Overview & Scrutiny

Inner North East London Joint Health Overview and Scrutiny Committee

All Members of the Inner North East London Joint Health Overview and Scrutiny Committee are requested to attend the meeting of the Committee to be held as follows:

Wednesday 10 February 2021,

7.00 pm
This meeting will be held virtually. You can watch the meeting via YouTube livestream at

Tim Shields
Chief Executive, London Borough of Hackney
Contact:
Jarlath O'Connell
☎ 020 8356 3309
✉ jarlath.oconnell@hackney.gov.uk

Members: **Cllr Ben Hayhurst, Cllr Peter Snell and Cllr Patrick Spence**
Co-Optees

Agenda

ALL MEETINGS ARE OPEN TO THE PUBLIC

Hackney

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Overview & Scrutiny

Inner North East London Joint Health Overview and Scrutiny Committee

All Members of the INEL JHOSC are requested to attend the meeting of the Committee to be held as follows

Wednesday, 10 February 2021

7.00 pm

This meeting will be held remotely and livestreamed on Hackney Council's YouTube channel at https://youtu.be/gXa0uuHcZrM

Contact:
Jarlath O'Connell
☎ *0771 3628561/ 020 8356 3309*
✉ jarlath.oconnell@hackney.gov.uk

Tim Shields
Chief Executive, London Borough of Hackney

Members: **Cllr Ben Hayhurst**
Cllr Peter Snell
Cllr Patrick Spence

AGENDA

ALL MEETINGS ARE OPEN TO THE PUBLIC

1	**Election of Chair and Vice Chair**
2	**Welcome and introductions**
3	**Declarations of interest**
4	**Covid-19 impacts in Secondary Care in INEL boroughs**
5	**Covid-19 Strategy for roll out of vaccinations in INEL boroughs**
6	**North East London System response to NHSE consultation on *'Integrated Care next steps to building strong and effective Integrated Care Systems across England'***
7	**Update on recruitment process for new Accountable Officer for NELCA and Senior Responsible Officer for ELHCP**
8	**Minutes of previous meeting**

9	**INEL JHOSC work programme**
10	**Any other business**

Agenda

Inner North East London Joint Health Overview and Scrutiny Committee (INEL JHOSC)

Date **Wednesday 10th February 2021**

Time **7.00 p.m.**

Venue **This meeting will be held remotely and livestreamed on Hackney Council's YouTube channel at https://youtu.be/gXa0uuHcZrM**

Contact: Jarlath O'Connell, Overview & Scrutiny Officer
jarlath.oconnell@hackney.gov.uk

Hackney currently holds the Secretariat for the 5-borough committee.

In order to comply with social distancing guidance issued by the Government and Public Health England arising from the Covid-19 pandemic, this meeting will be conducted via teleconferencing arrangements.

Should you have any accessibility requirements which we need to consider please contact the officer above.

Inner North East London Joint Health Overview and Scrutiny Committee (INEL JHOSC)

MEMBERSHIP at January 2021:

Common Councilman **Michael Hudson** - City of London Corporation
Councillor **Ben Hayhurst** - London Borough of Hackney
Councillor **Peter Snell** - London Borough of Hackney
Councillor **Patrick Spence** - London Borough of Hackney
Councillor **Ayesha Chowdhury** - London Borough of Newham
Councillor **Anthony McAlmont** - London Borough of Newham
Councillor **Winston Vaughan** - London Borough of Newham
Councillor **Shah Suhel Ameen** - London Borough of Tower Hamlets
Councillor **Mohammed Pappu** - London Borough of Tower Hamlets
Councillor **Gabriela Salva-Macallan** - London Borough of Tower Hamlets
Councillor **Umar Ali** - London Borough of Waltham Forest
Councillor **Nick Halebi** - London Borough of Waltham Forest
Councillor **Richard Sweden** - London Borough of Waltham Forest

OBSERVER MEMBER:
Councillor Neil Zammett - London Borough of Redbridge

SUBSTITUTES:
Common Councilman Christopher Boden (Substitute Member) - City of London Corporation

Agenda

No.	*Item*	*Contributor*	*Duration*	*Timing*
1	Election of Chair and Vice Chair		3 mins	19.00
2	Welcome and introductions		1 min	19.03
3	Declarations of interest		1 min	19.04
4	**Covid-19 impacts in Secondary Care in INEL boroughs - verbal update** Dashboard of main pressures on the Barts Health Hospitals due to Covid (e.g. age ranges of cohorts, acuity, need for tranfers, oxygen provision, staffing challenges, discharge barriers, step down in elective care)	Alwen Williams	10 min update 20 mins Q&A	19.05
5	**Covid 19 Strategy for roll-out of vaccinations in INEL boroughs – summary paper** - Overview of progress in vaccinations in INEL boroughs	A clinician TBC and Jane Milligan	10 min update 20 min Q&A	19.35
6	**ELHCP's response to NHSE consultation on *'Integrated Care next steps to building strong and effective Integrated Care Systems across England* submitted on 8 Jan - verbal update** - To explain NEL System's response and its rationale	Marie Gabriel and/or Henry Black agenda to include: a) original consultation document b) ELHCP's response	5 min update and 10 min Q&A	20.05
7	**Update on recruitment process for new Accountable Officer for NELCA and Senior Responsible Officer for ELHCP**	Marie Gabriel	5 mins	20.20
8	Minutes of previous meeting and Matters Arising		1 min	20.25
9	INEL JHOSC future work programme		3 mins	20.26
10	Any other business		1 min	20.29

Note: Any 'Submitted Questions' or Petitions will be dealt with under the relevant agenda item.

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Item No **4**	**INNER NORTH EAST LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (INEL JHOSC)**
Report title	**Covid-19 impacts in Secondary Care in INEL boroughs**
Date of Meeting	10 February 2021
Report Author	Dame Alwen Williams DBE Group Chief Executive, Barts Health NHS Trust
Attending	Dame Alwen Williams DBE Group Chief Executive, Barts Health NHS Trust
OUTLINE	The purpose of the item is to receive a verbal update from the Chief Executive of the largest acute trust in the INEL area on the main pressures being experienced in secondary care at present due to the Covid-19 pandemic. This includes an overview on: the numbers affected, age ranges, acuity, the need for transfers, oxygen provision, staffing challenges, discharge barriers and challenges with step down in elective care.
RECOMMENDATION	The Committee is requested to NOTE and where necessary to COMMENT on the report.

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Item No **5**	**INNER NORTH EAST LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (INEL JHOSC)**
Report title	**Covid-19 – strategy for roll-out of vaccinations in INEL**
Date of Meeting	10 February 2021
Report Author	Jane Milligan (Accountable Officer for North East London Commissioning Alliance and Senior Responsible Officer for East London Health and Care Partnership)
Attending	Jane Milligan (Accountable Officer for North East London Commissioning Alliance and Senior Responsible Officer for East London Health and Care Partnership) Dr Mark Rickets, Chair City and Hackney CCG David Maher, Managing Director, City and Hackney CCG
OUTLINE	The purpose of the item is to receive an overview of the progress being made with the Covid-19 vaccinations programme in the INEL boroughs. Attached please find a briefing report. Also the most up to date national Covid vaccinations data can be found on this webpage https://www.england.nhs.uk/statistics/statistical-work-areas/covid-19-vaccinations/
RECOMMENDATION	The Committee is requested to NOTE and where necessary to COMMENT on the report.

