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NORTH LINCOLNSHIRE COUNCIL

HEALTH AND WELLBEING BOARD

21 December 2020

Chairman: Councillor Robert Waltham MBE

Venue: Virtual Meeting Microsoft Teams

Time: 3.00 pm

E-Mail Address: Dean.gillon@northlincs.gov.uk

AGENDA

1. Welcome and Introductions

2. Substitutions

3. Declarations of Disclosable Pecuniary Interests and Personal or Personal and Prejudicial interests

4. To approve as a correct record the minutes of the meeting of the Health and Wellbeing Board held on 16 November 2020. (Pages 1 - 6)

5. Forward Plan and Actions from previous meetings.

6. Questions from members of the public

PLEASE NOTE, ALL PAPERS WILL BE TAKEN 'AS READ' TO ENCOURAGE DISCUSSION

7. COVID-19 Outbreak Management and Control. (Pages 7 - 12)
   Report and Presentation by the Deputy Chief Executive.

8. COVID-19 Vaccination Programme. (Pages 13 - 16)
   Report by the Chief Operating Officer, North Lincolnshire CCG.

9. Integrated Working - Children. Winter Grant Scheme. (Pages 17 - 20)
   Winter Grant Scheme – Report by the Head of Early Help and Protection.

10. Integrating Care. Next steps for building strong and effective integrated care systems across England. (Pages 21 - 64)

Next Steps for Building Strong and Effective Integrated Care Systems Across England.

a. Verbal Presentation by NHS England/ICS representatives
b. Consideration of a response from the Board to the ongoing consultation.

11. Date and time of next meeting.
18 January 2021, 3pm

12. Any other items which the Chairman decides are urgent by reason of special circumstances which must be specified.

NORTH LINCOLNSHIRE COUNCIL

HEALTH AND WELLBEING BOARD

16 November 2020

PRESENT: - Councillor Waltham MBE in the Chair

Dr Faisel Baig (Vice-Chair), Nikki Alcock, Jilla Burgess-Allen, Carrie Butler, Mick Gibbs, Simon Green, Cllr Hannigan, Becky McIntyre, Karen Pavey, Cllr Rose, and Alex Seale.

Cllrs Ellerby, O'Sullivan and Wilson attended the meeting in accordance with Procedure Rule 37(b).

Dean Gillon was also in attendance.

The meeting was held virtually via MS Teams.

330 **WELCOME AND INTRODUCTIONS -** The Chairman welcomed all those present to the meeting and invited all attendees to introduce themselves.

331 **DECLARATIONS OF DISCLOSABLE PECUNIARY INTERESTS AND PERSONAL OR PERSONAL AND PREJUDICIAL INTERESTS –** There were no declarations of disclosable pecuniary interests and personal or personal and prejudicial interests.

332 **MINUTES - Resolved -** That the minutes of the meeting of the Health and Wellbeing Board, held on 14 September 2020, be approved as a correct record.

333 **FORWARD PLAN AND FORTHCOMING ACTIONS – UPDATE ON THE NHS PHASE 3 RECOVERY PLAN BY THE CHIEF EXECUTIVE, NORTH LINCOLNSHIRE CCG** – The Chief Operating Officer, North Lincolnshire CCG, tabled a report providing the Health and Wellbeing Board with an overview of the final Phase 3 planning submission for the Humber Health and Care system, and setting out the priorities for the remainder of 2020/21 including how the system planned to respond to local challenges and the associated risks.

The Chief Operating Officer described the priorities below:

- Accelerating the return to near-normal levels of non-Covid health services, making full use of the capacity available in the 'window of opportunity' between now and winter.

- Preparation for winter demand pressures, alongside continuing vigilance in the light of further probable Covid spikes locally and possibly nationally.

- Doing the above in a way that takes account of lessons learned during the first Covid peak; locks in beneficial changes; and explicitly tackles fundamental challenges including: support for our staff, and action on inequalities and prevention.

The Chief Operating Officer discussed the Recovery Plan in greater detail, outlining current and future actions, and the challenges that were likely to arise.

Resolved – (a) That the Health and Wellbeing Board note the updated phase 3 plan for the Humber Health and Care system and the associated risks, and (b) that the Forward Plan and Forthcoming Actions report be noted.

334 **QUESTIONS FROM MEMBERS OF THE PUBLIC** – There were no questions from members of the public.

335 **INTEGRATED WORKING – ADULTS. ADULT SOCIAL CARE WINTER PLAN AND STRATEGIC COMMISSIONING PLAN –** The Director: Adults and Community Wellbeing submitted a report and presentation on the Adult Social care Winter Plan. The purpose of the report was to:

- Inform Health and Wellbeing Board members of the publication of the Department for Health and Social Care policy paper 'Adult social care: Our COVID-19 winter plan 2020 to 2021'.
- Provide assurance that the expectations set out in the Department of Health & Social Care Winter Plan have been incorporated within existing North Lincolnshire integration plans, and
- Inform Health and Wellbeing Board members that this approach has been taken in collaboration with people who need care and carers, North Lincolnshire CCG, local NHS organisations, care providers and the voluntary and community sector.

