to ensure that this expanded role for ICSs does not create additional bureaucracy or duplication with other organisations.

NHSE/I remains focused on ensuring full ICS coverage in England by April 2021, with some of the remaining STPs becoming ICSs in November 2020 and the remainder agreeing development plans with their regional teams to meet the April 2021 deadline. NHSE/I will maintain the current footprints of the 42 systems as they currently stand through to April 2022 but recognises that smaller systems may need to join up functions (especially for provider collaboration) to carry out their 'at scale' activities effectively. NHSE/I will support the ability of ICSs to more formally combine as they take on new roles "where this is supported locally".

Renewed emphasis on the role of providers within ICSs

The document states that "all NHS provider trusts will be expected to be part of a provider collaborative" and join up services both within places (vertical integration through place-based partnerships) and through at scale provider collaborative arrangements (horizontal integration). Trusts will rightly remain the key unit of delivery for secondary care services and drive integrated care within and across systems, and some may develop further to deliver integrated care provider or lead provider contracting models. The proposals call on providers to play an "active and strong leadership role" in ICSs through their representation on ICS partnership boards and role in making decisions about system priorities and resource allocation.

At scale provider collaboratives

NHSE/I envisages collaboratives of acute, mental health and ambulance providers at ICS level – or pan-ICS level for providers working in smaller systems – to allow them to operate at scale, deliver specialist care effectively and provide equal access. NHSE/I will publish further guidance in early 2021 describing

different provider collaborative models, which will likely cover a range of formal and informal arrangements. However, there is some recognition from NHSE/I that these collaboratives will vary in scale and scope, and not necessarily be aligned to ICS boundaries. NHSE/I has therefore set out minimum standards for provider collaboratives to deliver relevant programmes, agree and implement changes developed by clinical and operational networks, challenge and hold each other to account (e.g. open book finances) and enact mutual aid arrangements.

In our view, trusts should retain the autonomy to work with their local partners to determine what type of provider collaborative arrangements work best for their local circumstances, rather than a 'one size fits all' national approach. We will explore with colleagues from NHSE/I and DHSC whether the national policy and legislative framework proposed is sufficiently enabling and has the right accountability, governance and financial structures underpinning it.

Place-based partnerships

This document positions 'place' (defined as an upper tier local authority area or other footprint that makes sense for local communities) as the building block for the ICS. NHSE/I has codified an ambition for each 'place' to offer a certain level of service provision to its local population, including but not limited to access to preventative services and support for the vulnerable. This 'offer' will be delivered through partnerships between NHS providers (community health and mental health), local government (including social care), primary care and the voluntary sector working together with delegated budgets to join up services. NHSE/I emphasises the importance of primary care clinical leadership, joint working with local authorities (often through joint appointments or shared budgets) and a clear relationship with the Health and Wellbeing Board (HWB).

The document also introduces the idea of an NHS place leader to work with the local authority and voluntary sector to support Primary Care Networks (PCNs), join up health and care, identify people at risk and coordinate contribution to social and economic development. The ICS will use the principle of subsidiarity to devolve appropriate resource, autonomy and decision-making capabilities to these place leaders.

Governance and public accountability

NHSE/I is now directing ICSs to firm up their governance and decision-making arrangements in 2021/22 to reflect their growing roles and responsibilities. These should be determined locally but consistently involve some minimum standards including:

- 'Place' leadership arrangements, which include joint decision-making arrangements with local government and representation on the ICS board.

- Provider collaborative leadership arrangements, which include joined up decision-making arrangements across providers and representation on appropriate ICS board(s). While local flexibilities are welcome the document is therefore unclear on how providers that are not referenced as being members of collaboratives – notably community providers – or individual trusts will ensure their views are heard at the ICS partnership board.
- Individual organisational accountability within the system governance framework. NHSE/I confirms that the formal and statutory responsibilities and accountability of individual providers remain unchanged in 2021/22, but the accountability relationship between providers, place-based partnerships and provider collaboratives will need to be defined by ICSs (and may change depending on whether and how ICSs are placed on a statutory footing).

During 2021/22, ICSs will need to develop systematic arrangements to involve lay and resident voices and the voluntary sector in its governance structures. ICSs should involve all system partners in the development of service change proposals to ensure decisions are not slowed down. ICSs should also seek to ensure that all the relevant bodies feel ownership and involvement in the ICS.

We will need to explore the potential implications of 'collective accountability' for system operational and financial performance, and how that interplays with trusts' accountabilities to ensure there are clear governance arrangements in place, and avoid duplication.

Financial framework

This document seeks to establish ICSs as key bodies for financial accountability and embeds recent changes to contracting arrangements and ICS-led revenue allocations and capital spending limits and controls. It confirms that NHSE/I will increasingly organise NHS finances at ICS level, giving allocation decisions and duties to ICS leaders (working with provider collaboratives to distribute in line with national rules for mental health/community and primary care, as well as local priorities) and rolling out the blended payment model for secondary care services. NHSE/I want to foster collective system ownership of the financial envelope and support ICSs to codify how financial risk will be managed across places and between provider collaboratives. New powers will make it easier to form joint budgets with the local authority, including for public health functions.

ICSs will manage a 'single pot' including CCG commissioning budgets, primary care budgets, the majority of specialised commissioning spend, some other directly commissioned services, sustainability and transformation funding. ICSs will divide this into place funding, block contracts to providers and a small ICS central budget, and develop incentive arrangements and outcome measures. While NHSE/I

indicates that providers will be able to influence allocations via the ICS partnership board, there is concern from some trusts that the bigger players in a system are able to advocate for more funding than others and it is challenging to engage in this process if you are a provider working across several systems.

NHSE/I will set out in the 2021/22 NHS operational planning guidance how they will support ICSs to begin operating more collective financial governance in 2021/22 and prepare for the powers/duties outlined above.

As members will be aware, we are closely engaged with NHSE/I colleagues on the development of the financial architecture for 2021/22 (and the implications of the current arrangements) and will be working with trusts and national policy makers as this approach evolves.

Regulation and oversight

This policy document proposes a greater role for ICSs in regulation and oversight, in exchange for greater autonomy assuring delivery within a system. The proposals raise some questions about the interplay of roles and between the NHSE/I regional teams and the ICS, and what peer support between providers will look like in practice.

NHSE/I is taking practical steps to adapt its regulatory functions to support systems, including focusing on how local arrangements are improving pathways, maximising use of resources and acting in partnership to achieve joint financial and performance standards. We expect the system oversight framework (out for consultation in early 2021) will set consistent expectations of systems and their constituent organisations. The proposed future Intensive Recovery Support Programme will give support to systems facing the greatest quality and/or financial challenges. In 2021, NHSE/I will introduce an 'integration index' to support greater adoption of system- and place-level performance data/outcomes measures to be developed by each ICS (presumably agreed with their NHSE/I region).

NHSE/I will issue guidance under the NHS provider licence that good governance for NHS providers includes a duty to collaborate and ensures NHS Foundation Trust directors' and governors' duties to the public support system working. NHSE/I maintains there is an important role for patient choice, including choice between qualified providers.

How commissioning will change

The policy document sets out how commissioning activities and resources will change in three significant ways, which will be broadly welcomed by trusts:

1. Strategic commissioning will take place at ICS level, including assessing population health needs and prioritising how to address them, modelling capacity and demand, and tackling health inequalities. NHSE/I states it is the commissioning activities that must be coterminous with ICS boundaries before April 2022 (rather than CCGs themselves). Under option 2 in the legislative proposals, current CCG functions would subsequently be transferred to core ICS business.
2. Other commissioning activities will move to provider organisations/collaboratives/place-based partnerships, including service transformation and pathway redesign. Systems should agree which functions are delivered at place and system level depending on what makes sense for their size.
3. The current focus on transactional commissioning and contracting will shift to population health analytics and outcomes measurements. The proposals intend to make full use of expertise residing in CCGs and provide continuous employment until March 2022.

Changes to the national commissioning arrangements for specialised services

The policy document explicitly references moving strategic commissioning, decision making and accountability for specialised services to either ICS, multi-ICS or national level (depending on what is most appropriate). Clinical networks and provider collaboratives will drive quality improvement, service change and transformation. NHSE/I is considering allocating budgets on a population basis at regional level (rather than provider-based allocations) for specialised services from April 2021 and will provide further information in due course. Adjustments will be made in the first year to ensure stability. NHSE/I will publish a needs-based allocation formula before using it to inform allocations against an agreed pace of change in future years. This phased approach is welcome as getting the geographies for specialised commissioning right is a complex task and the resources must follow the responsibilities.

Other key policy developments

The policy document emphasises the **importance of ICSs embedding clinical and professional leadership**, including PCN representation at place and system level. It also sets out how **data and digital technology will be at the heart of system working**, with ICSs having a named SRO with clear accountability for data and digital on the ICS partnership board and developing a system-wide digital transformation plan.

NHSE/I describes all the policy developments in this document as aiding the NHS in becoming a better **partner for local authorities and the voluntary sector in meeting local population needs**, which seems an evolution of the previous narrative of ICSs being jointly owned by the NHS and local government.

While the ambition for "progressively deepening relationships" between the NHS and local authorities remains, there is little detail on what this would look like beyond the suggestion of "delegated functions and funding". There is a suggestion that HWBs could be a way to align decision making with local government but we are aware that relationships with HWBs vary across the country. Some ICSs are developing more innovative ways of getting this horizontal accountability right, but it is still a challenge.