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East London Health & Care Partnership

Covid-19 update for INEL JOSC
10 February 2021

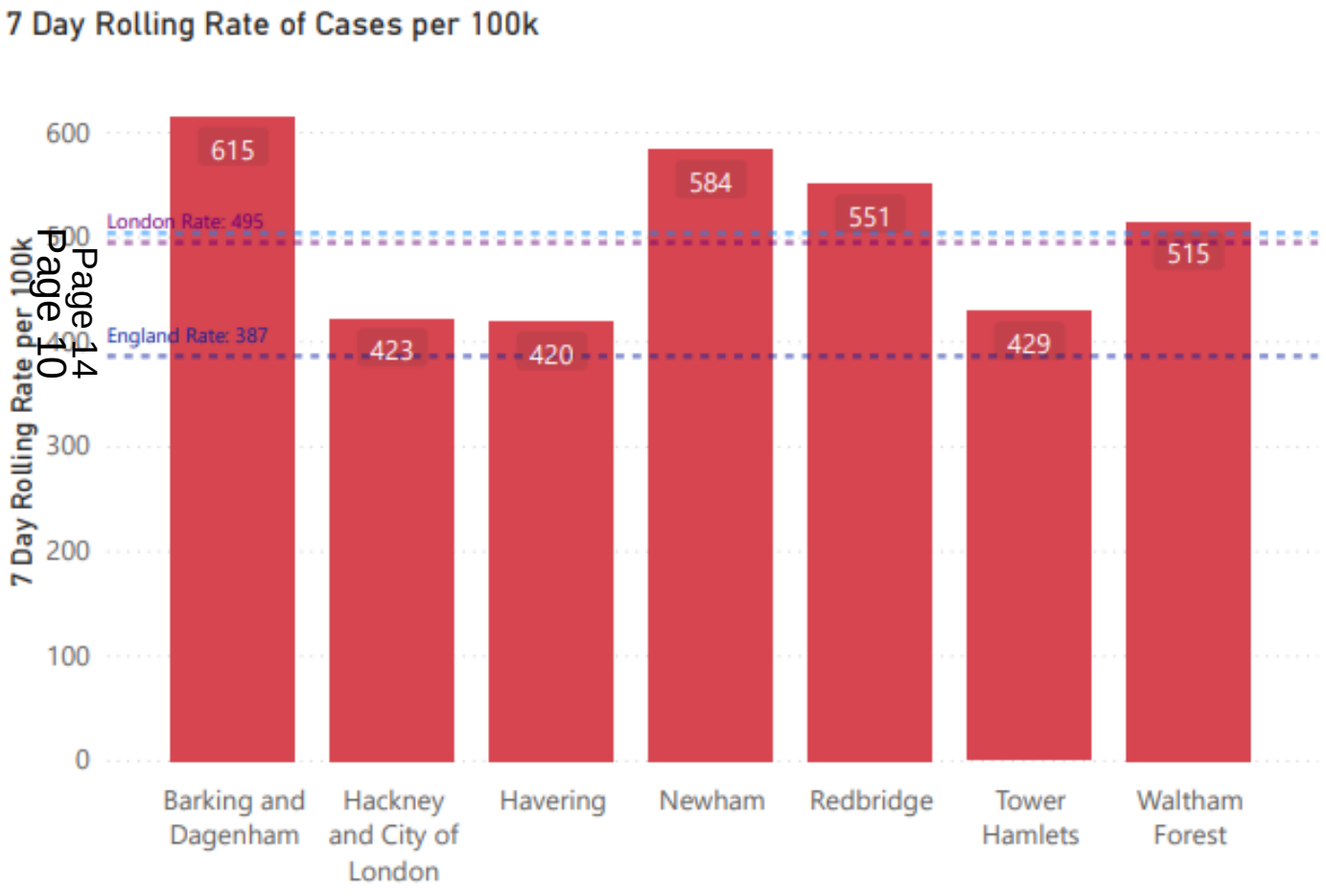
- Prevalence of Covid
- Vaccine progress
- Vaccine sites
- How you can help
- Frequently Asked Questions

The data provided is from 28 January 2021, unless otherwise stated.

Covid-19 prevalence

Last day reported 23 Jan

East London Health & Care Partnership



Weekly Change (% cases)

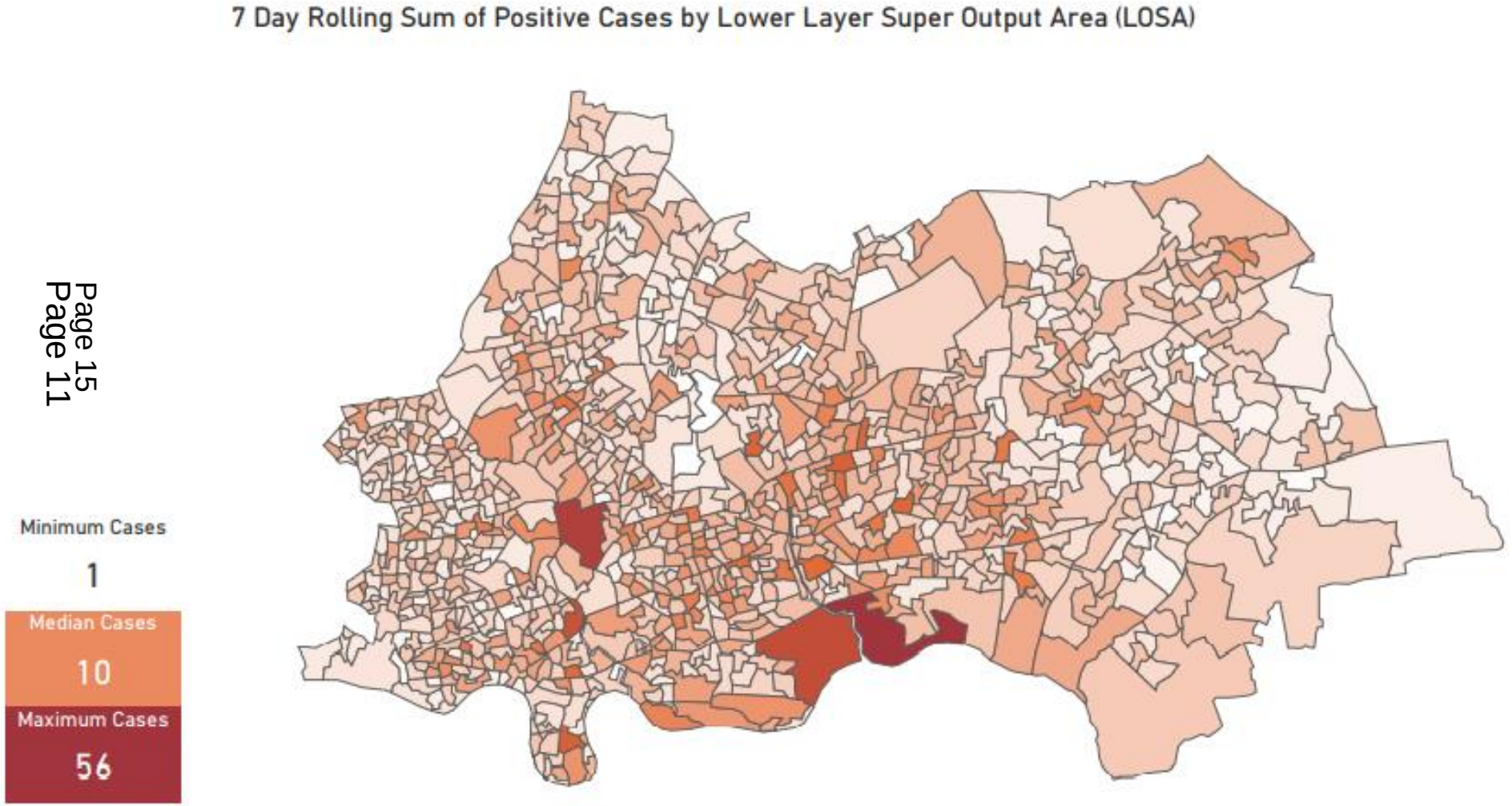
Barking and Dagenham	-33.4%
Hackney and City of London	-35.1%
Havering	-37.5%
Newham	-35.4%
Redbridge	-28.3%
Tower Hamlets	-40.0%
Waltham Forest	-31.9%

Data source: PHE testing dataset. Data is reported with a weekly lag due to the way data is captured.

Covid-19 prevalence

Last day reported 23 Jan

East London Health & Care Partnership



Data source: PHE testing dataset. Data is reported with a weekly lag due to the way data is captured.

Vaccine progress - headlines

East London Health & Care Partnership

- We have now vaccinated:
  - around 150,000 people in north east London. That's about half of cohorts 1-4 (which account for about 88% of Covid deaths).
  - Over 3,000 residents in care homes for older people (66% of the cohort)
  - 38,000 people aged 80 and over (66% of the cohort)

  We have also given around 9,000 second doses

We are on track to vaccinate all those who wish to be vaccinated in cohorts 1-4 by mid February i.e.

1. All residents in care homes for older adults and staff
2. Everyone aged 80 and over and all frontline health and social care staff
3. Everyone aged 75 and over
4. Everyone aged 70 and over and those who are clinically extremely vulnerable

- The order in which we are vaccinating residents is determined by the JCVI (Joint Committee on Vaccination and Immunisation).