The Director explained that this winter was likely to place unique pressures on the health and care system. COVID-19 would be co-circulating with seasonal flu and other viruses, and transmission may increase over the winter period. These pressures create risks to the health and wellbeing of both people who need care and support and the social care workforce, including unpaid carers and social care providers, which may impact on capacity. As such, it was essential that local partners work closely together to ensure a level of preparedness for the additional pressures that may be faced this winter.

The Director set out the three overarching priorities within the DHSC Winter Plan for holistic support to the sector which were:

- Ensuring everyone who needs care or support can get high-quality, timely and safe care throughout the autumn and winter period
- Protecting people who need care, support or safeguards, the social care workforce, and carers from infections including COVID-19
- Making sure that people who need care, support or safeguards remain connected to essential services and their loved ones, whilst protecting individuals from infections including COVID-19.

The Director then gave a detailed presentation on the Integrated Adults Partnership's Strategic Commissioning Plan 2020/24. This set out the integrated approach and commissioning intent in relation to meeting the health and social care needs of the adult population of North Lincolnshire. The presentation covered all relevant issues, such as workforce development, the Strategic Framework, Organisational Model, and outcomes and priorities.

The Board discussed the Winter Plan and the Strategic Commissioning Plan, highlighting the importance of both in responding to forthcoming challenges, and to ensuring effective services were planned, commissioned, and delivered for local people.

Resolved - (a) That the Health and Wellbeing Board note the requirement for local partners to work together to ensure a preparedness for the additional pressures that adult social care may face this winter, ensuring everyone who needs care or support can get high-quality, timely and safe care throughout the autumn and winter period; (b) that the Health and Wellbeing Board note that the expectations set out in the national winter plan policy have been incorporated within existing North Lincolnshire integration plans, and (c) that the Health and Wellbeing Board encourage the review of the Health and Wellbeing Strategy to incorporate the request of the people with lived experience and their carers.

336 **INTEGRATED WORKING – CHILDREN. CHILDREN'S COMMISSIONING STRATEGY 2020/24 –** The Director: Children and Community Resilience submitted a report informing the Health and Wellbeing Board about the Children's Commissioning Strategy 2020/24. The Director explained that the commissioning strategy clarified the integrated 'One Family Approach' and commissioning intent in relation to health, social care and education for children, young people and families.

The Children's Commissioning Strategy 2020/24 had been developed through the Integrated Children's Trust to enable education, health and social care services working with children and families to have a shared understanding and ambition for children in North Lincolnshire. The strategy would form the work of, and be monitored by, the Integrated Children Trust and provide a conduit between the integrated care partnership arrangements and the Health and Wellbeing Board.

The strategy signalled an intent to work together and integrate both services and commissioning functions where these improve outcomes for children and families and to prioritise those where they have additional need.

Resolved - That the Health and Wellbeing Board note the North Lincolnshire Children's Commissioning Strategy 2020/24

337 **COVID-19 OUTBREAK MANAGEMENT AND PREVENTION** - The Director of Public Health submitted a report updating the Board on progress on the seven themes within the North Lincolnshire Outbreak Prevention and Management Plan and discussing key areas for focus for the forthcoming period. The update also outlined North Lincolnshire's position in relation to risk alert levels and restrictions imposed.

The Director explained that North Lincolnshire Council was committed to working with our local people to keep them safe, well, prosperous and connected. Successful prevention and management of local outbreaks was therefore vital to break the chains of COVID- 19 transmission and enable people to return to and maintain a more normal way of life.

New national restrictions were introduced on 5 November 2020. These new measures would apply nationally for four weeks up to Wednesday 2 December. At the end of the period, the government would look to return to a regional approach based on the latest data. At the point of the national restrictions being introduced North Lincolnshire was in the alert level 'high' tier.

The Director stated that North Lincolnshire Council remained the lead organisation for local outbreak prevention and management, within a national framework and with the support of NHS Test and Trace, PHE and other government departments. The North Lincolnshire Outbreak Prevention and Management Plan set out the collaborative and preventive approach and confirmed that key staff continue to monitor case data on a daily basis and target resources as appropriate to prevent and reduce transmission across the area.

The Director then gave updates on each of the seven themes, as outlined within their report, including care homes, educational settings, testing, and contact tracing.

The Board discussed the report, including scenario planning and how care and nursing homes can be supported more efficiently, with the Director responding accordingly.

Resolved - That the Health and Wellbeing Board note the Outbreak Prevention and Management activity as outlined in the report.

338 **ANNUAL REVIEW OF LOCAL ARRANGEMENTS TO SAFEGUARD AND PROMOTE THE WELFARE OF CHILDREN AND YOUNG PEOPLE 2019/20** – The Director: Children and Community Resilience submitted a report requesting that the Health and Wellbeing Board note the publication of the Annual Report of Local Arrangements to safeguard and promote the welfare of children and young people 2019/20 and to consider the review in relation to planning, commissioning and budget setting. The report demonstrated that the Children's Multi Agency Resilience and Safeguarding (MARS) Local Arrangements:

- effectively met statutory obligations
- was effective in providing help and protection to children
- benefitted from strong and consistent leadership
- had made good progress against its areas of focus
- listened and responded to the voices of children and young people
- had swiftly and confidently responded to the challenges posed by COVID-19

The Director explained that, in North Lincolnshire, children, young people, families and communities were at the heart of what we do and across the partnership. The arrangements were aspirational and committed to improving outcomes for children, so they can achieve their potential and be in their families, in their schools and in their communities. Through our Children's MARS Local Arrangements, the overarching aim was to effectively help and protect children and families across the early help and safeguarding system.

