City Integrated Commissioning Board
Meeting in-common of the City and Hackney Clinical Commissioning Group and the City of London Corporation

Hackney Integrated Commissioning Board
Meeting in-common of the City and Hackney Clinical Commissioning Group and the London Borough of Hackney

Joint Meeting in public of the two Integrated Commissioning Boards on Thursday 10 December 2020, 10.00 – 12.00
Microsoft Teams

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Item no.	Item	Lead and purpose	Documentation type	Time	Page No.
1.	**Welcome, introductions and apologies**	Chair	Verbal	10.00	-
2.	**Declarations of Interests**	Chair *For noting*	Paper		3-7
3.	**Questions from the Public**	Chair	None		-
4.	**Minutes of the Previous Meeting & Action Log**	Chair *For approval*	Paper		8-14
5.	**ICS Development – Next Steps**	David Maher *For discussion*	Paper	10.05	15-85
6.	**City & Hackney Operating Model & CCG Merger: Transitional Governance from 2020/21**	David Maher *For approval*	Paper	10.10	86-93
7.	**People & Places Group Progress Update**	Jonathan McShane *For endorsement*	Paper	10.45	94-101
8.	**Neighbourhoods Programme Planning – 2021/22**	Nina Griffith *For discussion*	Paper	11.00	102-122
9.	**Pathways Homeless Discharge Service**	Nina Griffith *For approval*	Paper	11.30	123-148

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10.	**M7 Financial Report**	Sunil Thakker / Ian Williams / Mark Jarvis *For noting*	Paper	11.45	149-160
11.	**Workstream & Program Risk Registers**	Matthew Knell *For noting*	Paper	11.50	161 (Appx)
12.	**AOB & Reflections**	All	None	11.55	-
-	**Integrated Commissioning Glossary**	*For information*	Paper	-	163-168
-	**Wellbeing Practitioner Project Extension**	*For information*	Paper	-	Annex A
-	**Integrated Care Partnership Plan**	*For Information*	Paper		Annex B

Date of next meeting:

14 January – Microsoft Teams

Integrated Commissioning
2020 Register of Interests

Forename	Surname	Date of Declaration	Position / Role in C&H System	Business / Organisation of the Interest	Nature of Interest / Position	Type of interest
Simon	Cribbens	12/08/2019	City ICB advisor/ regular attendee Accountable Officers Group member	City of London Corporation	Assistant Director - Commissioning & Partnerships, Community & Children's Services	Pecuniary Interest
				City of London Corporation	Attendee at meetings	Pecuniary Interest
				Providence Row	Trustee	Non-Pecuniary Interest
Sunil	Thakker	11/12/2018	City and Hackney ICB advisor/ regular attendee	City & Hackney CCG	Chief Financial Officer	Non-Pecuniary Interest
Ian	Williams	20/03/2020	Hackney ICB advisor/ regular attendee	London Borough of Hackney	Group Director, Finance and Corporate Resources	Pecuniary Interest
				n/a	Homeowner in Hackney	Pecuniary Interest
				Hackney Schools for the Future Ltd	Director	Pecuniary Interest
				NWLA Partnership Board	Joint Chair	Pecuniary Interest
				London Treasury Ltd	SLT Rep	
				London CIV Board	Observer / SLT Rep	
				Chartered Institute of Public Finance and Accountancy	Member	Non-Pecuniary Interest
				Society of London Treasurers	Member	Non-Pecuniary Interest
				London Finance Advisory Committee	Member	Non-Pecuniary Interest
				Schools and Academy Funding Group	London Representative	Non-Pecuniary Interest
				Society of Municipal Treasurers	SMT Executive	
				London CIV Shareholders Committee	SLT Rep	
				London Pensions Investments Advisory Committee	Chair	Non-Pecuniary Interest
Ruby	Sayed	07/11/2019	City ICB member	City of London Corporate	Member	Pecuniary Interest
				Gaia Re Ltd	Member	Pecuniary Interest
				Thincats (Poland) Ltd	Director	Pecuniary Interest
				Bar of England and Wales	Member	Pecuniary Interest
				Transition Finance (Lavenham) Ltd	Member	Pecuniary Interest
				Nirvana Capital Ltd	Member	Pecuniary Interest
				Honourable Society of the Inner Temple	Member	Non-pecuniary interest
				Independent / Temple & Farringdon Together	Member	Non-pecuniary interest
				Guild of Entrepreneurs	Founder Member	Non-pecuniary interest
				Bury St. Edmund's Woman's Aid	Trustee	Non-pecuniary interest
				Housing the Homeless Central Fund	Trustee	Non-Pecuniary Interest
				Asian Women's Resource Centre	Trustee & Chairperson	Non-pecuniary interest
Mark	Jarvis	02/03/2020	City ICB advisor / regular attendee	City of London Corporation	Head of Finance	Pecuniary Interest
Anne	Canning	21/07/2020	Hackney ICB advisor / regular attendee Accountable Officers Group member	London Borough of Hackney	Group Director - Children, Adults & Community Health	Pecuniary Interest
Honor	Rhodes	11/06/2020	Member - City / Hackney Integrated Commissioning Boards	City & Hackney Clinical Commissioning Group	Lay Member	Pecuniary Interest
				Tavistock Relationships (manages the City Wellbeing Centre)	Director	Non-Pecuniary Interest
				HUHFT	Daughter is employed as Assistant Psychologist	Indirect interest
				n/a	Registered with Barton House NHS Practice, N16	Non-Pecuniary Interest
Gary	Marlowe	27/08/2020	GP Member of the City & Hackney CCG Governing Body ICB advisor / regular attendee	City & Hackney CCG Governing Body	GP Member	Pecuniary Interest
				De Beauvoir Surgery	GP Partner	Pecuniary Interest
				City & Hackney CCG	Planned Care Lead	Pecuniary Interest
				Hackney GP Confederation	Member	Pecuniary Interest
				British Medical Association	London Regional Chair	Non-Pecuniary Interest
				n/a	Homeowner - Casimir Road, E5	Non-Pecuniary Interest
				City of London Health & Wellbeing Board	Member	Non-Pecuniary Interest

Forename	Surname	Date of Declaration	Position / Role in C&H System	Business / Organisation of the Interest	Nature of Interest / Position	Type of interest
				Local Medical Committee	Member	Non-Pecuniary Interest
				Unison	Member	Non-Pecuniary Interest
				CHUHSE	Member	Non-Pecuniary Interest

Forename	Surname	Date of Declaration	Position / Role in C&H System	Business / Organisation of the Interest	Nature of Interest / Position	Type of interest
Anntoinette	Bramble	05/06/2019	Member - Hackney Integrated Commissioning Board	Hackney Council	Deputy Mayor	Pecuniary Interest
				Local Government Association	Member of the Children and Young Board	Pecuniary Interest
				Schools Forum	Member	Pecuniary Interest
				SACRE	Member	Pecuniary Interest
				Admission Forum	Member	Pecuniary Interest
				HSFL (Ltd)		Non-Pecuniary Interest
				GMB Union	Member	Non-Pecuniary Interest
				Labour Party	Member	Non-Pecuniary Interest
				Urstwick School	Governor	Non-Pecuniary Interest
				City Academy	Governor	Non-Pecuniary Interest
				Hackney Play Bus (Charity)	Board Member	Non-Pecuniary Interest
				Local Government Association	Member	Non-Pecuniary Interest
				Lower Clapton Group Practice	Registered Patient	Non-pecuniary interest
Marianne	Fredericks	26/02/2020	Member - City Integrated Commissioning Board	City of London	Member	Pecuniary Interest
				Farringdon Ward Club	Member	Non-Pecuniary Interest
				The Worshipful Company of Firefighters	Liveryman	Non-Pecuniary Interest
				Christ's Hospital School Council	Member	Non-Pecuniary Interest
				Aldgate and All Hallows Foundation Charity	Member	Non-Pecuniary Interest
				The Worshipful Company of Bakers	Liveryman	Non-Pecuniary Interest
				Tower Ward Club	Member	Non-Pecuniary Interest
Christopher	Kennedy	09/07/2020	Member - Hackney Integrated Commissioning Board	Hackney Council	Cabinet Member for Health, Adult Social Care and Leisure	Pecuniary Interest
				Lee Valley Regional Park Authority	Member	Non-Pecuniary Interest
				Hackney Empire	Member	Non-Pecuniary Interest
				Hackney Parochial Charity	Member	Non-Pecuniary Interest
				Labour party	Member	Non-Pecuniary Interest
				Local GP practice	Registered patient	Non-Pecuniary Interest

Forename	Surname	Date of Declaration	Position / Role in C&H System	Business / Organisation of the Interest	Nature of Interest / Position	Type of interest
Randall	Anderson	15/07/2019	Member - City Integrated Commissioning Board	City of London Corporation	Chair, Community and Children's Services Committee	Pecuniary Interest
				n/a	Self-employed Lawyer	Pecuniary Interest
				n/a	Renter of a flat from the City of London (Breton House, London)	Non-Pecuniary Interest
				Member	American Bar Association	Non-Pecuniary Interest
				Masonic Lodge 1745	Member	Non-Pecuniary Interest
				Worshipful Company of Information Technologists	Freeman	Non-Pecuniary Interest
				City of London School for Girls	Member - Board of Governors	Non-Pecuniary Interest
				Neaman Practice	Registered Patient	Non-Pecuniary Interest
Andrew	Carter	12/08/2019	City ICB advisor / regular attendee	City of London Corporation	Director of Community & Children's Services	Pecuniary Interest
				Petchey Academy & Hackney / Tower Hamlets College	Governing Body Member	Non-pecuniary interest
				n/a	Spouse works for FCA (fostering agency)	Indirect interest
David	Maher	19/06/2019	Accountable Officers Group Member ICB regular attendee/ AO deputy	City and Hackney Clinical Commissioning Group	Managing Director	Pecuniary Interest
				World Health Organisation	Member of Expert Group to the Health System Footprint on Sustainable Development	Non-Pecuniary Interest
				NHS England, Sustainable Development Unit	Social Value and Commissioning Ambassador	Non-Pecuniary Interest
Rebecca	Rennison	26/08/2020	Member - Hackney Integrated Commissioning Board	Freelance Project Work		Pecuniary Interest
			Deputy Mayor and Cabinet Member for Finance, Housing Needs and Supply	Hackney Council	Cabinet Member for Finance and Housing Needs	Pecuniary Interest
				Cancer52Board	Member	Non-Pecuniary Interest
				Clapton Park Tenant Management Organisation	Board Member	Non-Pecuniary Interest
				North London Waste Authority	Board Member	Non-Pecuniary Interest
				Residential Properties		Non-Pecuniary Interest
						Non-Pecuniary Interest
				GMB Union	Member	Non-Pecuniary Interest
				Co-Operative Party	Member	Non-Pecuinary Interest
				Labour Party	Member	Non-Pecuniary Interest
				Fabian Society	Member	Non-Pecuniary Interest
				English Heritage	Member	Non-Pecuniary Interest
				Pedro Club	Board Member	Non-Pecuniary Interest
				Chats Palace	Board Member	Non-Pecuniary Interest
Henry	Black	03/03/2020	NEL Commissioning Alliance - CFO	Barking, Havering & Redbridge University Hospitals NHS Trust	Wife is Assistant Director of Finance	Indirect interest
				Tower Hamlets GP Care	Daughter works as social prescriber	Indirect interest
				NHS Clinical Commissioners Board	Member	Non-financial professional
Jane	Milligan	26/06/2019	Member - Integrated Commissioning Board	NHS North East London Commissioning Alliance (City & Hackney, Newham, Tower Hamlets, Waltham Forest, Barking and Dagenham, Havering and Redbridge CCGs)	Accountable Officer	Pecuniary Interest
				North East London Sustainability and Transformation Partnership	Senior Responsible Officer	Pecuniary Interest
				n/a	Partner is employed substantively by NELCSU as Director of Business Development from 2 January 2018 on secondment to Central London Community Services Trust.	Indirect Interest
				Stonewall	Ambassador	Non-Pecuniary Interest
				Peabody Housing Association Board	Non-Executive Director	Non-pecuniary interest
Mark	Rickets	24/10/2019	Member - City and Hackney Integrated Commissioning Boards	City and Hackney Clinical Commissioning Group	Chair	Pecuniary Interest
			Primary Care Quality Programme Board Chair (GP Lead)	Health Systems Innovation Lab, School Health and Social Care, London South Bank University	Wife is a Visiting Fellow	Non-financial professional interest
			Primary Care Quality Programme Board Chair (GP Lead)	GP Confederation	Nightingale Practice is a Member	Professional financial interest
			CCG Chair Primary Care Quality Programme Board Chair (GP Lead)	HENCEL	I work as a GP appraiser in City and Hackney and Tower Hamlets for HENCEL	Professional financial interest

Forename	Surname	Date of Declaration	Position / Role in C&H System	Business / Organisation of the Interest	Nature of Interest / Position	Type of interest
			CCG Chair Primary Care Quality Programme Board Chair (GP Lead)	Nightingale Practice (CCG Member Practice)	Salaried GP	Professional financial interest
Jake	Ferguson	30/09/2019	Chief Executive Officer Member	Hackney Council for Voluntary Service Voluntary Sector Transformation Leadership Group which represents the sector across the Transformation / ICS structures.	Organisation holds various grants from the CCG and Council. Full details available on request.	Professional financial interest Non-financial personal interest
Helen	Fentimen	14/02/2020	City of London Member	Member, Labour Party Member, Unite Trade Union Chair, Governors Prior Weston Primary School and Children's Centre		Non-financial personal interest Non-financial personal interest Non-financial personal interest
Tracey	Fletcher	26/08/2020	Chief Executive - Homerton University Hospital	Inspire, Hackney	Trustee	Non-pecuniary interest
Sandra	Husbands	26/08/2020	Director of Public Health	Association of Directors of Public Health Faculty of Public Health Faculty of Medical Leadership and Management	Member Fellow Member	Non-Pecuinary Interest Non-Pecuinary Interest Non-Pecuniary Interest
Jon	Williams	02/03/2020	Attendee - Hackney Integrated Commisioning Board	Healthwatch Hackney	Director - CHCCG Neighbourhood Involvement Contract - CHCCG NHS Community Voice Contract - CHCCG Involvement Alliance Contract - CHCCG Coproduction and Engagement Grant - Hackney Council Core and Signposting Grant Based in St. Leonard's Hospital	Pecuniary Interest

Meeting-in-common of the Hackney Integrated Commissioning Board
(Comprising the City & Hackney CCG Integrated Commissioning Committee and the London Borough of Hackney Integrated Commissioning Committee)

and

Meeting-in-common of the City Integrated Commissioning Board
(Comprising the City & Hackney CCG Integrated Commissioning Committee and the City of London Corporation Integrated Commissioning Committee)

Minutes of meeting held in public on 12 November 2020
Microsoft Teams

Present:

Hackney Integrated Commissioning Board

Hackney Integrated Commissioning Committee

Cllr Christopher Kennedy	Cabinet Member for Health, Adult Social Care and Leisure (ICB Chair)	London Borough of Hackney
Cllr Susan Fajana-Thomas	Cabinet Member for Community Safety	London Borough of Hackney
Cllr Rebecca Rennison	Cabinet Member for Finance, Housing Needs and Supply	London Borough of Hackney

City & Hackney CCG Integrated Commissioning Committee

Dr. Mark Rickets	Chair	City & Hackney CCG
David Maher	Managing Director	City & Hackney CCG
Honor Rhodes	Governing Body Lay member	City & Hackney CCG

City Integrated Commissioning Board

City Integrated Commissioning Committee

Randall Anderson QC	Chairman, Community and Children's Services Committee	City of London Corporation
Helen Fentimen	Member, Community & Children's Services Committee	City of London Corporation
Marianne Fredericks	Member, Community and Children's Services Committee	City of London Corporation

In attendance

Alex Harris	Integrated Commissioning Governance Manager	City & Hackney CCG
Alice Beard	Communications Manager	City & Hackney CCG
Anne Canning	Group Director – Children, Adults and Community Health	London Borough of Hackney

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Chris Lovitt	Deputy Director of Public Health	London Borough of Hackney
Denise D'Souza	Director of Adult Social Care	London Borough of Hackney
Diana Divajeva	Principal Public Health Analyst	London Borough of Hackney
Eeva Huoviala	Head of Engagement	City & Hackney CCG
Henry Black	CFO	NE London Commissioning Alliance
Ian Williams	Group Director, Finance and Corporate Services	London Borough of Hackney
Jake Ferguson	Chief Executive Officer	Hackney Council for Voluntary Services
Jonathan McShane	Integrated Care Convenor	City & Hackney CCG
Jon Williams	Executive Director	Healthwatch Hackney
Matthew Knell	Head of Governance & Assurance	City & Hackney CCG
Kat Buckley	Senior Commissioning Officer: Learning Disabilities	London Borough of Hackney
Nina Griffith	Workstream Director: Unplanned Care	City & Hackney CCG
Paul Coles	General Manager	Healthwatch City of London
Simon Cribbens	Deputy Director, Community and Childrens' Services	City of London Corporation
Siobhan Harper	Workstream Director: Planned Care	City & Hackney CCG
Stella Okonkwo	Integrated Commissioning Programme Manager	City & Hackney CCG

Members of the public were also present on the call, though are not named here for privacy reasons.

Apologies – ICB members

Jane Milligan

Ruby Sayed

Cllr Bramble (Cllr Fajana-Thomas sub)

Other apologies

1. Welcome, Introductions and Apologies for Absence

1.1. The Chair, Cllr Chris Kennedy, opened the meeting.

1.2. Apologies were noted as listed above.

2. Declarations of Interests

2.1. The **City Integrated Commissioning Board**
- **NOTED** the Register of Interests.

2.2. The **Hackney Integrated Commissioning Board**
- **NOTED** the Register of Interests.

3. Questions from the Public

3.1. There were no questions from members of the public.

4. Minutes of the Previous Meeting & Action Log

4.1. The **City Integrated Commissioning Board**
- **APPROVED** the minutes of the previous meeting.
- **NOTED** the action log.

4.2. The **Hackney Integrated Commissioning Board**
- **APPROVED** the minutes of the previous meeting.
- **NOTED** the action log.

5. Transition Group Report – Feedback from ICB Development Session

5.1. David Maher introduced the item. He noted that the transition to a single CCG would be based on the principle that 98% of the resource allocation would be deployed locally by the ICPB. There were also ongoing discussions about the future role of Health and Wellbeing Boards.

5.2. The immediate task at hand was to prepare for the Winter. We would also be doing deep-dive reviews of the Integrated Delivery Plan at the ICB in the coming months.

5.3. Staff would TUPE over to a NEL CCG. There was unlikely to be any major restructure to local teams. We would be discussing development of the Neighbourhood Health and Care Board in early 2021. Early in the new year, we would also have a local handbook which would outline how the ICP would work.

5.4. Sunil Thakker confirmed that S75 arrangements would continue. We would also be involving the voluntary sector in the board.

- **VCS Enabler Work paper to be brought back to February ICB.**

5.5. David Maher also added that there would be ongoing work with the Neighbourhoods team on mental health. He would keep ICB members informed of this work.

5.6. The **City Integrated Commissioning Board**

- **NOTED** the proposals and the verbal update on the feedback received at the ICB Development session;
- **APPROVED** that further work now take place in order to continue to develop transitional governance arrangements and prepare further detail around these proposals for further review at a third ICB Development session next year.

5.7. The **Hackney Integrated Commissioning Board**

- **NOTED** the proposals and the verbal update on the feedback received at the ICB Development session;
- **APPROVED** that further work now take place in order to continue to develop transitional governance arrangements and prepare further detail around these proposals for further review at a third ICB Development session next year.