Vaccination settings

East London Health & Care Partnership

- **Primary care-led vaccination centres**
  - Patients contacted by local primary care to attend a local site
  - Roving teams visiting care homes, the housebound and other settings to vaccinate those who are unable to come to a vaccination centre
- **Centres booked through the national booking portal**
  - Patients generally contacted by letter sent nationally, although this will be supplemented locally
  - Large scale vaccination sites. Currently Excel in Newham and Westfield
  - Community pharmacies.
- **Hospital vaccination hubs – aimed at staff and visitors to hospitals**
  - All of our NHS acute providers have established vaccination clinics
  - Mainly vaccinating frontline NHS staff, social care and home care staff, other health and care staff who work for private providers, charities etc

North East London vaccination centres

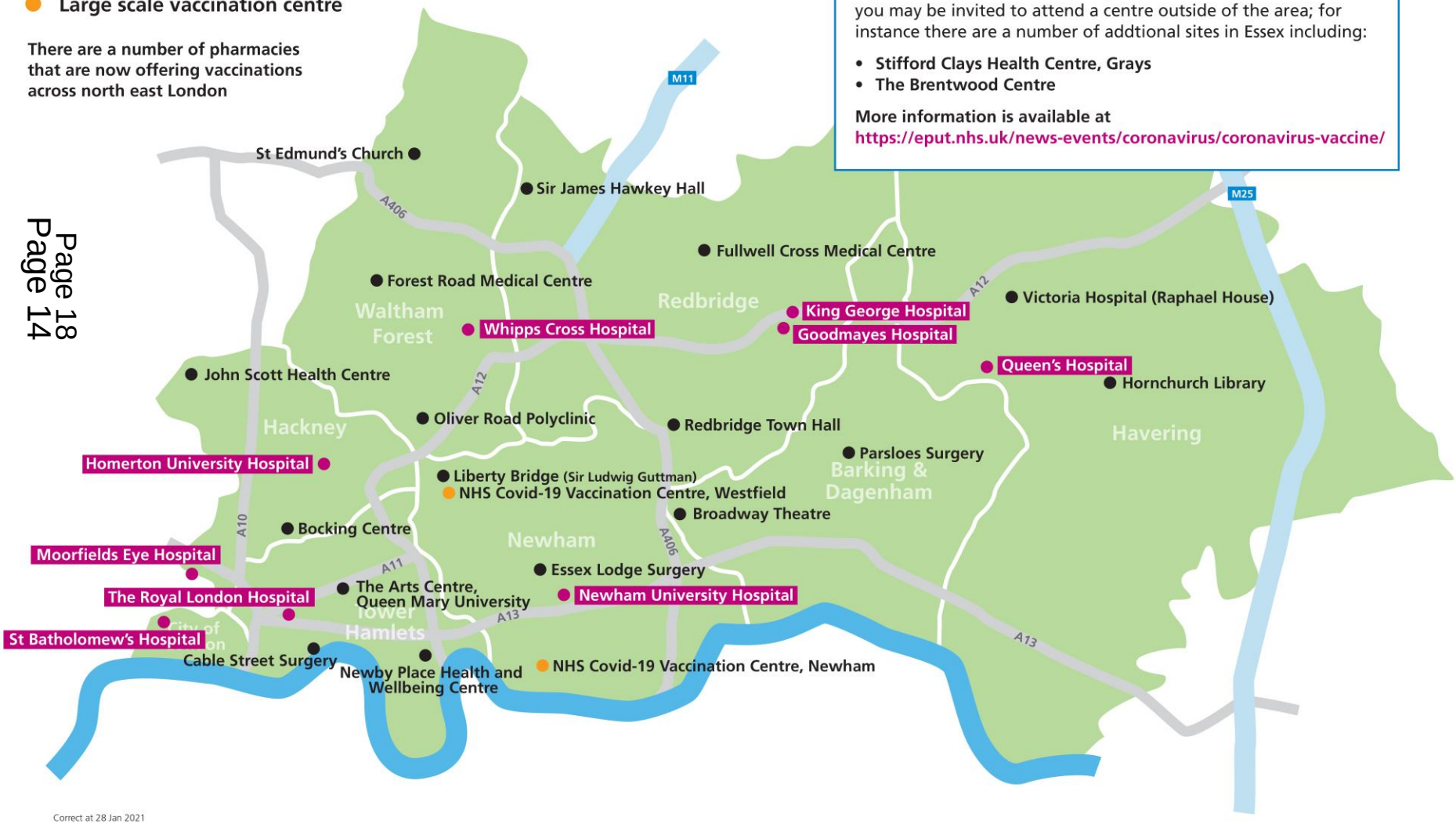
- Hospital vaccination hubs
- Primary Care vaccination centres
- Large scale vaccination centre

There are a number of pharmacies that are now offering vaccinations across north east London

If you are registered at a GP surgery outside of North East London you may be invited to attend a centre outside of the area; for instance there are a number of addtional sites in Essex including:

- Stifford Clays Health Centre, Grays
- The Brentwood Centre

More information is available at
https://eput.nhs.uk/news-events/coronavirus/coronavirus-vaccine/



Correct at 28 Jan 2021

How you can help…

1. **Please help the NHS by not contacting us for a vaccine**. We are prioritising vaccinating people who experts have agreed will benefit the most. We will let people know when it is their turn. People can visit www.eastlondon.nhs.uk/ourplans/covid-19-vaccination-programme.htm for details. Please **attend your booked appointment**
2. Follow all the guidance to **control the virus and save lives**. NHS services are really stretched at the moment, we need to you to protect yourself, your family, friends and others, and your NHS. The latest national guidance on how to keep yourself and your loved ones safe is available here.
3. Follow our social media, **dispel untrue statements**, point people to our website for the facts: www.eastlondon.nhs.uk/ourplans/covid-19-vaccination-programme.htm
4. **Don't get taken in by scams.** The NHS will never ask you for money for a vaccination.
5. If you would like to **volunteer** book online here: https://www.bankpartners.co.uk/northeastlondon/vacbank/jobs/

Frequently Asked Questions

East London Health & Care Partnership

- **We are using all vaccine that is provided to us**. We are ensuring as more vaccine becomes available we will continue to use every dose.
- We **are currently contacting anyone aged 70+, care homes and frontline health and social care staff, and anyone who is clinically extremely vulnerable**.
  - If you get more than one invitation, choose the most convenient
  - We will be opening up more sites
  - We will come to you if you are housebound
- The **vaccine will not protect you if you haven't had it.**
- The MHRA, the **official regulator has said the vaccines have good safety profiles** and offer a high level of protection.
- There are **no foetal/meat/animal derivatives,** or porcine products
- **Second doses have been postponed** because even with just one dose the Pfizer/BioNTech vaccine and the Oxford/AstraZeneca vaccine have been estimated to offer 74-89% effectiveness from two weeks after it is given.
  - Every time we vaccinate someone a 2nd time, we are not vaccinating someone else for the first time. If a family has two elderly grandparents and there are two vaccines available, it is better to give both 80% than to give one 95 % protection with two quick doses, and the other grandparent no protection at all.

Item No **6**	**INNER NORTH EAST LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (INEL JHOSC)**
Report title	**North East London System response to NHSE consultation on *'Integrated Care next steps to building strong and effective Integrated Care Systems across England'***
Date of Meeting	10 February 2021
Report Author	a) *Integrated Care – next steps to building strong and effective Integrated Care Systems across England* – a consultation document from NHSE and NHSI b) East London Health and Care Partnership's response
Attending	Marie Gabriel, Independent Chair, North East London Integrated Care System
OUTLINE	On 26 November NHS England launched a consultation on the next steps for Integrated Care Systems in England. They asked respondents to choose: *Option 1: a statutory committee model with an Accountable Officer that binds together current statutory organisations.* *OR* *Option 2: a statutory corporate NHS body model that additionally brings CCG statutory functions into the ICS*. (their preferred option) On 8 January East London Health and Care Partnership responded to the consultation on behalf of the partners in the NEL area.
RECOMMENDATION	The Committee is requested to NOTE the response.

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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 effect 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 2021.

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 24 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. ICSs therefore have the potential to reduce bureaucracy through increased collaboration, leaner oversight through streamlined assurance structures and smarter data-sharing agreements.

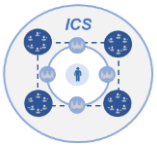
1.8. To deliver the core aims and purposes set out above, we will need to devolve more functions and resources from national and regional levels to local systems, to develop effective models for joined-up working at "place", ensure we are taking advantage of the transformative potential of digital and 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.

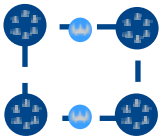
1.15. Our ambition is to create an **offer to the local population of each place**, to ensure that in that place everyone is able to:

- 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 need 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. The 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 or 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; and
  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 citizens' 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 the 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 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 electronic patient records (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; and

- 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 removing 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 the 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 they 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 a 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 take 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 contact england.legislation@nhs.net or write with any feedback to NHS England, PO Box 16738, Redditch, B97 9PT by Friday 8 January 2021.