There was a statutory requirement to publish an annual report, which set out what has been done as a result of local arrangements and described how effective these arrangements had been in practice. The 2019/20 annual report had been endorsed by the Children's MARS Board on behalf of the three safeguarding partners from North Lincolnshire Council, North Lincolnshire Clinical Commissioning Group and Humberside Police. The annual report was then required to be distributed through relevant governance routes across the three safeguarding partner organisations and relevant partnership arrangements also to be considered in relation to planning, commissioning and budget setting.

The annual report provided a review of activity and impacts in respect of Children's MARS functions, including funding, performance, voice and stakeholder engagement, training, scrutiny and assurance and child safeguarding practice reviews.

The Board discussed the contents of the annual review and report, asking a number of relevant questions, which the Director responded to.

Resolved – That the Health and Wellbeing Board receive the Annual Report of Local Arrangements to safeguard and promote the welfare of children and young people 2019/20 and consider this where relevant in relation to planning, commissioning and budgets setting processes.

339 **HEALTH AND WELLBEING BOARD GOVERNANCE AND MEMORANDUM OF UNDERSTANDING UPDATE** - The Director: Governance and Partnerships submitted a report requesting that the Health and Wellbeing Board consider possible revisions to the Memorandum of Understanding to ensure that the Board's governance arrangements are compatible with outbreak management requirements. The report also contained potential further measures that would ensure that local arrangements are robust, ensure suitable oversight, and minimise the risk of Covid-19 outbreak.

The Director explained that the Health and Wellbeing Board acted as the local member-led and democratically accountable body for local arrangements to prevent outbreaks of Covid-19. The operational and technical implementation and delivery of the Outbreak Management arrangements is the responsibility of the Health Protection & Outbreak Management Group, which meets weekly. A number of further proposed measures to strengthen local arrangements were outlined, including the Board meeting more regularly and extending its membership.

Resolved – (a) That the proposed amendments set out in the Memorandum of Understanding be accepted and implemented, and (b) That the Board extend the frequency of its meetings, making such arrangements as necessary.

329 **DATE AND TIME OF NEXT MEETING** – The Director: Governance and Partnerships confirmed that Board members would be informed of the date of the next meeting in due course.

Report of the: Deputy Chief Executive

Agenda Item 7
Meeting 21 December 2020

NORTH LINCOLNSHIRE COUNCIL

HEALTH & WELLBEING BOARD

COVID-19 OUTBREAK PREVENTION AND MANAGEMENT UPDATE

1. OBJECT AND KEY POINTS IN THIS REPORT

1.1 Progress update against each of the 7 themes in the North Lincolnshire Outbreak Prevention & Management Plan

1.2 Key areas of focus for the outbreak prevention and management in North Lincolnshire for the forthcoming period

1.3 Outline of North Lincolnshire's position in relation to risk alert level and local restrictions

2. BACKGROUND INFORMATION

2.1 North Lincolnshire Council is committed to working with our local people to keep them safe, well, prosperous and connected. Successful prevention and management of local outbreaks is vital to break the chains of COVID- 19 transmission and enable people to return to and maintain a more normal way of life.

2.2 On 23 November 2020 Government published the COVID-19 Winter Plan. This plan sets out the programme for suppressing the virus, protecting the NHS and the vulnerable, keeping education and the economy going and providing a route back to normality. The Government's objectives are to:

- Supress the virus – bring the R number below 1 and keep it there. Measures include the use of restrictions.
- Finding new and more effective ways of managing the virus and enabling life to return closer to normal. This includes:
    - Vaccines – following approval of the Pfizer BionNTech vaccine a UK wide vaccination programme commenced on 8 December 2020.
    - Treatment – effective treatments will continue to be vital to manage the virus even as vaccines are rolled out

    - Mass community testing – strengthened targeted community testing will support the identification and isolation of people who do not have symptoms but are unintentionally spreading the virus.
- Minimise damage to the economy and society, jobs and livelihoods. This means ensuring the right support is available for jobs and that early year's settings, schools, further education providers and universities continue their excellent work in ensuring a safe environment for students to learn.

2.3 The Winter Plan also set out a targeted regional tiered approach to restrictions. On 2 December following the end of national restrictions, North Lincolnshire was placed into Tier 3 Very High Local Alert Level. This was reviewed by Government on the 16 December 2020 and authorities in the Humber region remain in Tier 3 – Very High Alert. The next formal review is scheduled for 30 December 2020.

2.4 In addition to the local restrictions tier arrangements Government have published guidance for the Christmas period. Different rules will apply on the 25 December 2020 only. This includes a relaxing of rules to form a Christmas bubble that will enable people to spend time together in private homes, to attend places of worship, or meet in a public outdoor place.

2.5 Targeted proactive communications continue to be a priority action with strong messages being pushed to reinforce that the vaccine is not a signal to change behaviour and the importance to continue with hands, face and space and self-isolation. The council and North Lincolnshire CCG have issued a joint message in the run up to Christmas to reinforce the need to follow guidance.

2.6 The council continues to lead local outbreak prevention and management, within a national framework and with the support of NHS Test and Trace, PHE and other government departments.