6. Winter Communications

6.1. Nina Griffith, Alice Beard and Eeva Huoviala introduced the item. From September 2020 to March 2021, all NHS organisations were required to deliver key messages around keeping well during winter, with a particular focus on flu vaccinations.

6.2. From a public engagement perspective, we had looked at how to support our winter priorities – one way was making sure we had continuous community insight. We have also done extensive local engagement with colleagues. We continue to communicate with parents around flu vaccinations for children and we were also working with the Homerton Maternity team on pregnant women.

6.3. Eeva Huoviala noted the challenges to engagement due to mistrust of central government messaging. However, people were still generally more trustful of messaging from local organisations. One of the main challenges was on countering peoples' fear of side effects from immunisations. There were also some misconceptions around the supposed health benefits of children being allowed to catch illnesses – generally speaking, this was not advisable.

6.4. Randall Anderson highlighted the public perception that there were distribution issues around the flu vaccine. Marianne Fredericks also highlighted the need to roll out vaccinations to rough sleepers. Helen Fentimen added that she was concerned about the ability of the government to deliver the covid-19 vaccine given the issues that had arisen with test and trace.

6.5. Eeva Huoviala responded that a lot of effort had been placed into reaching otherwise hard to reach groups. We have also done targeted focus groups with the refugee communities. Furthermore, we were attending interfaith fora to discuss outreach to faith communities.

6.6. Sandra Husbands highlighted the issue of the pneumococcal vaccine. This vaccine was not available to everyone and was not repeated every year – it was, instead, a vaccine that was targeted at specific cohorts.

6.7. Siobhan Harper also stated that there had been some issues around rough sleepers and access to vaccinations a few weeks ago, but this had been since resolved.

- **Update on vaccinations to be brought to ICB in early 2021.**

6.8. The **City Integrated Commissioning Board**
- **ENDORSED** the winter communications and engagement plan.

6.9. The **Hackney Integrated Commissioning Board**
- **ENDORSED** the winter communications and engagement plan.

7. Autism Strategy

7.1. Siobhan Harper introduced the item. The paper had been developed over the last few years. An action plan would be brought to a future ICB, subject to approval of this strategy.

7.2. Honor Rhodes commended the report, saying it was one of the best she had read. She highlighted the differing presentations of autism in women. Siobhan Harper noted that this was a big part of the work contained in the report. Kat Buckley stated that the relationships were the key element – some of the key themes that had come through were about sexual relationships and understanding appropriate behaviours.

7.3. Cllr Rennison asked for more information on the work done on the autism spectrum. Kat Buckley responded that some on the spectrum have learning disabilities but this was not the case for all autistic people. There were also differences in those diagnosed as children and those who were diagnosed as adults.

7.4. Cllr Fajana-Thomas highlighted the role of the police as they were an important element of public service interaction with those with autism. Kat Buckley responded that the police had been part of the autism alliance, and there had been specific local training with the police force.

7.5. The **City Integrated Commissioning Board**
- **APPROVED** the All-Age Autism Strategy for City & Hackney.

7.3 The **Hackney Integrated Commissioning Board:**
- **APPROVED** the All-Age Autism Strategy for City & Hackney.

8. Covid-19 Financial Impacts / Month 6 Finance Update

8.1. The report was introduced by Ian Williams. He noted that local authorities had been hit hard by loss of income from parking, rent, events and venue hire. However, we were continuing to lobby for extra resource where we could.

8.2. Honor Rhodes asked whether a capital scheme review would affect our primary care developments. Ian Williams responded that we were doing work with GP surgeries and it would not have an impact as the schemes were self-finding.

8.3. Cllr Rennison noted the strong financial management that existed within the London Borough of Hackney. We were taking the financial position seriously and have strong measures in place.

8.4. Sunil Thakker stated that he was available to talk through the finer detail of the CCG finances, and the presentation would be brought back to the next meeting. The position was changing and we would update the ICB as and when appropriate. The CCG was in a good place financially and the finances were being managed well.

8.5. Gary Marlowe added that we were hearing about support for general practice but this was being coupled with cuts to budget, which was dispiriting. Sunil Thakker responded that cuts had been the case for all CCGs, however he could work with members on formulating a response.

8.6. The **City Integrated Commissioning Board**

- **NOTED** the report.

8.4 The **Hackney Integrated Commissioning Board:**

- **NOTED** the report.

9. Risk Register

9.1. The report was introduced by Matthew Knell. No comments were received.

9.2. The **City Integrated Commissioning Board**

- **NOTED** the register.

9.3 The **Hackney Integrated Commissioning Board:**

- **NOTED** the register.

AOB & Reflections

City and Hackney Integrated Commissioning Programme Action Tracker

Ref No	Action	Assigned to	Assigned date	Due date	Status	Update
ICBMay-4	Sunil Thakker to bring back updated progress report on **CCG contracting position.**	Sunil Thakker	14/05/2020	Aug-20	Open	Guidance still not received.
ICBMay-5	David Maher and Jonathan McShane to share a paper at a future ICB on the **provider alliance approach to service delivery, outcomes and patient experience.**	Jonathan McShane	14/05/2020	Jul-20	Open	
ICBNov-1	**VCS Enabler paper** to be brought back to February ICB.	Alex Harris	12/11/2020	Dec-20	Closed	On the forward planner.
ICBNov-2	Update on **vaccinations** to be brought to ICB in early 2021.	Alex Harris	12/11/2020	Dec-20	Closed	On the forward planner for January.

Title of report:	Integrating care - Next steps to building strong and effective integrated care systems across England
Date of meeting:	10th December 2020
Lead Officer:	David Maher – CCG Managing Director
Author:	Stella Okonkwo – IC Programme Manager
Committee(s):	Integrated Commissioning Board - for feedback
Public / Non-public	Public

Executive Summary:

It is the expectation 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, NHSE/I has set out proposals in this paper on its view of the strategic and operational direction of system working. These proposals detail how systems and their constituent organisations will accelerate collaborative ways of working in future. This paper is positioned to open up a discussion about how ICSs could be embedded in legislation or guidance.

The purpose of this report is to seek views and feedback on these NHSE proposals from all interested individuals and organisations including the people who use and work in services to understand their priorities. These views will help inform future system design work and that of government should they take forward these recommendations in a future Bill.

Feedback on the proposals are to be sent to *cahccg.integratedcommissioning@nhs.net* by the ***30th of December 2020*** at the latest. All feedback will be collated and submitted to NEL on the 4th of January 2021

The NEL ICS Exec will submit a response to NHSE on the 8th of January 2021 after hearing from local stakeholders.

Recommendations:

The **City Integrated Commissioning Board** is asked:

- To **NOTE** the report;

The **Hackney Integrated Commissioning Board** is asked:

- To **NOTE** the report;

Strategic Objectives this paper supports [Please check box including brief statement]:

Deliver a shift in resource and focus to prevention to improve the long term health and wellbeing of local people and address health inequalities	☒	The document sets out the NHSE proposal for a shift in the devolution of resources to places and sectors, addressing areas of greatest need and tackling inequalities through

		targeted investment in line with locally-agreed health priorities.
Deliver proactive community based care closer to home and outside of institutional settings where appropriate	☒	The document builds on the commitments within the long term plan for the delivery of care within communities using stronger partnerships in local places between the NHS, local government and others and proposes a more central role for primary care in providing joined-up care.
Ensure we maintain financial balance as a system and achieve our financial plans	☒	The paper sets out the NHSE proposal for greater focus on a collective system ownership of the financial envelope, how finances will be organised and deployed at the ICS level and proposes an accountability framework that will enable and drive system collaboration around funding and financial accountability, commissioning and risk management.
Deliver integrated care which meets the physical, mental health and social needs of our diverse communities	☒	The paper builds on the route map set out in the NHS Long Term Plan, for the delivery of an integrated health and care operating model joined up locally around the needs of our communities and residents.
Empower patients and residents	☒	The paper proposes a model of engagement that will ensure that patients and residents retain a strong voice in the decision making process.

Specific implications for City

There are no specific implications for the City of London at this stage

Specific implications for Hackney

There are no specific implication for LB Hackney at this stage

Patient and Public Involvement and Impact:

At this stage, this document is being shared across the City and Hackney health and care system to seek views and feedback on the proposed options from the people who use and work in services to understand their priorities and help inform further policy and legislative change.

Clinical/practitioner input and engagement:

This paper will be presented to the Clinical Executive Committee on the 9th December 2020 and subsequently a meeting is being set up to discuss this at the Membership forum on the 17th December 2020.

Communications and engagement:

At this stage, this document is being shared across the City and Hackney health and care system to seek views and feedback on the proposed options from all interested individuals and organisations including the people who use and work in services to understand their priorities and help inform policy and legislative change. Feedback and responses are being expected from various stakeholders by the 30th of December 2020.

Equalities implications and impact on priority groups:

Should these proposals be developed further and proposed by Government as future legislation, the expectation is that a full assessment of the impact of these proposals on equalities and public and parliamentary engagement and scrutiny will be carried out as is appropriate.

Safeguarding implications:

No explicit safeguarding implications to be drawn out from this report

Impact on / Overlap with Existing Services:

These proposals envision that from April 2021 all parts of our health and care system will be working together to deliver integrated local services to our residents.

Main Report

Background and Current Position

It is the expectation 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, NHSE has set out proposals in this paper on the next steps to building strong and effective integrated care systems across England. These proposals detail how systems and their constituent organisations will accelerate collaborative ways of working in future.

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

The proposals have been designed to serve four fundamental purposes:

1. Improving population health and healthcare
2. Tackling unequal outcomes and access

3. Enhancing productivity and value for money
4. Helping the NHS to support broader social and economic development

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

- Stronger **partnerships in local places** between the NHS, local government and others, with a more central role for primary care in providing joined-up care
- **Provider organisations** being asked to step forward in formal collaborative arrangements that allow them to operate at scale
- Developing **strategic commissioning** through systems, 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.

The purpose of this report is to seek views and feedback on these NHSE/I proposals from all interested individuals and organisations including the people who use and work in services to understand their priorities. These views will help inform future system design work and that of government should they take forward these recommendations in a future Bill.

For brevity, the East London Health & Care Partnership (ELHCP) have provided the key points from the NHSE document in a summary version with details of the governance models put forward by NHSE/I and asking for your preferred option: option 1 or 2 (on slide 12).

The NEL ICS Exec will be submitting a response to NHSE (england.legislation@nhs.net) on the 8th of January after hearing from local stakeholders by 4 January 2021

Options
The two options being proposed include:

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

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

Option 2
Statutory Corporate NHS Body Model – *NHSE/I preferred*

- Re-purposed NHS body to undertake CCG duties
- Requires agreed framework of duties and powers

- ICS AO would be a full time role
- No Organisational powers of veto
- Less conflicts of interest
- Better for long term ambition and vision?

Proposals
The proposal has been based on option 2.

Conclusion
The ICB is invited to discuss and provide feedback on these proposals.

Supporting Papers and Evidence:

1. A summary version from NEL of the NHSE next steps to building strong and effective integrated care systems across England has been attached
2. On the day briefing: *Integrating care*, NHS England and NHS Improvement

Sign-off:

David Maher – CCG Managing Director

East London Health & Care Partnership

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

NHSE/I November 2020v1.3

Executive Summary

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

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

Executive Summary

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

- stronger **partnerships in local places** between the NHS, local government and others, with a more central role for primary care in providing joined-up care
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In addition to setting out expectations for how integrated care systems will work from April 2021, the document also describes options for giving ICSs a firmer footing in legislation likely to take effect from April 2022 (subject to parliamentary decision).

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

Background

It builds on the commitments and ambitions set out in:

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

Flagstones of development are:

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

Build on LTP observations

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

Purpose

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

Priorities

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

Integrated Care Systems

East London Health & Care Partnership

Partners will work together to determine:

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

“Place” - a building block for ICSs

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

Practical steps

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

Practical steps

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

Specialist commissioning principles

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

Legislative proposals to:

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

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

East London Health & Care Partnership

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

- Establish a mandatory ICS board
- Explicitly duty for all members (CEOs) to deliver the system plan
- Retains individual organisation duties & outcomes
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Staff Stability

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

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

NHSE commitment:

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

Implications and next steps

East London Health & Care Partnership

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

Your feedback

East London Health & Care Partnership

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

Thank You

East London Health & Care Partnership

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London | E15 1DA

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

East London Health & Care Partnership
Citizen's Panel

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

Integrating care

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

Contents

Introduction

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

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

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

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

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

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

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

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

1. Purpose

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

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

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

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

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

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

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

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

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

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

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

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

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

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

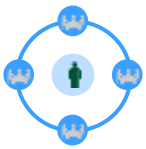
Devolution of functions and resources

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

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

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

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



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

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

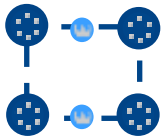
1.15. Our ambition is to create an **offer to the local population of each place**, to ensure that in that place everyone is able to:

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

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

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

Developing provider collaboration at scale



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

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

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

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

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

2. Putting this into practice

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

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

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

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

Provider collaboratives

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2.16. From April 2022, this will include:

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

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

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

Place-based partnerships

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

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

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

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

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

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

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

The NHS's offer to local government

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

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

Clinical and professional leadership

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

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

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

- A primary care perspective at system level.

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

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

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

Governance and public accountability

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

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

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

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

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

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

  They may flexibly define:

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

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

  They may flexibly define:

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

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

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

iv. their voting arrangements on the ICS board.

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

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

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

  It may flexibly define:

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

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

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

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

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

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

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

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

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

Financial framework

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

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

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

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

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

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

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

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

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

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

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

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

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

Data and Digital

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

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

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

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

Build smart digital and data foundations

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

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

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

Connect health and care services

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

Use digital and data to transform care

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

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

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

Put the citizen at the centre of their care

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

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

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

Regulation and oversight

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

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

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

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

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

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

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

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

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

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

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

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

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

How commissioning will change

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

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

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

improving outcomes, rather than managing contract performance between organisations.

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

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

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

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

Specialised commissioning

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

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

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

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

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

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

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

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

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

accountability for tackling inequalities and for improving population health.

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

3. Legislative proposals

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

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

3.3. Recommendations included:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Option 2 – a statutory ICS body

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

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

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

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

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

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

Our approach

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

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

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

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

Questions

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

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

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

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

4. Implications and next steps

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

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

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

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

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

The NHS England and NHS Improvement's operating model

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

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

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

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

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

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

4.10. The new operating environment will mean:

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

against their specific health challenges and population health priorities.

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

Transition

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

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

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

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

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

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

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

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

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

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

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

4.22. Our commitment is:

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

Next steps

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

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

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

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

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

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

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

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

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

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

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

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

Key points

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

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

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

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

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

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

Background

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

The purpose of ICSs

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

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

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

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

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

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

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

Renewed emphasis on the role of providers within ICSs

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

At scale provider collaboratives

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

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

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

Place-based partnerships

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

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

Governance and public accountability

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

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

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

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

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

Financial framework

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

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

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

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

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

Regulation and oversight

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

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

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

How commissioning will change

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

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

Changes to the national commissioning arrangements for specialised services

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

Other key policy developments

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

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

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

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

Legislative proposals for ICSs

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

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

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

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

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

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

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

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

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

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

NHS Providers view

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

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

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

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

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

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

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

How is NHS Providers responding?

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

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

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

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

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

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

Title of report:	**City & Hackney IC Operating Model & CCG Merger: Transitional Governance from January 2021**
Date of meeting:	10 December 2020
Lead Officer:	David Maher – CCG Managing Director
Author:	Carol Beckford – Transition Director
Committee(s):	• Integrated Communications & Engagement Enabler Group – 16 December • CCG Governing Body – 18 December 2020 • SOCG – December (date TBC) • CCG Members Forum – 7 January 2021 • PPI Committee – 14 January 2021
Public / Non-public	Public

Executive Summary:

The purpose of this paper is to set out the high-level steps and the timeline for moving from City & Hackney's current governance arrangements to the governance arrangements required to underpin the new integrated care operating model within the context of a North East London (NEL) Integrated Care System, a single NEL CCG and the City & Hackney local system.

Recommendations:

The **City Integrated Commissioning Board** is asked:

- To **APPROVE** the transition of the ICB to the Integrated Care Partnership Board (ICPB) and the establishment of the Neighbourhood Health & Care Board (NH&CB)

The **Hackney Integrated Commissioning Board** is asked:

- To **APPROVE** the transition of the ICB to the Integrated Care Partnership Board (ICPB) and the establishment of the Neighbourhood Health & Care Board (NH&CB)

Strategic Objectives this paper supports [Please check box including brief statement]:

Deliver a shift in resource and focus to prevention to improve the long term health and wellbeing of local people and address health inequalities	☐	
Deliver proactive community based care closer to home and outside of institutional settings where appropriate	☐	
Ensure we maintain financial balance as a system and achieve our financial plans	☐	
Deliver integrated care which meets the physical, mental health and social needs of our diverse communities	☒	Transition to a new City & Hackney wide integrated care operating model to focus on addressing population health outcomes

Empower patients and residents	☐	

Specific implications for City

Members of the City of London will contribute to shaping the new IC operating model, ICPB and NH&CB

Specific implications for Hackney

Members of London Borough of Hackney will contribute to shaping the new IC operating model, ICPB and NH&CB.

Patient and Public Involvement and Impact:

Representatives of PPI Committee were integral to the ICB Development Session 29 October 2020 where they participated in the thinking that has informed this paper. They will be invited to future ICB/ICPB Development sessions as transition progresses

Clinical/practitioner input and engagement:

Representatives from CCG GP Consortia, and the Primary Care Network Clinical Director's team were integral to the ICB Development Session 29 October 2020 where they participated in the thinking that has informed this paper. Additionally, the CCG members forum have been involved and will be central to ensuring the transitional work take full advantage of the existing GP leadership in C&H. They will be invited to future ICB/ICPB Development sessions as transition progresses

Communications and engagement:

Communications and engagement signoff is not required for this paper. However, the communications and engagement team will use the contents of this paper to create internal and external communications content.

Equalities implications and impact on priority groups:

Not required at this stage

Safeguarding implications:

No safeguarding issues

Impact on / Overlap with Existing Services:

There is no impact on existing service provision

Main Report

Background and Current Position

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

Options

There are no options for consideration.

Proposals

We recommend the transition plan set out in the report because this is the most pragmatic way of migrating from the current operating model to the new integrated care operating model. The transition plan ensures that we engage in a timely fashion with the right stakeholders at the right time. We will have our critical governance arrangements in place, on time, ready for the establishment of the merged NEL CCG merger (1 April 2021). We will have prepared the groundwork for City & Hackney to play a proactive role within the NEL Integrated Care System (ICS).