NHSE/I is advocating for the NHS Bill to **formalise the merger of NHSE/I** and expects Parliament to use the legislative opportunity to **specify the Secretary of State's powers of direction over NHSE**. In the meantime, NHSE/I will further develop its operating model, including supporting systems through thinner regional teams, delivering fewer national programmes and increasing ICSs' autonomy in terms of assurance. NHSE/I describes the primary interaction between the regions and collective ICS leadership, with limited cause for national functions to intervene with individual providers.

Legislative proposals for ICSs

Discussions are underway within government about the possible content of the NHS Bill, which is likely to be introduced in late spring 2021; this will probably be the only chance this parliament for NHS legislation so we expect the Bill to cover a wide range of topics, including the original NHSE/I legislative proposals (September 2019). However, it is clear that the government and national NHS bodies have developed their thinking on the legislative change required to embed system working since these proposals. NHSE/I now sees a supporting policy framework as insufficient to deliver its vision of system working, and are looking to strengthen their original recommendation to put ICSs on a statutory footing by establishing voluntary joint committees at ICS level. NHSE/I now believes any statutory ICS model should be mandatory to provide long-term clarity in terms of accountability and future-proof ICSs.

NHSE/I is proposing two options for putting ICSs on a fuller statutory basis:

- **Option 1: a statutory, mandatory ICS board/joint committee** model with an Accountable Officer (AO) (chosen from the chief executives/AOs of the ICS board's mandatory members) that binds together current statutory organisations and enables collective decisions across/between providers, commissioners and local authorities. The AO role would be recognised in legislation and have duties in relation to the board's function. There would be a duty on all members to comply with the system plan and new powers for CCGs to delegate population health functions to providers. Current accountability structures would be unchanged.
- **Option 2: a statutory ICS body** that repurposes the CCG and brings CCG statutory functions into the ICS (and potentially some NHSE commissioning functions). This will create a new framework of duties and powers, replacing the CCG governing body and GP membership model with the ICS board, which would have as a minimum representatives from NHS providers, primary care and local

government, alongside an ICS chair, chief executive and chief financial officer. The power of individual organisational veto would be removed. The ICS leader would be a full-time accounting officer role with a primary duty to secure effective service provision that meets population needs.

NHSE/I is seeking views on the following questions, which will help inform their recommendations to government. We will of course engage with our members and respond in full.

Q1. Do you agree that giving ICSs a statutory footing from 2022, alongside other legislative proposals, provides the right foundation for the NHS over the next decade?

Q2. Do you agree that option 2 offers a model that provides greater incentive for collaboration alongside clarity of accountability across systems, to Parliament and most importantly, to patients?

Q3. Do you agree that, other than mandatory participation of NHS bodies and Local Authorities, membership should be sufficiently permissive to allow systems to shape their own governance arrangements to best suit their populations needs?

Q4. Do you agree, subject to appropriate safeguards and where appropriate, that services currently commissioned by NHSE should be either transferred or delegated to ICS bodies?

These proposals represent a significant evolution in NHSE/I's thinking about how to embed system working arrangements. We will need to consult widely with trust leaders on their views about how these arrangements could improve outcomes for patients and support a fuller collective focus on population management and a reduction in health inequalities. We will work with colleagues in NHSE/I and trusts to consider the impacts of these proposals on their existing accountabilities and powers and ensure any new legislative framework is sufficiently enabling and allows for appropriate local determination.

NHS Providers view

The proposals set out in this policy document represent a step change in the evolution of system working. They offer greater clarity on NHSE/I's view of the strategic direction of system working, underpinned by detailed policy and legislative proposals ahead of an NHS Bill expected next year.

Overall, the document sets out a welcome translation of what a 'system by default' operating model could look like. There is now a clear national plan to accelerate ICS development in 2021/22. This anticipates legislative change aimed at underpinning those developments from April 2022.

We welcome the proposed shift to strategic commissioning and away from transactional contracting, as well as the clear emphasis on the pivotal role of trusts, and other providers, as leaders and co-leaders

of collaborative arrangements at neighbourhood, place and system level. It makes sense to collaborate and deliver different services at different levels of scale, but all of these partnerships will need appropriate resourcing and cannot necessarily continue operating from within the existing staff base. Trust leaders tell us that 80% of care is delivered locally where people live, so it is right to position 'place' as the key building block for integrated care in partnership with local government and others. This emphasis on providers and place, and avoiding creating ICSs as new style, all powerful, Strategic Health Authorities, provides a sensible and pragmatic approach to the next stage of development of system working that we welcome.

As ever, the detail of the document – and the two options to place ICSs on a statutory footing – raises a host of complex and important questions about the detailed operation of the proposals in practice. The existence of providers, provider collaboratives, neighbourhoods, places, ICSs and NHSE/I regions, will require clear, effective, non-duplicative "plumbing and wiring" in areas such as governance, accountabilities, financial flows and statutory responsibilities. The document sets out approaches in these areas where we, inevitably, have questions and possible concerns. We therefore welcome the period of engagement on these issues that the paper triggers. We will want to talk to members about them as we know there is a spectrum of views on many of these issues across the provider sector.

What we do know is that trust leaders – and partners from across the health and care system – are cautious about any top-down, inflexible reorganisation of the NHS, particularly in the middle of a pandemic. While NHSE/I is rightly seeking to avoid such disruption, we will work with them, the Department of Health and Social Care (DHSC), and others, to seek an enabling national policy and legislative framework. With that in mind, NHSE/I and DHSC must facilitate a robust debate with the health and care sector about the scale and implications of both these proposals and the proposed legislative reform, which we are ready and eager to contribute to.

What we do know is that trust leaders – and partners from across the health and care system – agree with NHSE/I about the need to avoid any top-down, inflexible reorganisation of the NHS, particularly in the middle of a pandemic. While NHSE/I is rightly seeking to avoid such disruption, we will work with them, the Department of Health and Social Care (DHSC), and others, to seek an enabling national policy and legislative framework. With that in mind, NHSE/I and DHSC must facilitate a robust debate with the health and care sector about the scale and implications of both these latest proposals and the proposed legislative reform, which build on the prior proposals we have already supported. We are ready and eager to contribute.

How is NHS Providers responding?

Over the last few months NHS Providers has already been extensively involved in commenting on drafts of this document as it developed and the broadly policy development process that underpinned it. We will make an extensive written response to this consultation document on behalf of the provider sector, informed by trusts views, including those of the member reference group we have established to underpin this work in detail. Individual trusts and ICSs/STPs may also wish to respond to the consultation in their own right, and we would welcome trusts sharing these responses with us to help us form a representative view.

We welcome the government's commitment to engage on its legislative proposals ahead of a further period of significant legislative change for the NHS, and expect a formal engagement process to begin shortly. It seems likely that this will be the single chance for NHS legislation this parliament and we are therefore expecting an omnibus Bill covering a range of different areas. We understand that the original NHSE/I legislative proposals will be included, with the proposals on ICS statutory underpinning amended following this consultation. Initial engagement has deliberately been concentrated on ICSs in law, hence the document issued today. Chris Hopson, our Chief Executive has already contributed to an initial stakeholder meeting chaired by the Secretary of State for Health and Social Care.

We will continue to work closely with the senior leadership at NHSE/I and DHSC, and their officials, to feed in the views of trust leaders, influence their thinking and test the detail of both the proposals in today's document and the wider emerging Bill. This will include, but is not limited to additional policy documents we expect to be forthcoming including: the guidance around provider collaboratives that NHSE/I plans to publish in early 2021, the NHS Operational Planning Guidance 2021/22 and the detailed drafting of the NHS Bill over the next six months.

We have also fed into the COVID-19 phase four planning process, including convening a roundtable series with senior NHSE/I representatives to help shape the NHS Operational Planning Guidance 2021/22. These conversations focused on the financial framework, system governance and operational challenges. We will continue to influence the ask of the provider sector for 2021/22.

Finally, we will undertake extensive engagement in anticipation of the NHS Bill, which we expect to be announced in the forthcoming Queen's Speech and introduced in late spring 2021 following a period of public engagement. We do not expect a draft Bill, but expect some form of extensive pre-legislative engagement. We will continue to raise the profile of trust leaders' views and concerns with ministers, NHSE/I senior team and our staff level contacts.

Contact: Georgia Butterworth, Policy Advisor (systems)
georgia.butterworth@nhsproviders.org

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Hackney

Health in Hackney Scrutiny Commission 6th January 2021 **Cabinet Member Question Time**	Item No **7**

OUTLINE

It is customary for each Cabinet Member to attend one Cabinet Member Question Time Session each year with their relevant Scrutiny Commission. The purpose is to allow Members to ask questions on areas separate from reviews or other key work programme items being considered during that year.

To make these sessions manageable questioning is confined to **three** agreed topic areas. There are no formal papers and the Cabinet Member makes a verbal statement which is followed by a Q&A.

For this session these will be:

1. What are your reflections over the past year?
2. What are your 3 personal ambitions for your portfolio over the year ahead / where you would like to make a personal difference?
3. What do you see as the biggest challenge over the next year and why?

Attending for this session will be: Cllr Chris Kennedy, Cabinet Member for Health, Social Care and Leisure.

ACTION

The Commission is requested to give consideration to the discussions.

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Hackney

Health in Hackney Scrutiny Commission 6th January 2021 **Minutes of the previous meeting and matters arising**	Item No **8**

OUTLINE

Attached please find the draft minutes of the meeting held on 18th November 2020.