2.7 A system-wide approach to the roll out of targeted testing and the COVID-19 vaccination programme across North Lincolnshire is underway. By 21 December circa 2000 vaccines have been administered in North Lincolnshire.

2.8 The North Lincolnshire Outbreak Prevention and Management Plan sets out our collaborative and preventive approach and we continue to monitor case data on a daily basis and target resources as appropriate to prevent and reduce transmission across the area.

2.9 **Progress update** - A summary of the progress made to date against each of the seven key themes in the North Lincolnshire Outbreak Prevention and Management Plan along with priority actions and next steps is given below.

2.9.1 Care Homes

- Cases of COVID-19 in care home settings continue to be closely

monitored with the situation across our care homes showing significant improvement.

- NHS Test and Trace is making regular COVID-19 testing available to eligible Extra Care and Supported Living settings.
- All front-line health and social care staff are being prioritised to get the flu vaccination.
- Government have announced a new regime of lateral flow testing for care homes which is currently being rolled out to staff, residents and visitors.
- Further guidance on visiting care homes has been received and a letter has been sent to local care homes, with the position being kept under regular review.
- Care home workers and the over 80s have been prioritised locally for the Pfizer-BioNTech vaccine.
- Roll out of vaccinations into care home settings will commence on the 23 December 2020.

2.9.2 Education settings

- All North Lincolnshire schools have remained open since 1 September 2020 with the exception of a very small number closing for 2/3 days for a deep clean.
- Intelligence from regional networks is that schools in North Lincolnshire are being enabled to remain open by locally informed timely advice regarding close contacts and closing bubbles.
- The remote learning offer in schools in well planned with good take up by children not in school.
- Government have announced that lateral flow tests will be deployed to all secondary schools and colleges from January 2021.
- A staggered return for some secondary school pupils has been announced by Government with many pupils receiving remote education for the first week back in the new year and not returning to the classroom until the week commencing 11 January 2020.

2.9.3 High-risk workplaces, communities and locations

- Overall, the number of cases in business premises are reducing in line with a decline in community transmission.
- We continue to work with businesses to manage local outbreaks as they occur. The focus remains on sectors where transmission risks are highest, particularly food retailers.
- Pro-active targeted work is being undertaken with the retail sector and with Houses of Multiple Occupation (HMO’s).
- Covid prevention assistants are now in place and working proactively where needed on an evidence and intelligence led basis.

2.9.4 Local testing

- There continues to be good capacity for Pillar One and Pillar 2 testing locally
- Priority cohorts for the roll out of lateral flow testing have been identified and arrangements are being put in place to deliver testing across a number of settings in North Lincolnshire, as part of a Humber wide approach.

2.9.5 Contact tracing

- The proportion of NHS test and trace cases completed for North Lincolnshire is currently above the Yorkshire and Humber and England average.
- Any cases not contacted by the national team after 24 hours are passed to local contact tracing teams.
- Local contact tracing arrangements have been established in North Lincolnshire with staffing levels good and capacity available to scale up if required.
- As at 15 December 2020, 365 local contacts have been passed from the national test and trace service with attempted contact made in all cases.
- Further developments are being explored alongside lateral flow testing to carry out local contact tracing in conjunction, to complement this approach.

2.9.6 Data integration

- All data in relation to case information is held in one place and reported as one version of the truth.
- Further improvements continue to take place as the system develops and refines with a dashboard currently being developed.

2.9.7 Vulnerable people and diverse communities

- Targeted communications aimed at specific vulnerable groups regarding self-isolation, social distancing and preventative behaviours continues with circa 300 visits paid to individuals.
- Support to communities continues through the community enablement team and covid community champions.
- Financial support continues to be provided to individuals who are experiencing financial hardship. This support is made up of self-isolation grants with over 200 grants of £500 being paid out. In addition 65 applications for the hardship grant have been approved with the majority of applications being for white goods, followed by food and utilities.
- The voluntary and community sector are working with adults to complete a programme of support re: home support and hospital discharge

3. OPTIONS FOR CONSIDERATION

3.1 The Health and Wellbeing Board is asked to consider the report and note the work undertaken to date by the Health Protection and Outbreak Management Group, and the planned next steps to ensure we prevent outbreaks of COVID-19 and respond effectively and early to emerging outbreaks

4. ANALYSIS OF OPTIONS

4.1 Successful prevention and management of local outbreaks is vital to break the chains of COVID-19 transmission, along with rollout of community testing and vaccinations to enable people to return to and maintain a more normal way of life.

5. FINANCIAL AND OTHER RESOURCE IMPLICATIONS (e.g. LEGAL, HR, PROPERTY, IT, COMMUNICATIONS etc.)

5.1 Financial implications associated with the councils Covid-19 response and recovery are being monitored

6. OTHER RELEVANT IMPLICATIONS (e.g. CRIME AND DISORDER, EQUALITIES, COUNCIL PLAN, ENVIRONMENTAL, RISK etc.

6.1 Implications and risks associated with Covid-19 are being monitored constantly and mitigations being implemented as necessary