Conclusion

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

Supporting Papers and Evidence:

No appendices

Sign-off:

City & Hackney CCG: David Maher – CCG Director

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

December 2020

Context

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

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

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

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

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

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

Governance transition – some assumptions (1 of 2)

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

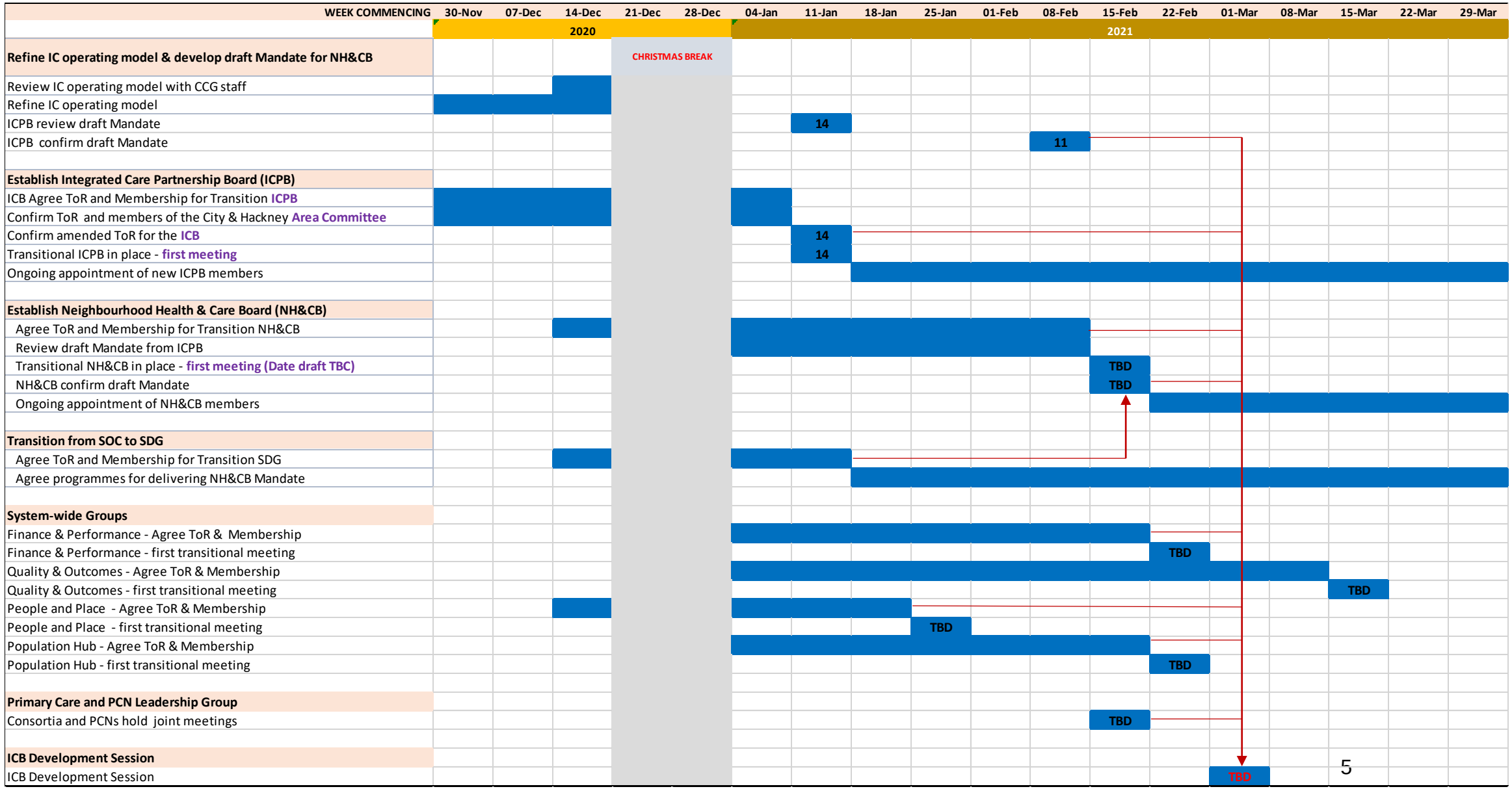
Both ICPB & NH&CB will have agreed transitional ToR and board membership before April 2021.
We expect these to be “transitional” and subject to change in the light of more information and experience

Governance transition – some assumptions (2 of 2)

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

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

Governance – transition timeline



Title of report:	*People and Place Group progress update*
Date of meeting:	10 Dec 2020
Lead Officer:	Jonathan McShane
Author:	Eeva Huoviala
Committee(s):	SMT – verbal update for information - 1 December 2020 ICB – for information and endorsement of next steps - 10 December 2020 PPI Committee - for information and endorsement of next steps – 10 December ICCEEG - for information and endorsement of next steps – 16 Dec
Public / Non-public	Public

Executive Summary:

This papers outlines the progress that has been made between January 2020 and November 2020 on developing the City and Hackney People and Place group including feedback from stakeholder engagement to date. It also includes the proposed areas of future work identified as areas of priority as we move forward with setting up this group.

Recommendations:

City and Hackney Integrated Commissioning Boards are asked:

- To **NOTE** the report and consider and endorse the areas identified for future work.

Strategic Objectives this paper supports:

Deliver a shift in resource and focus to prevention to improve the long term health and wellbeing of local people and address health inequalities	☐	
Deliver proactive community based care closer to home and outside of institutional settings where appropriate	☐	
Ensure we maintain financial balance as a system and achieve our financial plans	☐	
Deliver integrated care which meets the physical, mental health and social needs of our diverse communities	☒	
Empower patients and residents	☒	

Specific implications for City

N/A

Specific implications for Hackney

N/A

Patient and Public Involvement and Impact:

The CCG's Patient and Public Involvement (PPI) Committee have had a central role in shaping the draft Terms of Reference for the People and Place group. Led by Jonathan McShane (Integrated Care Convener), Ann Sanders (CCG Lay Member for Patient and Public Involvement) Catherine Macadam (CCG Associate Lay Member for Equality, Diversity and Sustainable Development) and Eeva Huoviala, (CCG Head of Public Engagement), and building on a list of recommendations made by the PPI Committee in 2019, a number of discussions have taken place with PPI members to pin down the broad remit and the key principles for this new group. These were developed into draft Terms of Reference (see Appendix A), which key stakeholders across the local partnership were invited to comment on during September and October 2020.

Clinical/practitioner input and engagement:

- PPI Clinical Lead Dr Anu Kumar has been involved in developing the draft TOR and continues to input via PPI and by representing the work at clinical and practitioner forums;
- Stakeholder survey was circulated widely to all local GP practices, PCN and Neighbourhood contacts

Communications and engagement:

YES
See above section on PPI

Comms Sign-off

Ann Sanders, Eeva Huoviala

Equalities implications and impact on priority groups:

The group has a remit around equality, diversity and sustainability, and ensuring these are considered throughout the new local model. Stakeholder engagement has identified the representativeness of the group's membership as a key to the success. The group will also work closely with the new City and Hackney Inequalities Task Group.

Safeguarding implications:

N/A

Impact on / Overlap with Existing Services:

- ICPB
- PPI Committee
- VCS Enabler Group
- Inequalities Task Group
- Neighbourhoods
- NEL engagement structures

Main Report

People and Place Group

Progress report to City and Hackney Integrated Care Board (December 2020)

As we move towards a single CCG, an ICS for North East London and an Integrated Care Partnership for City and Hackney, there will need to be changes to governance to reflect the new system.

Ensuring that the patient and public voice, equality and diversity and sustainability and social value remain at the heart of our local system is a priority for the Integrated Care Partnership Board (ICPB) and its partners. There are also other important areas of focus that need to be represented in any new governance arrangements.

There will be an Integrated Care Partnership Board that sets the strategic direction of the City and Hackney health and care system and a Neighbourhood Health and Care Board that will oversee the delivery of integrated health and social care across City and Hackney. These boards will be supported by a number of sub groups:

- People & Place
- Quality and Outcomes
- Members Forum
- Finance & Performance
- Primary Care/PCNs
- Practitioners Forum

This paper outlines the progress that has been made between January 2020 and November 2020 on developing the City and Hackney People and Place group. It is proposed that this group will be a sub-group of the new Integrated Care Partnership Board in City and Hackney, with a remit around patient and public involvement and co-production, equality and diversity, and sustainability and social value at strategic decision making level.

1. Developing the Terms of Reference

The CCG's Patient and Public Involvement (PPI) Committee have had a central role in shaping the draft Terms of Reference for the People and Place group. Led by Jonathan McShane (Integrated Care Convener), Ann Sanders (CCG Lay Member for Patient and Public Involvement) Catherine Macadam (CCG Associate Lay Member for Equality, Diversity and Sustainable Development) and Eeva Huoviala, (CCG Head of Public Engagement), and building on a list of recommendations made by the PPI Committee in 2019, a number of discussions have taken place with PPI members to pin down the broad remit and the key principles for this new group. These were developed into draft Terms of Reference (see Appendix A), which key stakeholders across the local partnership were invited to comment on during September and October 2020.

The main vehicle for commenting on the draft Terms of Reference was via an online survey which was cascaded widely to local partner organisations and stakeholder groups. The survey received a total of 29 responses from the following cohorts:

London Borough of Hackney (5)
City of London Corporation (2)
NHS City and Hackney CCG (11)
Healthwatch City of London (1)
Healthwatch Hackney (2)
Community and voluntary sector (1)
Patient and service user representatives (5)
Unidentified (2)

Additional feedback was received in writing from City and Hackney Older People's Reference Group. Relevant comments from ICB development session in November 2020 have also been noted.

The survey was extended to encourage contributions from providers and others not included in the above list.

2. Feedback from key stakeholders

Sixty-two percent (n=18) respondents felt that the draft Terms of Reference clearly sets out what the group aims to achieve in terms of governance, while 34.5% (n =10) said this was partially the case. Only one person (3.5%) felt that the Terms of Reference did not clearly set out the purpose of the group. Comments and questions from participants were focused around wanting to know more about the legal status of the new ICPB, and the proposed membership of the group. Some respondents also felt that the group's relationship with other governance structures beyond the ICPB, such as the Neighbourhood Health and Care Board, needed to be clarified.

Feedback to date tells us that stakeholders consider the following areas as the most important ones for the group to have in depth understanding and experience of:

- Specialist insight into particular communities and their health needs, such as people with disabilities, migrant and refugee communities, older residents, children and young people, faith groups etc. (78.6%, n = 22, included in the top three most important things);
- Lived experience of health and social care services in City and Hackney (75%, n=21, included in the top three most important things);
- Specialist subjects such as equality and diversity, sustainability, particular types of health services and conditions (e.g. mental health services, maternity services, long-term conditions etc.) (42.9%, n= 12, included in the top three most important things);
- The eight Neighbourhoods and what matters to them (39.3%, n= 11, included in the top three most important things).

It was perceived as less important for the group to have links to local patient experience, campaign and activist groups and VCS groups, although it is worth noting that it is possible this reflects the respondent cohorts.

Respondents described the potential main benefits of the People and Place group as increasing transparency, democratic decision making and civic participation; sense checking and challenging decision making; acting as a representative voice for local communities with particular focus on reducing inequalities; and ensuring that co-production, equality &diversity and sustainability are embedded in the local partnership. Again, respondents emphasised the importance of the above to be informed by real life, lived experiences.

In terms of potential issues it was clear that the group not being representative of the local communities was seen as the biggest risk to mitigate against. Participants were also clear that the group should not be where engagement happens, but rather a place for engagement to be developed, checked and scrutinised. To this end some respondents also felt that its relationship with other engagement groups such as the Integrated Care Engagement and Communications Enabler Group and local authority scrutiny forums should be clear.

3. Timeline

January - October 2020	Stakeholder engagement
December 2020	Progress update to ICB and PPI Committee
January 2021	Draft membership developed

February 2021	Draft membership update to ICB and PPI Committee
March 2021	Recruitment launched for core membership
April 2021 shadows PPI Committee	People & Place core group meets in conjunction with /
	Review core membership, identify gaps
May 2021	Further recruitment to People and Place Group

4. Future work to be done

- Setting out an initial membership for the group and how we would go about recruiting members ensuring that membership is as representative as possible, and able to draw from lived experience;
- Setting out how the group relates to other parts of governance including ICPB, NHCB and the Communications and Engagement and VCS Enabler Groups;
- Looking at how issues relating to equality and diversity will be managed as there is a clear role for the Quality and Outcomes Group in this area;
- Establishing stronger links with our clinical communities incl. the City and Hackney practitioner forum, PCNs and Neighbourhood based clinicians .

Supporting Papers and Evidence:

Appendix A – People and Place Draft Terms of Reference

Sign-off:

N/A

Appendix A: Terms of Reference

As we move towards a single CCG, an ICS for North East London and an Integrated Care Partnership for City and Hackney, there will need to be changes to governance to reflect the new system.

Ensuring that the patient and public voice, equality and diversity and sustainability and social value remain at the heart of our local system is a priority for the Integrated Care Partnership Board (ICPB) and its partners. There are also other important areas of focus that need to be represented in any new governance arrangements.

There will be an Integrated Care Partnership Board that sets the strategic direction of the City and Hackney health and care system and a Neighbourhood Health and Care Board that will oversee the delivery of integrated health and social care across City and Hackney. These boards will be supported by a number of sub groups:

- People & Place
- Quality and Outcomes
- Members Forum
- Finance & Performance
- Primary Care/PCNs
- Practitioners Forum

Status and role of the group

- The People and Place Group is a formal sub-committee of the Integrated Care Partnership Board (ICPB) and is directly accountable to the ICPB.
- The Chair of the People and Place Group will have a place on ICPB.
- The purpose of the P&P Group is to ensure appropriate assurance, advice and challenge is given to the new Integrated Care Partnership Board and Neighbourhood Health and Care Board in the areas of:
    - Patient and public involvement and engagement
    - Co-production
    - Equality and Diversity (Shared with Quality Group)
    - Sustainability and Social Value

The Group should also provide assurance, advice and challenge to the NEL CCG and ICS. Details of how this will happen have to be worked through across NEL.

Key responsibilities

PPI

- To support the Integrated Care Partnership Board and Neighbourhood Health and Care Board in embedding the views of patients and the public in its commissioning decisions and delivery of service
- To ensure that the participation, views and voices of patients and the public across neighbourhoods in City and Hackney influence and inform every aspect of the Integrated Care Partnership.
- To monitor and report on how the Integrated Care Partnership and its member organisations are discharging their commitments under the Co-Production Charter and any legal responsibilities around Patient and Public Involvement and Patient Choice.

- To advise the ICPB and NHCB on relevant strategies, plans and communications related to public and patient involvement and engagement.
- To monitor the quality of services from a patient and public perspective and to ensure that issues of concern are addressed.
- To support a PPI Forum that brings together representatives from across City and Hackney.

Equalities and Diversity

- To support the ICPB and NHCB in ensuring that equalities and diversity are fully embedded in the systems and processes for commissioning and delivery of services and that statutory duties in relation to equalities and diversity are fulfilled.
- To ensure that tackling health inequalities across neighbourhoods in City and Hackney remains a core principle that influences and informs every aspect of the Integrated Care Partnership.
- To advise the ICPB and NHCB on equalities and diversity issues relating to their strategies, plans and decisions.
- To oversee the progress against equality standards (such as EDS2 (revised Equality Delivery System for the NHS), NHS Workforce Race Equality Standard (WRES) and Workforce Disability Standard. (WDES) and other relevant quality/equality monitoring and reporting mechanisms.
- To ensure a co-productive approach is taken to addressing inequalities in City and Hackney, including the development of an ICP board Equality and Diversity action plan.

Sustainability and Social Value

- To support the ICPB and NHCB in ensuring that sustainability and social value are fully embedded in the systems and processes for commissioning and delivery of services and that statutory duties in relation to them are fulfilled.
- To ensure that sustainability remains a core principle that influences and informs decision-making across the Integrated Care Partnership.
- To oversee the development and implementation of a strategy for health and social care partners as anchor institutions.
- To advise on relevant strategies, plans and communications related to sustainability and social value for the ICPB and NHCB and to support them to ensure that staff, residents and stakeholders are involved in their production and properly informed about them.
- To ensure that a co-productive approach is applied in taking forward the sustainability and social value agendas of the ICP.

1.1. Membership

To be informed by the stakeholder survey and agreed once roles and responsibilities of each element finalised.

Title of report:	Neighbourhoods – Emerging Plans for 2021/22
Date of meeting:	10th December 2020
Lead Officer:	Nina Griffith and Mark Golledge
Author:	Mark Golledge (with system partners)
Committee(s):	This item is being presented to ICB so that emerging plans for Neighbourhoods in 2021/22 can be shared. It is with a view to seeking ICB member views and suggestions so that the full business case proposal can be bought back to ICB in January 2021. The proposals outlined in the presentation have been informed by proposals from system partners drawing on the work that has been delivered in 2020/21. This is therefore presented as proposals from system partners for the 2021/22 programme. When returning in January 2021 the full proposals will have been reviewed by: - System Operational Command Group - Better Care Fund Governance Group - CCG Finance and Performance Committee - CCG Governing Body
Public / Non-public	Public

Executive Summary:

The Neighbourhoods Operating Model and delivery plan agreed in February 2020 by ICB sets out our vision for Neighbourhoods across City and Hackney. We remain committed to the principles and delivering the overall vision.

In 2020/21 we have seen significant challenges due to COVID-19. This year partners have worked together to prioritise certain areas of delivery through the programme.

Significant work has been undertaken across all 8 Neighbourhoods as a result. This includes activity led by the voluntary and community sector to rollout Neighbourhood-based forums (Neighbourhood Conversations) for collaboration and community insight, by partners in establishing Neighbourhood-based multi-agency support for some of our more vulnerable residents and in working with community navigation providers to coordinate support residents with non-medical needs. COVID-19 has highlighted to partners the need for Neighbourhood-based approaches.

The presentation draws together the progress and achievements that have been made through the Neighbourhoods programme so far this year. It also summarises the proposed priorities and projects for 2021/22 that are being considered. These are all focused on delivering new ways of working that will help contribute towards improving outcomes and addressing local inequalities within the 8 Neighbourhoods across City and Hackney.

The purpose of bringing this presentation is to seek ICB member views on these proposals.

Recommendations:

Both the City of London and Hackney Integrated Commissioning Board **are asked to discuss the emerging proposals for 2021/22**. ICB members are asked to review the content of the 2021/22 proposals outlined within the presentation and provide views that can inform a full business case returning to ICB in January 2021.

Strategic Objectives this paper supports [Please check box including brief statement]:

Deliver a shift in resource and focus to prevention to improve the long term health and wellbeing of local people and address health inequalities	☒	A key part of our approach to Neighbourhoods is enabling a greater focus on prevention and addressing local health inequalities. Putting a greater focus on navigation and connection with residents via Neighbourhood-based community navigators is a key part of the approach.
Deliver proactive community based care closer to home and outside of institutional settings where appropriate	☒	Neighbourhoods is proposing a greater focus on proactive community-based care and improved multi-agency support for residents.
Ensure we maintain financial balance as a system and achieve our financial plans	☒	As we see more resources come into the community whether through recruitment to new roles, through links with voluntary sector provision or a closer link from specialist services with community-based teams we would like to see this delivering more effective community based care.
Deliver integrated care which meets the physical, mental health and social needs of our diverse communities	☒	Neighbourhoods is focused on delivering integrated and coordinated care and support for residents. This includes but extends beyond just physical health. The wider engagement of both voluntary sector organisations as well as wider council services remains key to achieving the overall vision.
Empower patients and residents	☒	A number of projects being delivered through Neighbourhoods are already testing and identifying ways to empower patients and residents. Our plans for 2021/22 include activity to develop further our approach to co-production.

Specific implications for City

It is critical that the work in Shoreditch Park and the City Neighbourhood continues to engage with City of London Corporation so that views are fully represented in both operational delivery and decision making. The priorities and projects described are as relevant for City of London as they are for Hackney. The City of London has already been involved in improving MDT working (including voluntary sector in City of London) and the proposals around resident engagement align with work being undertaken by Healthwatch with City of London residents.

Specific implications for Hackney

The proposed priorities and projects are relevant for Hackney. This includes specific work led by LB Hackney (in areas such as adult social care and children's services) as well as work being undertaken by partners that will benefit City residents. The new models of care described within the proposals already (and will continue) to involve a range of Hackney services.

Patient and Public Involvement and Impact:

The Neighbourhoods Resident Involvement Group continues to play an important role within the overall programme. This group brings together residents and is supported by Healthwatch. Representatives from this group form part of the Neighbourhoods Delivery Group that have helped shape the 2021/22 priorities and proposals.