MATTERS ARISING

Action from 23 September meeting

Action at 7.6

ACTION:	*Executive Director of Healthwatch to explore with the CE of the GP Confederation on developing a Protocol for GP Practices on supporting those who cannot readily access their GPs via digital means and on establishing a consistent standard across all the Practices in Hackney.*

This item will be postponed and held with the item on the Executive Response to our review on "Digital first primary care and the implications for GP Practices" which is still awaited.

Action from 18 November meeting

Action at 4.9(i)

ACTION:	*Interim Group Director Adults Health and Integration to provide Members with a note on the Quality Assurance Framework on Care Homes commissioned by the borough and to provide clarification on how regularly the risk assessments of Care Homes are being updated.*

This is awaited.

ACTION

The Commission is requested to agree the minutes and note the matters arising.

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Hackney

London Borough of Hackney
Health in Hackney Scrutiny Commission
Municipal Year 2020/21
Date of Meeting: Wednesday, 18 November 2020

Minutes of the proceedings of the Health in Hackney Scrutiny Commission held virtually from Hackney Town Hall, Mare Street, London E8 1EA

Chair	**Councillor Ben Hayhurst**
Councillors in Attendance	**Cllr Peter Snell (Vice-Chair), Cllr Kam Adams, Cllr Kofo David, Cllr Michelle Gregory, Cllr Deniz Oguzkanli, Cllr Emma Plouviez and Cllr Patrick Spence**
Apologies:	
Officers In Attendance	**Denise D'Souza (Interim Group Director for Adults, Health and Integration) and Chris Lovitt (Deputy Director of Public Health)**
Other People in Attendance	**Councillor Christopher Kennedy (Cabinet Member for Health, Social Care and Leisure), Councillor Yvonne Maxwell (Mayoral Advisor for Older People), David Maher (MD, NHS City & Hackney CCG), Dr Mark Rickets (Chair, City and Hackney CCG), Nina Griffith (Workstream Director Unplanned Care, Integrated Commissioning, CCG), Jon Williams (Executive Director, Healthwatch Hackney), Tracey Fletcher (Chief Executive, Homerton University Hospital NHS Foundation Trust), Diane Jureidin (Manager, Acorn Lodge), Simon Bottery (Senior Fellow – Social Care, The King's Fund), Adelina Comes-Herrera (Assistant Professorial Research Fellow in Care Policy and Evaluation Centre, LSE), Laura Sharpe (Chief Executive, City & Hackney GP Confederation)**
Members of the Public	**7**
YouTube link	https://youtu.be/6VE2Pk5CnGU
Officer Contact:	**Jarlath O'Connell** ☎ 020 8356 3309 ✉ jarlath.oconnell@hackney.gov.uk

Councillor Ben Hayhurst in the Chair

1 Apologies for Absence

1.1 Apologies for absence were received from Dr Sandra Husbands.

2 Urgent Items / Order of Business

2.1 There was no urgent business and the order of business was as on the agenda.

3 Declarations of Interest

3.1 There were none.

4 Care Homes and Covid 19

4.1 The Chair stated that the purpose of this item was to examine how local care homes are coping during the Covid-19 pandemic and to seek reassurance that the local system is now better prepared for the second wave, should it occur. He explained that there would be four short briefings from Adult Services, the Manager of Acorn Lodge and two external guests from LSE and from The Kings Fund after which there would be a panel discussion.

4.2 Members gave consideration to a briefing paper from Adult Services.

4.3 The Chair welcomed for this item

Denise D'Souza (DD), Interim Group Director for Adults, Health and Integration
Diane Jureidin (DJ), Manager, Acorn Lodge
Adelina Comes-Herrera (AC), Assistant Professorial Research Fellow, Care Policy and Evaluation Centre, LSE
Simon Bottery (SB), Senior Fellow – Social Care, The King's Fund
Cllr Christopher Kennedy (CK), Cabinet Member for Health, Social Care and Leisure
Tracey Fletcher (TF), Chief Executive, HUHFT
Nina Griffith (NG), Workstream Director Unplanned Care, Integrated Commissioning

And stated that DD, DJ, AC and SB would give brief presentations and then open the item up for discussion.

4.4 DD took Members through the briefing paper in detail. She explained the context of care home provision in Hackney. She stated that there had been 20 Covid related deaths during the March-April peak in Hackney. She explained the local structures and how there were 16 CQC registered care homes in Hackney with 331 beds but only 4 were nursing homes for elderly people with 226 beds in total. Islington, by contrast has 48 care homes she said. She stated that the new policy of Home First came in on 1 Sept. She detailed its three levels relating to levels of need. She stated that new funding had come from the NHS to pay for the first 6 weeks of care and that Adult Services then carried out assessments to plan the next steps for those patients. The big challenge was the lack of PPE and difficulties with the delivery of that. There had been a lot of concern about staff and their health and wellbeing and managing staff sickness had been an issue. They had received grants to improve infection control which they were able to pass on to Providers. A new national policy on care home visits had come in and there was also now a

dashboard which provided national tracker system giving vital live information on case rates and capacity across the system. There had been new training for staff. There had been a 3% uplift for 3 months for Providers to help with PPE purchase. Now the focus was on the winter plan and on testing of all patients before discharge. Another key aspect of the work was the alignment with Neighbourhoods programme.

4.5 DJ described their experience at Acorn Lodge Care Home since March. A big issue for them had been infection control and getting up to speed was a challenge. Also accessing PPE in the first 6 wks of the pandemic had been another challenge. Another issue was identifying the more obscure symptoms of Covid in frail patients with co-morbidities. Keeping families informed and reducing their anxiety and adapting End of life Care plans was another key focus. Managing care home staff who needed to isolate and covering shifts was another challenge. Acorn Lodge benefited from valuable close working with their GP. There had been no real testing until the second half of May she explained. If second wave come about, she stated, systems were now in a much better place and there was sufficient PPE, testing was happening weekly for staff and every 4 weeks for residents. If residents showed symptoms they were tested on the same day and then isolated. She explained that they didn't mix staff or residents across units. Visiting continued to provide the biggest challenges however. Window visiting and zoom video conferencing were taking place. Risk assessments were done on those at end of life stage so that 1 or 2 members of the family could visit. There was much more confidence and surety in the whole system now she concluded.

4.6 AC described some international comparisons e.g. with Hong Kong and Singapore. The share of residents who died in care homes was the same as proportion who died outside care homes which tells us that despite all attempts it was still very difficult to keep virus out of care homes. She stated that the practice of cohorting was an excellent measure and has had impact internationally. She stated that it was all down to test, trace and isolate and the isolate bit was the most difficult in care homes. Infrastructure remained a challenge in care homes and the characteristics of many people in care homes e.g. patients with dementia, means that it will always be difficult to implement these principles (very hard to keep patients compliant) and that it requires resourcing. She added that it was also very difficult to measure the numbers of those dying in the community. Excess deaths in private households were an issue. Many were relying on carers and many of them were self-funders. What is their access to PPE and who is paying for it, she added. Care homes were never designed to be isolation facilities and so many have trouble converting. She stated that in parts of Asia they had a very strict policy of moving positive patients out of care homes. It was controversial but enabled care homes to keep outbreaks to just 1 or 2 patients and this was something to consider when a care home doesn't have the right facilities. Using another space outside is an option worth exploring she concluded.

4.7 The Chair asked whether the pandemic had acted as a catalyst for a reform of the care home sector. SB replied that with social care reform it was very difficult to predict what was going to happen next.

4.8 SB gave a verbal presentation where he summarised 5 sets of issues which he thought a Scrutiny Commission should attend to and these were:

(a) Are our care home residents safe
The focus here needed to be on adequacy of testing, keeping an eye on adequate provision of PPE and more broadly on the tension between the safety and the happiness of residents.

(b) Are our care home residents happy
The average care home stay was 18 months and if residents had to remain isolated in their own rooms how would this impact on their mental health and wellbeing. It was necessary to look at how visiting policies are devised and operated. The government had a pilot on visiting policies and it would be necessary to keep an eye on this.

(c) Are our care homes in the right places
Were proper assessments done before discharge from acute settings or elsewhere. He stated that there was some Red Cross research on what happens to people afterwards which had revealed instances of no proper follow up. Percentages of who is in what care pathways needed to be examined and the national guidance should not be seen as an absolute guideline for every authority. In relation to costs, there was the issue about discharging paying care home residents in an emergency into places where the rates are higher than what the Council normally pays for them. What would be done long term for those patients in terms of the council's ability to afford to continue to keep them in that setting, he asked.

(d) How will the care home sector survive the pandemic
He stated that a 90% occupancy level was the minimum that care homes needed in order to survive. Numbers had generally dropped to 85% in the pandemic. The numbers of self-funders, who pay more, fell by a third and those who are council funded also fell sharply as individuals and families decided not to move into a care homes at the present time because of fears of catching covid. The compounded cost of PPE is another major budget issue.

(e) How will it be possible to staff care homes in any second wave.
High levels of staff sickness and isolation initially had now levelled off and vacancy rates in sector, s a whole, had been falling, he explained. One impact of the recession (exacerbated by Covid) was that more people were now happy to work in the sector than before. The government plans to limit the number of people working in more than one home would also have an economic impact.

4.8 Chris Lovitt (Deputy Director of Public Health) (present for item 6) presented some slides on care home Covid incidence and deaths. There had been more Covid cases in the beginning of the first wave and of course there had been less testing then. Hackney then had a second spike in Aug-Sept but much fewer cases because of the mitigation work which had taken place, so there had been successes. There were obvious continuing challenges in nursing homes and the issue in homes for those with Learning Disabilities or Mental Health were quite different.