7. OUTCOMES OF INTEGRATED IMPACT ASSESSMENT (IF APPLICABLE)

7.1 A council-wide approach to assessing the impact of Covid-19 has been adopted

8. OUTCOMES OF CONSULTATION AND CONFLICTS OF INTERESTS DECLARED

8.1 Ongoing consultation with a range of partners and key stakeholders are integral to our local response to Covid-19

9. RECOMMENDATIONS

9.1 That the Health and Wellbeing Board notes the Outbreak Prevention and Management activity as outlined in the report.

DEPUTY CHIEF EXECUTIVE

Church Square House
SCUNTHORPE

North Lincolnshire
DN15 6NR
Author: Rachel Johnson
Date: 20 December 2020

Report of the Chief Operating Officer
North Lincolnshire CCG

Agenda Item 8
Meeting 21st December 2020

NORTH LINCOLNSHIRE COUNCIL

Health and Wellbeing Board

Covid-19 Vaccination Programme

1. OBJECT AND KEY POINTS IN THIS REPORT

The purpose of the report is to update the Health and Wellbeing Board on the latest position of the Covid-19 Vaccination Programme.

This report covers the phase 1 model of the programme including the early priority cohorts and how they will be managed.

2. BACKGROUND INFORMATION

Following confirmation that the Pfizer/BioNTech Vaccine had been approved in England to treat Covid-19, the NHS will be the first healthcare system in the world to offer the COVID-19 vaccine to those most at risk.

All GP practices were asked to collaborate to identify one suitable premises from which their Primary Care Network (PCN) Grouping would be capable of delivering the requirements of the Covid Vaccination Enhanced Service if approved. It is anticipated that 3 further PCN sites which have been approved by NHS England will come on line quickly to support the further roll out of the vaccine. These sites will provide good geographic coverage for the North Lincolnshire patch.

The GP practices are expected to work within their PCN Grouping to co-ordinate and deliver the vaccinations at scale and in line with the requirements set out.

The Vaccination Prioritisation list is identified below:

- Older adults' resident in a care home and care home workers.
- All those 80 years of age (and over) and Health and Social Care Workers;
- All those 75 years of age and over;
- All those 70 years of age and over;
- All those 65 years of age and over;

- High-risk4 adults under 65 years of age;
- Moderate-risk5 adults under 65 years of age;
- All those 60 years of age and over;
- All those 55 years of age and over;
- All those 50 years of age and over.

The initial prioritisation ask has now changed and is for those in the over 80 cohort who can attend the designated site for a vaccination to be vaccinated first. This is because the Pfizer/BioNTech vaccine cannot be transported once it has been thawed from its storage temperature of -70 degrees. This means that the vaccine cannot be taken in to care homes at this stage. As soon as there is any change to information on stability for further transfer or regulatory approval of subsequent vaccines that can be transported, then the care home cohort will be the next priority. However any Care Home residents attending hospital who is eligible may be offered the vaccination during their visit.

Each site stood up will need to deliver 975 doses of the vaccine to priority patients. Once received at the practice site, the vaccine will need to be used quickly in the days following delivery. The shelf life is 3.5 days of vaccination following delivery, with storage at 2-8°C.

Nationally a number of hospital hub sites were also stood up in the week commencing 7th December for critical hospital staff and over 80s attending hospital. The closest site to North Lincolnshire was Castle Hill Hospital Cottingham. North Lincolnshire provided contact details for care home staff should any be available to access this site. Care home, social care, front line NHS and other key staff will be able to access the primary care led vaccine response as that starts to be fully rolled out.

In North Lincolnshire our first site which will be stood up will be the Ironstone Centre in Scunthorpe which is in the South Network who are working to identify and call eligible patients to book them in for next week (week commencing 14th December 2020). Following this, our other 3 PCN sites will be stood up in a phased manner. Based on current information about the first COVID-19 vaccines which may be used, scheduling of COVID-19 vaccines for the first and second dose should be separated by an interval of at least 21 days. Primary Care Networks will use a call/recall system to ensure that patients are booked in for their second dose.

The System being used to capture vaccination data will be Pinnacle which is a web-based system so no changes are required to practices I.T. equipment. Access to the systems will be provided free of charge to Primary Care Networks designated sites, as will the associated training. Locally our Primary Care Networks are using a system called GP Connect to schedule bookings and rotas which enables the different GP Systems used to talk to each other.

The CCG are liaising with the communications teams across Humber Coast and Vale and locally to understand the plan to share key information and details with the public to encourage as many patients as possible to have the vaccine. One of the key public messages to patients is to assure them that practices will contact them directly when the practice is ready to vaccinate that particular cohort rather than patients directly contacting the practice to manage demand or inappropriate patients attending the practice.

3. **OPTIONS FOR CONSIDERATION**

3.1 The Paper if for information only.

4. **ANALYSIS OF OPTIONS**

4.1 The Paper if for information only.

5. **FINANCIAL AND OTHER RESOURCE IMPLICATIONS (e.g. LEGAL, HR, PROPERTY, IT, COMMUNICATIONS etc.)**

5.1 All required equipment is being provided free as part of the Vaccination Programme.

6. **OTHER RELEVANT IMPLICATIONS (e.g. CRIME AND DISORDER, EQUALITIES, COUNCIL PLAN, ENVIRONMENTAL, RISK etc.)**

6.1 There is a security risk at the vaccination sites which Humberside Police are aware of and are liaising with PCNs on.