Many of the proposed activities are building on work already being undertaken in 2020/21 and engaging residents and patients within their specific projects such as mental health, adult social care and partnership work led by the voluntary and community sector.

Clinical/practitioner input and engagement:

This is a system wide programme with partners owning the programme collectively.

Clinical input and engagement remains a key part of the programme. Proposals provided by individual partners have been shaped by practitioner engagement within individual services.

In addition, the six priorities for 2021/22 have been informed by continued engagement with practitioners via Neighbourhoods Delivery Group and Informal Group as well as specific engagement with PCNs.

Communications and engagement:

Yes – communications and stakeholder engagement is critical.

In working up the proposals engagement has been taking place with the communications and engagement enabler (who also form part of the Neighbourhoods Delivery Group).

One of the questions ICB is asked to consider is how we can collectively engage with and inform a broader base of residents about the Neighbourhoods Programme.

Equalities implications and impact on priority groups:

Helping to address inequalities (both of access to services and of outcomes) is a key purpose for Neighbourhoods. Neighbourhoods are about bringing together services (including voluntary and community sector) to work with residents to improve outcomes for populations of 30-50,000 people.

The community insight gathered through Neighbourhood Conversations and the data being gathered to inform Neighbourhood profiles are helping to inform this response. Our response to COVID-19 has exposed further these inequalities. It has also highlighted the importance of Neighbourhoods as one means to work with local communities to understand and address these.

Safeguarding implications:

The original vision for Neighbourhoods was developed out of a need to improve multi-agency working in relation to safeguarding. This remains a core focus of the programme and the multi-agency working that has been increased through the programme in 2020/21 has had a specific safeguarding focus.

Impact on / Overlap with Existing Services:

Neighbourhoods is about improving multi-agency working between community-based services (such as voluntary sector, mental health, social care) as well as blurring the lines with specialist support services.

In addition, the focus of Neighbourhoods remains to improve services and support being delivered to residents in the community.

Main Report

Please see accompanying presentation.

Supporting Papers and Evidence:

None – see presentation.

Sign-off:

David Maher – City and Hackney CCG

Tracey Fletcher – Workstream SRO

Neighbourhoods - Emerging Plans for 2021/22

(10th December - ICB)

Introduction

- **The high level delivery plan for Neighbourhoods was set out in the Operating Model and developed further during the course of 2020.** We remain committed to these principles and delivering this overall vision. We know plans will need to continue to evolve based on new partnerships that are being formed both regionally and locally.

- **Locally and nationally there have been significant challenges due to COVID-19, which has exacerbated long-standing inequalities. In response partners have worked together to prioritise some aspects of the programme and adapted others**. COVID-19 has confirmed to system partners the relevance and importance of Neighbourhoods. It is crucial that we do not lose the momentum and traction of many of the projects currently being delivered through this programme.

- As a system we want to discuss with you the **proposed plans for Neighbourhoods for 2021/22 that builds on the work undertaken in 2020/21.** These have been developed by system partners.

- We will be bringing a **full business case proposal to ICB in January 2021** to request to fund Neighbourhoods from the Better Care Fund as in previous years. This will also focus on how we embed this way of working into day-to-day practice in City and Hackney as well as answer questions around longer-term sustainability of this approach. We will also show how the proposed funding aligns to delivery of the priorities.

- Before we bring the full business case back **we would like your input to help shape the programme** going into next year.

- **Today we will be sharing with you:**
    1. A brief reminder of our Neighbourhoods approach and our journey
    2. An update on what has been happening this year
    3. Draft priorities for 2021/22
    4. A summary of the proposed projects that will be delivering against these priorities
    5. A summary of the approach to evaluation

Our City and Hackney Neighbourhoods approach

- The Neighbourhoods Programme has a small coordinating central team but **brings together partners from across the system** to drive this work forward.
- **The priorities and projects outlined in these slides are being undertaken by a wide and inclusive group of partners working together,** who are considering more than just medical and social care needs.
- **What is being presented here has been developed from work with system partners and is therefore collectively owned**. We have also continued to involved the Neighbourhood Resident Involvement Group in the approach.
- Partners continue to be **committed to place-based integration** in City of London and Hackney. We are **aligned and working very closely together with Primary Care Networks (PCNs)** and the priorities we have set out directly support PCN development.
- **In informing our approach continue to look outside City and Hackney to areas such as Frome and Wigan (see appendix).** There are some similarities with our Neighbourhoods approach e.g. asset based approaches, Neighbourhoods as the focal point for integration, the emphasis on behaviours culture and trust, the importance of schools and GPs as a pillar in the Neighbourhood and the importance of investment in the sustainability of voluntary and community organisations.

At the heart of Neighbourhoods is:

- A focus on culture, values and behaviours across teams, organisations and with residents
- Taking an asset-based, strengths based approach to working with residents
- Moving services and support for residents closer to the community
- A focus on kindness, compassion and fostering a sense of community

1. Where we are in developing our approach to Neighbourhoods

Phase 0 – Develop vision, gain commitment and secure funding (Yr 1 (18/19))

Phase 1 - Develop Neighbourhood models - test & learn (Yr 2 (19/20))

Phase 2 - Put the foundations in place across City & Hackney

Phase 3 – 1st transformation in priority areas (Yr 3 (20/21))

Phase 4 – Further transformation & extend core Neighb'hood team (Yrs 4-6)

Phase 5 - Integrate extended team in line with priorities (Yrs 7-10)

Where we have been

- Developed the vision for Neighbourhoods across City & Hackney and gain partner buy-in
- Early engagement with residents about Neighbourhood approach and wellbeing priorities
- Secured funding to support service transformation in line with vision
- Supported the establishment of Primary Care Networks across City and Hackney

Where we have been

- Developed clear operating model for Neighbourhoods and multi-year delivery plan
- Developed new Neighbourhood service models in key areas such as adult community nursing, adult social care, adults with SMI
- Tested new approaches to community navigation to support adults with complex needs
- Piloted approach to multi-agency working (anticipatory care)

Where we are now

- Identified link roles across services that would work in each Neighbourhood & supported joint working
- Identifying technology and data requirements to support integrated working
- Transformation continued in areas such as social care & serious mental illness & disorder
- Developing behaviour, culture and skills approach for Neighbourhood teams
- Re-prioritised the programme in 20/21 to respond to COVID-19 including:
- Rolling out MDT working for priority groups - into each of the 8 Neighbourhoods
- Developed our approach to community navigation & supporting people with non-medical needs
- Rolled out Neighbourhood Conversations to facilitate community engagement

Where we are going

- Bring together blended Neighbourhood teams around the life course
- Develop our collective vision for estates for Neighbourhoods and test this in local areas
- Establish Neighbourhood Partnerships across all areas monitoring Neighbourhood outcomes
- Build on MDT working to enhance integrated processes and improvements to joined up care
- Begin to co-locate / link in extended Neighbourhood team depending on priorities for each Neighbourhood
- This involves teams beyond just health and social care
- Neighbourhood partnership identifying and working on local interventions for Neighbourhood groups
- More services being delivered directly in the community

1. What progress is being made this year

In 2020/21 we have prioritised work to support the local response to COVID-19, with a specific focus on addressing health inequalities. This has focused on three key areas.

1. Developing the service infrastructure for working at Neighbourhood level

- **Key services that work at a Neighbourhood footprint have identified link staff** that are now connecting with each Neighbourhood to improve multi-agency working.
- **This includes community therapies, adult social care, mental health and community navigators.** These services are already starting to form the basis of Neighbourhood blended (multi-agency) teams.
- **A range of specialist health services and wider council services, have identified how best to align to Neighbourhoods** and maximise the opportunities offered by Neighbourhood level multi-agency working.
- **Services are working towards reorganising around a Neighbourhood footprint** e.g. adult social care, community nursing.
- **Partners have worked together to improve access into and coordination of community navigation support.** This work was critical during the COVID-19 response and we are testing 'Neighbourhood networks' that will better coordinate navigation provision in each area.

1. What progress is being made this year

2. Strengthening partnership working within Neighbourhoods

- **Primary Care Networks that were launched nationally just over a year ago are working collaboratively together**. Funding from Neighbourhoods is supporting leadership development for PCN Clinical Directors and PCNs are engaging with wider system partners in delivery.
- A core partnership group has been established in Well Street Common to support the delivery of a **VCSE led, cross-sector partnership** in the Neighbourhood.
- In response to COVID-19 and led by HCVS, **Neighbourhood Conversations** have been established in each of the 8 areas. These bring together a range of partners and **provide a forum for disseminating information, sharing local insight and building relationships.**
- **These Neighbourhood conversations are helping to build local engagement, generate new connections and kick-start collaborative projects** e.g. improving digital access or exploring alternative options for engaging residents.

3. Taking a more proactive and integrated approach to care and support for residents

- **Partners have come together to establish multi-agency Neighbourhood working in each of the 8 Neighbourhoods during COVID-19.** This has brought together partners from across City and Hackney to support some of our more vulnerable residents. This has also been linking up with children, young people to take a family approach.
- **Partners are working together to roll out Neighbourhood approaches in mental health** with the establishment of **Neighbourhood blended teams** including community connector roles with the voluntary sector. Implementation has started in Clissold Park and Hackney Marshes and is being rolled out to other Neighbourhoods.
- Partners **have developed an approach for multi-professional education and peer support to assist multi-agency working** within the 8 Neighbourhoods. This is intended to be delivered to teams during 2021.
- **Children and young people's work is underway to improve multi-agency working for 0-5s and 6-19s** (working on a Neighbourhood footprint) including the provision of specialist children's support in Woodberry Wetlands.

1. What outcomes have we started to see

On strengthening partnership working in Neighbourhoods:

"Being part of this Partnership meant that I had connected with lots of organisations and people before Covid-19, which really helped with the response work. This shows the value of the partnership; being able to work better with others in the ward I cover."
Local Councillor

On taking a more proactive and integrated approach to care and support:

Adults: "The best thing has been being able to make connections, put faces to names and have a direct contact to community services. As a GP it can be quite isolating. It's a supportive environment to learn about other services in City and Hackney. There's a wealth of services in City and Hackney and it's a disservice not to know about these" ***GP, Springfield Park***

Children and Young People: 'I was really impressed with how well the meeting functioned, its comprehensive preparation and its holistic approach to cases. There was really good systematic consideration of other people in the household; the MDT thought about the impact of an individual's needs on the rest of the household' **Child and Adolescent Mental Health Service Primary Care Liaison Nurse, Woodberry Wetlands**

And the impact for residents:

- L is a 60 years old, female patient of Lower Clapton Practice in Hackney Marshes
- L suffers with chronic pain, has osteoarthritis, type 2 diabetes, obesity, pressure ulcers, chronic constipation and has a catheter in situ
- She recently moved to a new flat and has had some recent falls
- Discussions with L focused on what was most important to her which is managing her pain
- L has received a coordinated approach to managing her chronic pain, catheter and pressure ulcers

Discussions took place including: GP, Wellbeing Practitioner, Pharmacist, Psychologist in the Pain Service, adult social care, community therapies, community mental health team.

Next steps / actions agreed

- Those working with L met and are working with each other
- The psychologist from the Pain Service agreed to speak with the pain consultant to facilitate a face-to-face review of joint medicine and psychological support for L
- The GP and the Pain Service will work closely with one another to better manage L's pain
- The Adult Community Rehabilitation Team agreed to visit L's new home and conduct a review

2. Our proposed priorities for 2021/22

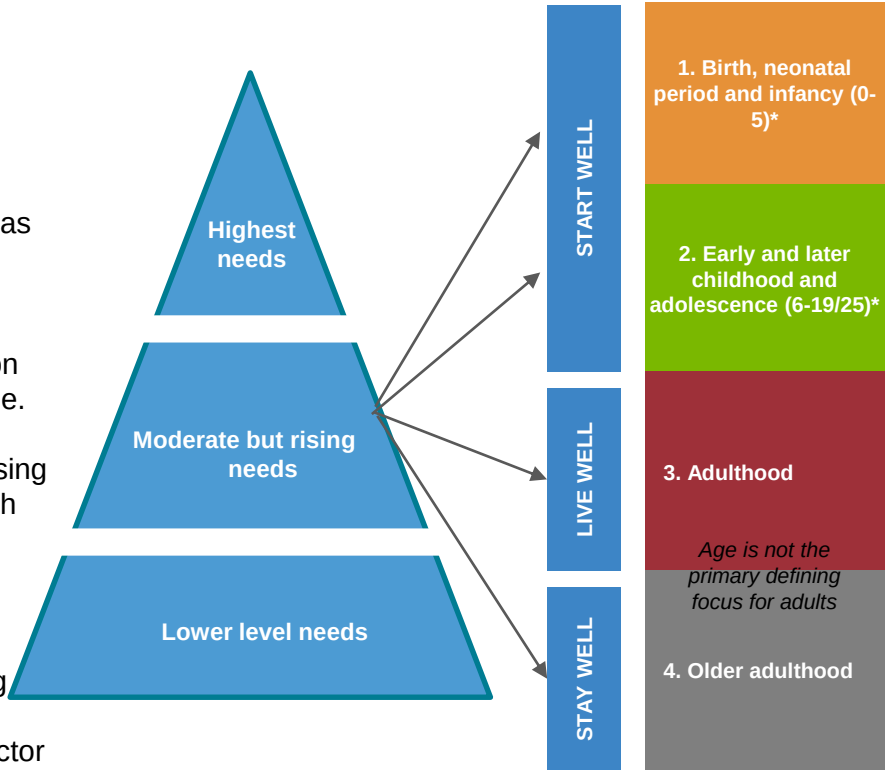
Partners have developed six priorities for 2021/22

- **Priority 1:** To take a more proactive and joined up approach to supporting City and Hackney residents with rising needs (*based around the life course - see next slide*).
- **Priority 2:** To continue to redesign services that will make up Neighbourhood based blended teams to support residents identified in priority 1.
- **Priority 3:** To provide coaching and OD support to Neighbourhood based blended teams that enhances trust and supports collaborative working.
- **Priority 4:** To establish meaningful and sustainable approaches to resident involvement. This includes developing a strong Neighbourhood culture where the VCS and residents feel connected and have influence.
- **Priority 5:** To test and begin to establish partnership arrangements (at an operational and strategic level) in each Neighbourhood drawing on work in Well Street Common
- **Priority 6:** To put in place arrangements to improve our knowledge of and act on health outcomes and inequalities

3. Our proposed priorities for 2021/22

As partners we are proposing a more central life course approach in 2021/22:

- We described our vision for Neighbourhoods in the Neighbourhoods Operating Model earlier in the year.
- We are taking a life-course approach based which is person-centred (not condition based). This draws on learning from other areas such as Wigan.
- Taking this approach will give greater clarity on how Neighbourhood teams will come together to support different cohorts of the population and also enable an increased the focus on children and young people.
- We plan to focus more on supporting residents with moderate and rising needs. This will support the new anticipatory care requirements which are expecting to be a requirement for Primary Care Networks in 2021/22.
- This will allow us to:
  - Take a more proactive approach to identifying and supporting residents at an earlier stage **(priority 1)**.
  - Bring together multi-agency teams including the voluntary sector / specialist teams **(priority 2)**.
  - Provide multi-professional education and peer support to these teams **(priority 3)**.



And a family / intergenerational approach throughout

3. A summary of projects that will deliver on these six priorities

Our approach to delivering the work in 2021/22:

- The planned approach for 2021/22 builds on work that has been undertaken this year.
- System partners have come together to develop a number of projects that will help us deliver on the six priorities.
- Neighbourhoods is a partner-led programme with equity between system partners at the heart. The voluntary and community sector remains a key partner in the approach and we will continue to ensure that Neighbourhoods maintains its commitment to engaging with local communities.
- The programme is working collaboratively with City of London Corporation, City Healthwatch and other City-based services.
- The first priority involves a series of projects that will be based around the life course (see next slide). This will enable us to take a more proactive approach to identifying residents and ensuring that care and support is more person-centred.
- System partners have developed an overall programme plan for Neighbourhoods in 2021/22 (available separately).

Partners supporting delivery in 2021/22:

We are anticipating that the following partner organisations will be leading on specific aspects of the programme in 2021/22.

The role of these organisations is to facilitate work with other partner organisations:

- Office of Primary Care Networks
- Hackney Education
- Homerton University Hospital
- Healthwatch (City and Hackney)
- Hackney CVS
- LB Hackney
- City of London Corporation
- East London Foundation Trust
- Community Pharmacy
- CCG

We are also exploring work with housing for 2021/22.

3. A summary of projects that will deliver on these priorities:

<u>Priority 1</u>: We are lining up a series of cross-cutting projects (around the life course) delivering more proactive support to residents

Start Well

Through the 8 Neighbourhoods we will:

- **0-5s:** Work with children identified as needing early support through improved links between primary care and multi-agency teams (MATs) as well as for child health
- **6-19s:** Support children who are absent from school/miss appointments by improving links between schools and health

Live Well

Through the 8 Neighbourhoods we will:

- Continuing the rollout of Neighbourhood blended teams in mental health
- Develop ways to improve access for vulnerable young people in transition (18-25) working with system partners
- Identify and facilitate improvements to long-term condition pathways in planned care e.g. stroke and respiratory

Stay Well

Through the 8 Neighbourhoods we will:

- Adopt a more proactive approach to supporting older residents with increasing care needs i.e. frailty
- Improve multi-agency working between specialist and community teams to support these residents
- Test, develop and embed a personalised care approach for older people

Whilst also continuing an inter-generational focus

4. A summary of projects that will deliver on these six priorities

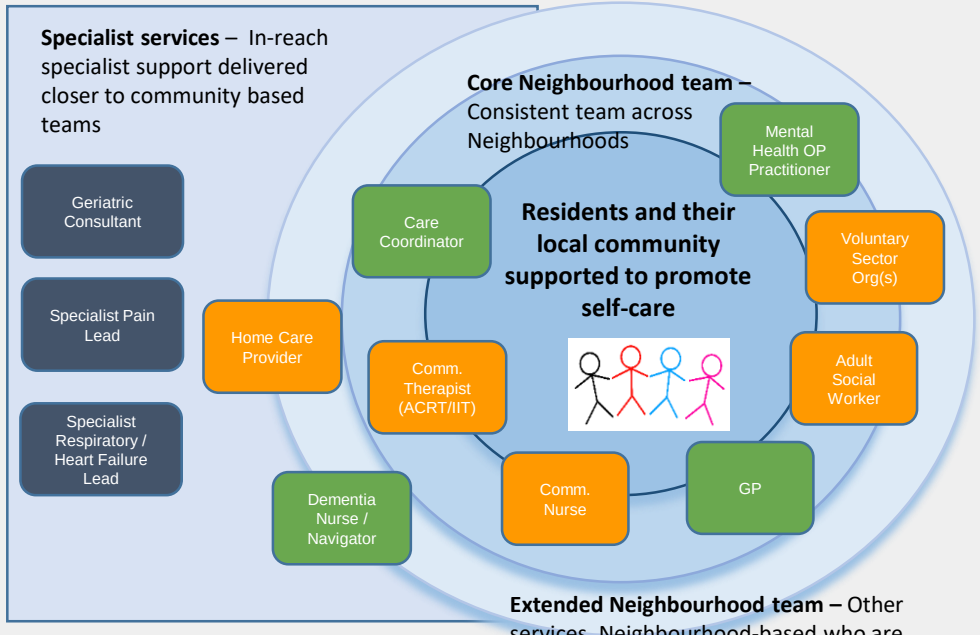
<u>Priority 2</u>: Partners will work together to redesign services around a Neighbourhood-based footprint - individuals in these services will form Neighbourhood-based blended teams.