4.29. 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

NHS England and NHS Improvement
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8 January 2020

Via email

North East London Integrated Care System response to the NHSE/I paper "Next steps for integrated care"

As a newly designated ICS we have shared and discussed the paper in a number of different forums and with a range of stakeholders including provider CEOs, LA CEOs, CCG Chairs, Healthwatch representatives and staff. We have been on a journey to become an ICS over the last few years and are pleased that the paper is in line with our direction of travel and that neither of the options laid out in the legislative proposals will disrupt our intentions. The proposals need to ensure that as an ICS we can devolve decision-making and resources as far as possible to local partnerships of NHS bodies and local authorities, building on the Integrated Care Partnerships and other arrangements that have been developed already and which have strengthened during the response to the ongoing Covid-19 pandemic.

In principle our preference is option two which we believe will help us move to a more integrated way of working sooner. It will bring more stability for our staff and provide the accountability and leverage for the ICS to deliver its priorities. However the detail of how it will work needs further clarity as follows:

- Detail is needed on areas such as managing conflict, change and transformation and managing situations where not everyone is in agreement so that decision making is not slowed down and is as seamless as possible.
- The paper suggest that no organisation can veto a decision but how would this work in reality? There is a balance to be made between sharing ownership and responsibility and the statutory responsibility of individual bodies, so careful thought needs to be given to the governance that frames this.
- Given the above, we believe that it is not just the roles of CCGs that need to change; the statutory powers and responsibilities of Foundation Trusts will also need to change to ensure they are more firmly grounded in order to focus on delivery of ICS outcomes.
- A duty to co-operate is quite loose and we will need some stronger incentives and requirements to make delivering population health everyone's business. A clear financial and contracting framework better suited to aligning system priorities is required – enabling resources to be invested in line with population need and supporting organisations to work together to drive value rather than encourage them to act independently to drive growth. National versus local priorities and measures of performance will be critical as well as a mechanism for agreeing this across multiple partners. What are the levers to exert in order to develop system accountability for whole population planning if differences/clashes exist between partner organisations' priorities?
- One of the cornerstones of CCGs is the importance of clinical leadership – particularly that of experienced primary care leaders. We would like to see the legislation maintain and develop the voice of clinical leaders from primary care and demonstrate how the local voice continues to be heard in the new governance, ensuring we do not lose what we have in place already.
- Similarly, there needs to be more clarity about how the lay members and non-executives will be involved and able to influence at an ICS rather than just at the organisational level.

- Because of our size as an ICS, with a population of around 2 million, as well as our seven place based partnerships matching our local authority boundaries, we also have Integrated Care Partnerships covering more than one borough. We welcome the emphasis on the role of place but further clarity is needed on the relationship with other local partnerships. In addition there needs to be a stronger emphasis on joint commissioning and delivery of integrated health and care at a place level.

For north east London it is essential that any changes ensure there is a greater emphasis on the role of local authorities in addressing health inequalities and improving health outcomes as well as their role in strengthening democratic accountability in decision making. Additionally we fundamentally believe any development of integrated care needs to develop the importance of meaningful and systematic participation of residents.

North east London response to the feedback questions:

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?

In principle, we are supportive of the move to ensure ICSs have the right statutory footing and authority to make effective decisions and be held accountable to the local population. We have been working closely as providers and commissioners for some time and would welcome the opportunity to establish decision making joint committees and formally bring together providers and commissioners. It is important that the legislation should provide a foundation not just for the NHS but for a genuine partnership of the NHS with local government across health services, social care and the wider determinants of population health.

Q.2. 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?

Ultimately we would welcome legislative change with minimal disruption particularly as we continue to respond to the ongoing Covid-19 pandemic, but at the same time ensures there is robust decision making and resources to strengthen partnerships of NHS and local government at a local level.

Option two makes the most practical sense and would be best particularly for our staff, noting the reassurance for CCG employees with regard to terms and conditions. We welcome the reassurance about the continued need for commissioning functions and the role this will play. However we would also welcome further clarity on ‘repurposing CCGs’, particularly clarity and reassurance around what happens to the CCG’s legal duty to involve patients and residents if CCGs are abolished.

We also welcome the emphasis on the role of local government in future plans for ICSs as they are an equal partner around the table and it is essential that any change allows us to strengthen the relationships and approach we have already developed and builds on our significant progress to date. In many ways, the proposal could go further and be more ambitious about the role of health and social care integration as it is light on details around social care. Additionally the proposal could define how ICS’s plan and provide their own services to ensure greater integration with local authorities. Further clarity is also needed on continuing health care (CHC) and the Better Care Fund where local government and NHS responsibilities and financial regimes are currently blurred.

We have made great strides in developing our provider alliances, particularly over the last 12 months and welcome the opportunity to continue to develop these as well as our place based approach which is fundamental to the way we work in NEL.

Finally, it would be helpful if the legislation could provide the necessary support to ICS's to ensure that when out of hospital services are transformed there is a focus on place based working, including primary care, community and mental health services, with an emphasis on local provision and addressing health inequalities.

Q.3 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?

Certainly across north east London we have built our integrated approach around what works best for each place, rather than applying a one size fits all arrangement. For example our three CCGs in BHR have worked collectively since 2013 and have a well-established integrated care partnership and the same approach across our City and Hackney footprint, whereas across Tower Hamlets, Newham and Waltham Forest we work much more on a borough basis. Shaping our own governance arrangements to best suit population need would be essential for us to ensure we continue to build on the progress we have already made. We would like to ensure that any change enables local partnerships to take initiatives and have discretion to use resources to respond to local need. The legislation should clarify the functions best dealt with at ICS level (and regional and national level) with a strong presumption that as much decision making as possible should be at local level.

In addition we do want a strong voice for our primary care colleagues ensuring there is good primary care representation as part of our ICS governance, so further clarity on this would be helpful and the freedom and scope to create our own approach utilising the strong clinical voice we have across NEL is essential.

Q.4 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?

In principle, yes we do agree to this. However we would want to see greater clarity on how this would work in practice, in particular clinical pathways and the operating model and population management approach. Given our close proximity to other London ICSs as well as Essex we would want to see an approach that took in to account population flow as well as footprint.

Across NEL we have already made significant progress with how we operate services such as cancer across a broader footprint and we would welcome the opportunity to build on this and reduce some of the layers of governance.

In conclusion we are broadly supportive of the proposals laid out in the paper and would welcome further clarity on the areas outlined. Our overarching priority is what is best for patients and their engagement in our new systems is critical, so we welcome any further steps to ensure this is front and centre of our ICS.

Jane Milligan
Senior Responsible Officer
NEL ICS

Marie Gabriel
Independent Chair
NEL ICS

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Item No **7**	**INNER NORTH EAST LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (INEL JHOSC)**
Report title	**Update on recruitment process for new NELCA Accountable Officer and Senior Responsible Officer for ELHCP**
Date of Meeting	10 February 2021
Report Author	Marie Gabriel, Independent Chair, North East London Integrated Care System
Attending	Marie Gabriel, Independent Chair, North East London Integrated Care System
OUTLINE	The purpose of this item is to receive a verbal update on the recruitment process for a new AO for the NEL Commissioning Alliance and SRO for the East London Health and Care Partnership to replace Jane Milligan.
RECOMMENDATION	The Committee is requested to NOTE the report.