7. **OUTCOMES OF INTEGRATED IMPACT ASSESSMENT (IF APPLICABLE)**

7.1 Not applicable.

8. **OUTCOMES OF CONSULTATION AND CONFLICTS OF INTERESTS DECLARED**

8.1 Not applicable.

9. **RECOMMENDATIONS**

9.1 This report is for information only.

DIRECTOR OF Chief Operating Officer North Lincolnshire CCG

Church Square House
SCUNTHORPE
North Lincolnshire
Post Code
Author: Adam Ryley
Date: 10 December 2020
Background Papers used in the preparation of this report – None

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Report of the Head of Early Help and Protection

NORTH LINCOLNSHIRE COUNCIL

HEALTH AND WELLBEING BOARD

COVID-19 WINTER GRANT SCHEME

1. OBJECT AND KEY POINTS IN THIS REPORT

1.1 This report updates the Health and Wellbeing Board on the local implementation of the government's recently announced COVID Winter Grant Scheme.

1.2 A decision on implementing the Winter Grant Scheme was taken by the Children and Families Cabinet Member on 9 December 2020.

2. BACKGROUND INFORMATION

2.1 On Sunday 8 November 2020, the government announced the introduction of the £170 million COVID Winter Grant Scheme - a package of extra targeted financial support for those in need over the winter period. The funding allocation for North Lincolnshire is £532,566, which is due to be released in the first week of December 2020 and will run until the end of March 2021.

2.2 Government guidance issued by the DWP states that 'the objective of the COVID Winter Grant Scheme is to provide support to vulnerable households and families with children particularly affected by the pandemic throughout the winter period where alternative sources of assistance may be unavailable'. The clear focus of the Scheme is to help those in most need with the cost of food, energy, water bills (including sewerage) and other essentials.

2.3 This Scheme is part of a wider winter support package for families and children, including:

- expansion of the Department for Education's (DfE's) Holiday Activities and Food programme, across England next year. This investment of up to £220 million will be delivered through grants to local authorities to ensure provision of the scheme for Easter, summer and Christmas in 2021.
- increasing the value of the Department for Health and Social Care's Healthy Start vouchers from £3.10 to £4.25 from April 2021.
- DEFRA will provide further funding for local charities through well-established networks to provide immediate support to front-line food aid charities, including food banks, who are supporting those most vulnerable due to the economic impacts of COVID-19.

2.4 Considerable flexibilities have been given to Local Authorities in determining their own local eligibility framework and approach, with the ability to deliver the scheme through vouchers or grants, or other mechanisms. The main requirements are that at least 80% must be spent on families with children, with up to 20% for households without children, which includes care leavers and under 25's with Special Educational Needs and/or Disability (SEND). The

guidance supports Local Authorities in working with other local organisations to deliver the Scheme, and to use local knowledge and data to identify and prioritise support for specific vulnerable groups.

2.5 Following initial scoping activity and informal consultation across the council, with schools and with the local voluntary sector, proposals to deliver the Scheme in North Lincolnshire have been developed as follows:

2.6 Local Eligibility Framework and Approach

a) Free School Meal (FSM) Scheme

2.6.1 Although there is no requirement to fund FSM over school holidays, doing so is in line with the policy intent behind the Scheme, and reflects the focus given to 'holiday hunger' and the impact of COVID 19 on poorer families in the national press and across social media. There is recent precedent in North Lincolnshire for funding FSM during holiday periods, and an established system for the purchase and distribution of vouchers to eligible families. Informal consultation has taken place with a number of schools who have expressed support for taking the same approach over the Christmas break.

2.6.2 Alongside this group, it was agreed that families with children eligible for 2-year old funding are also issued food vouchers at the same rate, to increase coverage for all children 2-16 with equal eligibility.

b) Welfare Assistance Support

2.6.3 It was agreed that this element of the scheme should build on the processes developed in July to deliver the Defra emergency assistance grant scheme, which is administered under a commissioned contract by North Lincolnshire CAB. Bringing the two schemes together provides a range of benefits including:

- Utilising the existing emergency assistance grant application process and data capture systems already deployed enables rapid roll-out. The systems are tested which will harness business process efficiencies through the creation of a streamlined single application process for residents

- Drawing on CAB's considerable expertise and trusted reputation in providing advice and guidance for residents and the opportunity to 'make every contact count' supporting our outcomes of safe, well, prosperous, and connected. This includes, for example, providing applicants with help with debt and money worries together with broader needs such as information about skills, training, or employment.

- Enabling CAB to work with their extensive collaborative network of voluntary and community organisations in North Lincolnshire to access partner capacity for delivery

2.7 Taking a targeted approach

2.7.1 There will be equality of opportunity to apply for grants within the Scheme, however the experience of similar schemes suggests that a targeted approach will be needed to ensure those who are most in need find out about and are enabled to apply for grants. To this end, the Scheme will be promoted across relevant teams, services, schools, and agencies, including the voluntary sector, with specific communications going directly to a small number of highest priority groups.

2.7.2 For example, to maximise applications from families with infants aged 0 – 2 who may need support with food and bills, information about the Scheme will be sent to the parents of all

children in this age range. Health visitors, nursery nurses, and children's centre staff will then specifically target families known to be experiencing, or at risk of experiencing hardship.