- In 2021/22 system partners will continue the redesign of services so that teams are 'Neighbourhood-based'.
- Blended teams are already beginning to form around the life course approach identified in priority 1.
- This redesign work is planned to take place in:
  - Adult Social Care
  - Adult Community Nursing
  - Adult Community Therapies
  - Pilot a Neighbourhood-based approach to home care
  - Delivering our Neighbourhood community navigation approach

<u>Priority 3</u>: Partners will work together to commission coaching and OD to support the development of blended Neighbourhood teams

- This will include multi-professional education and peer support to enhance multi-agency working and Neighbourhood-based engagement events for staff.

<u>Example - Blended Neighbourhood Team for 'Stay Well'</u>: We anticipate seeing a series of blended Neighbourhood teams begin to form around population cohorts i.e. the life course. This Neighbourhood-based team will be responsible for proactively identifying residents and working together to coordinate their care.



4. A summary of projects that will deliver on these six priorities

Priority 4: Partners will work together to establish meaningful and sustainable approaches to resident involvement. This includes developing a Neighbourhood culture where the VCS and residents feel connected and have influence.

a). Develop and test an approach for resident engagement within Neighbourhoods

Led by Healthwatch this work will:

- Pilot and test the community influencer approach (active and connected residents) and develop an approach (toolkit and support) for rollout
- Identify existing resident involvement and channels of involvement within Neighbourhoods and work with partners to develop proposals for future involvement approaches
- Embedding co-production across the programme through training and work with Neighbourhoods Resident Involvement Group

This will complement existing work being carried out in the City of London on resident engagement and being led by Healthwatch.

b). Develop an approach for voluntary and community sector engagement within Neighbourhoods

Led by HCVS this work will:

- Continue the Well Street Common Partnership, assess and develop a plans for future rollout (this will directly support the delivery of priority 5)
- Continue the delivery of Neighbourhood Conversations in the other 7 Neighbourhoods, gathering community insight & specific themed work arising from local priorities
- Explore and develop voluntary sector hosting arrangements into Neighbourhood Conversations

4. A summary of projects that will deliver on these six priorities

Priority 5: Test and begin to establish both operational team working (for Neighbourhood blended teams) and strategic partnership arrangements in each Neighbourhood

Partners committed in the Neighbourhood Operating Model to form strategic partnerships in each Neighbourhood. The City of London will be involved in helping shape this. Working together with HCVS and applying the learning from Well Street Common, PCNs and system partners will:

- Work with HCVS to take the learning and application from Well Street Common Partnership and work together to agree the approach for other Neighbourhoods. This will involve:
- Testing and agreeing the purpose and roles of Neighbourhood Partnerships;
- Agreeing the partners to be involved;
- Developing arrangements for how this can be rolled out and be feasibly sustained;

Additionally, working with PCNs work will be undertaken to create real operational team working within Neighbourhoods. This will include exploring workforce models that enhance multi-agency working and draw on new roles being recruited within PCNs.

Priority 6: To put in place arrangements to improve our knowledge of and act on health outcomes and inequalities

This priority is about improving our arrangements within Neighbourhoods to understand and act on health outcomes. This activity will focus on improving our approach in this area . By working with the Population Health Hub the work will involve:

- Contributing to the development of a City and Hackney Strategy and Action Plan for Population Health.
- Supporting PCNs with Health Inequalities requirements for 21/22.
- Participating in wave 3 of the NHSE/I Population Health Academy

Partners are also keen to explore the development of Neighbourhoods Inequalities Plans on a Page - linking to the overall City and Hackney Inequalities Plan.

4. Developing an evaluation framework for Neighbourhoods

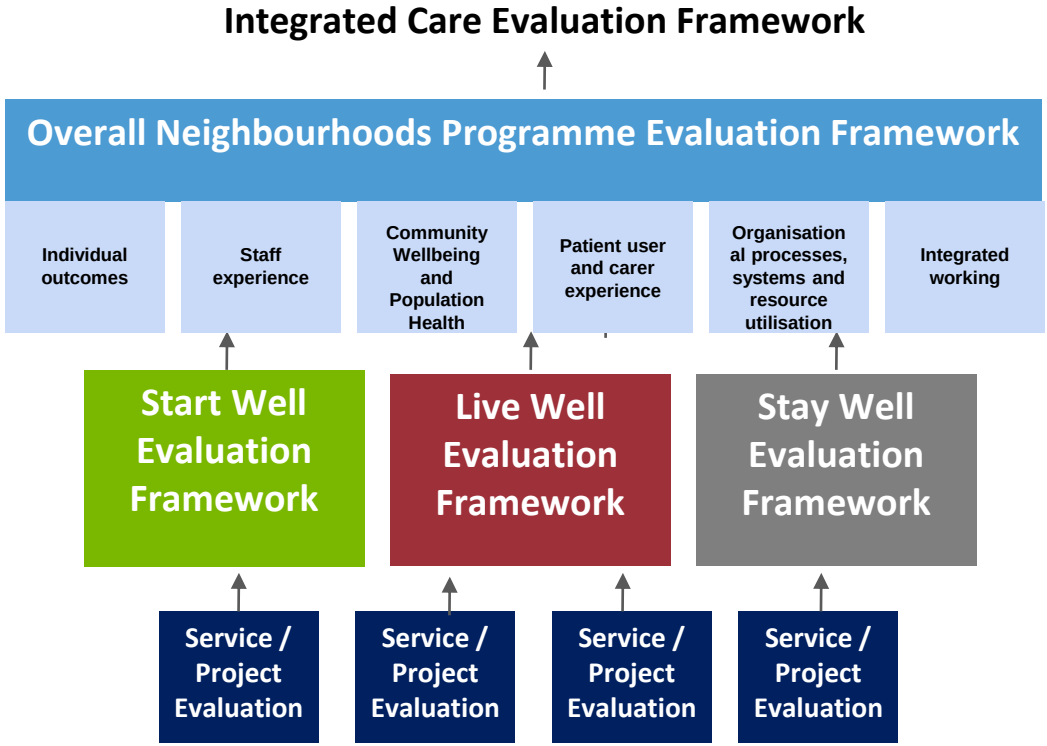
We are intending to work with Cordis Bright to develop an evaluation framework for Neighbourhoods. This work will form part of the broader City and Hackney Integrated Care evaluation. Work is being undertaken to further develop the approach based on feedback from the evaluation steering group but it is envisaged this will involve three areas:

1. **A stocktake of Neighbourhoods and future recommendations** through engagement with residents, frontline staff, middle managers and system and learning from other areas around the country.

2. **Development of an overall theory of change and evaluation framework for Neighbourhoods.** This will align to the original six outcome domains.

3. **Development with service partners of a theory of change for 'start well', 'live well' and 'age well'.** Cordis Bright will link with a range of services across the system to develop these although the extent to which Cordis Bright is involved in all 3 of these areas is to be agreed.

    - **Start Well** - CYPMF workstream
    - **Live Well** - ELFT (Mental Health Transformation)
    - **Stay Well** - Homerton Hospital (Frailty Pathway)



We also expect individual services that will be funded in 2021/22 to be carrying out their own evaluation of the work to test the impact.

Discussion

We would like to use this discussion to inform what we bring back in January.

Specifically we'd like you to reflect on:

1. We feel that our ambitions for Neighbourhoods are aligning to the recent publication 'Integrating care: Next steps for building strong and effective integrated care systems' published in November, but what else do we need to take into account from these national, regional and local developments as we shape the future approach?

2. The priorities for the programme in 2021/22 and the projects - *do you feel these are the right areas of focus?*

3. Using the learning from Wigan - *what is our level of ambition for Neighbourhoods in City and Hackney?*

4. The evaluation for the programme outlined in the proposal - *what else might we need to consider and how can this better connect to the system wide evaluation?*

5. How we engage with and inform a broader base of residents about the Neighbourhoods Programme - *what would we need to consider in doing this?*

Comparison with other areas

Learning from Wigan

- In developing our approach to Neighbourhoods in City and Hackney we are also learning from other areas.
- This includes Wigan. Whilst the context is very different there are some key elements which have underpinned the Wigan approach:

Proud to be part of The Deal in partnership with Wigan Council

Elements of the Wigan approach which are similar to the Neighbourhoods Programme

- **Service Delivery Footprints** - 7 SDFs (30-50,000) which are the focal point for service delivery
- **GPs and Schools** as the pillars of engagement within each SDF
- **An asset based approach** focused on community navigation
- **Multi-agency place based teams** with regular SDF huddles
- **An intelligence-led proactive approach** to identifying residents
- A significant programme focusing on **behaviours, culture and trust**

Elements of the Wigan approach that we may want to develop further in City and Hackney

- **The Deal** - a social contract between the council & citizens
- **Service Delivery Footprints** - wider public services who are organised around SDFs e.g. have practitioners/staff dedicated to working in an SDF
- **Investment in local communities** - significant emphasis on locally led community activities *(already activity underway in City and Hackney)*
- **Dedicated Service Delivery Footprint lead** (in each SDF) who are not linked to a specific service/sector. They are the partnership conveyors in the place

Title of report:	Pathway Homeless Hospital Discharge Team Business Case
Date of meeting:	10/12/2020
Lead Officer:	Nina Griffith
Author:	Cindy Fischer
Committee(s):	1. Rough Sleepers and Health Partnership Group – for endorsement – 21 September 2020 2. Discharge Steering Group – for endorsement – 22 September 2020 3. System Operational Command Group – for endorsement - 21 October 2020 4. City and Hackney CCG Finance and Performance Group – for approval – 28 October 2020
Public / Non-public	Public

Executive Summary:

- The business case and recommendations are based on the findings of an independent needs assessment, carried out by the charity Pathway between December 2019 and March 2020.
- The current numbers of people attending the hospitals mean that the discharge system is overstretched and there is a large variability in response, which needs to be standardised. There are delays to discharges and a high readmission rate for Homerton at 29%.
- The Pathway approach is tailored to meet the needs of the local homeless population. The recommendation is to have a team of five posts with additional input from housing teams. This team will support both the Homerton University Hospital Foundation Trust and the City and Hackney Centre for Mental Health.

Recommendations:

[Recommendations should be clear and not open to interpretation, should always describe the recommended option, including reference to any financial commitment, and, where appropriate, should be split into separately numbered recommendations.]

e.g. The **City Integrated Commissioning Board** is asked:

- To **APPROVE** two year non-recurrent funding totaling £446,881 (by the CCG) for the establishment of a Homeless Hospital Discharge Team based in the Homerton University Hospital Foundation Trust and the City and Hackney Centre for Mental Health.
- To **APPROVE** that existing City of London Housing services will engage with the Homeless Discharge Team regarding any eligible individuals.

The **Hackney Integrated Commissioning Board** is asked:

- To **APPROVE** two year non-recurrent funding (by the CCG) for the establishment of a Homeless Hospital Discharge Team based in the Homerton University Hospital Foundation Trust and the City and Hackney Centre for Mental Health.
- To **APPROVE** that existing London Borough of Hackney resources will also be aligned to form part of the Homeless Discharge Team:

○ Social Worker from the Integrated Discharge Service, plus time from the 1-year pilot Social Worker post in Mental Health ○ Existing Discharge Housing Officer ○ Additional Housing input

Strategic Objectives this paper supports [Please check box including brief statement]:

Deliver a shift in resource and focus to prevention to improve the long term health and wellbeing of local people and address health inequalities	☐	
Deliver proactive community based care closer to home and outside of institutional settings where appropriate	☒	This team will be hospital based but effectively have a foot in the community, working with community teams to prevent and reduce hospital attendance and find long term housing options for individuals.
Ensure we maintain financial balance as a system and achieve our financial plans	☐	
Deliver integrated care which meets the physical, mental health and social needs of our diverse communities	☒	
Empower patients and residents	☐	

Specific implications for City

Pathway teams exist at the University College London Hospital and the Royal London Hospital. This means that homeless individuals from the City of London will already have access to the Pathway teams if admitted to these hospitals. The teams also know to refer to the City of London for any eligible rough sleepers.

This new team will support any homeless individuals from the City of London admitted to the Homerton Hospital or the City and Hackney Centre for Mental Health.

Specific implications for Hackney

This new team will support any homeless individuals from the London Borough of Hackney admitted to the Homerton Hospital or the City and Hackney Centre for Mental Health.

Patient and Public Involvement and Impact:

The service was developed utilising case studies of local homeless individuals developed by St Mungo's. There are service user representatives on the Discharge Steering Group who have been involved in discussions on Homelessness and the development of this model since April 2019.

The development of the service should have a positive impact on public and patient perceptions of service providers.

Clinical/practitioner input and engagement:

The charity Pathway have developed a homeless discharge team franchise model, written about within the NHS Long Term Plan.

Commissioners have worked with Pathway and clinicians at the Homerton, ELFT and local authority, including Housing teams to develop the local service.

Communications and engagement:

We do not require stakeholder engagement; however, communications plans will be part of the mobilisation plans for this service.

Equalities implications and impact on priority groups:

We believe the service will support the reduction of inequalities experienced by the homeless population. These individual are among the most vulnerable groups in society and have significantly worse health outcomes and life expectancy than the general population.

Homeless men and women die young – by an average age of 47 for men and 43 for women. This compares to 79.5 for males and 83.1 for females in the general population.

Safeguarding implications:

This team should help to reduce any safeguarding issues and the implications of people being discharged to the street.

Impact on / Overlap with Existing Services:

Pathway teams exist at the University College London Hospital and the Royal London Hospital. This means that homeless individuals from the City of London will already have access to the Pathway teams if admitted to these hospitals. The teams also know to refer to the City of London for any eligible rough sleepers.

There have been a number of service changes happening due to the Covid-19 pandemic and other planned activity that may impact on the teams functioning and delivery.

A homeless service mapping exercise has taken place recently as part of the work supporting the creation of a Homeless Hospital Discharge Pathway (HHDP). This shows a significant number of services, which offer support, outreach or health interventions and accommodation schemes (i.e. supported housing, short-term or emergency accommodations, and COVID-19 hotel accommodation) for both the City of London and London Borough of Hackney. The gap is a comprehensive presence in the HUH/CHCMH hospital environments through enhanced care coordination and discharge planning. If a patient is identified as homeless in the hospital, they are typically referred to the Greenhouse at the point of discharge.

It is crucial that the Pathway Hospital Discharge Team develop clear links with all the Homelessness services that exist to ensure coordination, reduce duplication and prevent people falling between services.

Sign-off:

[Papers for approval by the ICBs must be signed off by the appropriate senior officers. Any paper with financial implications must be signed by the members of the Finance Economy Group.
If there are any legal implications which require consultation with legal counsel, please make reference to that below.
Please ensure you have appropriate sign off for your report, along with the papers. Papers which have not been signed-off by the appropriate officers will not be considered]

Workstream SRO: Tracey Fletcher, Chief Executive, HUHFT

London Borough of Hackney: Sharon Lyons, Interim Director of Adult Services, LBH

City of London Corporation: Simon Cribbens, Assistant Director, CoLC

City & Hackney CCG: David Maher, Managing Director

City and Hackney
Clinical Commissioning Group

Title: **Homeless Hospital Discharge Pathway Business Case**

Authority: **London Borough of Hackney**

Author: **Mark Watson & Cindy Fischer**

Date: **October 2020**

Preface

This proposal was developed before the publication of the new NHS Hospital Discharge Service: Policy and Operating Model, published on the 21 August 2020.

This policy requires that as of the 1 September, those patients who no longer meet the criteria to reside in hospital need to be discharged on the same day. Both the Homerton and ELFT have reported recent increased activity with homeless patients without recourse to public funds. These individuals may need to be moved into B&B's; however, there is no active support to move them on.

It highlights the importance of this proposal.

1. Summary and Recommendations

1.1 Summary

A Pathway Team in a hospital provides 'end to end' support for patients who are homeless. It involves not only medical staff, but a range of multidisciplinary professionals with expertise in social care, housing law and benefits issues, ensuring that a patient's full range of needs are supported.

Many patients who are homeless at HUH and CHCMH are currently being discharged to sleep rough. This severely hampers their recovery e.g. wounds dressings cannot be hygienically maintained, medication cannot be kept dry and may be stolen, and mental health conditions often deteriorate.

In this situation, many patients will rapidly become ill again and will be readmitted to hospital. In effect, the cost of the previous health intervention has been lost because the care needs could not be maintained.

Pathway teams intervene in that cycle of homelessness and illness. This model of intervention is the only evidence-based approach to homeless in-patients which has been shown to improve patient housing status and quality of life after discharge from hospital.

The Pathway approach is recommended in the NHS Long Term Plan 2019 and the NHSE Menu of Evidence Based Interventions to Reduce Health Inequalities 2019

The Pathway approach is tailored to meet the needs of the local homeless population.

1.2 Recommendations

I. To agree to non-recurrent funding of **£446,881** for the establishment of a Homeless Hospital Discharge Pathway team based in the Homerton University Hospital, and the City and Hackney Centre for Mental Health (CHCMH). The costs will be for a 2-year period with a view to mainstream the service using system savings and potential Better Care Funding if resources allow. The service is to be jointly commissioned by the London Borough of Hackney and City and Hackney CCG.

II. To agree that existing resources will also be aligned to form part of the Homeless Discharge Team:

- Social Worker time from the existing Integrated Discharge Service plus time from 1-year pilot Social Worker post in Mental Health
- Existing Discharge Housing Officer

2. Options Appraisal and Business Case

2.1 The business case and recommendations is based on the findings of an independent needs assessment, commissioned by the Discharge Group. The work was carried out by the charity Pathway between December 2019 and March 2020 and funded via the Better Care Fund.

The needs assessment had a number of recommendations, two of which need investment and a business case. (1) The setting up of a hospital homeless team and (2) The setting up of step up and step down beds.

This business case covers (1) - The setting up of the hospital discharge team.

The needs assessment reviewed homeless patients who attended the Homerton University Hospital (HUH) and the City and Hackney Centre for Mental Health (CHCMH).

Quantitative and qualitative data was gathered and analysed, including 26 interviews with key staff.

The needs assessment data suggests that the Homerton is seeing 574 homelessness admissions per year and there were 1168 A&E attendances in the March 2019 - January 2020 period. The number of unique individuals will be lower.

29% of admitted homeless patients were readmitted to hospital within 28 days. 14% of homeless patients attending A&E reattended within 7 days

The re-admissions rate is particularly high and could, at least in part, relate to adequate discharge plans not being in place. We also do not know the figures for patients readmitted to other hospitals nearby, or the number of patients who self -discharge.

We were told that for coding purposes in the City and Hackney Centre for Mental Health (CHCMH) 'last known address' is recorded routinely even if the patient is known to be homeless when seen. Even when they are asked about their accommodation status, homeless patients may give a 'care of' address such as a friend's address, or that of a day centre, or other facility out of embarrassment, or fear of discrimination. This will mean that they show on the system as having an address, when in reality they do not.

Therefore, given that we do not have accurate figures for CHCMH but can estimate that at least another 3-4 patients per week would be referred from there, a final figure of approximately 800 admissions of people who are homeless per year across both sites can be assumed.

The report made the following recommendations:

1) Set up a Pathway in-reach team

2) Implement a multidisciplinary homelessness team meeting

3) Set up outreach provision to enhance community support

4) Explore options for a step-up/step-down facility

5) Design and implement a staff education programme

This business case supports recommendation 1, 2, 3 and 5. A further business case will cover the need for additional step up and step down facilities.

The report stated that "The current numbers of people attending the hospitals mean that the discharge system is overstretched and there is a large variability in response, which needs to be addressed and

standardised. There are delays to discharges, particularly among patients from outside the area, or who are not eligible for local housing. There is a high readmission rate to HUH at 29%. Areas of good practice (in-reach housing worker for City and Hackney patients from HUH) need additional clinical support to improve management of patients in hospital, increase the involvement of local services, and extend provision to all patients who are experiencing homelessness, from both sites."