4.9 Members asked detailed questions the following responses were noted:

(a) The Chair commented that the significant excess deaths which took place nationally in care homes over and above those who tested positive should be noted and that there was a need for some caution in deducing that the figures being

published show the full picture. He also asked whether the other 3 nursing homes in Hackney were able to 'cohort' and if not what they were doing to ensure safety. DD responded that in newer built homes it was easier to cohort but in converted buildings it proved more difficult. There was also much work being done on designated beds and in roll out of the latest standards on infection control. Nina Griffith (Unplanned Care Workstream Director) described the local approach to cohorting and the audit that took place. 2 of the 4 nursing homes can cohort (Acorn Lodge and Mary Seacole). Across the Learning Disability and Mental Health homes there was a more mixed picture. They had however put in place contingency arrangements for those. They also had also 6 interim Supported Living flats in which to discharge people to before they go back to their homes or Housing with Care settings.

(b) Members asked whether staff moved between homes? DD replied that they didn't. NG explained the strict national guidance on this. It was not easy to police she added but the issue hadn't arisen locally, and they had been given assurances by the providers and they worked very closely with them. DJ added that Acorn Lodge do not use agency staff and staff do not move around. She added that she and the Clinical Manager also did clinical care when the need arose.

(c) Members asked when rules had come in regarding testing prior to discharge from acute settings. They also asked whether a Director of Public Health might be able to override isolation warnings from the NHS Test & Trace App once risk assessments had been in place by a Provider. Cllr Snell gave an example of an issue he came across as Chair of a Learning Disabilities charity providing services in another borough. He also described how families in effect do their own risk assessments. He also praised Acorn Lodge for how it encourages people to mix and socialise and he asked if more could have been done to support them.

NG replied that the rule came in re discharge testing 15 April and she described the timeline leading up and how the rules had become stricter. Associated Guidance however had been vague she added.

(d) The Chair asked Tracey Fletcher (CE of HUHFT) about the current discharge rules at the Homerton. TF stated that patients were tested 2 days before they anticipated a discharge and they waited for results to come back before anyone was discharged. If there was an extreme example, as outlined by Cllr Snell, they would only ever discharge to a care home when a plan was discussed and fully agreed with the receiving care home about how they would manage that patient. She added that now test results were coming back much more rapidly thus facilitating more prompt discharge.

(e) The Chair asked about managing the impact of staff testing positive and what do to and would a risk assessment override an NHS T&T isolation warning. Cllr Snell stated he had written to the CE of Hackney Council on the general points. Once the NHS T&T app identifies that you've been with someone who has been infected you are warned about the fines if you don't comply and this was preventing key workers from attending work, which was then causing problems for many small care charities. The Chair asked if there were systems are in place to troubleshoot scenarios like these. DD replied that you cannot override the Test and Trace instructions and you have to obey the App. Rapid testing was the solution in a scenario like this, she added.

(f) The Chair asked about people in private households needing care and whether that was being monitored and if they were being provided with support and PPE. DD

replied that they were of course reaching out to home care providers. A lot of these clients would be paying for private care and the Council would not be across that. They had also been reaching out with PPE offers to carers. There was a general worry about the stability of the care home market as many were choosing not to go into care homes at present and people were also not wating care or support staff to be coming into their own homes, despite often needing advanced care, and this needed to be tackled.

(g) The Chair asked AC re best practice on accessing self-funders in order to assist them. AC stated that these issues were long term and there isn't a national system of data to enable us to identify self-funders. The care system can identify diagnoses of dementia and can offer PPE. She added that there was certainly scope for more proactive policies here. DD agreed that that informal carers also needed access to support.

(h) The Chair asked DJ about the CQC rating of Acorn Lodge possibly impacting on its 'designated setting' for the discharge of Covid patients from acute hospitals. You need to have the highest two ratings for this designation.

DJ replied they had a past infection control inspection that wasn't fully compliant, they since had a re-inspection but had not received the outcome of that, which would enable them to be formally confirmed as a designated setting. In the meantime, they were continuing to accept acute discharges because the few cases involved were being tested and they were able to isolate them in their own private rooms in the home when not ready to go into their Covid cohort section. As of that week they had no covid positive patients. They had had one asymptomatic outbreak in July. All staff were negative and all residents were negative.

(i) Members asked about the lack of choice for Hackney residents in care home provision and about the monitoring of quality of delivery, of safety and of resources

DD detailed the Quality Assurance Framework they have in place and the broader CQC regulatory system for care homes. The Council has its own QA mechanisms and they worked with the care home managers. They supported the Acorn Lodge evidence to CQC in order to assist them because they had all the QA evidence on record that was needed by the CQC.

ACTION:	**Interim Group Director Adults Health and Integration to provide Members with a note on the Quality Assurance Framework on Care Homes commissioned by the borough and to provide clarification on how regularly the risk assessments of Care Homes are being updated.**

(j) Members asked how often risk assessments are updated. NG replied that through the pandemic the Commissioning Team Council were very regularly in contact with all the care homes. There was a normal update cycle but much more regular weekly conversations with the care homes since the pandemic for example about working out how 'cohorting' would operate.

(k) The Chair asked about whether rapid discharge was the correct policy at present. NG replied that all got tested before they left the hospital. Only designated care homes can receive people that are positive and Mary Seacole should soon have the

same arrangement in place as Acorn Lodge. Also, interim supported living arrangements had been put in place and nobody was being discharged into a regular care environment.
(l) The Chair echoed SBS point about ensuring the best care environment for a person. SB added that in the rush to get people out of acute settings during the peak of the pandemic there needed to be an analysis of whether those patients always ended up in the right place for them. NG added that different rates of pay between providers did provide a challenge in planning but it was important to note that there were no current bed pressures at HUHFT, unlike at BHRUT for example, and no rash decisions were having to be taken. They had a 'Discharge Single Point of Access' system in place which was now mandated through national guidance and this had worked really well in the City and Hackney system. This referred to a hospital-based hub that brings together all the partners involved in a patient's discharge: OTs, care workers, hospital staff etc. They do also have to place some people out of borough on occasion which is not ideal, but they were not placing anyone in the wrong place for them.

(m) The Chair asked about the lessons which had been learned from the second wave in the North West of the country and what had emerged there about the impact on care homes. AC replied that it wasn't easy to compare both times because for example the testing situation had been so different the first time. Share of deaths in hospitals of care home residents was increasing a little bit. They were also hoping that this time people who have Covid will be more readily admitted to hospital and in addition they now have much better treatments in place, than in April, so even very old people are responding better to treatment.

(n) The Chair asked Tracey Fletcher whether, because pressures had been so great during the first wave, eligibility thresholds for care home residents being admitted to acute settings had been raised unduly.

TF replied that it was always based on a clinical assessment. The policy would never have been not to take care home patients. She added that City and Hackney was in a fortunate position in that it worked really well as a system. They had never got into the position of having people queuing up outside the hospital. Anyone who needed to be admitted was.

4.10 The Chair thanked all the contributors for their comments and contributions and the Care Home and NHS staff for their excellent work at this very difficult time.

RESOLVED:	**That the briefing paper and discussion be noted.**

5 Unplanned Care Workstream - Update

5.1 Members gave consideration to a presentation "Integrated Commissioning – Unplanned Care Workstream Update".

5.2 The Chair welcomed:

Tracey Fletcher (TF), Chief Executive, HUHFT and SRO for the Unplanned Care Workstream of Integrated Commissioning
Nina Griffith (NG), Workstream Director Unplanned Care, Integrated Commissioning

5.3 In introducing her paper NG stated that she had last spoken to the Commission in January and when writing this update was shocked at how much had changed since then. She stated that the pandemic had emphasised the importance of the work they were doing on the Neighbourhood model and on better integrated discharge and indeed prompted them to progress it more quickly. She added that End of Life Care is a key element of their portfolio of work and a lot of thinking and more focused work had gone into it since the pandemic. Since the summer they were working on the Winter Planning and this also required a renewed focus in light of the pandemic. The danger of a second wave coinciding with the normal winter pressures must be averted.

5.4 Members asked detailed questions and in the response the following was noted:

(a) Chair asked about the problems with NHS 111 and scope for a reform to it that might provide some confidence. He commented that C&H had gone from being badly served by a poor private provider to having a locally run top-class service to seeing that being replaced by a poorer quality sub-regional solution where, at best, only 30% of callers got to speak to a doctor.

NG admitted that there had been a lot of recent national policy direction on NHS 111. Initially patients are dealt under a standard algorithm until they are progressed into triage. National money had gone in to increase capacity and the recent KPIs were showing that the service had responded very well to the pandemic despite a shaky start. The system does well on access and on the numbers who receive a clinical assessment, she added, but they are getting feedback that the public are feeling like they're talking to an algorithm that doesn't suit their needs. The structures in place are now good she added and there is an NEL Urgent and Emergency Group which is chaired by Tracey Fletcher and this gives C&H more levers to improve the system than it had previously and also levers to work better with London Ambulance Service. She added that when your GP is open it is always a better option than contacting NHS 111. They are also aware that there needs to be better targeting of 111 to get the right people to use the system and there is a need to accept that there will always be a few who will walk through the A&E front door and they will have to be supported too.