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Item No **8**	**INNER NORTH EAST LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (INEL JHOSC)**
Report title	**Minutes of the previous meeting and Matters Arising**
Date of Meeting	10 February 2021
Report Author	Roger Raymond/ Jarlath O'Connell – INEL JHOSC Support officers
OUTLINE	**MINUTES** Attached are the draft minutes of the meeting held on 25 November 2020. **MATTERS ARISING from meeting on 25 November** Re item on Whipps Cross Redevelopment, attached please find 1) Response to Norma Dudley's question re capacity issues in the Whipps Cross Redevelopment (item 8c) 2) Response to Christopher Sill's question re suitability of the site for maternity services during the construction phase (item 8d) **MATTERS ARISING from meeting on 30 September** Re Item on Overseas Patients Charging, the Committee has received a further question from NELSON with a call to protect residents who are impacted by denial of free NHS in-patient care. Because of time constraints at this meeting the Chair asked that the Submission be circulated to INEL members for consideration

	so that a verbal response can be given by the Chair at the meeting. The original request is at item 8e.
RECOMMENDATION	The Committee is requested to AGREE the minutes and NOTE the various matters arising

INNER NORTH EAST LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (INEL JHOSC)

Meeting held on 25th November 2020
Zoom Virtual Meeting

Present:

Councillor Winston Vaughan (Chair, London Borough of Newham)

Councillor Ben Hayhurst (Vice-Chair, London Borough of Hackney)
Councillor Gabriela Salva-Macallan (Vice-Chair, London Borough of Tower Hamlets)

City of London Corporation:
Common Councilman Michael Hudson

London Borough of Newham:
Councillors Ayesha Chowdhury

London Borough of Hackney:
Councillors Peter Snell

London Borough Tower Hamlets:
Councillor Shad Chowdhury

London Borough of Waltham Forest:
Councillor Richard Sweden

In Attendance:

Councillor Neil Zammett Chair, Outer North East London Joint Health Overview and Scrutiny Committee (ONEL JHOSC), London Borough of Redbridge
Jane Milligan, Accountable Officer, NECLA and SRO, ELHCP
Marie Gabriel, Independent Chair, ELHCP
Alwen Williams, Group Chief Executive Officer, Barts Health NHS Trust
David Maher, Managing Director, City and Hackney CCG
Steve Collins, Executive Director of Finance, WEL CCGs
Dr. Muhammad Naqvi, Chair, Newham CCG
Ken Aswani, Chair, Waltham Forest CCG
Martin Cunnington, ELHCP COVID-19 Testing Programme Co-ordinator
Alastair Finney, Whipps Cross Redevelopment Director, Barts Health NHS Trust
Dr Heather Noble, Medical Director, Whipps Cross Hospital

Jarlath O'Connell, Scrutiny Officer, London Borough of Hackney
Roger Raymond, Senior Scrutiny Policy Officer

Apologies: London Borough of Hackney:
Councillor Patrick Spence

1. WELCOME AND INTRODUCTIONS

1.1 The Chair welcomed Members, witnesses and members of the public to the meeting.

1.2 The Chair told the Committee that Councillor Kahar Chowdhury is no longer representing Tower Hamlets on the Committee. He will be replaced by Tower Hamlets in due course.

2. DECLARATIONS OF INTEREST

2.1 Councillor Peter Snell declared an interest as the Chair of Trustees of DABD UK.

3. MINUTES OF PREVIOUS MEETING

3.1 The accuracy of the minutes of the meeting on 24 June 2020 were considered.

RESOLVED:

That the minutes of the meeting on 24 June 2020 were agreed as a correct record.

4. NOTES OF THE LAST MEETING

4.1 The Chair told the Committee that the notes from the meeting from the meeting held on 30 September 2020 were not 'official minutes' as the last meeting had to go into 'informal mode' due to technical issues in broadcasting the meeting.

4.2 Councillor Peter Snell requested an amendment to the notes to correct his declaration of interest. The notes were amendment to note that Councillor Peter Snell as the Chair of Trustees of DABD UK.

4.3 The accuracy of the notes of the meeting on 30 September 2020 were considered.

RESOLVED:

That the notes of the meeting on 30 September 2020 were agreed as a correct Record, after the minor amendment.

5. SUBMITTED QUESTIONS

5.1 The question submitted by Norma Dudley, North-East London Save our NHS (NELSON) is contained in Appendix A.

5.2. The answer for this question is contained in Appendix A.

5.3 Alastair Finney (Whipps Cross Redevelopment Director) gave some opening commentary on the Whipps Cross Redevelopment Programme which would be discussed in more detail later in the meeting. Committee Members asked officers to liaise with Norma Dudley to obtain details of the pieces of research that she mentioned in her accompanying statement.

5.4 The question submitted by Christopher Sills, Hackney resident is contained in Appendix A.

5.5 The answer for this question is contained in Appendix A.

It was RESOLVED that the Committee:

i. Noted the questions; and
ii. Agreed that written responses would be provided to Norma Dudley and Christopher Sills.

6. NHS INEL RESPONSE TO THE CORONAVIRUS PANDEMIC COVID-19 UPDATE (WINTER PREPAREDNESS)

6.1 The Chair thanked Marie Gabriel, Independent Chair, ELHCP and NHS colleagues for attending the meeting. The Chair recognised the work that the NHS and its partners were doing to manage the Coronavirus Pandemic. Marie Gabriel informed the Committee that the presentation would be led by Jane Milligan, Senior Responsible Officer, ELHCP and supported by other colleagues in attendance including Alwen Williams, Group Chief Executive Officer, Barts Health NHS Trust and Dr. Muhammad Naqvi, Chair, Newham CCG. The Chair invited Jane Milligan, to make some brief introductory remarks on the NHS response to the Coronavirus Pandemic.

6.2 Jane Milligan told the Committee that the NHS had moved back into 'Level 4' emergency' in the light of the rise in Coronavirus cases in London. North East London had reinstated the Incident Centre 8am to 8pm seven days a week. A system chief executive group has started meeting weekly again to oversee the response and NHS, partners and local authorities were working together closely on managing the emergency.. They were also getting prepared for the winter and continuing to work in partnership to support Care Homes and Home Care providers, for example. She also outlined how north east London also successfully received funding to provide enhanced mental health and wellbeing support to NHS and social care staff.

6.3 Jane Milligan told the Committee that the flu vaccination programme was underway in order to achieve the aim to vaccinate 75% of 'at risk' population groups and people over 65. She also outlined how the NHS is preparing with partners to be ready for the potential vaccine roll out.

6.4 Alwen Williams briefed the Committee on the Trust's response to the current pandemic and the plans for winter. She also briefed the Committee on the conversion of 14th and 15th floor of Royal London Hospital as a COVID intensive care ward and how many patients had been treated to this time.

6.5 Dr. Muhammad Naqvi briefed the Committee on the work being conducted to address health inequalities in North East London. The work involved analysing all the data that had been gathered in relation to COVID. He explained they were developing a set of principles to be included in an 'Anchor Charter' for North East London, which focused on the opportunities to reduce inequalities and support local economic recovery around employment and skills, for example. Work would also support discussions around advice and support for clinically vulnerable groups, and supporting primary care to protect vulnerable patients.

6.6 Responding to Committee Members' questions about the capacity at Royal London Hospital COVID Intensive Ward, Alwen Williams told the Committee that the response would be dependant on how many patients were admitted, and the effect this would have on the need for additional staff drawn from other services. Responding to Committee Members' questions on testing and social isolation for staff, Alwen Williams told the Committee that regular testing was in place for clinical staff. Any positive results for staff using lateral flow test would mean them being sent for a polymerase chain reaction (PCR) test as a follow-up. The service department would conduct an assessment to asses which staff members should isolate.

6.7 Responding to Committee Members' question on a NHS 111 triaged system for A&E, Alwen Williams told the Committee that there is a national initiative to encourage members of the public to contact 111 and staff would direct patients to the correct pathway. It was explained with 111 First people can have an appointment booked for them at a nearby A&E if it's needed and would help to

reduce waiting times and support social distancing in waiting rooms. It would still be possible to turn up at A&E and to contact 999 in an emergency. Responding to Committee Members' questions on the vulnerable patients with learning difficulties, Jane Milligan told the Committee that there had been a lot of work to help protect vulnerable patients such as those with learning difficulties and learn from the evidence being produced about the illness. Dr. Muhammad Naqvi also told the Committee about the annual health checks for patients with learning difficulties to ensure that GPs can support them and that there have been over 800+ checks in Newham in quarter 1 and 2 this year.

6.8 Responding to Committee Members' questions on Testing Centres, Jane Milligan told the Committee that Local Authorities were working to ensure Testing Centres were easily as possible to accessible. Responding to Committee Members' questions on 'Step Down' facilities to provide temporary accommodation for patients who have been discharged from hospital, David Maher, Managing Director, City and Hackney CCG told the Committee that currently NHS services in North East London had supported door-to-door services and effective infection control for discharged patients. There had been some work in North Hackney with the Orthodox Jewish community to provide some temporary accommodation for Patients in overcrowded Homes of Multiple Occupancy (HMOs) but that this was a systematic issue in this community. Committee Members suggested that the NHS partners should look into commissioning some work in this area.