There is an opportunity to improve input to A&E and ACU areas such as early identification of people who are homeless prior to admission, or when attending A&E, to provide up to date information and to intervene with frequent attenders.

The Pathway approach is tailored to meet the needs of the local homeless population. For Homerton University Hospital NHS Trust and City and, Hackney Centre for Mental Health we would recommend a team comprising of:

- a hospital Nurse (Band 7) with knowledge of the hospital system, for example a current discharge co-ordinator. This role should be full time and be supported by:
- a part time Pathway GP to provide clinical leadership and guidance (3 days per week)
- advocacy and Hospital Discharge Housing Worker (full time)
- adult Social Care Social Worker (full time)
- occupational Therapist (full time)
- input from existing and planned additional Housing In-reach service for patients with 'local connection' to Hackney.

The team's work would include:

- case work for all patients who are homeless
- a weekly ward round to see all current in-patients in order to plan and monitor progress
- a weekly multidisciplinary team meeting to which hospital and community services are invited to discuss recent or current cases and formulate discharge plans.

Other work may include:

- education sessions for hospital staff on identifying and supporting homeless patients,
- supporting student teaching and elective placements,
- overseeing any step up / step down beds.

- making links and relationships with other teams including (but not exhaustive)

    - ❖ Substance Misuse
    - ❖ Probation/IOM
    - ❖ Advocacy and legal services
    - ❖ Imigration team/ Praxis
    - ❖ Domestic Violence and Women's services
    - ❖ LGBTQ Support services
    - ❖ Legal Support and Advice

2.2 How this fits with current provision

Pathway teams exist at the University College London Hospital and the Royal London Hospital. This means that homeless individuals from the City of London will already have access to the Pathway teams if admitted to these hospitals. The teams also know to refer to the City of London for any eligible rough sleepers.

There have been a number of service changes happening due to the Covid-19 pandemic and other planned activity that may impact on the teams functioning and delivery.

A homeless service mapping exercise has taken place recently as part of the work supporting the creation of a Homeless Hospital Discharge Pathway (HHDP). This shows a significant number of services, which offer support, outreach or health interventions and accommodation schemes (i.e. supported housing, short-term or emergency accommodations, and COVID-19 hotel accommodation) for both the City of London and London Borough of Hackney. The gap is a comprehensive presence in the HUH/CHCMH hospital environments through enhanced care coordination and discharge planning. If a patient is identified as homeless in the hospital, they are typically referred to the Greenhouse at the point of discharge.

It is crucial that the Pathway Hospital Discharge Team develop clear links with all the Homelessness services that exist to ensure coordination, reduce duplication and prevent people falling between services.

There is a current review of Therapy services at Homerton Hospital and part of the OT role would be to make links between the Pathway team and mainstream physical and mental health therapy services.

There are also changes underway to redesign the structure of the Homerton Discharge Service in order to fully embed a discharge to assess Home First approach and meet the requirements of the new Discharge Policy.

Implementation of the team and ongoing delivery must be managed in light of these interdependencies.

This new team prioritises health and housing needs, ensuring:

- Identification of a patient's housing status will be much earlier in the admission process.
- The team will be able to start to ascertain the individuals local connections and identify a discharge address.
- They will continue to work with this individual to ensure they move on from a discharge bed to a more stable home.

2.3 Criteria for Referring into the team

The essence of the Pathway team is that there is little or no formal criteria, with a low threshold to refer to encouraging referral from staff.

All HUH and CHCMH patients should be referred to the Pathway team **who do not have somewhere safe to go on discharge**. Therefore those who are homeless, at risk of homelessness or residing in temporary / insecure housing should all be referred to the team.

Hospital staff will be encouraged to have conversations with patients early in the admission process about whether they have a safe discharge destination. If they do not, then the patients should be referred to the team.

The Referral process will be streamline; wards will be required to make referrals via email or mobile with basic needs and risk information, however they will not be required to complete a referral form. Acknowledging that this cohort will typically have had a long history of contact with institutions, requiring them to repeat their life story multiple times with numerous agencies, the Pathway team will take a lead in completing patients needs and risk assessment.

It is a priority to host or link the Pathway GP with the Green House GP Surgery; this will enable the Pathway GP to develop a better understanding of the client group; many of the patients being discharged from HUH who have a Hackney connection will already be registered with the Green House GP Surgery. Ultimately we want to reduce the revolving door of hospital admissions and the only way we can successfully do this is to ensure patients continue receiving the right medical treatment in the community in an environment where their needs as a homeless person are understood.

2.4 Equality Impact Assessment (EIA)

A full Equality impact assessment (EIA) has been completed for this project. Information in the EIA is derived from the Combined Homelessness and Information Network (CHAIN), a multi-agency database recording information about rough sleepers and the wider street population in London.

The immediate issue is that the numbers of people the needs assessment identified as homeless coming out of the two sites (800+) far outstrips the official numbers of homeless people recorded on CHAIN for Hackney (94). As another example of this, the needs assessment reported 20 females who were homeless and gave birth and 50 females where admitted for Maternity care/treatment, while the CHAIN data only recorded 22 homeless females.

The EIA highlights that we do not have robust data on the hospital homeless cohort and we therefore recommend that in the first year of the team being set up, it starts to collect this data and we repeat the EIA at the end of year one.

Health inequalities: A review in Feb 2018 from Public Health England South East shares information and support to help local authorities prevent and reduce homelessness.

Homeless men and women die young – by an average age of 47 for men and 43 for women. This compares to 79.5 for males and 83.1 for females in the general population.

An estimated 41% of people classified as 'rough sleepers' have long-term physical health problems such as heart disease, diabetes and addiction problems, compared to 28% of the general population. Another 45% have been diagnosed with mental health issues, compared to 25%. (PHE 2018).

Similarly, the Unhealthy State of Homelessness health audit by Homeless Link, highlights the far reaching inequalities experienced by the homeless population:

- 73% of homeless people reported physical health problems. 41% said this was a long term problem.
- 80% of respondents reported some form of mental health issue, 45% had been diagnosed with a mental health issue.
- 39% said they take drugs or are recovering from a drug problem, while 27% have or are recovering from an alcohol problem.
- 35% had been to A&E and 26% had been admitted to hospital over the past six months.
- 41% of homeless people reported a long-term physical health problem (compared to just 28% of the general population).
- 45% had been diagnosed with a mental health problem (25%).
- 36% had taken drugs in the past six months (5%).
- 35% do not eat at least two meals a day.
- Two-thirds consume more than the recommended amount of alcohol each time they drink.
- 77% smoke.
- 15% of respondents with physical health needs reported not receiving help.
- 17.5% of those with mental health issues and 16.7% with alcohol issues would like support but are not receiving it.
- 7% have been denied access to a dentist or GP.

Evidence collected from the Charity “Pathways” demonstrate how the specialist hospital homeless discharge team will help reduce the number of days spent in hospital:

Hospital attendance and admission rates in the 90 days before and after ‘Pathway admission’ spells in UCLH homeless patients (*n*=396)			
	90 days prior to Pathway admission	90 days post Pathway admission	% change
A & E presentation	747	466	37.6%
Hospital admission	1081	318	66.0%
Bed days	2507	549	78.1%

Pathway’s findings also indicate that the homeless population are more likely to engage with health services with the result of longer term better health outcomes and a reduction in readmissions, specifically:

- Complex multidisciplinary care has shown to improve health and other self-assessed outcomes
- Pathway teams of in-hospital GPs and nurses, amongst other team members, have developed a model of holistic care for homeless patient
- UCLH saw significant reductions in presentation, admission and bed days of patients previously treated with the Pathway model of multidisciplinary care

This evidence demonstrates that support across the areas of not just health but housing, finance and social support is needed

2.5 Strategic Context:

NHS Long Term Plan:

The first Pathway team was launched in 2009 with rigorous evaluation built into each subsequent pilot, so that all current Pathway teams are now recurrently funded. The positive outcomes from these evaluations culminated in the Pathway approach being cited as best practice in a case study in the 2019 NHS long term plan, (p42), and the NHSE Menu of Evidence Based Interventions to Reduce Health Inequalities.

Delayed Transfers of Care:

Reducing delayed transfers has been a key focus of recent national policies, such as the Better Care Fund (a pooled budget to help councils and NHS organisations to plan and work together to deliver local services). In its 2017/18 mandate to NHS England, the Department of Health set a target for delayed transfers to be reduced to no more than 3.5 per cent of all hospital bed days by September 2017.

While the Covid-19 pandemic has temporarily halted recording of DToC, hospitals have to complete daily sitrep submissions which include data on the number of patients not meeting criteria to reside and the reasons for the delays.

2.6 Preferred Option and Governance Arrangements:

The preferred option is to create a homeless hospital based discharge team using a mix of existing staff resources and establishing new key posts based on the evidence and recommendations of the Pathway proposal. This mixed approach demonstrates value for money based on the expected outcomes and benefits of the team, and will help the long term sustainability of the team.

The team would be embedded within the Integrated Discharge Service at the Homerton. The Nurse and Occupational Therapist would be directly employed by the Homerton Hospital. Both posts would report to the Discharge Planning Lead Nurse. The OT would also require clinical supervision and professional leadership which would come via the Acute Medical Therapies Team Band 7 OT with oversight from the Inpatient Therapies Lead.

The GP would be employed by the East London Foundation Trust which manages the Green House GP Surgery and also provides a GP in the Royal London Hospital Pathway team.

2.7 ALTERNATIVE OPTIONS (CONSIDERED AND REJECTED)

Do Nothing:

There is a key safety risk to vulnerable patients if the partnership were to decide to Do Nothing. Other hospitals around the country have had incidents where homeless patients have been discharged to the street, medically fit, but then died or suffered serious deterioration as a result of the combination of ill health and street conditions.

We know from some case studies that we have not always discharged homeless patients appropriately; however, we try not to discharge people directly to the streets. Our DToC figures show we can have long delays for homeless people trying to find ‘move on’ accommodation.

The Pathway needs assessment also showed us that there are poorer health outcomes for homeless people and this inequality would continue.

Contract Out:

We could consider tendering for a whole team to take on this role; however, the arrangements we developed during COVID with homeless team colleagues showed a great willingness to work together and also showed that it's often easier to make change from within an organisation.

Pathways recommended a Band 7 nurse who currently has experience within the hospital system as the nurse has already gained trust and understands the environment. Staff members who are embedded in existing teams bring greater influence.

The option of creating a separate team would necessitate either funding the whole team, or having a mixed team of in house and external staff.

Smaller team

A smaller team would be less costly in the short term; however, the local audit and Pathway best practice demonstrated that the number of homeless individuals coming through the hospital justified the size of the proposed team. Hospitals with more than 200 homeless patients presenting each year require a full, clinically led, Pathway team which comprises a GP, Band 7 nurse and a housing worker. The experience of Pathway's existing teams is that every additional 100 homeless presentations over this number is likely to require an additional FTE member of staff.

A smaller team would not have the capacity to meet the demand and therefore be less effective.

2.8 Success Criteria/Key Drivers/Indicators:

Where hospitals have had a homeless discharge pathway they have been able to demonstrate the following success and key deliverables, as follows:

- Reduced Delayed Transfer of Care (DToC)
- Pathway improves outcomes for homeless patients.
- Better health 90 days after discharge and less rough sleeping [1]
- Improved housing outcomes on discharge [23456]
- Pathway improves capacity in a busy hospital by reducing the average duration of admissions for homeless patients and by reducing subsequent A&E attendance and the number and duration of subsequent unplanned admissions expressed as total bed days. (12578 below)

Outcomes include:

- Health related quality of life increase
- Decrease in avoidable admissions
- Decrease in A&E attendances
- Reduced re-admission rate
- Hospital capacity and efficiency gains
- Less rough sleeping and improved housing outcomes on discharge
- Hospital is able to manage Homelessness Reduction Act (HRA) Duty to refer requirements

NHS Outcomes Framework Domains & Indicators

The project would meet all 5 NHS outcome domains:

Domain 1	Preventing people from dying prematurely	□
Domain 2	Enhancing quality of life for people with long-term conditions	□
Domain 3	Helping people to recover from episodes of ill-health or following injury	□
Domain 4	Ensuring people have a positive experience of care	□
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	□

[1] Hewett N et al. A general practitioner and nurse led approach to improving hospital care for homeless people. BMJ 2012; 345:e5999

[2] MPath. A review of the first 6 months of the pilot service.

[3] Hewett N et al. Randomised controlled trial of GP-led in-hospital management of homeless people ('Pathway'). Clin Med 2016;16(3):223-9.

[4] Evaluation of the Homeless Hospital Discharge Fund.

[5] Dorney-Smith S et al. Integrating health care for homeless people: the experience of the KHP Pathway Homeless Team. Br J HealthcManag 2016;22(4):225-34.

[6] Zana Khan, Sophie Koehne, Philip Haine, Samantha Dorney-Smith,(2019) "Improving outcomes for homeless inpatients in mental health", Housing, Care and Support, Vol. 22 issue: 1, pp.77-90.

Adult Social Care Outcomes Framework (ASCOF) measures

The project would also support all 5 Adult Social CAre outcomes:

Domain 1	Enhancing quality of life for people with care and support needs	□
Domain 2	Delaying and reducing the need for care and support	□
Domain 3	Ensuring that people have a positive experience of care and support	□
Domain 4	Safeguarding people whose circumstances make them vulnerable and protecting from avoidable harm	□

2.9 Whole Life Costing/Budget:

New Posts - Salary

Post	**Host**	**Y1 Cost**	**Y2 Cost (+2%)**	**Total**
Band 7 Nurse F/T mid-point including on costs and inner London weighting	Homerton	£60, 088	£61,290	£121,378
Band 6 OT mid-point including on costs and inner London weighting	Homerton	£49,867	£50,864	£100,731
Salaried GP 6 sessions including on	ELFT - Greenhouse	£86,471	£88,201	£174,672

costs				
Sub-total		£196,426	£200,355	£396,781

Non Salary Costs:

	Year 1	Year 2
Patient admission support costs: ● humanitarian issues (clothes, toiletries), ● Identity documents to support housing & benefits claims, ● patient transport costs to/from appointments & to accommodation ● ad hoc expenses	£5,000	£5,100
Pathways Franchise Costs	£20,000	£20,000
Total	£25,000	£25,100

Total request from CCG

	Year 1	Year 2	Total
Salary costs	£196,426	£200,355	£396,781
Non Salary	£25,000	£25,100	£50,100
Total	£221,426	£225,455	£446,881

2.10 Policy Context:

London Borough of Hackney

LBHs Vision includes the following "We're working to make Hackney a place for everyone, where all our residents, whatever their background, have a chance to lead healthy and successful lives……" and this proposal will give greater life chances to homeless people with poor health and help improve their homeless status and well as their health.

In his manifesto, the Mayor of Hackney has committed to eliminate rough sleeping in our borough. Hackney has developed a Rough Sleeping Strategy will play a key role in helping us to achieve this. The strategy focuses on:

1. Prevention
2. Outreach

3. Pathways out of rough sleeping and homelessness

All of which will form the basis of the work of the proposed team.

City & Hackney CCG

Our vision for the City and Hackney health economy is

- Patients in control of their health and wellbeing;
- A joined-up system which is safe, affordable, of high quality, easy to access, saves patients' time and improves patient experience;
- Everyone working together to reduce health inequalities and premature mortality and improve patient outcomes;
- Getting the best outcomes for every £ we invest through an equitable balance between good preventative services, strong primary and community services and effective hospital and mental health services which are wrapped around patient needs;
- Services working efficiently and effectively together to deliver patient and clinical outcomes and providers in financial balance.

This proposal will ensure that the homeless patient will have better control over their health by being supported to gain permanent accommodation. It's a coordinated joining up of the system between the hospital, hospital discharge teams and homeless teams to reduce health inequalities, improve outcomes for the person and avoid premature deaths.

2.11 Consultation/Stakeholders:

Stakeholders were interviewed to hear their views on the current hospital discharge process for homeless patients. This was from both the acute and mental health service perspective. Interviews were held with representatives covering clinical and non-clinical positions in the hospitals as well as a variety of community support services. The views of Hackney Council and the CCG representatives were also covered in this stakeholder interview phase.

Each interviewee was asked about their involvement in the care and discharges of people who are homeless. Interviews explored current practice and experience, including examples of good practice and priority areas for improvement. Conversations also considered practical suggestions for how improvements could be achieved.

Interviews have helped to identify some common themes arising from the assessment. The findings, along with the data analysis, have also informed the final recommendations in this report. 26 individuals were interviewed from the CCG, LBH, Housing, Homerton, ELFT and the Voluntary sector.

The following section summarises the themes and main findings from the stakeholder consultation.

Findings from the various discussions broadly fall under the following categories:

- Effectiveness of the hospital discharge process
- Links with other services/coordinating responses
- Housing, hostels and accommodation
- Education & training
- Benefits of a Pathway team

Service User voice was heard in the form of Case Studies, although from a commissioning perspective the Discharge Sub Group has two experts by experience who have been involved in the review of this issue and who are also on the task and finish group to implement the recommendations.

Key issues and concerns from one of the main case reviews were:

- Despite the complexities of this case being known weeks before discharge, no concrete arrangements were made to prevent a discharge to the street
- No OT assessment was undertaken while in hospital
- Discharged on a Friday afternoon, when no care can be arranged over the weekend
- Discharged to the street (in direct conflict with the Homeless Reduction Act 2018)
- Discharged without methadone script or address for care to be delivered to

This case only came to our attention because of the 'Dogs on the street' worker. Had it not been for her tenacity, we suspect A would have ended up being another death on the street.

2.12 Risk Assessment/Management:

There is a key safety risk to vulnerable patients if the partnership were to decide to Do Nothing. Other hospitals around the country have had incidents where homeless patients have been discharged to the street, medically fit, but then died or suffered serious deterioration as a result of the combination of ill health exacerbated by living on the street.

There is considerable continued financial risk to the system if not employing such a team to facilitate timely and safe discharges of homeless patients. These are twofold in their elements. Having patients who are medically fit, but not 'street' fit, taking up beds because they have nowhere to go is both costly and a greatly inefficient use of acute beds. Anecdotally there are a number of cases in other centres where the homeless team have managed to secure someone safe accommodation to be discharged to where they would otherwise have 'blocked' a bed for days, possibly weeks, having nowhere to go.

This is particularly the case for out of area patients where the discharge team –through no fault of their own - do not have the time, expertise or connections to be able to facilitate a complex discharge of a patient with ongoing medical condition(s) and alcohol and/or substance misuse issues in the area, let alone to an area beyond this.

Risk	Likelihood	Impact	Over all	Action to avoid or mitigate risk
	L – Low; M – Medium; H - High			
Do nothing	We already know 800 homeless people came to Homerton causing 321 days delay	Increase in DToC and cost to the system of having beds filled with medically fit patients	H	Establishing a team would reduce DToC
Lack of long term funding	Requested funding is for 2 years helping to establish the project and demonstrate good outcomes. We hope that we can demonstrate system savings through reduced length of stay and reduced re-admissions.	This will be assessed based on the success of the 2 year pilot.	M	Clear data collection and regular review of system metrics. BCF funding needs to be reviewed to support new projects which support BCF metrics and partners need to review BCF funding allocations.

2.13 Market Testing (Lessons Learnt/Benchmarking):

Options for service delivery could include the use of a framework or outsourcing to a third party provider, including the third sector. A framework is not available or suitable so that was discounted.