(b) Jon Williams (Executive Director, Healthwatch Hackney) expressed concern about the lack of patient and public involvement in recent health changes mainly because of speed of change during the pandemic and on concerns they have about the return of a more medicalised model of health care. He said there will be a need to recover the situation once the pandemic had passed. He noted that the emerging partnership priorities coming out of the Integrated Commissioning Board were very medicalised and care needed to be taken about this. If we lose sight of the wider ambitions for public involvement, he added, we won't be able to tackle the transformation work which is necessary.

NG replied that through the emergency response they were moving at such a pace that they didn't consult and collaborate with service users in the way they normally would have because it hadn't been feasible to do so. They had now started doing this again and have public representatives on the Discharge Steering Group for example. She referenced a CCG event that week on Winter Pressures involving the community and hoped to work more closely with Healthwatch on more of those. On the over

medicalised model, she stated she was surprised to hear this and said she had seen the opposite in the winter planning work where they were much more focused on how to support vulnerable communities. It had taken a broader and much less medicalised approach but she would take Healthwatch's comments on board.

(c) Members asked about the need to improve on the Coordinate My Care system. Cllr Snell reminded members that the Commission's own End of Life Care review had uncovered that some care homes were unhappy about discharges from acute to care home settings and of a poor working relationship between acute providers, London Ambulance Service and the care homes. NG replied that 'My CMC' was about to be implemented as the next phase of CMC and that is would be the more user-led side of this care planning tool.

(d) Members asked about the national announcement of a write-off of the debts of NHS Acute Trusts and expressed concern that top down reorganisation of the NHS would be imposed on Hackney and the borough would then be impacted by the much higher debts in neighbouring CCG areas. TF explained the budget changes in the NHS due to the pandemic. The issue of 'control targets' had been altered as a consequence of the whole financing regime changing with a shift to block contracts and use of new Covid money coming in to the system and the impact of unplanned expenditure which they hadn't anticipated. She explained the difference between 'aged debt' and the inability of some trusts to operate within their 'positive run rate' and how some trusts struggled with one or both of these requirements. She stated that HUHFT for example received £340m and planned to operate within that but some trusts find they cannot do so under their allocation, some were carrying over historical debt for whatever reason. It was the historic debt element that is affected by the changes, it is being taken out of the budget methodology which includes Revenue and being put in the Public Revenue Capital element. She added that this was quite a technical change and her Director of Finance would be in a better position to give a more detailed response. The Chair thanked her for this and stated that he and Cllr Snell would pick this up at the next INEL JHOSC meeting.

5.5 The Chair thanked TF and NG for their attendance and for their briefings and for their hard work during the whole pandemic period.

RESOLVED:	**That the report and discussion be noted.**

6 Covid-19 Test Trace and Isolate

6.1 Members gave consideration to a tabled presentation *Covid 19 update to Health in Hackney Scrutiny Commission*. This was tabled in order for it to be up to date on the day of the meeting.

6.2 The Chair welcomed for this item:

Chris Lovitt (CL), Deputy Director of Public Health, City and Hackney

6.3 CL took members through the highlights of his slide presentation on the latest Covid data for Hackney. It also detailed the latest news on the fast-developing plans for vaccinations. He stated that the tentative indications were that the rate of increase in infection was now slowing and they were hoping that the lockdown was now starting to have an impact. There were some worrying signs that rates for over 60s were rising again in Hackney and were higher than

the London average. A key concern was that that's where you got most of hospitalisations and deaths. The number of people being tested was slightly below the average for London but holding up well. The positivity rate was now back towards the average for London. Most of the Covid cases being diagnosed were in the 20-29s yr group and now rising in the 30-39s yr group. If the rise continued to creep up the age range there would be problems

6.4 The Chair asked whether the recent spike had been linked to parents of children in school. CL replied that it wasn't and recently there was quite a proportion of cases who picked it up pubs and hospitality venues. He illustrated the dense red spots in the map where there were a number of clusters. Over the border in Tower Hamlets there were spots arising from student halls of residence. Previously there had been a North-South split in the borough, but this was no longer the case. Wards in the North had seen significant drops. He stated that they were seeing the successes of the local contributions to the Test and Trace programme and there was a desire nationally now for local authorities to take on more of a role. The target for the national Test & Trace was 80% and City and Hackney locally had been able to get up to that level. He stated that there was obviously much interest in vaccinations and the finding of the latest efficacy trials was fantastic news. Public Health was still not able to get all the information necessary for example when will the vaccine be licensed and delivered and who will get priority and what the technical details of distribution will be. Work is ongoing and they were making plans at speed but he cautioned that what people were seeing in the news was the latest press releases from the vaccine manufacturers but a lot more detailed information was required by the Public Health system. On Rapid Testing he stated that they were now waiting for more detailed information from DHSC on the requirements and licences for these tests. Soon they should be able to provide more rapid test results and so be able to deploy to asymptomatic people. The new test centre in Stamford Court would begin the day after the meeting as a 7 day a week testing centre, thus increasing the capacity in the north of the borough. Capacity was now good.

6.5 Members asked detailed questions and in the responses the following was noted:

(a) The Chair asked about Hackney being in the pilot for new lateral flow tests noting that local authorities were supposed to get 10k of them, but it was unclear whether there would be strings attached. CL clarified that C&H would get 10k tests at first and then up to 10% of local population perhaps every fortnight. It was not yet clear what the dynamics of that testing regime will be, and which areas or cohorts would be targeted for rapid testing and the frequency of that testing. He added that we needed to be clear whether this was a pilot and for how long as it is always a challenge in public health to know when to stop doing something as much as when to start.

(b) Members asked what was being done to prevent second spike in north of borough and about the need for more data on the spread of Covid in schools

CL replied that it would be difficult to predict when any second spike might occur. Lots of work had been undertaken to improve communications and messaging in the north of the borough as well as some enforcement and these had proved successful There

was a need to ensure we don't get those high rates again, he added. If this happened, they would immediately up the messaging and engagement, as necessary. As regards schools, they did not have a league table on Covid. All schools have school bubbles and he could provide more detail on specifics on request. There was a detailed spread sheet. He added that if we get the lateral flow testing, schools would be very good places to start to deploy them.

(c) Members asked about how vulnerable residents might secure help with transport to test centres as some are remote and also about the risks to the elderly in pubic parks from accidental exposure from passing joggers and what might be done to mitigate this e.g. one way systems in park.

CL replied that for those having transport issues they could always access tests by going online and the test would be sent to them to arrive the next day. They had ensured there was a good distribution of test centres and there were four in the borough and one in the City.

On the issue of dangers from joggers, most transmission was via droplets so it was a concern. The suggestion of one-way traffic systems in parks was a good one and he would take that away and discuss with the other relevant departments in the Council. Public Health encouraged people, particularly the elderly, to get out and do physical activity so this shouldn't be curtailed but again, it would be important to keep a 2m distance from joggers where possible.

(d) JW asked whether harsher police enforcement would be properly publicised to the community in advance, in order to assist better community relations, as many in the community can be distrustful of institutions.

CL replied that Cllr Kennedy was fully aware of the work being done here with the police on ensuring that there is clear messaging in the community. They were making it clear that if you don't comply with the public health regulations you run risk of enforcement action and fines of up to £10K have been levied. There was more to be done but there was very clear messaging and those fines were very substantial for an individual.

(e) Cllr Kennedy commented that he had been on a group call of a Cabinet Members for Health with the Secretary of State and when Mr Hancock was asked when and how the lateral flow tests would be resourced he had replied "Yes, I can hear you".

6.5 The Chair thanked CL for his report and for his attendance.

RESOLVED:	**That the report and discussion be noted.**

7 Senior Management Restructure in Adult Services

7.1 The Chair stated that he had asked for an update on some significant senior management changes which had taken place in Adult Services in the Council and Members gave consideration to a short briefing note. He welcomed for this Denise D'Souza (DD), Interim Group Director for Adults, Health and Integration.

7.2 DD stated that she had started work in Hackney relatively recently and when she had arrived she fully supported the plans in train to split the Adults and Childrens' Divisions. A previous authority she had worked at had trialled a merger and it had not been a success. She stated that in terms of the statutory responsibilities she is answerable to CQC and DHSC whereas Anne Canning is answerable to DfE and Ofsted. When she first joined the CACH directorate meetings were heavily focused on children's issues, as necessary, and adults' issues sat further down the pecking order on the agenda. The new structure will afford greater focus on Adult Services and because there can have more time, they can do things a bit differently and support each other in different ways. The system has to work for the borough she added and while "twin hatters" as they're described can work in very small boroughs, it is not suitable in a borough like Hackney. There was also a need to ensure that Public Health can keep its own focus and of course there was an ongoing challenge around transition to adult services. Because of this they will of course keep a focus on the joint work and try and enhance it. In the context of Covid pressures, pressures on the care system and the impact of the recent cyber attack, she was confident that this change was the right decision for the borough.

7.3 The Chair asked whether the Director of Health Integration was a permanent post. DD replied that it has now been fully funded. In the original DPR it had been for just 2 years but would now be a permanent post.

7.4 The Chair thanked DD for her report and for her attendance.

RESOLVED:	**That the report and discussion be noted.**

8 Minutes of the Previous Meeting

8.1 Members gave consideration to the draft minutes of the meeting held on 14 October and noted the matters arising.

RESOLVED:	**That the minutes of the meeting held on 14 October be agreed as a correct record and that the matters arising be noted.**

9 Work Programme 2020/21

9.1 Members' gave consideration to the updated work programme for the Commission. The Chair stated that the next meeting would include a focus on the digital divide in primary care and some concerns about poor access during the pandemic and the challenges there.