6.9 Committee Members' asked questions about the processes in terms of monitoring how hospitals discharge patients to care homes. Jane Milligan told the Committee that there were a number of multi-agencies involved and groups meet to share good practices and make improvements. She also welcomed Members sharing any specific case information with the NHS to ensure that they are aware of any problems and so the NHS and their partners could learn from them. Heather Noble (Medical Director, Whipps Cross) also told the Committee about the process related to discharge patients that were carried out to help with infection control, such as testing residents of care homes within 24-48 hours after returning to care homes and informing families, residential and care providers if they could be a risk of Coronavirus. Responding to Committee Members' questions related to the National Test and Trace System, David Maher, Managing Director, City and Hackney (CCG) told the Committee that Local concerns had been discussed in Hackney and with t the local MP.

The Committee RESOLVED to:

Note the update; and

The Chair thanked those present for their attendance and contributions to the discussion.

7. WHIPPS CROSS REDEVELOPMENT UPDATE

7.1 The Chair invited Alastair Finney (Whipps Cross Redevelopment Director) and Heather Noble to give a presentation to the Committee on the Whipps Cross Redevelopment proposals. Alastair Finney told the Committee that Whipps Cross Hospital was a hospital with high-activity for its size. Therefore a proposal had been developed to secure a new hospital to be built on the site of the existing hospital. He noted that over 40% of the estate pre-dates the NHS and the condition of the estate leads to increased safety risks for patients, negatively impacts on privacy, dignity and infection control as well as on patient and staff experience of the hospital environment. He also noted that the current estate constrains the ability to implement proposed new models of care envisaged in the Whipps Cross Health and Care Services Strategy.

7.2 Alastair Finney told the Committee that the vision for the redevelopment of Whipps Cross had been developed with – and was shared by – both health system and local government partners, and endorsed by Government as one of the six trusts to be named in phase 1 of the national Health Infrastructure Plan (HIP). He explained that the Strategic Outline Case (SOC) was submitted to Department of Health and Social Care (DHSC) earlier this year. A summary of this was published in September 2020, setting out the core assumptions in key area. It was envisaged that the preferred way forward was to build a brand new hospital on the site of former nurses' accommodation. This would result in significant land to be released for redevelopment, including 1,500 new homes and the opportunity for other health and care services and community facilities

7.3 Alastair Finney told the Committee that an Architect-Led Design Team, Ryder Architecture, has begun work on developing hospital design ideas and on plans for the whole site, to inform an outline planning application in early 2021. He expected that the demolition of disused buildings on the site of the former nurses' accommodation (the preferred way forward for the location of the new hospital) is due to begin in coming months. Work will be undertaken on the options for car parking in the coming weeks.

7.4 Dr. Heather Noble told the Committee that Clinical Strategy was a transformation that Whipps Cross Hospital had to undertake and with the SOC and the Coronavirus Pandemic had meant that some other assumptions in the plan could be tested and piloted. In light of these tests and pilots, each services were able to going through the strategy and fine tune it to ensure that it was fit for purpose.

7.5 Dr. Heather Noble gave some example of the tests and pilot to the Committee. Whipps Cross had been able to maintain a more extensive elective surgery programme this winter in the way they the hospital had been able to manage its beds. Another example was the use of home monitoring equipment for pregnant women to check blood pressure and urine tests so they didn't have to visit the hospital. There has also been an expansion in virtual consultations where it had been possible to reduce visits to the hospital. The concept for

the new hospital would be:

- First, to help people stay healthy
- Second, if people are unwell, to provide care and support as close to their home as possible so they do not need to attend hospital
- Third, if hospital care is necessary, to ensure people are seen and treated quickly and safely discharged home as soon as they are able to, with the support in place to help them stay there

7.6 Dr. Heather Noble told the Committee that the presentation in the papers included an example of the pathway that a patient may expect to take in the new hospital. It would involve early referral, medical optimisation, early rehab and discharged home. If successful it could lead to improving patient journeys can have an impact of reducing an average 5.5 day hospital stay to 3.3 days. Responding to Committee Members' questions on monitoring services and ensuring there was disruption in the construction of the new hospital, Heather Noble told the Committee that Whipps Cross Hospital had a risk register that was monitored closely.

7.7 Dr Ken Aswani, Chair, Waltham Forest CCG told the Committee that the Out-of-Hospital/Integrated Care System was very well developed and were being tested. Alastair Finney gave some examples of how they were engaging with staff, patients and the public. There had been some 'virtual' public meetings in October and November that were held in each of the three main boroughs served by the hospital (Waltham Forest, Redbridge and Epping Forest District) with around 180 people taking part. Some working groups and focus groups had been established to inform and develop our thinking in key areas such as health and care services, hospital design and site masterplanning. The pre-planning application consultation process had been launched. He concluded the presentation by telling the Committee that construction of a new hospital was expected to begin in Autumn 2022 and completed in Autumn 2026.

Suspension of Rule 9 of Part 4.1 of the Council's Constitution

To suspend rule 9 (Duration of meeting) of Part 4.1 of the Council's Constitution in order to extend the meeting for up to half an hour beyond 9.00p.m.

7.8 Responding to Committee Members' questions on accommodation for key workers, Alastair Finney told the Committee that it was expected that 50% of the new housing would be designated as affordable and the Trust would continue to monitor the demand from key workers for accommodation. Responding to Committee Members' questions on the cost of the new hospital, Alastair Finney told the Committee that the average indicative budget for each of the redevelopment schemes in the Government's first wave hospital building programme was £450m, but the final cost for Whipps Cross had not been determined. This would be undertaken through the development of the Outline Business Case. What had been decided was that it would not be PFI-funded project. Referring to points raised in the public questions and Members about

bed capacity, Dr. Heather Noble noted that the plans for the new hospital would have the flexibility to increase the amount beds that were available to meet surges in demand. She noted that during the Coronavirus Pandemic the integrated system had demonstrated the care plans could be operated safely and patients could also be transferred to other hospitals when necessary. In response to queries about funding switching to local authorities where they required to deliver more service, Heather Noble told the Committee that she expected the funding to move with the services.

7.9 Committee Members raised concerns regarding whether the project to build the new hospital would not overrun, causing it to go over budget. Alastair Finney told the Committee that there was no reason to believe the business case that was being developed would overrun and not complete in Autumn, if not before. Alwen Williams told the Committee that Barts Health NHS Trust officers would return to the Committee when the business case was completed and submitted to the Government. Committee Members agreed to send further questions directly to Barts Health NHS Trust.

The Committee RESOLVED to:

Note the report.

8. WORK PLAN

8.1 The Committee discussed the Work plan and suggested amendments

8.2 The Committee agreed the following items for the next meeting:

- ELHCP - AO update;

The Committee RESOLVED that the INEL JHOSC agree the amended Work plan.

8.3 The Chair would like to pass on his gratitude to Jane Milligan who would be moving on a new role in the New Year.

8.4 The Chair also noted that the Committee would be hosted by London Borough of Hackney for the next two years. He also thanked Robert Brown and Roger Raymond for the officer support that they had given the Committee on behalf of London Borough of Newham over the past two years.

9. DATE OF NEXT MEETING

It was noted that the next scheduled meeting of the Committee was 10 February 2021.

Chair: ……..

Date: ……

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Committee Response:

The Committee would like to thank Norma for her question and the statement given at the meeting. The Committee are grateful for her time and interest in the development that will take place at Whipps Cross Hospital. You mentioned a couple of NHS strategies as part of your statement and the Committee would be happy to look at these as part of its evidence gathering process in relation to Whipps Cross Hospital.

The Committee also received a presentation on the Whipps Cross Hospital Redevelopment from Alastair Finney (Whipps Cross Redevelopment Director), Heather Noble (Medical Director, Whipps Cross) and Alwen Williams, Chief Executive Officer, Barts Health NHS Trust at the meeting. The Committee probed the plans presented to them, namely concerns about the funding for the project and the timescales envisaged for completion. The Committee raised concerns about the possibility of maintaining the current level of services at the hospital as the development progresses. They also raised points about the modelling in terms of the amount of beds that would be provided at the new hospital. They asked whether there was any flexibility in the proposals to increase the amount of beds in the new hospital if necessary.

In light of the fact that some of the important questions regarding the plans cannot be answered at this stage of the project, the Committee has asked Barts Health NHS Trust officers to come back and address them in 2021. Therefore, the Committee will continue to scrutinise the plans in relation to the redevelopment of Whipps Cross Hospital as they progress.

Barts Health NHS Trust will address some of the issues raised in your background note:

Our clinical strategy has been developed with our local partners in primary care, community services and social care and is designed to improve services in a way that reduces the need for people to have to attend hospital and, if they do need to attend, reduces the amount of time they need to stay there.