While a tender process could be an option it was felt that we should build on the integrated services already in place between the Homerton and the London Borough of Hackney. The aim is to bring together existing in-house resources, matched with some new dedicated posts. The Greenhouse is well placed to host the GP and this fits strategically with the direction of this service. The model suggests that by the hospital employing the Band 7 nurse the individual will have greater power and influence.

This also fits with the wish for LBH and health to be more integrated and LBHs political drive to provide in-house services where it is deemed to be of benefit.

2.14 Savings and benefits

The model is supported by research on Pathway teams with the following evidence on the outcomes and savings that can be made.

Hewett N et al. A general practitioner and nurse led approach to improving hospital care for homeless people. BMJ 2012; 345:e5999.

An observational study of the first Pathway pilot, this compared outcomes for homeless patients identified from hospital records (No fixed abode, hostel address or registration with homeless practice) for two years before the service began and two years after implementation. A 30% reduction in bed days was observed, with positive feedback from patients and colleagues.

A review of the first 6 months of the pilot service. July to December 2013. Reporting outcomes for 100 homeless A&E frequent attenders showed a 47% reduction in A&E attendances, 48% reduction in admissions and 39% reduction in bed days

Hewett N et al. Randomised controlled trial of GP-led in-hospital management of homeless people ('Pathway'). Clin Med 2016;16(3):223-9. A two centre NIHR funded randomised controlled trial, at Royal London and Brighton and Sussex University Hospital. Quality of life scores (EQ-5D-5L) improved significantly in the intervention arm and quality-of-life cost per quality-adjusted life-year was £26,000. Street homelessness was reduced, the proportion of people sleeping on the streets after discharge was 14.6% in the standard care arm and 3.8% in the enhanced care arm.

Evaluation of the Homeless Hospital Discharge Fund. Homeless Link. 2015. This study evaluated 52 projects set up with a one-off government grant. The table on p37 summarises the outcomes. Projects were of 3 broad types, housing link worker in the hospital, accommodation with link worker, housing and clinical staff working together in the hospital (Pathway). The Pathway approach demonstrated best outcomes with 93% discharged into suitable accommodation, 89% receiving health support on discharge, 92% receiving housing support on discharge and 23% readmitted within 30 days.

Dorney-Smith S et al. Integrating health care for homeless people: the experience of the KHP Pathway Homeless Team. Br J Healthc Manag 2016;22(4):225-34. Using a comparison group of patients identified as homeless on hospital records before and after introduction of Pathway showed a 9% reduction in A&E attendances, and an 11% reduction in bed days at Guy's and St Thomas' and 56% of patients with improved housing status on discharge.

Zana Khan, Sophie Koehne, Philip Haine, Samantha Dorney-Smith, (2019) 'Improving outcomes for homeless inpatients in mental health', Housing, Care and Support, Vol. 22 Issue: 1, pp.77-90. This study of Pathway in an acute mental health setting (South London and Maudsley Trust) showed 74% of patients had improved housing status on discharge. Comparison with a control group in the hospital has also shown reduced bed days (in press).

Bristol Service Evaluation of Homeless Support Team (HST) Pilot in Bristol Royal Infirmary. Internal evaluation presented at Faculty for Homeless and Inclusion Health Conference March 2019. This evaluation compared outcomes for a control group of homeless patients identified from hospital records during the needs assessment, with the outcomes for patients seen by the Pathway team during the first 12 months. Results showed a 74.5% reduction in average duration of stay (11 to 2.8 days), 35.7% reduction in self-discharge, 62% reduction in re-admission within 28 days (132 to 50). Estimates of savings in secondary care costs were £921,300. Taking into account the costs associated with the team this equates to an overall saving of £766,300 annually.

Wyatt L. Positive outcomes for homeless patients in UCLH Pathway programme; British Journal of Healthcare Management 2017 Vol 23 No 8: p367-371 This audit examined secondary care activity for homeless patients in the 90 days before and after contact with the Pathway team at UCLH. This showed a 37.6% reduction in A&E attendances, 66% reduction in hospital admissions and a 78.1% reduction in bed days.

Gazey A, Wood L, Cumming C, Chapple N, and Vallesi S (2019). Royal Perth Hospital Homelessness Team. A report on the first two and a half years of operation. School of Population and Global Health: University of Western Australia, Perth, Western Australia. This evaluation demonstrates that the Pathway method is beneficial in other health care systems. Comparing secondary care activity for a year before and after contact with the Pathway team showed $7,302 cost savings per person, or $4.6 million in aggregate.

Cornes, M, Aldridge, R, Tinelli, M, Whiteford, M, Hewett, N, Clark, M, et al (2019), 'Transforming out-of-hospital care for people who are homeless. Support Tool & Briefing Notes: complementing the High Impact Change Model for transfers between hospital and home'. NIHR Policy Research Unit in Health and Social Care Workforce, The Policy Institute, King's College London, London. https://doi.org/10.18742/pub01-007 This work examines the role of in-hospital homeless teams on outcomes for patients and reports improved outcomes and cost-effectiveness when the Pathway model of clinically-led in-reach is utilised, particularly when used in conjunction with step down facility.

Local Audit Data

The main findings are that across the two sites, 800 people who are homeless are admitted each year, and the readmission rate within 30 days is 29% at HUH.

In the period March 2019 to January 2020 there were 1168 A&E attendances with a 14% re-attendance rate within 7 days.

Due to the Covid-19 pandemic, there is a block contract in place with the Trust so reduction in activity won't reduce the contract value; however, future contractual arrangements may return to activity based payments and reduction in activity should show system savings.

Reduction in Attendances:

Using the 9% reduction in A&E attendances shown at Guy's and St Thomas', a 9% reduction on 1168 attendances would 105 less attendances in a 11 month period or 115 less projected to 12 months activity (1274).

Reduction in DToC/Bed days

Taking the average excess bed day cost from 19/20 National Tariff & adding Homerton Market Forces Factor* (MFF) of 1.19, the average Bed Day cost for Emergency care from National tariff = 286+1.19 = £340 is an average cost for excess bed day

The **MFF takes the form of an index. This allows a provider's location-specific costs to be compared with every other organisation.*

Based on current data -

2019/20 we had 321 days lost (DToC) to people not being discharged as they had no home* to be discharged to. 321 x £340 = £102,000. Data from the audit didn't analyse whether the DToC were within the trim point or counted as excess bed days; however, there are definitely system savings that could be made.

* This figure is likely to be higher as we can only class a delay due to 1 issue and not multiple. For example an initial delay may have been documented as due to assessment and then homlessless. With the new discharge guidance; assessments cannot be done in the hospital so it's likely without the pathway we will see higher DToC for homlessness.

Reduction on length of stay

The report did not include length of stay data; however, local health partners produced a report "Barts and Homerton emergency care activity

by people who were homeless patients at (Feb 2019 to May 2020)" published in July 2020, which shows Homeless patients (8 days) had a longer mean length of stay in hospital compared to all other patients (3 days).

Reduction in Readmissions

The readmission rate within 30 days is 29% at HUH.

The pilot in the Bristol Royal Infirmary showed 62% reduction in readmission within 28 days (132 to 50).

3. SUSTAINABILITY ISSUES

3.1 Procuring Green

All partners (HUH; LBH and CCG) have sustainability policies and the service will be run in line with these policies. This will include encouraging staff to travel avoiding carbon emissions - e.g. walking, cycling and public transport while working in the team. The biggest impact will be by being able to (1) discharge people as soon as they are medically fit and so not using valuable and expensive hospital services to accommodate people and (2) being able to reduce readmissions.

3.2 Procuring for a Better Society

While the service is not being openly procured the principle of the service will significantly benefit the wider society and residents and those with a link to Hackney. This service is targeted at the most vulnerable homeless people in society whose health outcomes are some of the worst in England. It will ensure no one will be discharged to the streets and all homeless people coming into hospital will have a service that is skilled and designed to address their complex needs on a longer term basis, resulting in improved outcomes for the individual.

3.3 Procuring Fair Delivery

A full equality impact assessment has been completed. While the initial assessment does not highlight any negative impact this project will have on any of the protected characteristics, it does highlight the negative impact homlessness has on individuals and certain groups of people.

The EIA also highlights the lack of equality demographic data we have on homeless people coming into Homerton at the moment and the EIA sets out an action that within 12 months we will have collected this data and reviewed the EIA using this up to date information.

4. PROPOSED PROCUREMENT ARRANGEMENTS

4.1 Procurement Route and EU Implications: **Section 75** of the 2006 **Act** gives powers to local authorities and clinical commissioning groups to establish and maintain pooled funds out of which payment may be made towards expenditure incurred in the exercise of prescribed local authority functions and prescribed **NHS** functions. It is proposed that we would enter into a Section 75 agreement and the CCG would fund the following posts via the local authority:

- 1 WTE Band 7 Nurse
- 1 WTE Band 6 Occupational Therapist
- Part time Salaried GP (3 days/week)
- Ancillary costs as outline above

4.2 Resources, Project Management and Key Milestones:

Key Milestones	
Business Case Report to Rough Sleepers and Health Partnership Group meeting	21 September 2020
Business Case Report to Discharge group	22 September 2020
Business Care Report to SOCG	22 October 2020
Funding Case to be presented to CCG Finance and Performance Committee (FPC)	28 October 2020
Task & Finish group oversee implementation if agreed including specification, outcomes and procedures	30 October 2020
Agree and sign Section 75 Agreement	November 2020
Recruitment and movement of staff	November 2020
Mobilisation & Team operational	January 2020

4.3 Contract Documents: Anticipated contract type:

Service specification and Section 75 of the 2006 NHS Act.

4.4 Contract Management: The contract will be monitored by the BCF leads in LBH and CCG.

4.5 Key Performance Indicators:

Five explicit targets require reporting:

1. Referrals will be made to the discharge team within 1 day of identifying an individual has no safe place to be discharged to

2. 80% of patients appropriately referred to the team are seen and assessed within 2 working days of receiving the first referral

3. 100% of consenting homeless patients seen by the team are referred to the Local Authority under the Duty to Refer as appropriate

4. 100% of patients who do not have a GP, or who have an inappropriate GP on assessment, are assisted to register with an appropriate GP that they can access on discharge

5. Feedback is obtained from 10% of patients about their experience of care OR detailed targeted interviews and/or focus groups are undertaken with a smaller group of patients and quality improvement plans are put in place

BACKGROUND PAPER

Appendix 1

Pathway Needs assessment

Title of report:	Consolidated Finance (income & expenditure) 2020/2021 Month 7
Date of meeting:	10/12/20
Lead Officer:	Anne Canning, London Borough of Hackney (LBH) Jane Milligan, City & Hackney Clinical Commissioning Group (CCG) Simon Cribbens, City of London Corporation (CoL)
Author:	Fiona Abiade for Integrated Commissioning Finance Economy Group
Presenter:	Sunil Thakker, Executive Director of Finance, City & Hackney CCG Mark Jarvis, Head of Finance, Citizens' Services, City of London Ian Williams, Group Director, Finance and Corporate Resources, LBH
Committee(s):	City Integrated Commissioning Board Hackney Integrated Commissioning Board Transformation Board
Public / Non-public	Public

Executive Summary:

At month 7, the CCG reported a YTD overspend of £3.812m against a YTD allocation of £243.9m.This position includes an allocation top-up of £3.688m up to M4 to fully cover all COVID and other over spends from M1-4 but excludes M5 and M6 top-up funding.

At Month 7, LBH is forecasting an overspend of £6.7m inclusive of £4.9m in relation to Covid-19 expenditure.Covid-19 related expenditure includes significant investment to support the market through uplifts to care providers, additional staffing and PPE costs. The remaining £1.8m overspend is predominantly driven by care package costs in Learning Disabilities (LD), Physical and Sensory Support which are all within the Planned Care workstream, further details are set out within the report.

At Month 7, the City of London Corporation is forecasting a year end adverse position of £0.3m.

Recommendations:

The City Integrated Commissioning Board is asked:

- To **NOTE** the report.

The Hackney Integrated Commissioning Board is asked:

- To **NOTE** the report.

Strategic Objectives this paper supports [Please check box including brief statement]:

Deliver a shift in resource and focus to prevention to improve the long term	☐	

health and wellbeing of local people and address health inequalities		
Deliver proactive community based care closer to home and outside of institutional settings where appropriate	☐	
Ensure we maintain financial balance as a system and achieve our financial plans	☒	
Deliver integrated care which meets the physical, mental health and social needs of our diverse communities	☐	
Empower patients and residents	☐	

Specific implications for City

N/A

Specific implications for Hackney

N/A

Patient and Public Involvement and Impact:

N/A

Clinical/practitioner input and engagement:

N/A

Equalities implications and impact on priority groups:

N/A

Safeguarding implications:

N/A

Impact on / Overlap with Existing Services:

N/A

Main Report

Background and Current Position

[This section should include a brief explanation of the context, including reference to previous committee decisions, and an outline of the current situation, key issues and why the report is necessary.]

Options

[This section should present realistic courses of action, with financial implications, proposed beneficial outcomes and assessments of risk.]

Proposals

[This section should explain in more detail and justify the recommended course of action, setting out clearly what beneficial outcomes are expected.]

Conclusion

[This section should draw together and summarise the key points of the report.]

Supporting Papers and Evidence:

[Please list any appendices included with the report. Appendices should be clearly labelled and submitted as separate documents. Any additional references to supporting information or evidence, should be listed here with hyperlinks where possible.]

Sign-off:

[London Borough of Hackney: Ian Williams, Group Director of Finance and Corporate Resources City of London Corporation: Mark Jarvis, Head of Finance City & Hackney CCG: Sunil Thakker, Director of Finance

City of London Corporation
London Borough of Hackney
City and Hackney CCG

Integrated Commissioning Fund
Financial Performance Report

Month 7 - 2020/21

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City and Hackney CCG – Position Summary at Month 7, 2020/21

- In response to COVID-19, a temporary financial regime was put in place to cover the period 1 April 2020 to 31 July 2020. This was then extended for a further two months, whilst the restart plan for NEL was being developed.
- Table 1 summarises the baseline categories and high-level approach to calculating the 2020/21 expected expenditure

Table 1

Baseline service categories	Baseline provider categories	2020/21 expenditure calculation method
- **Acute** - **Mental health** - **Community health** - **Continuing care** - **Prescribing** - **Other primary care** - **Other programme services** - **Primary care delegated** - **Running costs**	NHS Trusts	Block contract value covering all NHS services
	Independent sector providers included within the scope of national contracts (Appendix 2)	Baseline adjustments to exclude spend on acute services for suppliers included in the national IS contract
	Other providers	Growth assumptions have been applied to adjusted baseline positions to calculate expected 2020/21 spend

- At month 7, the CCG reported a YTD overspend of £3.651m against a YTD allocation of £284.3m. This position includes an allocation top-up of £3.82m up to M4 and excludes M5, M6 and M7 top-up funding due of £4.354m.See monthly breakdown below;

C&H Over/(Under) Spend Summary 2020-21 at M6	Other Costs	Covid Costs	Total Over/(Under) Spend	Top-Up Funds Received	Net Top Up Required
April 2020 - M1	0	883	**883**	**0**	**883**
May 2020 - M2	300	114	**414**	**(996)**	**(582)**
June 2020 - M3	(57)	1,057	**1,000**	**(1,300)**	**(300)**
July 2020 - M4	19	1,373	**1,392**	**(1,392)**	**0**
August 2020 - M5	122	1,640	**1,762**	**0**	**1,762**
September 2020 - M6	987	1,194	**2,181**	**(132)**	**2,049**
M1-M6 Total	**1,371**	**6,261**	**7,632**	**(3,820)**	**3,812**
October 2020 - M7	(144)	686	**542**	**0**	**542**
M7 Total	**(144)**	**686**	**542**	**0**	**542**
2020/21 Grand Total	**1,227**	**6,947**	**8,174**	**(3,820)**	**4,354**

City and Hackney CCG – Position Summary at Month 7, 2020/21

	ORG	WORKSTREAM	Annual Budget £000's	YTD Performance: Budget £000's	YTD Performance: Spend £000's	YTD Performance: Variance £000's	Forecast: Forecast Outturn £000's	Forecast: Forecast Variance £000's
Pooled Budgets	Commissioned	Unplanned Care	18,926	10,884	10,884	0	18,914	12
		Planned Care	6,595	3,846	3,746	100	6,428	167
		Prevention	265	155	147	8	265	(0)
		Childrens and Young People	0	0	0	0	0	0
	Pooled Budgets Grand total		25,786	14,885	14,776	108	25,608	179
Aligned	Commissioned	Unplanned Care	120,664	70,492	71,605	(1,113)	120,511	153
		Planned Care	211,345	123,092	121,775	1,317	211,207	138
		Prevention	4,422	2,113	2,133	(20)	4,457	(35)
		Childrens and Young People	56,696	33,194	33,432	(239)	57,183	(487)
		Corporate and Reserves	30,088	12,928	16,632	(3,703)	33,306	(3,218)
	Aligned Budgets Grand total		423,215	241,819	245,578	(3,758)	426,664	(3,449)
Subtotal of Pooled and Aligned			**449,001**	**256,704**	**260,354**	**(3,650)**	**452,272**	**(3,271)**
In Collab		Primary Care Co-commissioning	49,538	28,338	28,338	0	50,080	(542)
Grand Total			**498,539**	**285,042**	**288,692**	**(3,650)**	**502,352**	**(3,813)**
CCG Total Resource Limit			**490,904**					
SURPLUS/(DEFICIT)			**(7,635)**					

- **Pooled budgets:** The Pooled budgets reflect the pre-existing integrated services of the Better Care Fund (BCF), Integrated Independence Team (IIT) and Learning Disabilities. At Month 7 these are expected to break even.
- **Aligned budgets:** The adverse forecast of £3.812m within Corporate and reserves is being driven by Covid 19 related expenditure per above.
- Non-recurrent schemes and QIPP Transformation schemes continue to be on-hold.
- Primary Care commissioning is reporting a break even position.

- At month 7, the CCG reported a YTD overspend of £3.812m against a YTD allocation of £243.9m.
- This position includes an allocation top-up of £3.688m up to M4 to fully cover all COVID and other over spends from M1-4 but excludes M5 and M6 top-up funding.
- From M7 onwards the NHSE/I top-up funding mechanism will only apply to Hospital Discharge costs. Other Covid and Non-Covid costs over and above the CCG's allocation will form part of the overall deficit declared of £7.6m. This deficit will be partly mitigated by NEL STP held Covid and growth funds and partly mitigated by CCG non-recurrent gains.
- The Acute portfolio is reporting a break even position which is in line with the funding values as prescribed by NHSE. From M7, the CCG is no longer making smaller value payments (below £0.5m pa.) to NHS Providers as required by M1-M7 Contract and Payments Guidance, with the exception of HUFT who will receive an additional £0.8m per month for Covid funds and growth.
- Mental Health and Community Services also broke even against the block payments in month 7. The Prescribing budget has also broken even against its YTD budget, however it should be noted that the underlying year end forecast is £0.7m overspent. This is to be partly offset by cost of Flu vaccine reimbursements by NHSE and year end accruals to meet remaining overspends.
- The full year deficit position of £7.6m relates to;
  - Unfunded GP Forward View costs that have in previous years been funded non-recurrently by NHSE/I
  - CHC deferred assessments from the Hospital Discharge programme
  - A number of covid related service extensions with various partner organisations.
- At the last submission to NHSE/I, the financial gap in NELSTP was £20.9m once all of the system growth, Covid and deficit funding were allocated. All of the NEL providers will break-even, with Barts £17m loss of income error corrected by NHSE/I and any other adverse movements during the year mitigated by the STP Reserve Fund.

***Accruals are included in the CCG YTD and forecast position, however they are only included in the forecast position of LBH and CoLC.**

London Borough of Hackney – Position Summary at Month 7, 2020/21

	ORG Split	WORKSTREAM	Total Annual Budget £000's	Pooled Annual Budget £000's	Aligned Annual Budget £000's	YTD Performance Budget £000's	YTD Performance Spend £000's	YTD Performance Variance £000's	Forecast Fcast Spend £000's	Forecast Variance £000's	Forecast Prior Mth Variance £000's
Pooled and Aligned Budgets	Commissioned & Directly Delivered	LBH Capital BCF (Disabled Facilities Grant)	1,525	1,525	-	763	125	638	1,525	-	-
		LBH Capital subtotal	1,525	1,525	-	763	125	638	1,525	-	-
		Unplanned Care (including income)	6,697	1,238	5,460	3,349	1,643	1,706	6,285	413	213
		Planned Care (including income)	71,668	35,803	35,864	35,834	42,094	(6,260)	78,833	(7,165)	(6,818)
		CYPM	9,539	-	9,539	4,769	1,358	3,411	9,539	-	-
		Prevention	24,559	-	24,559	12,280	10,791	1,489	24,546	13	13
		LBH Revenue subtotal	112,463	37,041	75,422	56,232	55,885	346	119,203	(6,740)	(6,592)
Grand total			113,988	38,566	75,422	56,994	56,010	984	120,728	(6,740)	(6,592)

113,998

At Month 7, LBH is forecasting an overspend of **£6.7m** inclusive of £4.9m in relation to Covid-19 expenditure - this is across both pooled and aligned budgets. Covid-19 related expenditure includes significant investment to support the market through uplifts to care providers, additional staffing and PPE costs. This does not include Covid-19 NHS discharge related spend where there is an agreement to fully recharge the cost to the CCG. The remaining £1.8m overspend is predominantly driven by care package costs in Learning Disabilities (LD), Physical and Sensory Support which are all within the Planned Care workstream.

Government Funding announced to date (£32.349m) to mitigate the impact of Covid-19 falls short of the Council's estimate of total spend and as a result the Council may need to consider the extent to which it ceases expenditure on non-essential work across both the revenue and capital budgets and what resources can be reallocated to fund the Council's response to the COVID-19 crisis as part of the Medium Term Financial Planning process.

In addition, to funding referred to above the Council has been allocated specific funding for care providers and NHS Track and Trace Services:

- For Adult Social Care, £600m was allocated for infection control in care homes to fight COVID-19 of which the council received £0.5m. A further £546m was recently announced, of which the council will receive £0.9m. The Council is required to passport the majority of these funds to care providers to support infection control.

- £3.1m was allocated to Hackney as part of the launch of the wider NHS Test and Trace Service. This funding will enable the local authority to develop and implement tailored local Covid-19 outbreak plans. A City and Hackney Health protection Board has been established and plans are being developed to allocate these funds accordingly.

Forecast positions in relation to the workstreams are as set out below:

- **CYPM & Prevention Budgets:** Public Health constitutes the vast majority of LBH CYPM & Prevention budgets which is forecasting a small underspend. The Public Health grant increased in 2020/21 by £1.569m. This increase included £955k for the Agenda for Change costs, for costs of eligible staff working in organisations such as the NHS that have been commissioned by the local authority. The remaining grant increase has been distributed to Local Authorities using the same percentage growth in allocations from 2019/20.

- **Unplanned Care:** The majority of the forecast underspend of £413k relates to Interim Care and is offset by overspends on care package expenditure which sits in the Planned Care work stream.

- **Planned Care:** The Planned Care workstream is driving the LBH overspend. This is primarily due to:

  - Learning Disabilities (LD) Commissioned care packages within this workstream is the most significant area of pressure, with a £1.1m overspend after a contribution of £2.7m forecasted (actual position currently is £2.45m agreed) from the CCG for joint funded care packages. Remaining cases still to be assessed for JF will be reviewed in 2020/21 to establish the baseline for the following financial year.

  - Physical & Sensory Support reflects an overspend of £3.1m, whilst Memory/Cognition & Mental Health ASC (OP) has a further budget pressure of £1m. Cost pressures being faced in both service areas have been driven by the significant growth in client numbers as a result of hospital discharges, and these forecasts include Covid-19 related expenditure.

  - Mental Health is forecasted to overspend by £1.1m and this is due to externally commissioned care packages (£1.4m) which is offset by an underspend on staffing (£0.3m). The Section 75 MH meetings will focus on developing management actions in collaboration with ELFT to reduce this budget pressure going forward.

- Management actions to mitigate the cost pressures include *My Life, My Neighbourhood, My Hackney* and increasing the uptake of direct payments. These actions are subject to ongoing review.

***Accruals are included in the CCG YTD and forecast position , however they are only included in the forecast position of LBH and CoLC.**

London Borough of Hackney - Risks and Mitigations Month 7, 2020/21

London Borough of Hackney

Risks	Full Risk Value £'000	Probability of risk being realised %	Potential Risk Value £'000	Proportion of Total %
Pressures remains within Planned Care	6,740	100%	6,740	100%
Coronavirus expenditure	Tbc	Tbc	Tbc	Tbc
TOTAL RISKS	6,885	100%	6,885	100%

Mitigations	Full Mitigation Value £'000	Probability of success of mitigating action %	Expected Mitigation Value £'000	Proportion of Total %
Personalisation and DPs - Increasing Uptake	TBC	TBC	TBC	TBC
My Life, My Neighbourhood, My Hackney	TBC	TBC	TBC	TBC
Review one off funding	6,740	100%	6,740	100%
Uncommitted Funds Sub-Total	6,740	100%	6,740	100%
Actions to Implement				
Actions to Implement Sub-Total	0	0	0	0
TOTAL MITIGATION	0	0	0	0

*Accruals are included in the CCG YTD and forecast position , however they are only included in the forecast position of LBH and CoLC.

London Borough of Hackney – Wider Risks & Challenges

- Covid 19 is having a major impact on the operation and financial risk of the Council Latest estimates show the impact across the General Fund and Housing Revenue Account totalling £72m with £44m being in relation to loss of income. To date, the Government has only allocated £32.349m of Emergency Grant Funding to Hackney. In respect of the Scheme to compensate for loss of income Councils will bear the first 5% of loss compared to budgeted income. Beyond this, 75p in the £ will be compensated, further detailed guidance is to be sent out imminently to local authorities but we currently anticipate that c£10m in compensation could be drawn down. We have set out in a report to Cabinet in July a detailed position for the current and future years and further update was provided to this Board in November.

- Over the period 2010/11 to 2019/20 core Government funding has shrunk from £310m to around £170m, a 45% reduction – this leaves the Council with very difficult choices in identifying further savings.

- Fair funding review, although delayed due to Covid-19, could redistribute already shrinking resources away from most inner London boroughs including Hackney.

- Demand for services increasing particularly in Children's & Families services, Adults Social Care and on Homelessness services.

- Additional funding through IBCF, winter funding, and the additional Social Care grant funding announced in the Spending Review 2019 has been confirmed for the lifespan of the current parliament but this additional funding is still insufficient. There has been an additional £300m of Social Care grant funding announced for Local Authorities in the latest Spending Review 2020, and we await further details in respect of this funding announcement.

- We still await a sustainable funding solution for Adult Social Care which was expected in the delayed White Paper.

***Accruals are included in the CCG YTD and forecast position , however they are only included in the forecast position of LBH and CoLC.**

City of London Corporation – Position Summary at Month 7 , 2020/21

				YTD Performance			Forecast Outturn	
	ORG Split	WORKSTREAM	Annual Budget £000's	Budget £000's	Spend £000's	Variance £000's	Forecast Outturn £000's	Forecast Outturn £000's
Pooled Budgets	Comm'ned & *DD	Unplanned Care	65	30	4	26	65	-
		Planned Care	118	45	-	45	85	33
		Prevention	60	30	30	-	90	(30)
Pooled Budgets Grand total			243	105	34	71	240	3

	ORG Split	WORKSTREAM	Annual Budget £000's	Budget £000's	Spend £000's	Variance £000's	Forecast Outturn £000's	Forecast Outturn £000's
Aligned Budgets	Comm'ned & *DD	Unplanned Care	342	157	140	16	342	-
		Planned Care	4,218	2,469	2,305	164	4,295	(77)
		Prevention	1,270	530	470	60	1,270	-
		Childrens and Young People	1,400	690	783	(92)	1,653	(253)
		Non - exercisable social care services (income)	-	-	-	-	-	-
Aligned Budgets Grand total			7,230	3,846	3,698	148	7,560	(330)
Grand total			**7,473**	**3,951**	**3,732**	**219**	**7,800**	**(327)**

* DD denotes services which are Directly delivered .
* Aligned Unplanned Care budgets include iBCF funding - £313k
* Comm'ned = Commissioned

- At Month 7, the City of London Corporation is forecasting a year end adverse position of £0.3m.
- Pooled budgets The Pooled budgets reflect the pre-existing integrated services of the Better Care Fund (BCF). These budgets are forecast to under spend at year end.
- Aligned budgets are forecast to overspend at year end. This is largely due to the pressures on children's social care.
- No additional savings targets have been set against City budgets for 2020/21.

***Accruals are included in the CCG YTD and forecast position , however they are only included in the forecast position of LBH and CoLC.**

Integrated Commissioning Fund – Savings Performance Month

City and Hackney CCG

- All transformation and QIPP initiatives planned for 2020/21 have been put on hold whilst the providers and commissioners of health and care respond to COVID-19.
- At Month 07, these schemes continue to be on-hold.

London Borough of Hackney

- Savings proposals are currently being reviewed, as to date no savings have been agreed for LBH

City of London Corporation

- The CoLC did not identify a saving target to date for the 2020/21 financial year.

Title:	Integrated Commissioning Risk Registers
Date of meeting:	10 December 2020
Lead Officer:	Matthew Knell – Head of Governance & Assurance, CCG Stella Okonkwo – Integrated Commissioning Programme Manager Workstream Directors
Author:	Workstream Directors & Programme Managers
Committee(s):	Integrated Commissioning Board, 10 December 2020
Public / Non-public	Public.

Executive Summary:

This report presents the detailed risk registers for the Integrated Commissioning workstreams and the IC Programme.

Recommendations:

The **City Integrated Commissioning Board** is asked:

- To **NOTE** the registers.

The **Hackney Integrated Commissioning Board** is asked:

- To **NOTE** the registers.

Strategic Objectives this paper supports:

Deliver a shift in resource and focus to prevention to improve the long term health and wellbeing of local people and address health inequalities	☒	The risk register supports all the programme objectives
Deliver proactive community based care closer to home and outside of institutional settings where appropriate	☒	The risk register supports all the programme objectives
Ensure we maintain financial balance as a system and achieve our financial plans	☒	The risk register supports all the programme objectives

Deliver integrated care which meets the physical, mental health and social needs of our diverse communities	☒	The risk register supports all the programme objectives
Empower patients and residents	☒	The risk register supports all the programme objectives

Specific implications for City

N/A

Specific implications for Hackney

N/A

Patient and Public Involvement and Impact:

N/A

Clinical/practitioner input and engagement:

N/A

Supporting Papers and Evidence:

Risk register cover sheets in agenda pack.

Full detailed registers circulated as appendices.

Sign-off:

Siobhan Harper – Director: Planned Care

Amy Wilkinson – Director: Children, Maternity, Young People and Families

Nina Griffith – Director: Unplanned Care

Carol Beckford – Transition Director

Integrated Commissioning Glossary

ACEs	Adverse Childhood Experiences	
ACERS	Adult Cardiorespiratory Enhanced and Responsive Service	
AOG	Accountable Officers Group	A meeting of system leaders from City & Hackney CCG, London Borough of Hackney, City of London Corporation and provider colleagues.
CPA	Care Programme Approach	A package of care for people with mental health problems.
CYP	Children and Young People's Service	
	City, The	City of London geographical area.
CoLC	City of London Corporation	City of London municipal governing body (formerly Corporation of London).
	City and Hackney System	City and Hackney Clinical Commissioning Group, London Borough of Hackney, City of London Corporation, Homerton University Hospital NHS FT, East London NHS FT, City & Hackney GP Confederation.
CCG	Clinical Commissioning Group	Clinical Commissioning Groups are groups of GPs that are responsible for buying health and care services. All GP practices are part of a CCG.
	Commissioners	City and Hackney Clinical Commissioning Group, London Borough of Hackney, City of London Corporation
CHS	Community Health Services	Community health services provide care for people with a wide range of conditions, often delivering health care in people's homes. This care can be multidisciplinary, involving teams of nurses and therapists working together with GPs and social care. Community health services also focus on prevention and health improvement, working in partnership with local government and voluntary and community sector enterprises.
COPD	Chronic Obstructive Pulmonary Disease	
CS2020	Community Services 2020	The programme of work to deliver a new community services contract from 2020.
DES	Directed Enhanced Services	
DToC	Delayed Transfer of Care	A delayed transfer of care is when a person is ready to be discharged from hospital to a home or care setting, but this must be delayed. This can be

		for a number of reasons, for example, because there is not a bed available in an intermediate care home.
ELHCP	East London Health and Care Partnership	The East London Health & care Partnership brings together the area's eight Councils (Barking, Havering & Redbridge, City of London, Hackney, Newham, Tower Hamlets and Waltham Forest), 7 Clinical Commissioning Groups and 12 NHS organisations. While East London as a whole faces some common problems, the local make up of and characteristics of the area vary considerably. Work is therefore shaped around three localized areas, bringing the Councils and NHS organisations within them together as local care partnerships to ensure the people living there get the right services for their specific needs.
FYFV	NHS Five Year Forward View	The NHS Five Year Forward View strategy was published in October 2014 in response to financial challenges, health inequalities and poor quality of care. It sets out a shared vision for the future of the NHS based around more integrated, person centred care.
IAPT	Improving Access to Psychological Therapy	Programme to improve access to mental health, particularly around the treatment of adult anxiety disorders and depression.
IC	Integrated Commissioning	Integrated contracting and commissioning takes place across a system (for example, City & Hackney) and is population based. A population based approach refers to the high, macro, level programmes and interventions across a range of different services and sectors. Key features include: population-level data (to understand need across populations and track health outcomes) and population-based budgets (either real or virtual) to align financial incentives with improving population health.
ICB	Integrated Commissioning Board	The Integrated Care Board has delegated decision making for the pooled budget. Each local authority agrees an annual budget and delegation scheme for its respective ICB (Hackney ICB and City ICB). Each ICB makes recommendations to its respective local authority on aligned fund services. Each ICB will receive financial reports from its local authority. The ICB's meet in common to ensure alignment.

ICS	Integrated Care System	An Integrated Care System is the name now given to Accountable Care Systems (ACSs). It is an 'evolved' version of a Sustainability and Transformation Partnership that is working as a locally integrated health system. They are systems in which NHS organisations (both commissioners and providers), often in partnership with local authorities, choose to take on clear collective responsibility for resources and population health. They provide joined up, better coordinated care. In return they get far more control and freedom over the total operations of the health system in their area; and work closely with local government and other partners.
IPC	Integrated Personal Commissioning	
ISAP	Integrated Support and Assurance Process	The ISAP refers to a set of activities that begin when a CCG or a commissioning function of NHS England (collectively referred to as commissioners) starts to develop a strategy involving the procurement of a complex contract. It also covers the subsequent contract award and mobilisation of services under the contract. The intention is that NHS England and NHS Improvement provide a 'system view' of the proposals, focusing on what is required to support the successful delivery of complex contracts. Applying the ISAP will help mitigate but not eliminate the risk that is inevitable if a complex contract is to be utilised. It is not about creating barriers to implementation.
LAC	Looked After Children	Term used to refer to a child that has been in the care of a local authority for more than 24 hours.
LARC	Long Acting Reversible Contraception	
LBH	London Borough of Hackney	Local authority for the Hackney region
LD	Learning Difficulties	
LTC	Long Term Condition	
MDT	Multidisciplinary team	Multidisciplinary teams bring together staff from different professional backgrounds (e.g. social worker, community nurse, occupational therapist, GP and any specialist staff) to support the needs of a person who requires more than one type of support or service. Multidisciplinary teams are often discussed in the same context as joint working, interagency work and partnership working.

MECC	Making Every Contact Count	A programme across City & Hackney to improve peoples' experience of the service by ensuring all contacts with staff are geared towards their needs.
MI	Myocardial Infarction	Technical name for a heart attack.
	Neighbourhood Programme (across City and Hackney)	The neighbourhood model will build localised integrated care services across a population of 30,000-50,000 residents. This will include focusing on prevention, as well as the wider social and economic determinants of health. The neighbourhood model will organise City and Hackney health and care services around the patient.
NEL	North East London (NEL) Commissioning Alliance	This is the commissioning arm of the East London Health and Care Partnership comprising 7 clinical commissioning groups in North East London. The 7 CCGs are City and Hackney, Havering, Redbridge, Waltham Forest, Barking and Dagenham, Newham and Tower Hamlets.
NHSE	NHS England	Executive body of the Department of Health and Social Care. Responsible for the budget, planning, delivery and operational sides of NHS Commissioning.
NHSI	NHS Improvement	Oversight body responsible for quality and safety standards.
	Primary Care	Primary care services are the first step to ensure that people are seen by the professional best suited to deliver the right care and in the most appropriate setting. Primary care includes general practice, community pharmacy, dental, and optometry (eye health) services.
PD	Personality Disorder	
PIN	Prior Information Notice	A method for providing the market place with early notification of intent to award a contract/framework and can lead to early supplier discussions which may help inform the development of the specification.
QIPP	Quality, Innovation, Productivity and Prevention	QIPP is a programme designed to deliver savings within the NHS, predominately through driving up efficiency while also improving the quality of care.
QOF	Quality Outcomes Framework	
	Risk Sharing	Risk sharing is a management method of sharing risks and rewards between health and social care organisations by distributing gains and losses on an agreed basis. Financial gains are calculated as the difference between the expected cost of

		delivering care to a defined population and the actual cost.
	Secondary care	Secondary care services are usually based in a hospital or clinic and are a referral from primary care. rather than the community. Sometimes 'secondary care' is used to mean 'hospital care'.
	Step Down	Step down services are the provision of health and social care outside the acute (hospital) care setting for people who need an intensive period of care or further support to make them well enough to return home.
SOCG	System Operational Command Group	An operational meeting consisting of system leaders from across the City & Hackney health, social care and voluntary sector. Chaired by the Chief Executive of the Homerton Hospital. Set up to deal with the immediate crisis response to the Covid-19 pandemic.
SMI	Severe Mental Illness	
STP	Sustainability and Transformation Partnership	Sustainability and transformation plans were announced in NHS planning guidance published in December 2015. Forty-four areas have been identified as the geographical 'footprints' on which the plans are based, with an average population size of 1.2 million people (the smallest covers a population of 300,000 and the largest 2.8 million). A named individual has led the development of each Sustainability and Transformation Partnership. Most Sustainability and Transformation Partnership leaders come from clinical commissioning groups and NHS trusts or foundation trusts, but a small number come from local government. Each partnership developed a 'place-based plans' for the future of health and care services in their area. Draft plans were produced by June 2016 and 'final' plans were submitted in October 2016.
	Tertiary care	Care for people needing specialist treatments. People may be referred for tertiary care (for example, a specialist stroke unit) from either primary care or secondary care.
	Vanguard	A vanguard is the term for an innovative programme of care based on one of the new care models described in the NHS Five Year Forward View. There are five types of vanguard, and each address a different way of joining up or providing more coordinated services for people. Fifty

		vanguard sites were established and allocated funding to improve care for people in their areas.
VCSE	Voluntary Community and Social Enterprise	