RESOLVED:	**That the updated work programme be noted.**

10 Any Other Business

10.1 There was none.

Duration of the meeting: 7.00-9.00 pm

Hackney

Health in Hackney Scrutiny Commission 6th January 2021 **Work Programme 2020/21**	Item No **9**

OUTLINE

Attached please find the latest iteration of the Commission's Work Programme. Please note this is a working document and is regularly updated.

ACTION

The Commission is requested to note the updated work programme and make any amendments as necessary.

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Health in Hackney SC - Rolling Work Programme for 2020-21 as at 18 Dec 2020

Date of meeting	Item	Type	Dept/Organisation(s)	Contributor Job Title	Contributor Name	Notes
9 June 2020	**Covid-19 Response**	Discussion Panel	Public Health	Director of Public Health	Dr Sandra Husbands	
deadline 31 May			Public Health England	Regional Director for London	Prof Kevin Fenton	
			Independent SAGE/ UCL	Professor at UCL	Prof Anthony Costello	
			Independent SAGE/ University of Newcastle	Professor at Newcastle	Prof Allyson Pollock	
			Durham County Council	Director of Public Health	Amanda Healy	
	Appointment of members to INEL JHOSC	Decision	Legal	Monitoring Officer		
9 July 2020	**Election of Vice Chair 20/21**	Decision	Legal	O&S Officer		
deadline 30 June	**Homerton Hosptal's contract for soft services**	Inquiry	HUHFT	Director of Finance	Phil Wells	
			HUHFT	Director of Workforce and Organisational Development	Thomas Nettel	
			UNISON	Area Officer for NHS	Michael Etherdige	
			UNISON	Unison rep at ISS	Naomi Byrne	
			GMB Union	Regional Organiser for NHS	Lola McEvoy	
	An Integrated Care System for NEL	Briefings	City & Hackney CCG	Managing Director	David Maher	
			City & Hackney CCG	Chair	Dr Mark Rickets	
	Covid-19 City & Hackney Restoraton and Resilience Plan	Briefings	City & Hackney CCG	Managing Director	David Maher	
			City & Hackney CCG	Chair	Dr Mark Rickets	
	Covid-19 update on Test, Trace and Isolate	Monthly briefings	Public Health	Director of Public Health	Dr Sandra Husbands	
30 July 2020 URGENT	**Re-location of inpatient dementia assessment services from Mile End Hospital to East Ham Care Centre**	Urgent briefing	ELFT	Consultant Psychiatrist and Clinical Lead for Older Adult Mental Health	Dr Waleed Fawzi	
			ELFT	Director of Operations	Edwin Ndlovu	
			Barts Health NHS Trust	Chair of Medicine Board and Outpatient Transformation	Neil Ashman	
			City & Hackney CCG	Programme Director Mental Health	Dan Burningham	
			City & Hackney CCG	Managing Director	David Maher	
	Covid-19 update on Test, Trace and Isolate	Monthly briefings	Public Health	Director of Public Health	Dr Sandra Husbands	
23 Sept 2020	**Covid-19 update on Test, Trace and Isolate**	Monthly briefings	Public Health	Deputy Director of Public Health	Chris Lovitt	

deadline 14 Sept	**An Integrated Care System for NEL**	Briefings	City & Hackney CCG	Managing Director	David Maher	
			City & Hackney CCG	Chair	Dr Mark Rickets	
			HUHFT	Chief Executive	Tracey Fletcher	
	Planned Care Workstream	Annual update	CCG-LBH-CoL	Workstream Director Planned Care	Siobhan Harper	
	Healthwatch Hackney Annual Report 2019/20	Annual report	Healthwatch Hackney	Executive Director	Jon Williams	
14 Oct 2020	**City & Hackney Safeguarding Adults Board Annual Reprot 2019/20**	Annual report	CHSAB	Independent Chair	Dr Adi Cooper OBE	
deadline 5 Oct			CHSAB/LBH	Head of Service Safeguarding Adults	John Binding	
	Children, Young People, Maternity and Families Workstream - Joint item with CYP Scrutiny Commission	Annual update	CCG-LBH-CoL	Workstream Director CYPMF Workstream	Amy Wilkinson	
	HUHFT Quality Account 2019-20	Annual report	HUHFT	Chief Nurse and Director of Governance	Catherine Pelley	
	Covid-19 update on Test, Trace and Isolate	Monthly briefings	Public Health	Director of Public Health	Dr Sandra Husbands	
18 Nov 2020	**Covid-19 and Care Homes**	Discussion Panel	Adult Services	Interim Strategic Director of Adult Social Services, Health and Integration	Denise D'Souza	
deadline 9 Nov			Acorn Lodge Care Home	Manager	Diane Jureidin	
			LSE	Assistant Professorial Research Fellow in the Care Policy and Evaluation Centre	Adelina Comas-Herrera	
			The King's Fund	Senior Fellow - Social Care	Simon Bottery	
			HUHFT	Chief Executive	Tracey Fletcher	
			CCG-LBH-CoL	Workstream Director Unplanned Care	Nina Griffith	
			LBH	Cabinet Member for Health Social Care and Leisure	Cllr Chris Kenndey	
	Unplanned Care Workstream	Annual update	CCG-LBH-CoL	Workstream Director Unplanned Care	Nina Griffith	
	Covid-19 update on Test, Trace and Isolate	Monthly briefings	Public Health	Dep Dir of Public Health	Chris Lovitt	
	Senior management restructure in Adult Services	Briefing	Adult Services	Interim Strategic Director of Adult Social Services, Health and Integration	Denise D'Souza	
6 Jan 2021	**Covid 19 update on Vaccinations roll-out**	Briefing	GP Confederation	Chief Exec	Laura Sharpe	
deadline 18 Dec	**Covid-19 update on Test, Trace and Isolate**	Monthly briefings	Public Health	Director of Public Health	Dr Sandra Husbands	
	NEL system response to national consultation on ICSs	Briefing	CCG	Managing Director	David Maher	

	Cabinet Member Question Time	Annual session	LBH	Cabinet Member for Health Social Care and Leisure	Cllr Chris Kenndey	
23 Feb 2021	**Hackney Local Account of Adult Care Services**	Annual report	Adult Services	Interim Strategic Director of Adult Social Services, Health and Integration	Denise D'Souza	
deadline 12 Feb	**TBC**					
	TBC					
	TBC					
31 March 2021	**New governance structure for the C&H Integrated Commissioning Partnership and the NEL Integrated Care System**	Briefing	NEL ICS	Managing Director C&H	David Maher	
deadline 19 March			NEL ICS	Chair C&H	Dr Mark Rickets	
	Neighbourhood Health and Care Services Board	Briefing	NEL ICS	System Leader for City and Hackney NHCSB	Tracey Fletcher	
	New Population Health Hub of Integrated Commissioning Partnership	Briefing	Public Health	Director of Public Health	Dr Sandra Husbands	
	Work programme discussion for 2021/22					

Note: There are no meetings scheduled for Dec or April. Separately, the Mayor of London and London Assembly elections will take place on 6 May 2021. Purdah begins c. 1 April.

ITEMS AGREED BUT NOT YET SCHEDULED

Possible date						
	REVIEW on 'Digital first primary care and the implications for GP Practices'	Executive Response to report agreed 12 Sept 2019	LBH	Cabinet Member for Health Social Care and Leisure	Cllr Chris Kenndey	
	Work towards developing a Protocol for Primary Care digital consultations	Briefing requested Sept 2020	GP Confederation	Chief Executive	Laura Sharpe	
			Healthwatch Hackney	Executive Director	Jon Williams	
July 2021	**Relocation of inpatient dementia assessment services to East Ham Care Centre**	Update requested from July 2020	ELFT	Consultant Psychiatrist and Clinical Lead for Older Adult Mental Health	Dr Waleed Fawzi	
			CCG or NEL ICS	Programme Director Mental Health	Dan Burningham	
			Healthwatch Hackney	Executive Director	Jon Williams	
TBC	**Extension of ISS contract for soft services at HUHFT**	Update requested from July 2020	HUHFT	Chief Executive	Tracey Fletcher	
			UNISON			

TBC	**Pathology Partnership between HUHFT and Lewisham & Greenwich NHS Trust**	Update requested from Jan 2020	HUHFT	Chief Executive	Tracey Fletcher	
TBC	**Covid-19 action plans to address disproportionate impact on minority ethnic communities**	Either separate of focus of a monthly briefing	HUHFT			
			ELFT			
			Adult Services			
			Primary Care			
TBC	**Cabinet Member Question Time**	Annual item	LBH	Cabinet Member for Health Social Care and Leisure	Cllr Chris Kennedy	
TBC	**Integrated Learning Disabilities Service**	Update on new model	Adult Services	Head of LD Services	Ann McGale	
TBC	**Implementation of Ageing Well Strategy**	Update requested Dec 2019	SPED	Head of Policy and Strategic Delivery	Sonia Khan	
TBC	**City and Hackney Wellbeing Network**	Update on new model	Public Health	Consultant in Public Health	Dr Nicole Klynman	
Postponed from March	**Air Quality - health impacts**	**Full meeting**	King's College London	Academic	Dr Ian Mudway	
			Public Health	Public Health Consultant	Damani Goldstein	
			Environment Services Strategy Team	Head Environment Services Strategy Team	Sam Kirk	
Postponed from March	**King's Park 'Moving Together' project**	Briefing	King's Park Moving Together Project Team	Project Manager for 'Moving Together' project	Lola Akindoyin	
			Public Realm	Head of Public Realm	Aled Richards	
Postponed from 1 May	**Tackling Health Inequalities: the Marmot Review 10 Years On**	**SCRUTINY IN A DAY**	Public Health	Director of Public Health	Dr Sandra Husbands	
	Sub Focus on Objective 5: Create and develop healthy and sustainable communities		NEL ICS	MD City and Hackney	David Maher	
			Planning	Head of Planning and Building Control	Natalie Broughton	
			Neighbourhoods and Housing	Head of Area Regeneration Team	Suzanne Johnson	
			Benchmarking other London Borough			
Postponed from July	**Neighbourhoods Development Programme**	Annual Update	GP Confederation	Chief Executive	Laura Sharpe	
			GP Confederation	Neighbourhoods Programme Lead	Mark Golledge	
TBC	**Future use of St Leonard's Site and NEL Estates Strategy**	**Discussion Panel**	LBH Chief Exec		Tim Shields	
			Adult Services		Denise D'Souza	
			NEL ICS		Jane Milligan	
			NEL ICS		Dr Mark Rickets	

			NEL ICS		David Maher	
			HUHFT		Tracey Fletcher	
			ELFT		Paul Calaminus	
			GP Confederation		Laura Sharpe	
			Healthwatch Hackney		Malcolm Alexander	
			HCVS		Jake Ferguson	
			Hackney Keep Our NHS Public			
	How health and care transformation plans consider transport impacts	Suggestion from Cllr Snell				
	Implications for families of genetic testing	Suggestion from Cllr Snell				
	Accessible Transport issues for elderly residents	Suggestion from Cllr Snell				
	What does governance look like at Neighbourhood level	Suggestion from Jonathan McShane				

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Hackney

London Borough of Hackney
Health in Hackney Scrutiny Commission
Municipal Year 2020/21
Date of Meeting: Wednesday, 6 January 2021

Minutes of the proceedings of the Health in Hackney Scrutiny Commission held virtually from Hackney Town Hall, Mare Street, London E8 1EA

Chair	**Councillor Ben Hayhurst**
Councillors in Attendance	**Cllr Peter Snell (Vice-Chair), Cllr Kam Adams, Cllr Kofo David, Cllr Michelle Gregory, Cllr Deniz Oguzkanli, Cllr Emma Plouviez and Cllr Patrick Spence**
Officers In Attendance	**Denise D'Souza (Interim Director Adults, Health and Integration) and Dr Sandra Husbands (Director of Public Health, Hackney and City of London)**
Other People in Attendance	**Tracey Fletcher (Chief Executive, HUHFT), Cllr Christopher Kennedy (Cabinet Member for Health, Social Care and Leisure), David Maher (MD, NHS City & Hackney CCG), Cllr Yvonne Maxwell (Mayoral Advisor for Older People), Dr Caroline Miller (Chair, C&H GP Confederation), Dr Mark Rickets (Chair, City and Hackney CCG), Laura Sharpe (Chief Executive, City & Hackney GP Confederation), Cllr Carole Williams (Cabinet Member for Employment, Skills and Human Resources), Jon Williams (Executive Director, Healthwatch Hackney)**
Members of the Public	**9 during livecast and 128 subsequent views.**
YouTube link	**The meeting in full can be viewed at https://www.youtube.com/watch?v=euvYB3sfFms**
Officer Contact:	**Jarlath O'Connell** 020 8356 3309 jarlath.oconnell@hackney.gov.uk

Councillor Ben Hayhurst in the Chair

1 **Apologies for Absence**

1.1 There were none.

2 Urgent Items / Order of Business

2.1 There was no urgent business. During the meeting Members agreed with Cllr Kennedy to postpone item 7 to the next meeting to allow additional time for items 4 and 5.

3 Declarations of Interest

3.1 There were none.

4 Covid 19 update from GP Confederation on vaccinations roll-out

4.1 The Chair stated that the purpose of this item was to get an overview on the roll out of the Vaccination Programme which was an at early and crucial stage. He welcomed to the meeting:

Laura Sharpe (LS), Chief Executive, City and Hackney GP Confederation
Dr Caroline Millar (CM), Chair, City and Hackney GP Confederation
Tracey Fletcher (TF), Chief Executive, Homerton University Hospital NHS Foundation Trust (HUHFT)
Dr Mark Rickets (MR), Chair, City and Hackney CCG

4.2 The Chair thanked TF for also attending for this item considering the current pressures on her and asked if she would give a verbal update on the current situation re Covid 19 at the Homerton Hospital.

4.3 TF stated that the Trust was the 4th highest in the country for proportion of Covid patients. In the first wave they'd had 118 maximum at one time but currently they were over 200. The positive aspect was that they had learnt a lot since then and treatments were now getting much better and hopefully this would produce better patient outcomes. They currently had 330 beds occupied rather than the typical 250 and they had 25 ICU beds instead of their usual 10. She also described the staff vaccinations programme which had begun on 5 Jan.

4.4 The Chair, on behalf of the Commission, stated that the borough had an immense debt to the Homerton staff for their efforts at this very difficult time. He added that it was alarming that 48% of the in-patients were under 45 and commented that there was an urgent need for a public communications campaign about the age ranges of those who are being affected.

4.5 In response to a Member's question on staffing, TF stated that compared to others, it was low but still they had a 20% vacancy rate for Critical Care Nurses. Staff absences due to either Covid symptoms or needing to self-isolate for family reasons were lower than they had been in April but remained a challenge.

4.6 Members gave consideration to a tabled paper 'Covid 19 Vaccination Update' from the CCG and the GP Confed. Laura Sharpe stated that 965 first doses

had been given at the Elsdale St site. That was just about to close and be replaced by a new dedicated Vaccination Centre at Bocking St and she thanked the Council for its sterling efforts in providing the site and helping to get it up and running so quickly. She clarified that 2nd doses were given to the over 80s at Elsdale St who had received their first dose there because to do otherwise for this frail cohort would have caused too much disruption and distress. They had done 956 of the 5300 estimated to be in Category 1 (over 80s and care home staff) and they were working down the categories. The second priory was health and social care staff including GPs, nurses, reception staff, staff at St Joseph's. She stated that she was getting 800 emails a day at the GP Confed as well as phone calls with people asking when their turn would be, so there was an urgent need for a clear comms message to go out about waiting to be called. She looked forward to having Bocking St up and running in the next few days and again thanked the Council for its support. The following week the second vaccination centre, at John Scott Medical Centre, would open. A marquee was going up there. She commented that these sites required a lot of space because of the need for separate waiting areas before and after which must allow for social distancing. She stated that the patient flow had to be smooth and the support from the Hackney Volunteer Centre with this had been excellent. In a couple of weeks, they could potentially be 12 hr days, 7 days a week. She added that the AstraZeneca vaccine was being targeted for care homes as it was easier transport and store in care homes and 'supported living' sites. They would also use it for the housebound over 80s as the Pfizer vaccine can't go to individual houses. Another challenge here was to keep the 40 GP Practices resilient during all this and there were daily check-ins with them. She was pleased that the CCG provided further funding for them so they can to agencies to secure additional staff. Another issue was fear of de-prioritisation in primary care and this should not be a concern locally. They had however got permission from Public Health to temporarily suspend the Health Check program in order to release capacity for Covid work. She described how the 'Oximetry at Home' service operated. This had been set up in a day and it greatly helps with reducing A&E admissions.

4.7 Members asked questions and in the responses the following was noted:

(a) In response to a question on the possibility of 24-hour vaccinations and on how to upscale the service, LS stated that they'd already engaged retired doctors and got community pharmacists involved, the latter being great at administering doses and being 'guardians of the vaccine'. She also discussed the potential to also use of non-clinical staff for distributing the easier Astra-Zeneca vaccine. It would be easiest to train non-clinical staff if needed on the AZ vaccination because of easier handling. MR described the various mass vaccinations sites opening across east London over the following weeks e.g. Excel and Westfield. Once more staff can be vaccinated then they could roll out more centres and more timeslots and carry out intensive bursts of activity. LS agreed stating that staffing the current opening times was a challenge and 24hrs would be impossible unless they could train and vaccinate more staff. MR described the process for managing the rare few allergic reactions which might take place and how they've planned for that. Vaccines were only withdrawn from anyone with an allergic reaction to the first dose and vaccines were not being limited necessarily if people had bad reactions to other vaccines or treatments. MR added that the focus in the vaccination programme was on the most in need and the most vulnerable in the top cohorts.

(b) In response to a question on vaccine hesitancy she replied that the numbers declining the offer had been very small. Some had just asked to wait and see how it affected others before they proceeded and those were kept in the system to return to later.

(c) In response to a question on vaccine hesitancy in care home staff she replied that this certainly was a challenge, and that she was in talks with Public Health on how to tackle it.

(d) In response to a question on the need for more oximeters she explained how the Oximetry at Home service operated. It begins with a GP referral and then they go to the patient's home and teach them how to use the equipment and make a judgement about the patient's ability to manage. She added that they currently had 300 oximeters but that there were some supply chain issues because of high demand.

(e) In response to a question on concern about potentially using non-clinical staff for vaccinations LS replied that, if they were used, they would be properly trained and supervised. Currently all vaccinators were either GPs or Pharmacists. She acknowledged that some people might be hesitant if the vaccinators were students and this would need to be carefully managed.

(f) In response to a question on giving the public a choice of type of vaccine and whether they can be mixed she replied that people would not be offered a choice and that the vaccines could not be mixed.

(g) In response to a question from Healthwatch on the need for urgent comms support LS stated Comms had to be expanded as she was, for example, currently receiving 600 email enquiries a day with requests about times of appointments. She added that the current Comms staff from the council, CCG and City were going the extra mile in producing comms material and signage and she was grateful for their hard work.

(g) In response to a concern from Healthwatch on the need to work with Adult Social Care on an urgent education/awareness programme on vaccine hesitance among care home staff, the Chair urged the Interim Group Director Adults Health and Integration and the Exec Director of Healthwatch to liaise outside of the meeting on how this could be progressed.

ACTION:	**Exec Director of Healthwatch to discuss education/awareness training on vaccine hesitancy for care home staff with Interim GD Adults, Health and Integration.**

4.8 Cllr Snell described in detail work as volunteer at one of the Vaccination Hubs and what a positive experience it had been. Members and LS thanked him for his efforts.

4.9 The Chair thanked the GP Confederation and CCG staff for attending to give a briefing on this at such a hectic time.

RESOLVED:	**That the briefing paper and discussion be noted.**

5 Covid 19 update from Public Health on test, trace and isolate

5.1 Members gave consideration to a tabled presentation "Covid-19 Update" from the Director of Public Health and the Chair welcomed for this item:

Dr Sandra Husbands (SH), Director of Public Health

5.2 SH took Members through the report in detail which covered latest data on incidence, the current key messages, an overview of all the testing channels in Hackney, a summary of areas of future focus and an overview of local contact tracing. She stressed the need for a local testing strategy to be responsive so that they can get the best value out of it for the immediate situation. There was a focus for example on continuous testing of essential workers and those in high-risk settings who cannot work from home. She explained that if they just tested everyone and most refused to self-isolate not much would be achieved, the aim therefore must be to really target the testing where it would deliver the best outcomes in terms of halting the spread.

5.3 Members asked questions and in the responses from Dr Husbands the following was noted:

(a) In response to a question on schools being the correct priority, SH stated that they had ensured that schools were getting enough of the lateral flow tests. They had been advised that schools would get up to a maximum of 10k per week if needed. They were also supporting school staff to develop their capability to administer the tests. Similarly, they were working with ELFT on how to best administer the PCR tests to children with learning disabilities as that test was neither easy nor pleasant to take.

(b) In response to a question about members of medical teams being worried about having tests in case the result then seriously impacted the teams capacity she stated that for medical, social care and VCS frontline teams this was a big issue and the risk would have to be discussed and weighed up with managers.

(b) In response to a question on asymptomatic individuals testing negative and the frequency for repeating tests she stated that the general rule being applied currently was not to encourage testing of those with are asymptomatic. The PCR test was different however in that it is highly specific and also highly sensitive such that people might still be testing positive long after they had been ill. The rule was that if you have symptoms get a PCR test and if not opt for a Lateral Flow test.

(c) In response to a question on whether there were sufficient resources for Public Health she explained that the key challenge was not having enough trained staff and not being able to get them in place quickly enough something shared by all Public Health teams.

5.4 The Chair thanked the Director of Public Health for her detailed report and for her attendance.

RESOLVED:	**That the report and discussion be noted.**

6 NEL system response to national consultation on Integrated Care Systems

6.1 The Chair explained that on 26 November NHS England had launched a consultation on the next steps for Integrated Care Systems in England. It would close in two days, on 8 Jan, and City and Hackney's Integrated Care Board Members were contributing to the single formal response from the NEL system. NHSE was asking respondents to choose one of two possible options for enshrining ICSs in legislation, without triggering a distracting (in their words) top-down re-organisation. The options were:

Option 1: a statutory committee model with an Accountable Officer that binds together current statutory organisations.

Option 2: a statutory corporate NHS body model that additionally brings CCG statutory functions into the ICS. (their preferred option)

6.2 Members' gave consideration to the following 4 documents:

1.) *Integrated Care – next steps to building strong and effective Integrated Care Systems across England* – the consultation document from NHSE
2.) East London Health and Care Partnership's summary of the proposals and comments on implications and next steps, which went to the December meeting of City & Hackney ICB
3.) A briefing to City and Hackney's ICBs on the transitional governance plans from January (for their Dec meeting)
4.) NHS Providers' briefing on 26 Nov, setting out their position on the changes

6.3 The Chair welcomed for this item:

Dr Mark Rickets (MR), Chair of City & Hackney CCG
David Maher (DM), Managing Director, City & Hackney CCG
Cllr Christopher Kennedy (CK), Cabinet Member for Health, Social Care and Leisure

6.4 DM took Members through an overview of the context for the consultation and the key points that would go into the NEL response. He described the 5 pillars in the NHS Long Term Plan and how they had ushered in a suite of new service models, promoted a greater emphasis on prevention and on digital care. He added that of course the latter had been rapidly accelerated by the requirements of the pandemic response. The 5th pillar was the need to create ICS and bring partners closer together and to enshrine Primary Care Networks in every borough. NHSE and NHSI in this consultation appeared to be pushing for a statutory ICS Board with new powers and the challenge locally was to make this work for City and Hackney where there had already been great strides taken in partnership working over many years. He stated that the NEL system response would indicate a preference for Option 2 i.e. the creation of a statutory ICS body.

6.5 Members asked questions and in the responses the following was noted:

(a) The Chair stated that his own preference would instead be for Option 1 as Option 2 appeared very 'top down' and did away with any local veto there might have been and appeared to include far less stakeholder engagement. He asked the Cabinet Member for Hackney Council's position. CK replied that he was in discussions with the Mayor on a possible LBH specific response to complement the NEL one. He stated that different areas were all at very different stages in the development of their ICSs. He stated that, notwithstanding the success in east London, there remained concerns for example in Tower Hamlets about the WEL grouping, which had been an NHS construct, and therefore there was a danger of ending up on a body which had many discontented partners within it. He added that there was a widely held view that even if many opted for Option 1 it was most likely that we would all end up in Option 2 eventually because the legislation would be written in such a way as to make that an inevitability. He added that the challenge therefore in City and Hackney was to preserve what was best about how we worked locally and to ensure that our Health and Wellbeing Board was robust and well used.

(b) The Chair commented that Option 2 was the corollary of a devolved health system as it was very top-down and that Local Authorities barely featured in the paper. On point 2.43 about new powers it was necessary to ask what these would be precisely. He added that the NHS had, in the past, dismissed concerns about the creation of the Single Accountable Officer and proceeded anyway and that councils had been sold the idea that NEL ICS's three subsystems would be protected and instead it now turned out there would be just a single CCG which would evolve into a single ICS. Option 2 did not provide any reassurance about local accountability he added.

(c) DM replied that this was an engagement process and he had concerns that this was an NHSE-NHSI driven document rather than one from the DHSC itself. He explained that currently CCGs are not sovereign bodies they are instead subservient to the NHS Commissioning Board and this sought to correct that. He agreed that it will be necessary to lead the debate on the response that the concept of 'Place' must be defined as coterminous with local authority boundaries. MR added that CCG Chairs in east London had all led on the merger into the Single CCG. The principles regarding 'Place', regarding finance flows needing to flow down to boroughs and on the need for shared accountability would continue to inform all their work as the ICS evolved.

(d) In response to a question about permissions for personal data to be shared across various health bodies, MR explained how data sharing currently operated at the patient level and that the new data system was a great improvement from a clinical perspective as it ended the need to be sharing pieces of paper. As a GP he said he only ever saw a snapshot of a hospital record and there were careful checks and balances built into the system.

(e) In response to a question on how the ICS can take account of local priorities across 8 local authorities, DM stated that this was a challenge, but it would be made clearer as the ICS developed and the draft legislation is published. CK added that he thanked the Commission Members for their comments and stated he would take these to the meeting he was having with the Mayor to finalise a Hackney Council response which will feed into a North East London system response.

(f) In closing the discussion, the Chair stated that the hierarchy of NHSE clearly wanted Option 2 but the Commission Members continued to have major reservations about it. He added that City and Hackney had had a good locally devolved model

over the past few years and that these changes would mean the borough would lose some local autonomy.

6.6 The Chair thanked the Cabinet Member and the CCG guests for their attendance. It was noted that DM would be departing for a new post in Northampton shire at the end of March and Members thanked him for his service to Hackney and his always constructive engagement with the Commission. The Chair stated that more formal thanks would follow in due course.

RESOLVED:	**That the report and discussion be noted.**

7 Cabinet Member Question Time with Cllr Kennedy

7.1 Members agreed with Cllr Kennedy to postpone this item to the next meeting so that additional time could be given to items 4 and 5.

8 Minutes of the Previous Meeting

8.1 Members gave consideration to the draft minutes of the meeting held on 18 November and noted the matters arising.

RESOLVED:	**That the minutes of the meeting held on 18 November be agreed as a correct record and that the matters arising be noted.**

9 Work Programme 2020/21

9.1 Members' gave consideration to the updated work programme for the Commission. The Chair stated that he would continue with the approach of keeping the meetings topical because of the pandemic and its impacts, not least on the ability of officers to engage at present.

RESOLVED:	**That the updated work programme be noted.**

10 Any Other Business

10.1 The chair stated that Hackney was taking on, for two years, the Chair and the Secretariat for the Inner North East London Joint Health Overview and Scrutiny Committee from its next meeting on 10 February.

Duration of the meeting: 7.00-9.00 pm

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