2.7.3 This approach will be taken for all of the vulnerable groups listed below, who have been identified following consultation across council service areas. These are:

- Care leavers and young parents receiving additional support
- New or recent universal credit applicants
- Families with babies eligible for healthy start vouchers
- 16-18 year-olds eligible for FSM, or eligible for a college bursary
- Home educated children who would normally be entitled to FSM
- Families and adults with no recourse to public funds
- Those receiving council tax support who are struggling to keep up payments (have paid 50% or less of debt)
- Vulnerable adults identified by adult social care services
- Young people up to the age of 25 with special educational needs or a disability (SEND)

2.8 Eligibility Criteria

2.8.1 It was agreed that the following criteria must be met before welfare assistance grants are made:

- The applicant must be a resident of North Lincolnshire and consent to appropriate identity checks.
- The applicant must be experiencing, or at risk of experiencing, food and/or fuel poverty due to a change in circumstances related to, directly or indirectly, the impact of the pandemic.
- The applicant must not have any other means to meet their need for food and/or energy (including water/sewerage bills).
- The applicant must be willing to accept food or fuel vouchers if the grant is awarded, unless exceptional circumstances apply.

3. OPTIONS FOR CONSIDERATION

3.1 There are no options to consider as this report is for information only.

4. ANALYSIS OF OPTIONS

4.1 As above, there are no options to analyse as this report is for information only.

5. FINANCIAL AND OTHER RESOURCE IMPLICATIONS (e.g. LEGAL, HR, PROPERTY, IT, COMMUNICATIONS etc.)

5.1 The grant allocation for the Scheme is £532,566 and is intended for the period 1 December 2020 to 31 March 2021.

6. OTHER RELEVANT IMPLICATIONS (e.g. CRIME AND DISORDER, EQUALITIES, COUNCIL PLAN, ENVIRONMENTAL, RISK etc.)

6.1 There are no other relevant implications.

7. OUTCOMES OF INTEGRATED IMPACT ASSESSMENT (IF APPLICABLE)

7.1 An IIA has been completed, which did not identify any negative impacts.

8. OUTCOMES OF CONSULTATION AND CONFLICTS OF INTERESTS DECLARED

8.1 No formal consultations are required, however the details agreed by the Children & Families Cabinet Member and which are set out in this report have been developed in conjunction with representatives from a range of council service areas, following informal consultation with representatives from the local voluntary sector and local schools.

9. RECOMMENDATIONS

9.1 That the Board note the local implementation of the COVID Winter Grant Scheme.

Head of Early Help and Protection

Church Square House
30-40 High Street
Scunthorpe
North Lincolnshire
DN15 6NL

Author: Tom Hewis, Head of Early Help and Protection
Date: 27 November 2020

Background Papers used in the preparation of this report – COVID Winter Grant Scheme Guidance

HUMBER, COAST AND VALE HEALTH AND CARE PARTNERSHIP

Next steps to building a strong and effective integrated care system

Introduction

On the 24th November, a document published by NHS England and NHS Improvement (NHSEI) Integrating Care: Next Steps to Building Strong and Effective Integrated Care Systems across England set out guiding principles for the future of integrated care systems (ICSs) in England and outlined two proposals for how ICSs could be embedded in legislation by April 2022, subject to parliamentary decision.

The document proposes the future of ICSs being designed to serve a number of purposes:

- Improving population health
- Improving outcomes and addressing health inequalities
- Driving better quality and value
- Directly engaging the NHS with wider social and economic development
- Operating as an equal partner with local government and the voluntary and community sectors
- Co-producing strategies, plans and outcomes with patients, citizens and their representatives.

It also includes a number of practical policy changes which it suggests will be in place by April 2022, most notably:

- Place-based partnerships with focus on decisions taken closer to communities
- Provider collaboration (between partners usually at place) and provider collaboratives (usually providers from the same sector coming together)
- A change in emphasis for commissioning with a clearer focus on population health outcomes and strategic planning
- Putting ICSs on a statutory footing (two options proposed).

The proposals in the document are revolutionary for health and care in England and enable organisations within an ICS to work together to shape what is best for their health and care system.

What does this mean for Humber, Coast and Vale Health and Care Partnership?

Whilst the NHSEI document is seeking views on the proposals set out within it, much of the approach is already being developed or is in place in partnerships across England including in Humber, Coast and Vale and we need to build on that as we consider the detail and adjustments that need to be made to reflect the policy changes set out.

Across Humber, Coast and Vale, collaborative working between the NHS, local councils, the voluntary and community sector, other health and care and public sector organisations and our local communities has been evolving for many years, particularly at a local level. Our joint working has been underpinned by a shared belief that we are more successful in bringing about change and improving the lives of our local populations if we work together, we have created a vision for our population ***'in everything we do, we are helping local people to start well, live well and age well'*** and we have many successful examples of what we have achieved collaborating in new ways.

We have also already made commitments both in our Partnership Long Term Plan and in our more recent recovery plans to working together to improve the health of our population, address the health inequalities and provide better quality and value of care.

As a group of health and care partners we have also demonstrated our commitment to ***place,*** this will remain a main focus and strengthening local leadership, increasing integration and developing primary care in its broadest

sense, as both a foundation and as an equal partner in transforming services, will enable us to continue to improve the overall health and wellbeing of people living in our area.