Our planning assumptions are designed to meet future need and respond to it with increases in activity throughout the new hospital. Significant increases in MRI and CT scanning are planned, we anticipate increasing procedures in outpatients by over 30% and we are planning for an increase in deliveries in maternity. Our planning assumptions recognise the demands for NHS hospital care that will exist in 2026 and beyond and our activity is planned to grow to meet it, with improved services that out current buildings do not allow.

Our Health and Care Services Strategy for Whipps Cross has been led by clinicians, who are clear that more day case surgery and same day

emergency care is best practice, providing real benefits for patient experience and outcomes. This is certainly not unique to Whipps Cross. Unnecessary overnight stays in hospital do not help patients recover or improve their treatment – they can increase the risk of infection and keep people separated from family and carers unnecessarily. We want to treat more people using the best methods of care and are designing the new hospital to achieve that.

There will be more clinical space, with over two-thirds of the hospital given over to clinical space, compared to around just 50% today. For patients that do need to stay overnight, wards will be developed to modern standards with a significantly expanding proportion of single rooms, growing from around 17% today to over 50%, thereby improving patient experience and infection control.

Our Margaret Centre palliative care services will not be based in a separate building but based in the new hospital building alongside other services. Our clinical strategy set out plans for more closely integrated palliative and end of life care services in the future. Health professionals from across the system who identify a palliative or end-of-life care need will be able to ensure that patients receive a comprehensive needs assessment.

We continue to work with our community partners to support palliative and end-of-life care in the community. If patients do require specialist palliative care in an acute setting, then they will be cared for in the hospital.

Our partners in primary care and community services have begun to provide more care closer to people's homes through, for example, home monitoring and virtual appointments. In the hospital itself, we are aiming to provide more 'same day emergency care', supported by a significant expansion in the number of diagnostic tests we undertake and, increasingly, operations are being undertaken as 'day cases'. All of these measures will reduce the need for admissions and overnight stays.

These improvements are underpinned by investment. For example, the Clinical Commissioning Group (CCG) plan for Waltham Forest includes additional investment, in line with the NHS Long Term Plan, to support the shift of care and resources from the hospital environment as far as clinically safe and appropriate, so that people receive care as close to home as possible.

Waltham Forest will see a £12m rise in investment in primary care and community services by 2023/24 - investing in areas such as: improved access to GPs through more phone and video appointments; more support workers, with new roles such as social prescribers; and more care

and support packages available - including home monitoring - will help avoid attendance at hospital and speed up discharge from hospital.

We are confident that all of these improvements – in the community and in the hospital -will lead, over time, to around a 10% reduction in the number of days patients admitted as emergencies spend in hospital beds each year compared to today, thereby reducing the number of overall overnight beds required.

These assumptions will continue to be tested and will be a focus of the Whipps Cross Strategic Partnership Board, which brings together leaders from primary care, community services and social care.

Finally, the number of beds in any hospital is not fixed and we have the flexibility to respond to operational pressures as they go up and down with appropriate numbers of beds. The new Whipps Cross Hospital will provide us with greater flexibility and adaptability of spaces to be able to do this more effectively than today, and we also plan to retain some space on the wider site for possible future healthcare uses.

The new Whipps Cross Hospital will be designed to ensure flexibility and adaptability of spaces to enable us to meet future demands. For example through flexible, repeatable design, we will be able to change the function within the hospital, should it be required, to provide new services and respond to changing needs.

We will be able to scale up critical care rapidly if we need to and future proof the hospital for another pandemic through increasing the number of single rooms for greater infection prevention and control, segregating entrances and through designing our ward space for increased flexibility to respond to pressures. The new Whipps Cross hospital will be one of the first new hospitals to be built in the UK that incorporates the experience and lessons of Covid-19 in its design.

We also plan to retain some space on the Whipps Cross site for possible future healthcare uses. For example, we have identified the opportunity for a building that could house complementary primary and community facilities on the site. We and our local partners are considering what services could benefit from being co-located at Whipps Cross, to improve community facilities and to strengthen the provision of integrated care on the site.

The NHS has always needed to change how it uses its buildings, as new treatment options become available and new technology is introduced. However, we have previously had to adapt buildings that were never designed to be easily changed. We will make sure that flexibility and adaptability is incorporated into the design of the new hospital so that change in the future is easier, quicker and more cost effective to achieve.

The responses we have received in public, staff and council meetings have overwhelmingly welcomed the plans for a new Whipps Cross Hospital. Our planning is immensely benefiting from the questions people naturally have and the scrutiny that tests them. We will also ensure that best practice and research evidence informs our plans. This is a 'live' process and we will be publishing more detail as the plans develop that reflect and respond to the ideas and questions raised. We look forward to continuing to sharing these with everyone interested in understanding and contributing to the creation of the new Whipps Cross Hospital.

Question to Inner North East London Joint Health Overview Scrutiny Committee 25/11/20

Subject: **Whipps Cross Hospital Redevelopment**

Question: Given the risks to residents across North East London if the new hospital were to have insufficient capacity, will this Joint Scrutiny Committee do all in its powers to question and challenge the proposals being made by Barts Trust?

Background Information to the Question:

- Pre Covid, Whipps was running at 98/99% bed occupancy, sometimes with no free beds. NICE guidance states that once bed occupancy goes above 90%, infections, re-admissions and increased mortality are likely. Whipps is a severely overstretched hospital.
- Barts Trust are proposing 51 fewer beds in the redeveloped hospital than we have at present, and 109 fewer than needed, if there's no improvement to community services.
- Their proposal is based on a report – Waltham Forest Integrated Care Strategy 2019 - developed in three months by Carnall Farrar. The report makes claims for costs and savings of new models of community care with no data about existing community health services. It compares Waltham Forest with Rightcare peers in projecting improvements to keep people out of hospital, yet these peers have a higher median per capita spend on health than Waltham Forest.
- Barts proposes that the new hospital could be a centre of excellence for the care of older people across much of NE London – with fewer beds.
- Barts & WEL cite evidence that improvements can reduce average length of stays in hospital for older people by 2.2 days. But what they cite is research on the benefits of thorough pre-operative

assessments when over 65s have elective vascular surgery. Evidence specific to only one example of clinical treatment and care; it is not reasonable or safe to generalise these results to other treatments or conditions.

- Research of the Vanguard pilots published in June 2020 concluded: "integrated care policies should not be relied on to make large reductions in hospital activity in the short-run." It found no significant reduction in bed days.
- Last year the head of NHS England , Sir Simon Stevens, said bed closures had gone too far and that many areas will need more beds, despite plans to expand community services.
- The lack of hospice care (with all the services that provides) in the new hospital risks that terminally ill patients with distressing symptoms may end up dying at home without adequate specialist support.

Norma Dudley

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Committee Response:

The Committee would like to thank Christopher for his question.

Barts Health NHS Trust will address the issues raised in your question:

We do not agree with this suggestion, though we understand why people might be concerned be about disruption to services. One of the benefits of our approach to the construction process is that we have the space to build the new hospital on disused land without interrupting the existing hospital services which will continue to operate as normal up until the day they transfer to the new hospital.

The construction site is at the other end of the Whipps Cross site from the maternity department. Our current experience of refurbishing the maternity department and continuing to provide our full range of maternity services is very positive. There has been no reduction to the numbers of women booking in to our maternity service and we have actually seen an increase in births during this time. The improvements to the service have been very well received and there have been no complaints related to the building works.

We will of course monitor the impact of the construction process to all services closely and minimise any potential disruption.

Public Question – INEL JHOSC

Wednesday 25 November 2020

Would you agree with me that one problem during construction Whipps Cross Hospital is that a significant number of mothers will be unhappy to have their babies on a building site which means that they will elect to have their babies elsewhere.

My view is backed up by what young women told me during the election champagne and mothers with babies that I've talked to before lockdown who express the same opinion,

When dictating this letter my 21 year old daughter said the same thing too.

Everyone needs to try and establish now how much of a problem this is likely to be so that everyone concerned can come up with the best solutions even if that means that some mothers will transfer to hospitals like the Homerton.

Thank you very much in advance

Yours sincerely Christopher Sills

INEL JHOSC (Feb 10th 2021)

START
Submission from North-East London Save our NHS (NELSON), the umbrella group for NE London borough-based NHS community campaign groups.

NHS Hostile Environment: Protect our residents who are impacted by denial of free NHS in-patient care.

Please will INEL JHOSC (10th February 2021) protect our diverse communities' access to free NHS care, by stating support for the recommendation to government in the new NHS Confederation Report co-authored by Newham Clinical Commissioning Group's (CCG) ex vice-chair, Wayne Farah, who is currently co-facilitator of the NHS Confederation's BME Leadership Network.

Three actions**:**
1. **Support the recommendation** to government to:

"Review the potential for policies such as eligibility checks and overseas visitor charges to be a vehicle for promoting institutional racism. Such policies facilitate the hostile environment, disproportionately impacting BME staff, patients and service users."

in the new NHS Confederation Report.
'Perspectives from the front line: The disproportionate impact of COVID-19 on BME communities' (Dec 21st 2020)
NHS Confederation Report by Joan Saddler and Wayne Farah.
https://www.nhsconfed.org/-/media/Confederation/Files/Publications/Documents/Perspectives-from-the-front-line_FNL_Dec2020.pdf

2. **Ask each NHS Trust** that runs acute hospitals with in-patient beds in the INEL JHOSC boroughs to please,

"Consider referring your NHS patient charging procedures to the new independent, NHS Race and Health Observatory, hosted by the NHS Confederation, chaired by Marie Gabriel and run by Director Dr Habib Naqvi."

3. **Write to Dr Habib Naqvi** *giving the support of INEL JHOSC for the NHS Confederation report's recommendation quoted in 1. above*.

habib.naqvi@nhsconfed.org

Background to the above:

The NHS Confederation's report looks at the underlying factors in health inequalities exposed by COVID-19, one of which is the Hostile environment:

Quote from report (page 4) "Failure to lift ‘hostile environment’ policies, such as eligibility checks and NHS charges for overseas visitors, was seen as a contributing factor. Concerns were raised over their potential to promote direct and indirect racial discrimination, deterring people from seeking care when needed, particularly among migrant and refugee communities. To break down barriers to accessing healthcare, the government should take immediate steps to review the potential for hostile environment policies to be a vehicle for promoting institutional racism."

Quote from report (page 21)" Respondents highlighted particular concern over policies that were designed to enact ‘hostile environment’ legislation within the NHS, such as eligibility checks and NHS charges for overseas visitors. The policies, introduced in 2012 to make life difficult for undocumented migrants living in the UK, were notably brought to life by the Windrush Scandal in 2018. Interviewees warned that such measures could be promoting direct and indirect racial discrimination, deterring people from seeking care even when needed. The failure to lift them during the first wave was identified as a potential contributory factor to the disproportionate impact on BME communities."

Councillors will be aware of widespread anxiety in their boroughs, amongst their residents, reflected by our council leaders, mayors and MPs in north east London.
To end, we give only one example, from the Newham Mayor, Rokhsana Fiaz.
Now is the time for INEL JHOSC to add their voice in support of their residents.

https://www.newham.gov.uk/news/article/434/update-about-coronavirus-covid-19-from-mayor-rokhsana-fiaz-19-june-2020
Mayor Rokhsana Fiaz says,

"Current Government policy of NHS charging and data sharing will stop migrants accessing healthcare; and even if they are entitled to treatment, the fear surrounding access will act as a life threatening deterrent. In this pandemic, but also in general, we must defend and protect equal access to health care for every single member of our local community. Government policies that overwhelmingly target those from Black, Asian and Minority Ethnic backgrounds are not only discriminatory but immoral."
END

Item No **9**	**INNER NORTH EAST LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (INEL JHOSC)**
Report title	**Work Programme for the Committee**
Date of Meeting	10 February 2021
Report Author	Jarlath O'Connell, Support Officer for INEL JHOSC
OUTLINE	Attached is the future work programme for INEL JHOSC. This contains suggestions held over from the 2020/21. This is a working document which is updated regularly. The **provisional dates** for INEL JHOSC meetings for the next municipal year 2021/22 are as follows: **Wed 23 June 2021** **Mon 13 Sept 2021** **Tue 14 Dec 2021** **Mon 28 Mar 2022** These will be confirmed at the June meeting.
RECOMMENDATION	The Committee is requested to NOTE the updated work programme and to make any additions or amendments as necessary.

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INEL JHOSC Rolling Work Programme for 2020-21 as at 1 Feb 2021

Date of meeting	Item	Type	Dept/Organisation(s)	Contributor Job Title	Contributor Name	Notes
27 January 2020	**New Early Diagnosis Centre for Cancer in NEL**	Briefing	Barts Health NHS Trust	Clinical Lead	Dr Angela Wong	
			NCEL Cancer Alliance	Interim Project Manager	Karen Conway	
	Overseas Patients and Charging	Item deferred				
11 February 2020	**NHS Long Term Plan and NEL response**	Briefing	East London HCP	Senior Responsible Officer	Jane Milligan	
			Barking & Dagenham CCG	Chair	Dr Jagan John	
			East London HCP	Director of Transformation	Simon Hall	
			East London HCP	Chief Finance Officer	Henry Black	
	New Joint Pathology Network (Barts/HUHFT/Lewisham & Greenwich)	Briefing	Barts Health NHS Trust	Director of Strategy	Ralph Coulbeck	
			Homerton University Hospital NHS FT	Chief Executive	Tracey Fletcher	
	Municipal Year 2020/21					
24 June 2020	**Covid-19 update**	Briefing	East London HCP	Senior Responsible Officer	Jane Milligan	
			NEL Integrated Care System	Independent Chair	Marie Gabriel	
			Barts Health NHS Trust	Chief Executive	Alwyn Williams	
			HUHFT	Chief Executive	Tracey Fletcher	
			East London NHS Foundation Trust	COO and Dep Chief Exec	Paul Calaminus	
			Newham CCG	Chair	Dr Muhammad Naqvi	
			Waltham Forest CCG	Chair	Dr Ken Aswani	
			Tower Hamlets CCG	Chair	Dr Sir Sam Everington	
			WEL CCGs	Managing Director	Selina Douglas	
			City & Hackney CCG	Managing Director	David Maher	
	How local NEL borough Scrutiny Cttees are scrutinising Covid issues	Summary briefing FOR NOTING ONLY	O&S Officers for INEL			
30 September 2020	**Covid-19 update**	Briefing	East London HCP	Senior Responsbile Officer	Jane Milligan	
			East London HCP	Director of Trasformation	Simon Hall	
			East London HCP	Director of Finance	Henry Black	
			Barts Health NHS Trust	Group Chief Executive	Alwen Williams	
			HUHFT	Chief Executive	Tracey Fletcher	
			ELFT	COO and Deputy Chief Executive	Paul Calaminus	
			WEL CCGs	Managing Director	Selina Douglas	

			City and Hackney CCG	Managing Director	David Maher	
	Covid-19 discussion panel with the local Directors of Public Health	Discussion Panel	City and Hackney	DPH	Dr Sandra Husbands	
			Tower Hamlets	DPH	Dr Somen Bannerjee	
			Newham	DPH	Dr Jason Strelitz	
			Waltham Forest	DPH	Dr Joe McDonnell	
	Overseas Patient Charging - briefings from Barts Health and HUHFT	Briefing	Barts Health NHS Trust	Group Chief Medical Officer	Dr Alistair Chesser	
25 Nov 2020	**Covid 19 update and Winter Preparedness**	Briefing	East London HCP	Senior Responsbile Officer	Jane Milligan	
			NEL Integrated Care System	Independent Chair	Marie Gabriel	
			Barts Health NHS Trust	Group Chief Executive	Alwen Williams	
	Whipps Cross Redevelopment Programme	Briefing	Barts Health NHS Trust	Whipps Cross Redevelopment Director	Alastair Finney	
			Barts Health NHS Trust	Medical Director, Whipps Cross	Dr Heather Noble	
10 Feb 2021	**Covid-19 impacts in Secondary Care in INEL boroughs**	Briefing	Barts Health NHS Trust	Group Chief Executive	Alwen Williams	
	Covid-19 Strategy for roll out of vaccinations in INEL boroughs	Briefing	East London HCP	SRO	Jane Milligan	
			City and Hackney CCG	Chair	Dr Mark Rickets	
			City and Hackney CCG	MD	David Maher	
	North East London System response to NHSE consultation on ICSs	Briefing	NEL Integrated Care System	Independent Chair	Marie Gabriel	
	Update on recruitment process for new Accountable Officer for NELCA/SRO for ELHCP	Briefing	NEL Integrated Care System	Independent Chair	Marie Gabriel	
Municipal Year 2021/22						
23 Jun 2021						
13 Sept 2021						
14 Dec 2021						

28 Mar 2022						
	Items to be scheduled/ returned to:					
	NEL Estates Strategy					
	Whipps Cross Redevelopment					
	Cancer Diagnostic Hub					
	Review of Non Emergency Patient Transport					
	Digital First delivery in NHS					
	Mental Health					
	Homelessness Strategy					

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