We have also previously recognised that there will be aspects of our health and care system where it makes sense for us to collaborate at a larger scale. We have already established two strong ***partnerships*** across the Humber and in North Yorkshire and York. These arrangements are mindful of the potential changes to local government and allow for greater alignment and integration in the future between health, public health and social care. We have also established ***provider collaboratives*** between our acute, mental health and community service providers with the intention to empower each of the collaboratives to improve services for patients by working together to plan and to design and deliver specialist and other services that meet the needs of our population, where it makes sense to do so.

Therefore, building on what has been described above and in recognition of the direction, we are proposing that our future operating arrangements will continue to be developed around a single body across Humber, Coast and Vale, that will function through the two partnerships of Humber and North Yorkshire and York, supporting provider collaboration and delivery at place and the development of the Provider Collaboratives.

Next steps and how will we manage any change?

We recognise that these proposals have arrived at what is already an extremely challenging time for colleagues across all our partner organisations and wish to thank everyone for their continued efforts to go above and beyond in meeting the needs of our patients and keeping communities safe in the light of Covid-19. We will be mindful of this as we consider the next steps.

Over the next few weeks a collaborative partnership response to the proposals will be developed. Also, the leaders of each of our provider collaboratives, the Humber and North Yorkshire and York partnerships, chairs and members group and the clinical professional group with colleagues will be producing responses. Individual organisations may also wish to submit their own views. These will need to be submitted by 8th January 2021.

Across the Partnership the leaders have agreed to continue at pace, to define what the proposals in the document mean for all parts of our health and care system, so all colleagues can have greater clarity. They have also committed to managing any transition together as the changes will have implications for all parts of the system, however we acknowledge it will impact on some more than others and that any subsequent change process will cause individuals stress and worry. Therefore, we will use existing mechanisms to support the development and implementation.

The way forward will evolve and change as we gain greater clarity, we will endeavour to provide the detail and certainty for staff as quickly as possible. We will support the implementation with a management of change approach that ensures the staff affected, continue to be valued highly and where appropriate redeployed into meaningful and rewarding roles.

The change will be organised around a number of clear steps and we will continue to communicate with everyone but specifically with the areas and those staff who will be affected most. We will keep communication and engagement open as things progress through further through a variety of methods including staff briefings, written updates as well as virtual meetings.

A programme of support for staff will be developed and implemented as part of managing the change including understanding change and how to cope with change that is impacting on you.

With support from the Regional Director and working with the Regional Team and the other three ICSs in North East and Yorkshire we will continue to move forward with our thinking and aim to implement shadow arrangements from the 1st April 2021, with further work to be undertaken during 2021 as part of the transition period, prior to full implementation in April 2022.

Paper Title: Next Steps of Integrated Care Systems

Agenda item: 5 (Public session)

Report by: Amanda Pritchard, Chief Operating Officer, NHS England and NHS Improvement; Chief Executive, NHS Improvement

Paper type: For approval

Organisation Objective:

NHS Mandate from Government	☒	Statutory item	☐
NHS Long Term Plan	☒	Governance	☐
NHS People Plan	☐		

Action required:

The Boards are asked to:

- **Review** and **approve** the direction set out in the document *"Integrating care"* (Annex A).

Background

1. The development of Integrated Care Systems (ICSs) since 2018 has enabled NHS organisations, local councils, frontline professionals and others to join forces to plan and provide around residents' needs as locally as possible. They have improved health, developed better and more seamless services and ensured public resources are used where they can have the greatest impact.

2. The *NHS Long Term Plan* (2019) set out a widely supported routemap to tackle our greatest health challenges, with the development of ICSs integral to this ambition. This was further supported through practical guidance to ICSs in *Breaking Down Barriers to Better Health and Care (2019)* and *Designing ICSs in England* (2019).

3. In September 2019, NHSEI made a number of recommendations for an NHS Bill that included a firmer foundation for system working than the existing legislation (the National Health Service Act 2006 and the Health and Social Care Act 2012). These *recommendations to Government and Parliament for legislative change (2019)* 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 *Long Term Plan* ambitions.

Considerations

4. Annex A “Integrating care” builds on the **routemap 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.

5. 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.

6. It sets out ambition for how all parts of our health and care system can work differently, in particular:

   - 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;

7. It also describes options for giving ICSs a firmer footing in **legislation**, which sits 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.

8. The document **invites views** on these proposed options from all interested individuals and organisations.

9. Systems have a significant degree of variation in maturity and readiness to develop proposed ways of working. We will work with systems to ensure that they have arrangements in place so that as previously decided, ICSs are live by April 2021. We will set out a roadmap for this transition that gives assurance over system readiness for new functions as these become statutory.

10. 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 want to take an approach to these changes that is characterised by care for our people and no distraction from the ‘day job.’ 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.

Next steps

11. To finalise this document based on feedback from the Boards.

12. **To seek views on the updated proposals from interested individuals and organisations**. These views will help inform our future system design work and our recommendations to the that of government on the upcoming Health Bill.

13. To ensure that the proposals and requirements are captured and reflected in 2021/22 planning and technical guidance to the NHS.

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.

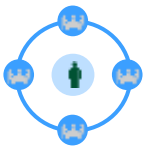
Devolution of functions and resources

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.

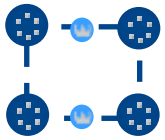
1.15. Our ambition is to create an **offer to the local population of each place**, to ensure that in that place everyone is able to:

- 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

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH