HEALTH AND WELLBEING BOARD

AGENDA

1 March 2021

at 11.00 a.m.

PLEASE NOTE: this will be a 'remote meeting', a public link to which will be available on the Hartlepool Borough Council website at least 24hrs before the meeting

MEMBERS: HEALTH AND WELLBEING BOARD

Prescribed Members:
Elected Members, Hartlepool Borough Council - Councillors Buchan, Thomas, Moore and Ward.
Representatives of NHS Tees Valley Clinical Commissioning Group
- Dr Timlin and David Gallagher
Director of Public Health, Hartlepool Borough Council – Craig Blundred
Director of Children's and Joint Commissioning Services, Hartlepool Borough Council - Sally Robinson
Director of Adult and Community Based Services, Hartlepool Borough Council - Jill Harrison
Representatives of Healthwatch - Margaret Wrenn and Vacancy

Other Members:
Managing Director, Hartlepool Borough Council – Denise McGuckin
Director of Neighbourhoods and Regulatory Services, Hartlepool Borough Council – Tony Hanson
Assistant Director of Joint Commissioning, Hartlepool Borough Council - Danielle Swainston
Representative of the NHS England - Dr Tim Butler
Representative of Hartlepool Voluntary and Community Sector - Tracy Woodall
Representative of Tees, Esk and Wear Valley NHS Trust - Dominic Gardner
Representative of North Tees and Hartlepool NHS Trust - Deepak Dwarakanath / Julie Gillon
Representative of Cleveland Police - Superintendent Sharon Cooney
Representative of GP Federation - Fiona Adamson
Representative of Headteachers – Sonya Black

Observer – Councillor Hall, Statutory Scrutiny Representative, Hartlepool Borough Council

1. APOLOGIES FOR ABSENCE

2. TO RECEIVE ANY DECLARATIONS OF INTEREST BY MEMBERS

3. MINUTES

3.1 To confirm the minutes of the meeting held on 7 December 2020.

3.2 To receive the minutes of the meeting of the Outbreak Control Engagement Working Group held on 10 November 2020 and 11 December 2020.

4. ITEMS FOR CONSIDERATION

4.1 Face the Public Event 2021 *(Director of Public Health)*

4.2 Covid-19 Updates

(i) Director of Public Health - *Presentation*
(ii) GP Federation – *Verbal Update*
(iii) NHS Tees Valley Clinical Commissioning Group – *attached*
(iv) North Tees and Hartlepool NHS Foundation Trust - *attached*

4.3 Ongoing Consultations

(i) 'Big Conversation' - *Tees, Esk and Wear Valley NHS Trust - Presentation*
(ii) ICS proposals - *NHS Tees Valley Clinical Commissioning Group – attached*

5. ANY OTHER BUSINESS WHICH THE CHAIR CONSIDERS URGENT

HEALTH AND WELLBEING BOARD

MINUTES AND DECISION RECORD

7 December 2020

The meeting commenced at 11.00 am and was an online remote meeting in compliance with the Council Procedure Rules Relating to the holding of Remote Meetings and the Local Authorities and Police and Crime Panels (Coronavirus) (Flexibility of Local Authority Police and Crime Panel Meetings) (England and Wales) Regulations 2020.

Present:

Councillor Moore, Leader of Council (In the Chair)

Prescribed Members:
Elected Members, Hartlepool Borough Council – Councillors Buchan, Thomas and Ward
Director of Public Health, Hartlepool Borough Council – Craig Blundred
Director of Children's and Joint Commissioning Services, Hartlepool Borough Council – Sally Robinson
Director of Adult and Community Based Services, Hartlepool Borough Council, Jill Harrison
Representatives of NHS Tees Valley CCG – Karen Hawkins and Jo Heaney
Representatives of Healthwatch – Christopher Akers-Belcher as substitute for Margaret Wrenn

Other Members:
Managing Director, Hartlepool Borough Council – Denise McGuckin
Director of Neighbourhoods and Regulatory Services, Hartlepool Borough Council – Tony Hanson
Assistant Director of Joint Commissioning, Hartlepool Borough Council – Danielle Swainston
Dr Tim Butler, NHS England
Representative of Cleveland Police – Chief Inspector Peter Graham as substitute for Superintendent Sharon Cooney
Representative of Tees, Esk and Wear Valley NHS Trust – Dominic Gardner
Representative of Hartlepool and Stockton Health GP Federation – Fiona Adamson
Representative of Headteachers – Sonya Black

Also in attendance:-
Nicola Childs, Commissioning Lead, Children and Young People, Tees Valley CCG
Darren Best, Teeswide Safeguarding Adults Board

Zoe Sherry**,** Healthwatch
Councillors Brenda Harrison, Sue Little, Amy Prince, Carl Richardson and Tony Richardson

Officers: Danielle Swainston, Assistant Director, Joint Commissioning
Neil Harrison, Head of Safeguarding and Specialist Services
Joan Stevens, Statutory Scrutiny Manager
Denise Wimpenny, Democratic Services Team

16. Chair's Opening Remarks

Prior to commencement of business the Chair welcomed Sonia Black who had recently been appointed as the Board's representative for Head Teacher's.

The Chair also referred to the recent appointment of Craig Blundred to the post of Director of Public Health at Hartlepool Borough Council.

17. Apologies for Absence

None.

18. Declarations of interest by Members

Councillor Thomas – as an employee of Health Watch and Mental health Champion.
Councillor Ward – as a holistic practitioner at Alice House Hospice.
Cllr C Richardson also declared an interest later in the meeting (Minute 23 refers)

19. Minutes

The minutes of the meeting held on 7 September 2020 were confirmed.

The minutes of the meeting of the Outbreak Control Engagement Working Group held on 5 October 2020 were received.

20. Teeswide Safeguarding Adults Board Annual Report 2019/20 *– Director of Adult and Community Based Services and Independent Chair of Teeswide Safeguarding Adults Board*

The Director of Adult and Community Based Services presented the Safeguarding Board's annual report for 2019/20, a copy of which was appended to the report. The Board was advised that Darren Best, who was in attendance at the meeting, had recently been appointed to the position of Independent Chair of the Teeswide Safeguarding Adults Board and had

replaced Ann Baxter following her recent retirement and would present future reports on behalf of the four local authorities.
The Board was advised that it was a legal requirement to produce and publish an Annual Report on the effectiveness of safeguarding arrangements in the local area. The report provided an assessment of work that had been undertaken during the year to achieve its objective and implement its strategy. Work undertaken across the services included raising awareness and developing the role of safeguarding champions, neglect, domestic homicide reviews as well as focus around domestic violence and substance misuse. The Independent Chair referred to salient issues included in the report and provided information in terms of his employment history, experience and background.

Board Members welcomed the new Independent Chair and took the opportunity to place on record their thanks to the former Chair, Ann Baxter, for her hard work and contributions for a number of years.

Reference was made to the impact of the current pandemic in terms of the reduction in the number of safeguarding alerts and the implications as a result. Emphasis was placed upon the importance of ensuring such alerts were closely monitored and identified as a priority going forward.

Decision

The Board noted and endorsed the 2019/20 Annual Report of the Teeswide Safeguarding Adults Board.

21. Mental Health – System Development and Response to Covid-19 Pandemic - Presentation *– Tees Esk and Wear Valleys NHS Foundation Trust*

The Board received a detailed and comprehensive presentation in relation to the system development and response to the Covid 19 pandemic. The presentation focussed on estimated additional demands for primary and secondary mental health services as a result of the pandemic, the impact on Hartlepool's children and young people and their experience of Covid, social determinants and impact of poverty on mental health, protective factors for mental health and wellbeing, work of the Hartlepool Mental Health Forum, the challenges around the increase in referrals as lockdown eased, mental health and wellbeing developments, children and young peoples' services, the importance of a commitment to emotional wellbeing, mental health and partnership working as well as successes and next steps.

The Board debated issues arising from the presentation including the importance of support for young carers, the benefits of exercise and the need for early intervention in terms of access to mental health support. Reference was made to the increase in the number of people who were previously not known to services pre-Covid and emphasis was placed upon the importance of voluntary and local authority services working together to

identify such individuals at the earliest opportunity to avoid greater levels of future provision.

Decision

That the contents of the presentation and comments of Board Members be noted.

22. Needs LED Neurodevelopmental Pathway for Children and Young People - *Director of Commissioning – Children and Young People – NHS Tees Valley*

The representative from NHS Tees Valley CCG provided an update on the implementation of the 'Needs Led Neurodevelopmental Pathway' for children and young people across Hartlepool and Stockton on Tees.

The report provided background information to partnership activity and actions undertaken to date. Whilst the pandemic had impacted on the ability to carry out ASD assessments as observations of the child in a number of settings was not possible due to restricted access, these observations were now back in place where education settings would allow access. Tees Valley CCG was also in the process of reviewing the Sunflower Sensory Programme to ensure it was meeting the needs of families, details of which were included in the report. The CCG, Local Authority and Parent Care Forum continued to work in partnership to promote the needs led approach with ongoing feedback being sought from parents. Statistical information was also provided in relation to the number of referrals and assessments.

In the discussion that followed, Board Members debated at length issues arising from the report. Clarification was provided in response to queries raised in relation to the positive feedback from parents, early intervention arrangements, progress to date in terms of integrating the ADHD diagnostic pathway into this system, changes in the family support team's working arrangements to meet the needs of families during the pandemic as well as examples of joint working on commissioning services. Board Members welcomed the report and, in particular, the positive changes to the assessment process and the support arrangements for families from the first point of contact to diagnosis, the benefits of which were outlined.

Decision

That the update and comments of Board Members be noted.

23. Covid 19 Update – Presentation *– Director of Public Health*

The Director of Public Health provided an updated presentation on the ongoing coronavirus position in Hartlepool as at 2nd December. The presentation focussed on the following:-

- Hartlepool and UK Covid 19 case rates per 100,000 population
- Weekly Covid cases as a comparator with the England average up to 27 November
- Covid cases rolling averages
- Hartlepool and England Covid 19 related death rates per 100,000 population
- Geographical locations of Covid cases in Hartlepool

In the discussion that followed, the Director of Public Health responded to issues raised arising from the presentation. Clarification was provided in relation to the proposed roll out arrangements of the Covid 19 vaccine in Hartlepool, the update of the flu-vaccine, the recently adopted referral process and support available for individuals suffering from long Covid.

At this point in the meeting Councillor C Richardson declared an interest referring to his mother's current residence in a care home.

In response to clarification sought on the proposed visiting arrangements in care homes, the Director of Public Health, representatives from the GP Federation and CCG updated Board Members in detail of their understanding of how the lateral flow tests for family members would be rolled out in care homes to enable visits to take place. It was highlighted that testing arrangements would be linked to visiting policies and tiers, the timescales of which were still uncertain.

Decision

The Board noted the contents of the presentation.

24. Date and Time of Next Meeting

It was reported that the next meeting would be held on 1 March 2021 at 11.00 am.

25. Chair's Concluding Remarks

The Chair took the opportunity to thank the Board for their contributions and to wish everyone a Merry Christmas and Happy New Year.

The meeting concluded at 13.10 pm.

CHAIR

HEALTH AND WELLBEING BOARD (OUTBREAK CONTROL ENGAGEMENT WORKING GROUP)

MEETING NOTES – 10 NOVEMBER 2020

The meeting commenced at 3.00 pm and was an online remote meeting in compliance with the Council Procedure Rules Relating to the holding of Remote Meetings and the Local Authorities and Police and Crime Panels (Coronavirus) (Flexibility of Local Authority Police and Crime Panel Meetings) (England and Wales) Regulations 2020.

Present:
Councillor Moore (Chair of the Health and Wellbeing Board) (Chair)
Councillor Thomas (Mental Health Champion)
Councillor Harrison (Children in Care Champion)
Denise McGuckin (Hartlepool Borough Council)
Michael Houghton (NHS Tees Valley Clinical Commissioning Group)
Rebecca Smith (substitute for Lesley Wharton (North Tees and Hartlepool NHS Trust)
Craig Blundred (Acting Director of Public Health, Hartlepool Borough Council)
T/Chief Insp Peter Graham (substitute for Sharon Cooney (Cleveland Police)
Jill Harrison (Hartlepool Borough Council)
Tony Hanson (Hartlepool Borough Council)
Ed Turner (Hartlepool Borough Council)
Julian Penton (VCS – Hartlepower)

Also in attendance:-
Dean Langstaff, Public Health Intelligence Analyst
Joan Stevens, Statutory Scrutiny Manager
Amanda Whitaker, Democratic Services Team

21. Apologies for Absence

Lesley Wharton, Supt Sharon Cooney and Christopher Akers-Belcher (due to technical issues)

22. Declarations of interest by Members

None

23. Minutes

The notes of the meeting held on 5th October 2020 were confirmed.

24. Coronavirus in Hartlepool – Data Update - Presentation (*Acting Director of Public Health*)

The Acting Director of Public Health and Public Health Intelligence Analyst provided a comprehensive presentation which updated the Working Group on the current outbreak situation in the Borough. Statistical data was provided in relation to the period up to 6th November with cases in Hartlepool significantly higher than the England average and continuing to rise.

Covid related death rates in Hartlepool and England, up to 16 October, were also higher than the England average. Details of covid cases by ward were also provided with the Hart ward/De Bruce ward border seeing a higher concentration of cases with no apparent key reasons identified.

Working Group members debated issues arising from the presentation and Officers provided further clarification in relation to the issues raised. The continued importance of preventative measures was highlighted. Members were updated on the covid situation in care homes and it was noted that weekly meetings were being held with care homes to share lessons which had been learnt. An elected member referred to the need for vigilance in schools and the need for schools to receive support was highlighted.

AGREED -

The presentation was noted.

25. Coronavirus - Local and National Restrictions – Verbal Update

The Working Group received an update from the Managing Director on the background and introduction of local and national restrictions. The Leader of the Council/Chair of the Working Group referred to the role of members of the Working Group and requested all to play a collective part in reducing the number of covid cases in the town during this period of 'lockdown'. Members reiterated that vigilance should continue and the Managing Director informed the Working Group that the Authority was working with North Tees and Hartlepool Trust so that health colleagues could work with the Authority to ensure key messages were communicated appropriately to the community.

AGREED -

The update was noted.

26. Covid-19 Community Champions Update (*Acting Director of Public Health*)

The Working Group was updated, by the Acting Director of Public Health, on the current situation in relation to covid community champions. A formal proposal was being collated and an update would be submitted to the next meeting of this working group. In response to clarification sought from an elected member, the Group was advised that Officers were not yet at the stage of identifying community champions.

AGREED –

The update was noted.

Any Other Business

The Mental Health Champion requested an update from the Director of Adults and Community Based Services in relation to the trend in terms of mental health issues during this 2nd 'lockdown' period. The Director advised that an update would be presented at the next meeting of the Health and Wellbeing Board and a report would be submitted to a future meeting of this Working Group in relation to mental health activity through the Authority's support hub.

Meeting concluded at 3.50 p.m.

CHAIR

HEALTH AND WELLBEING BOARD (OUTBREAK CONTROL ENGAGEMENT WORKING GROUP)

MEETING NOTES

11 DECEMBER 2020

The meeting commenced at 1.00 pm and was an online remote meeting in compliance with the Council Procedure Rules Relating to the holding of Remote Meetings and the Local Authorities and Police and Crime Panels (Coronavirus) (Flexibility of Local Authority Police and Crime Panel Meetings) (England and Wales) Regulations 2020.

Present:

Councillor Moore (Chair of the Health and Wellbeing Board) (Chair)
Councillor Thomas (Mental Health Champion)
Councillor Harrison (Children in Care Champion)
Craig Blundred (Director of Public Health, Hartlepool Borough Council)
Sally Robinson (Hartlepool Borough Council)
Tony Hanson (Hartlepool Borough Council)
Christopher Akers-Belcher (Healthwatch)
Julian Penton (VCS – Hartlepower)

Also in attendance:-

Peter Graham (Cleveland Police) (as substitute for Sharon Cooney)
Gemma Ptak (Hartlepool Borough Council) (as substitute for Jill Harrison)
Councillor Tony Richardson

Officers: David Cosgrove and Jo Stubbs, Democratic Services Team

28. Apologies for Absence

Denise McGuckin (Hartlepool Borough Council)
Lesley Wharton (North Tees and Hartlepool NHS Trust)
Sharon Cooney (Cleveland Police)
Jill Harrison (Hartlepool Borough Council)
Ed Turner (Hartlepool Borough Council)

29. Declarations of interest by Members

None.

30. Notes of the Meeting held on 20 November 2020

Confirmed.

31. Coronavirus in Hartlepool - Data Update - Presentation

(*Director of Public Health*)

The Director of Public Health updated the Working Group on the numbers of Covid-19 cases across the Borough. The Director commented that it was hoped the numbers of cases would drop below 200 per 100,000 in the next few days. However, this was still the highest rate in the North East and the 30th highest in the country. Hartlepool's numbers were still tracking higher that the England average.

There was no indication of whether the falling numbers would lead to a move from Tier 3 to Tier 2; it was understood that government would be looking at statistics around over 60's infection rates and the number of hospitalisations but no guidance had been given. The Director considered a move to Tier 2 before Christmas unlikely.

Heat maps showing the areas with the greatest numbers of cases and those with the greatest uptake of testing where shown and the Director commented that the disparity between the two maps was an issue that needed some work to promote testing in those areas with the highest numbers of confirmed cases.

Looking forward the Director highlighted the falling numbers but was concerned at the household mixing that was to be allowed at Christmas. The public would need to be reminded about distancing. The vaccine may be on the way but this was still going to be a long haul and people must still be on their guard against the virus.

The Chair commented that the Tees Valley Leaders and Mayors had pushed for the Tees Valley to be considered on its own in a discussion with the Minister recently as local people had heeded the messages and infection rates were falling.

The Healthwatch representative indicated that Healthwatch was available to support the Council and health colleagues in getting the messages out into the community, particularly those hard to reach sections of the community and those without social media/internet links.

There was a general view among those present that the governments relaxation of the restrictions over the five days of Christmas was ill-advised and the messages to the public needed to be consistent and clear. Reference was made to a letter being circulated by schools to parents which ahd been drafted by the Director of Public Health and the Director of Children's and Joint Commissioning Services.

An update at the next meeting was requested on the roll-out of the vaccination programme.

Decision

That the presentation be noted.

32. Covid-19 Community Champions - Presentation (*Director of Adult and Community Based Services*)

The Assistant Director, Preventative and Community Based Services gave a presentation on the ongoing work for the roll-out of the Community COVID Champions programme, the development of the training programme and the work with Hartlepower and local VCS organisations.

The existing Street Ambassadors scheme had been working well with the ambassadors focussed around the shopping centre and local schools. There had been 774 contacts with local people. It was commented that the street ambassadors needed to adhere to the same guidance on social distancing and wearing masks if they were to send the right messages to people.

There was comment on the track and trace system and its effectiveness particularly in the take up in shops and bars in the town. The Director of Neighbourhoods and Regulatory Services indicated that significant work was being undertaken with local businesses and action had been taken with those that were not complying with the regulations.

The Healthwatch representative stated that Healthwatch would assist in anyway it could with the recruitment of Community Champions; it already had a network of volunteers keen to help in any way they could.

Decision

That the presentation be noted and circulated to the Working Group.

33. Support Hub and support for the CEV Population – Update (*Director of Adult and Community Based Services*)

The Assistant Director, Preventative and Community Based Services updated the Working Group on the work of the Hartlepool Support Hub and the offer to those who were now defined as Clinically Extremely Vulnerable (CEV).

The Working Group was very positive around the work of the hub and its impact on the local community particularly those considered most vulnerable. A Member made reference was made to the recent news reports that future scheduled surgery appointments could be delayed for 2 to 3 years and asked if any such anxieties around delayed appointments was being reported. The

Assistant Director outlined the work around Active Hospitals which Hartlepool was now involved in a pilot with North Tees Hospital and the work with the GP Referral scheme into sport and recreation. The work in this regard with the local VCS community was also welcomed. An update at a future meeting was requested.

Decision

That the report be noted and an update provided to a future meeting.

34. Any Other Items which the Chairman Considers are Urgent

The Chair thanked all groups involved for their work during the pandemic. Particular thanks was extended to the Support Hub staff that had made such a significant difference to the local community. The Director of Public Health reinforced the advice around Hands-Face-Space particularly during the Christmas season where the message from all partners to the public needed to be that people must stay on their guard. Small sacrifices now would provide huge payback later.

The Director of Public Health reported that during the meeting the government had announced a reduction in the self-isolation period from 14 days down to 10 days.

The Chair extended season's greetings to all the working group members.

Meeting concluded at 2.10 pm.

CHAIR

HEALTH AND WELLBEING BOARD

1st March 2020

Report of: Director of Public Health

Subject: FACE THE PUBLIC EVENT 2021

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1. PURPOSE OF REPORT

1.1 To present to the Board initial proposals for the Health and Wellbeing Board's Face the Public event in 2021.

2. BACKGROUND

2.1 Part 2 (Article 10) of Hartlepool Borough Council's Constitution requires that the Safer Hartlepool Partnership, and the Health and Wellbeing Board, hold a Face the Public Event each year. The event to provide an opportunity for the Board to:

(i) Update on work during the last year;
(ii) Inform residents and Elected Members of future plans and challenges;
(iii) Consult / engage on the development of key partner strategies and plans for the Borough; and
(iv) Receive questions on their work, future plans and priorities.

3. FACE THE PUBLIC EVENT 2021

3.1 In accordance with the requirements of the Constitution, Face the Public events have been held annually since the establishment of the Health and Wellbeing Board in 2013. The exception to this being 2020, which saw the unavoidable cancellation of the 16th March 2020 event following the outbreak of the Covid-19 pandemic.

3.2 Whilst the response to the pandemic is still ongoing, and restrictions remain in place, consideration needs to be given to potential arrangements for the 2021 Face the Public. With this in mind, the Board is asked to approve initial proposals for a Face the Public Event, the timetable and structure of which will:

- Meet the requirements of the Council's Constitution;
- Accommodate the local authority election and purdah period; and
- Respond to the fluid nature of the pandemic and unknown timescale for movement in to the recovery phase of activity.

3.3 To this end, it is proposed that the 2021 Health and Wellbeing Board Face the Public Event be:

i) Held in September 2021; and

ii) Conducted remotely with the potential to incorporate socially distanced activities (should the Covid position change).

3.4 In terms of the proposed structure / purpose of the event, the re-examination of the JHWS priorities, undertaken in 2019, resulted in approval by the Health and Wellbeing Board on the 9th March 2020 of the following priority areas:-

i) Impact of violence (Inc. domestic violence) and drugs and alcohol;
ii) Maintenance of a universal offer for the whole population; and
iii) Development of a targeted 'place based' approach, widening the work being undertaken by the Council's Children's Services Department around 85 streets in the Victoria Ward.

3.5 Progression of the identified priorities, and development of the 'place based' approach, had been intended for 2020/21, however, this has been interrupted by the Covid-19 pandemic. The Face the Public Event provides an opportunity to restart the process for the implementation of the priorities, whilst also fulfilling the requirements of Hartlepool's Constitution.

4. RISK IMPLICATIONS

4.1 None.

5. FINANCIAL CONSIDERATIONS

5.1 None

6. LEGAL CONSIDERATIONS

6.1 None

7. CHILD AND FAMILY POVERTY

7.1 None

8. EQUALITY AND DIVERSITY CONSIDERATIONS

8.1 None.

9. STAFF CONSIDERATIONS

9.1 None.

10. ASSET MANAGEMENT CONSIDERATIONS

10.1 None.

11. RECOMMENDATIONS

11.1 That the Health and Wellbeing Board approves:

i) Initial arrangements for the 2021 Face the Public Event, as outlined in Sections 3.3 and 3.4 above.

ii) Delegation of approval of finalised arrangements for the event to the Director of Public Health in conjunction with the Chair of the Health and Wellbeing Board.

12. REASONS FOR RECOMMENDATIONS

12.1 To progress arrangements for the 2021 Health and Wellbeing Board Face the Public event.

13. BACKGROUND PAPERS

- Report and Minutes of the Health and Wellbeing Board - 9 March 2020
- Joint Health and Wellbeing Strategy 2018-25 (https://www.hartlepool.gov.uk/downloads/download/817/joint_health_and_wellbeing_strategy_2018-25)

14. CONTACT OFFICER

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NHS
Tees Valley
Clinical Commissioning Group

CCG's COVID-19 response and learning from Waves 1 and 2

1. Introduction

This report draws together some key messages as we reflect on our actions and learning during Phases 1 and 2 so we can continue to move forward and address the challenges to our local health and care system.

Phase 1 saw the NHS operating under a 'command and control' arrangement in order that immediate and co-ordinated actions were implemented urgently across the country in an attempt to slow the spread of the outbreak and free up as much NHS resource as possible so that we could prepare for, and respond to, the anticipated increase in patients requiring respiratory and critical care.

Covering a 3-month period (May 2020-July 2020), phase 2 focussed on the planning for the gradual reopening of the NHS following the suspension or reduction of services during phase 1 to release capacity for the critical care of COVID-19 patients. The purpose was to start to safely 'switch back on' critical non-COVID services and lock in the innovations that had happened as a consequence of the response to the crisis and to also restart some routine services.

The far-reaching impact of the pandemic has brought much grief, sorrow and worry to our population. As a CCG we continue to work closely with partners so that we do all we can to learn from the challenges posed and develop a stronger system that can not only recover from the Pandemic, but can learn and innovate for the benefit of those we serve.

2. Establishing our response framework

a. Legal framework

By way of background, the declaration of an NHS Level 4 national incident on 30 January 2020 marked an unprecedented time for the NHS as we responded to the COVID-19 Outbreak (subsequently declared as a pandemic on 11 March 2020 by the World Health Organisation). This was swiftly followed by the initiation of a 'command and control' arrangement in the early part of 2020, meaning that there were some changes to our operating framework to allow for the required far-reaching repurposing of NHS services, staffing and capacity.

This meant that under the Civil Contingencies Act 2004, NHS England would be responsible for co-ordinating the NHS response in collaboration with local commissioners, such as

ourselves, at a tactical level. NHS England has an Emergency Preparedness, Resilience and Response Framework (EPRR) in place to support their duties under the Act.

This resulted in:

- The CCG being under a duty to cooperate with NHS England in respect of NHS England's plans for reducing and/or mitigating the effects of the Covid pandemic;
- NHS England has the legal power to take such steps as it considers appropriate for facilitating a co-ordinated response to the pandemic by CCGs and relevant service providers;
- The Secretary of State directing NHS England to exercise CCGs' commissioning functions until 31st December 2020 for the purposes of directly or indirectly supporting the provision of services to address the pandemic, and
- NHS England National Command and Control will determine priorities for allocating available resources during a level 4 incident.

The Civil Contingencies Act 2004 specifies that responders to a national incident will be either Category 1 (primary responders) or Category 2 responders (supporting agencies). Category 1 responders are those organisations at the core of emergency response and are subject to the full set of civil protection duties. For health, Category 1 responders are:

- Department of Health on behalf of the Secretary of State
- NHS England
- Acute service providers
- Ambulance service providers
- Public Health England
- Local Authorities

The Act requires Category 1 responders to, amongst other things, maintain plans for the purpose of ensuring that if an emergency occurs or is likely to occur, they are able to perform their functions so far as necessary or desirable for the purpose of:

i. preventing the emergency;
ii. reducing, controlling or mitigating its effects, or
iii. taking other action in connection with it.

CCGs are Category 2 responders for health and, as such, they are expected to provide support to NHS England in relation to the co-ordination of their local health economy and co-operate with Category 1 responders in connection with the performance of those responders.

This work is brought together under the umbrella of Local Resilience Forums (LRF), which are multi-agency partnerships made up of representatives from category 1 and category 2 responders. Together, they work to identify potential risks and produce emergency plans to either prevent or mitigate the impact of any incident on their local communities. The CCG is a member of both the Cleveland LRF and the Durham and Darlington LRF.

In addition, the NHS Act 2006 allows for NHS England to take such steps as it considers appropriate for facilitating a co-ordinated response to an emergency by CCGs and relevant service providers. It also provides for the Secretary of State to make directions if they consider that by reason of an emergency it is appropriate to do so. Pursuant to this power,

the Exercise of Commissioning Functions by the National Health Service Commissioning Board (Coronavirus) Directions 2020 came into effect on 20 March 2020.

A further factor was the suspension of the usual operational planning process and implementation of a revised financial regime. As normal financial arrangements were suspended, no new revenue business investments could be entered into unless related to Covid-19 or unless approved by NHSE/I as consistent with a previously agreed plan. Provisions were made by NHSE/I for the reimbursement of costs incurred in responding to the outbreak.

On 19 June 2020 the Chief Medical Officer and the Government's Joint Biosecurity Centre downgraded the UK's overall Covid alert level, signifying that the virus remains in general circulation with localised outbreaks likely to occur. The NHS EPRR incident level moved from Level 4 (national) to Level 3 (regional) on 1 August 2020.

b. CCG Governance processes

As the situation concerning the pandemic and the related national guidance changed rapidly, it was necessary for the CCG to be able to adapt and respond appropriately and effectively. The CCG has a range of options available to it to ensure that it is able to take urgent decisions. This includes the general power outlined within the Constitution and Standing Orders for the use of emergency powers and urgent decisions. In addition, the Governing Body confirmed its agreement that urgent actions could be taken by the Accountable Officer and the members of the Director team and that these would be reported into relevant committees as appropriate.

In practice, the majority of the urgent decisions needing to be taken by the CCG related to the primary care agenda and all such decisions have been subsequently reported into the Primary Care Commissioning Committee, with a summary report also submitted to the Audit & Assurance Committee. Changes in the way our secondary care providers needed to operate (for example, cancellation of non-urgent operations) have been reported through our usual reporting mechanisms.

There was also agreement that some areas of routine local reporting would be postponed, so that priority could be given to those areas requiring urgent discussion or sharing. As pressures on agendas reduced, this reporting has been gradually reintroduced.

The CCG has been able to continue the operation of the Governing Body and Committee structure through the use of virtual technology. To ensure continued transparency, the use of virtual technology had been extended to allow members of the public to join the 'in-public' Governing Body and Primary Care Commissioning Committee meetings from July 2020. We recognise that this can lead to 'digital exclusion' and we aim to reintroduce physical meetings when it is safe to do so.

In response to the revised financial regime and reclaiming of COVID-related costs, our stringent financial governance arrangements continue to be in place to support this.

c. Internal co-ordination and revised working arrangements

To ensure rapid communication routes, business continuity mitigations and internal resilience, we implemented:

- Director on-call rota, 7 days a week, to ensure urgent actions or communications were addressed quickly and efficiently.
- Named directors were identified for:
    - Lead director for the pandemic at an ICP Level.
    - Lead director/SRO for CCG response
    - Lead director for the management of the Programme Management Office (PMO), including staff deployment.
- Involvement in the North East and Cumbria Deployment Hub (co-ordinated by the North of England Commissioning Support Unit), supporting further staff deployment across all organisations.
- The established PMO took on the role of understanding the capacity available across the CCG's staffing base in order to ensure that 'business as usual' and the delivery of our statutory duties was maintained as well as being able to respond to specific issues (such as delivering personal protective equipment or equipment to Practices and co-ordinating Sitreps to feed into the regional HR deployment hub managed by the Commissioning Support Unit).
- Daily (and then twice-weekly) virtual meetings between the Chief Officer and Directors to ensure system and local pressures were understood and shared; co-ordinating the allocation of leads for specific areas (eg. testing, PPE etc) and providing director oversight of the wellbeing of CCG staff.
- Financial regime implemented to support primary care and secondary care while ensuring we continued to adhere to the duties set out in Managing Public Money and other related financial guidance.
- Financial, performance and quality reporting into the Governing Body and its Committees was adjusted to reflect the revised operating environment.

The safety and resilience of our staff was a crucial consideration; and the following safeguards were put in place:

- The CCG's Business Continuity Plan was refreshed, including updating contact numbers and promoting the use of the CCG staff WhatsApp group.
- All staff were provided with equipment and virtual technology (MSTeams) to aid home working and the CCG offices were closed.
- All non-essential meetings were stood down.
- Individual agile working risk assessments were carried out for all staff and wellbeing conversations incorporated as part of 1-1 meetings and team meetings. Staff wellbeing resources continue to be promoted and shared.
- Recognising that not all staff were able to work effectively from home, the office was risk assessed in line with Government guidance and confirmed as being compliant with all measures. A booking system was introduced to ensure that minimal numbers of staff were on-site at any one time and to allow for effective tracking of contacts should a member of staff test positive.

These arrangements helped us to co-ordinate our efforts and focus on key priorities, thus also allowing us to provide support across the wider system.

3. Stronger together – working as a system

Throughout the response, we have worked closely with partners across the system to identify and overcome challenges. Close partnership working has been one of the positive by-products of the pandemic, with frequent joint working between all parts of our local

system. This has helped the development of many positive innovations in the delivery of patient care and the changes in the way health and care services worked together.

As the pandemic continued to spread; so did the knowledge and learning, and as a consequence, we needed to be agile in our response to changing guidance and this was an underlying theme across all areas. Some specific examples of how we have supported the system response include:

a. Senior system leadership

The Chief Officer and the director team have attended the Local Resilience Forum (LRF) meetings at a tactical and strategic level for both Cleveland and County Durham and Darlington; specific regional and national workstream groups and calls relating to, for example, testing, PPE etc. In addition, Chief Executives across the ICS have held calls on a weekly (or twice-weekly) basis since March. This approach has helped with problem solving, communications and implementation and, although time consuming, has harnessed a strengthened way of working. As part of this, the CCG has participated in at least weekly Health Co-ordinating Group virtual meetings chaired by the ICS Executive Lead, including CCG chairs in later months.

At an ICP level the CCG has co-ordinated and chaired the ICP Covid19 group, consisting of NHS provider partners from all sectors and local authority directors. This escalates issues to the ICS-wide meeting and into the LRFs where necessary.

Given the scale of the challenges we all face, we will continue to partner with local authorities and LRFs in providing mutual aid with our colleagues in social care, including care homes.

We are continuing to work across the ICP and ICS to agree collaborative leadership arrangements that support joint working and quick, effective decision making which is in the best interest of our populations, based on co-production, engagement and evidence.

b. Primary Care

The primary care response to COVID-19 has been significant and swift as new ways of working were required from primary care in order to most effectively meet the needs of patients requiring either urgent care or essential routine care. This has been done in line with national guidance and the NHS England 'Guidance and Standard Operating Procedures (SOP): General practice in the context of Coronavirus (COVID-19)' and related updates, although the fast-changing nature of the Guidance did result in some confusion, we have worked closely with colleagues to overcome this.

The CCG supported member practices in implementing a number of changes to deliver a comprehensive COVID-19 response that was in line with the national SOP, referred to above, and was safe for patients and staff.

- In line with national guidance, all practices across the Tees Valley moved to full telephone triage, however seeing patients in a face-to-face consultation where deemed clinically essential. This was achieved through segregating COVID-19 symptomatic and non-symptomatic patients within their own practice.

- Arrangements for every locality to have a designated site, in hours and at weekends, where COVID-19 symptomatic patients could receive face-to-face consultation, where considered essential following remote triage (Hot Clinics); enabling patients without symptoms to be seen at their own GP practice (Cold Clinics).
- Supported with the roll-out of digital equipment to facilitate remote working, which helped ensure all practices were able carry out remote triage and to access telephone, online and video consultations.
- Developed a workforce sitrep for practices to enable them (and the CCG) to understand the pressures at their Primary Care Network level and offer/receive mutual-aid if required.
- Temporary change to the 'GP Extended Access' services to ensure that during the pandemic, these services were adapted to meet the needs of patients and to offer additional support to GP Practices. Bank Holiday working was arranged where required.
- Developed and implemented processes to enable urgent decision-making for delegated functions, (eg branch closure requests, list closures, etc).
- Temporary suspension of the Local Incentive Scheme (LIS) for Q1 of 2020.
- Implemented a daily Primary Care Bulletin to keep practices updated of national and local guidance and support.
- Established a WhatsApp group in each locality for ease and speed of contact.
- Financial support relating to COVID-related expenses on the basis that this would be reconciled against any nationally directed payments.

A key development was the CCG's success in becoming a national pilot site to implement a COVID-19 virtual 'ward', now known nationally as *'Covid oximetry @ home'*; where patients who were COVID-positive or had symptoms of COVID-19 and not yet tested, would be admitted to the "ward" for up to 14 days and be monitored remotely using pulse oximetry.

The three GP Federations agreed to work collaboratively as an alliance to deliver the remote monitoring service, supported by the use of digital technology. Across the Tees Valley we worked with secondary care, NHSE/I and NHS Digital to develop an integrated service that participated in robust evaluation of the pilot, prior to national service roll out.

The *'Covid oximetry @ home'* was rolled out across the country in primary care from November 2020.

From the pilot it was found that the *'Covid oximetry @ home'* service had the following system benefits:

- Provides patient reassurance and safety
- Offers good clinical care and safety netting
- Provides appropriate escalation and admission pathways
- Enables clinicians to focus on the patients most in need of input whilst providing appropriate surveillance of the at risk cohort
- Provides a means to reduce length of stay with earlier identification of deterioration so better recovery and better outcomes
- Supports patients on discharge from hospital
- Supports patients to manage pressure on Emergency Departments, primary care and secondary care

c. Infection Prevention and Control (IPC) Guidance and support to Care Homes

Within the care homes in Darlington the current IPC service is provided through the existing IPC service from County Durham CCG; in Hartlepool and Stockton localities this is provided through a dedicated Infection Prevention and Control Nurse (IPCN) hosted by North Tees and Hartlepool NHS Foundation Trust (NTHFT) and within Middlesbrough and Redcar & Cleveland locality care homes through a dedicated IPCN hosted by South Tees Hospitals NHS Foundations Trust (STHFT). Due to the past Critical Care experience of the STHFT IPCN, the post holder was repatriated to support the hospital activity. To support this temporary move and continue an IPC service, the Tees Valley CCG Quality and Safeguarding Team made some interim changes to their structure.

Specialist support and advice - guidance on best practice, policy compliance

Specialist support and advice, together with guidance on best practice and policy compliance was provided within the context of evolving national guidance. This also included supporting the Local Authority, Primary Care, North of England Commissioning Support Unit and CCG colleagues. Frequently asked clinical questions included queries on the restrictions of visitors to care homes, recognising correct use of personal protective equipment (PPE) which dominated a number of the initial weeks due to supply constraints and interpretation of the PHE guidance, care and management of residents with Covid-19 symptoms, appropriate discharge from hospital and isolation management.

Training and education

We were able to provide training and education through a variety of resources and delivery platforms that included on-site, virtual or tele-conference to ensure continuity of previous (pre-Covid-19) education, training and support.

Nationally it became evident in early April that care homes were beginning to experience rapidly increasing number of Covid-19 infections and, sadly, an increase in the number of residents' deaths - although not in every care home. This led to a national directive from Ruth May, NHS England Chief Nurse for England, on 30th April 2020, to all Clinical Commissioning Groups to offer a bespoke training session into all Care Quality Commissioned registered care homes within their localities.

This involved each CCG identifying at least one member of staff to complete the national "Super Training", a virtual, practical session. Two Tees Valley CCG staff completed their super training and were then responsible for training a number of trainers to deliver the national training material (refresher on hand hygiene and the donning and doffing of PPE). These are both critical in ensuring staff are minimising the risk of infection transmission.

In terms of coverage, of the 206 care homes in the CCG's geographical remit, 97 had accessed virtual training, 106 had accessed face to face training and only three had declined the offer (these 3 were part of larger care home groups who had provided alternative training directly).

In addition, there have also been six bespoke sessions for Local Authority staff who visit care homes, two sessions for Domiciliary Care providers and one for the Continuing Health Care Team.

These interventions will have undoubtedly improved IPC practices and led to the reduction in Covid-19 and other infection transmission and consequently prevented the infection of residents, staff and the wider population.

d. Emergency Personal Protective Equipment (PPE)

The national supply chain challenges and availability of PPE was widely reported in the press and many industries and public sector offered support to help produce PPE to support the NHS. Although primary and social care providers (including primary care, adult social care, dentists, pharmacies, third sector, adult care homes and hospices) were required to continue to order PPE from their wholesalers, there was a need to support this with the provision of an emergency PPE 'service', which included the establishment of an emergency PPE hub. Daily discussions were in place across the ICS to support the system and co-ordinate the sourcing of products. Local and regional peer networks were established to support with advice and guidance.

The CCG played an important role in this, ensuring that strategic and operational leads were in place together with identified members of staff to support the sourcing, receipt, checking, storage, packaging and, along with members of Cleveland Fire Brigade, the distribution of PPE. Close working with CCG IPC colleagues ensured appropriate quality reviews and clinical advice was available. This was a challenging agenda to co-ordinate and manage; however there were no instances of us fully exhausting our PPE supply.

The team also worked closely with colleagues in continuing healthcare to ensure the provision of PPE to this vulnerable cohort.

e. Quality Surveillance

The National Quality Board Executive Quality Group had shared principles for the monitoring of quality during the pandemic period, which includes regional decisions on levels of quality surveillance in place, including those under the auspices of improvement boards and risk summits.

During the pandemic, quality and safety functions need to be delivered in a proportionate manner that supports the focus on the response to COVID-19 while, at the same time, ensures the oversight of quality is maintained.

The CCG has worked closely with providers to use existing internal monitoring methods and a shared approach to data flows.

During this period, we also revised our approach to the function of the CCG's committee and formed a new Quality Committee that includes membership from provider Trusts across our ICP. The first meeting was held on 3 November and provided an excellent springboard for us to further strengthen this more collaborative approach.

f. Working with providers on the implementation of NHSE's requirements

Some of the key response milestones during phases 1 and 2 included:

- Some clinical CCG staff deployed to work into clinical roles (in secondary or primary care as appropriate)
- Implementation of discharge from hospital guidance
- Responding to the instructions from NHSE on prioritisation of acute and community services during the pandemic
- Non-urgent elective operations cancelled
- Close working with Local Authority to discharge medically fit patients
- Block purchase of additional beds to support discharges
- Implementation of telephone triage, video consultations and face to face appointments based on clinical need
- Planning for stepping back up services.

The following gives a flavour of some of the areas of learning across our providers:

General

The importance of establishing an operational and tactical response framework at an early stage was recognised by providers so that the high volume of activity required and requests received are co-ordinated and addressed quickly and effectively. The involvement of staff across disciplines (including: community services, clinical, pathology, IT, estates & facilities, administrative staff) is crucial. This has strengthened the understanding that all staff have a huge contribution to make in planning and decision making.

Workforce Flexibility

A plan to review the medical and nursing workforce particularly in respect of respiratory, acute medical and chronic healthcare provision within the community in preparation for the anticipated resurgence of COVID activity and an emerging cohort of COVID survivors with associated medical needs.

Critical care workforce plan to be reviewed to consider a register of designated critical care staff who have maintained their training.

The introduction of a '*Consultant Passport'* to allow consultant staff to work between Foundation Trust sites worked well and this is being further explored to allow more flexible workforce planning in future.

Rapid Hospital Discharge

Providers and social care working together to review and build on redesigned processes and protocols to facilitate discharge across the Tees Valley in a safe way.

g. Children and adult safeguarding

The pressures of the pandemic and associated 'lockdown' added to the potential for increased safeguarding concerns and this was exacerbated by the reduced footfall through provider services (eg. health, education and social care) meaning that less face-to-face contact with vulnerable adults or children could hide instances of harm. Sadly, there was

also an increase in nationally reported cases of domestic abuse. In terms of Looked After Children, there were additional complications regarding foster carers who needed to self-isolate.

To address this, the portfolios within the CCG's quality and safeguarding team were reconfigured so that essential work was prioritised. Key actions included:

- Lists of vulnerable children identified within local authorities – monitoring of children via school (face-to-face or telephone contacts for children not in school).
- Looked After Children requiring an Initial Health Assessment were assessed by clinical need and seen face-to-face with appropriate PPE if needed.
- Telephone contacts with vulnerable adults or those that were shielding were arranged via NHS/Local Authority partners.
- Designated Nurses maintained regular contact with acute providers and local authorities to address local issues and to share learning.
- The Cumbria and North East Designated Forum collated local intelligence in order to share learning and inform services.

h. **Children and Young People's Services and SEND**

To ensure that we were able to fulfil our statutory responsibilities in line with the revised operating framework, we worked closely with Trust colleagues and Designated Clinical Officers to ensure appropriate sharing of information so that we could continue to support vulnerable children and young people during the pandemic.

Again, the use of technology was harnessed and, working with providers, Zoom sessions were introduced with parent carer forums and excellent feedback has been received on this approach.

4. Phase 3

This report focusses on the lessons learned from Phases 1 and 2 – which helped us plan and respond to the requirements of Phase 3 shown below.

Phase 3 priorities:

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

i. Restoring full operation of all cancer services.
ii. Recovering the maximum elective activity possible in the run-up to winter, making full use of the NHS capacity available, as well as re-contracted independent hospitals.
iii. Restoring service delivery in primary care and community services.
iv. Expanding and improving mental health services and services for people with learning disability and/or autism.

b. **Preparing for winter demand pressures, alongside continuing vigilance in the light of further probable Covid spikes**.

i. Continuing to follow good Covid-related practice to enable patients to access services safely and protect staff, whilst also preparing for localised Covid outbreaks or a wider national wave.
ii. Preparing for winter.

c. Undertaking the above in a way that took 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.

Through our local group, whose membership includes local Foundation Trusts, the Local Medical Council, GP Federations, NHSE / I, Directors of Public Health and Directors of Adult Services, we have been coordinating the Tees Valley response to Sir Simon Stevens' Covid19 Phase 3 Planning letter to ensure the restoration and resetting of local health and social care services. The sharing and partnership working in this group is an encouraging sign for the future, where a focus on people, places and systems, rather than individual organisations is both encouraged and necessary.

5. Conclusion and next steps

This summary paper belies the amount of work and dedication shown by the CCG and all our partner organisations in dealing with system pressures on a scale never previously experienced. We must not forget that our staff are fatigued from the previous phases and are also supporting their families and friends cope with the daily challenges this pandemic has brought. We must ensure that we do all we can to work together to lessen the load wherever we can so that we can continue to support our population's health.

The system has responded remarkably well and has learned lessons along the way, which are invaluable as we continue to tackle the current phase of the pandemic.

Key priorities for the CCG and the Tees Valley ICP at the time of writing include:

- Continuing to respond to Covid-19 demand
- Progressing the Covid-19 vaccination programme
- Maximising capacity in all settings to treat non-Covid-19 patients
- Responding to other emergency demand and managing winter pressures
- Supporting the health and wellbeing of our workforce

David Gallagher

Chief Officer

25 January 2021

North Tees and Hartlepool NHS Foundation Trust

Covid Pandemic– The story so far

Hartlepool Health and Wellbeing Board

1. Introduction

As with all health and social care providers, North Tees and Hartlepool Foundation Trust has met multiple challenges during the current Covid-19 pandemic, some of which have brought with them many clinical and operational unknowns.

The impact of the continuous Covid pressures across the Trust cannot be underestimated, resulting in significant operational issues during the both Wave 1 and Wave 2/3, peaking at the highest levels during December, January and still on going.

Wave 1 and wave 2 have both brought significant pressures, however the second wave of Covid has resulted in a much higher level of admissions.

The Trust has seen some of the highest levels of Covid admissions within the region since the start of the second wave in September, with between 100 and 200 plus beds occupied daily by Covid patients from the 1st October to date, peaking at 216 in January. The high number of admissions has mirrored the community infection rates in Hartlepool and Stockton which have often been higher than national and regional rates during the pandemic.

During January, the higher acuity of the Covid patients admitted has seen Critical Care beds escalate into theatres, with the baseline 16 beds increasing to 26, an overall capacity increase of 62%. The Northeast and Cumbria critical care Network has coordinated patients and resources across the region and all providers have used surge capacity to meet the demand for critical care beds. This has had a consequential impact on elective capacity although urgent, emergency and cancer surgery has been maintained.

Staffing resource has been considerably reduced, with the Covid sickness, test and trace isolation and shielding of Clinically Extremely Vulnerable (CEV) staff having a significant impact on service delivery.

The aging infrastructure of the hospital site, with limited single rooms to manage infection control and restricted Critical Care capacity compared to some of the larger hospital providers, has also brought with in a number of additional challenges.

However, despite these pressures, the Trust has continued to deliver the safest, quality and timely services to our population, reviewing and transforming our pathways to accommodate the challenges that have arisen.

This report provides an overview of the impact of Covid on resources, the clinical and operational challenges, the impact on staff health and wellbeing, however also outlining the innovative practices implemented to both absorb the emergency pressures and recover business as usual

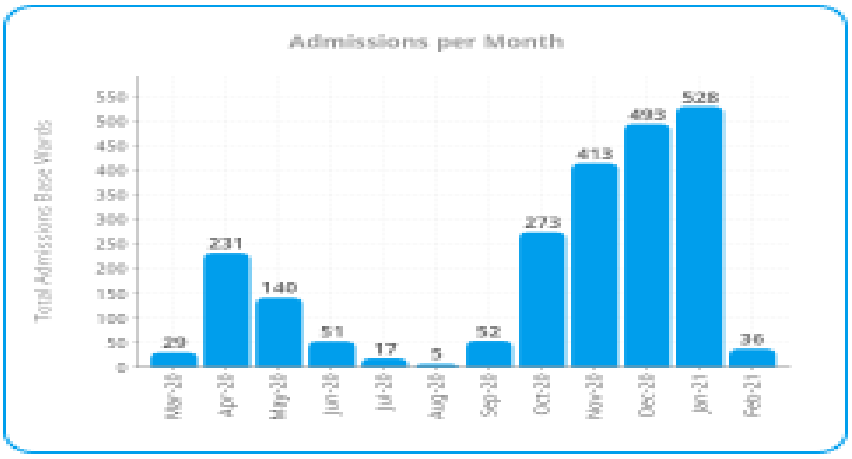
2. Covid Impact

During the second wave of Covid, where the pressures increased significantly compared to Wave one, the rate of new daily Covid admissions ranged between 3 and 35 per day, the equivalent of a full ward in one day at its peak.

The average beds occupied by Covid patients each day ranged between 26 at the lowest point and 216 at the peak, the equivalent of 7 wards and 42% of the overall occupied beds.

Graphic 1 below provides an overview of the month on month Covid admissions

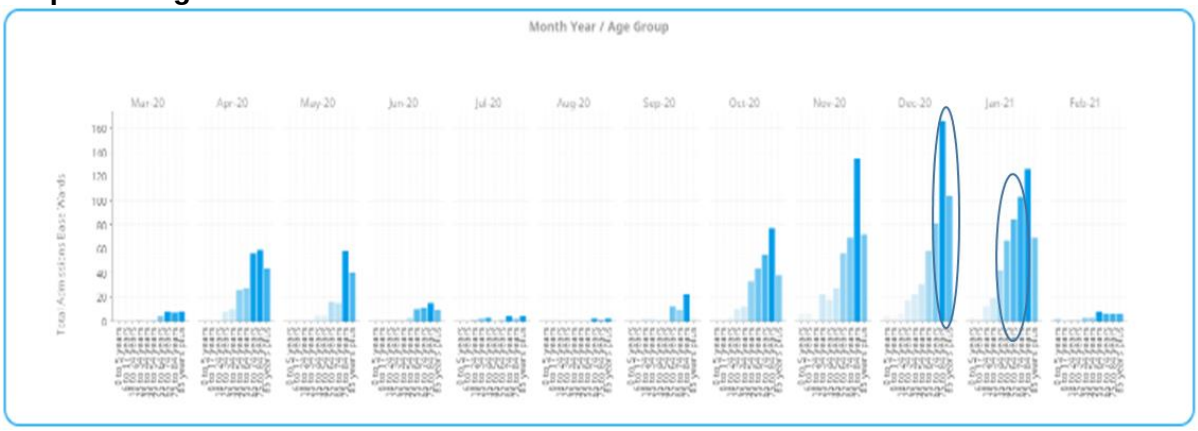
Graphic 1: Covid Admissions profile March to date (as at 2nd February)



The acuity of the patients on the acute wards has been significantly higher, with up to 40% of the patients requiring additional NIV oxygen support. This has affected existing oxygen supply within the organisation, requiring additional infrastructure to accommodate the increased requirements. A higher level of nursing care has also been necessary for these patients, with increased nurse to patient ratio supporting the required enhanced nursing care.

The profile of admissions was across all ages see Graphic 2 below, however with the 75 and above seeing the higher rates of admission. There was evidence of a shift to the under 75-age group in January, which could potentially be reflective of the Christmas lift of lock-down restrictions.

Graphic 2: Age Profile of Covid Admissions

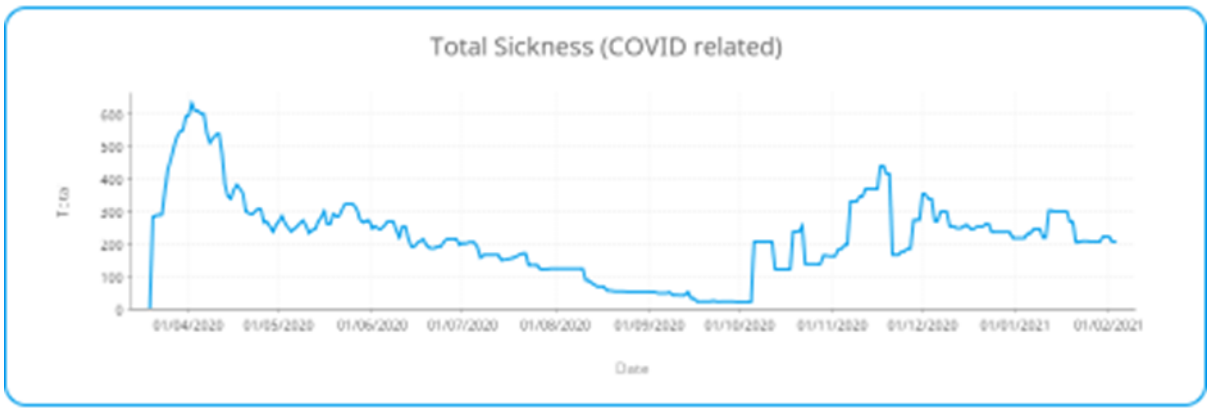


The impact of the Covid pandemic on staffing resource has been extensive, with absence levels associated with Covid ranging between 20 staff absent per day at the lowest point and

633 at the highest point, see Graphic 3. On average of circa 200 staff per day are still absent due to either being Covid symptomatic, self-isolating due to Track and Trace or Clinically Extremely Vulnerable.

This absence is on top of the sickness levels for other reasons, currently running at approximately 4% of the workforce, and alongside the regular vacancy rate.

Graphic 3: Covid related absence



The high absence rate has resulted in significant pressures on the delivery of both elective and emergency services, resulting in a number of routine, less urgent services being reduced, in order to release clinical and non-clinical staff for re-deployment into the more pressured acute wards to support emergency service delivery

3. Governance

The impact of the sustained Covid pressure over the previous 12 months has required an increased level of resilience, both at organisational level and as a health and social care system. Appropriate governance structures have been required to ensure the Trust, alongside healthcare partners could react appropriately to the challenges.

To support this, the Trust embedded a number of tactical groups covering, clinical advisory group, resilience and recovery planning, workforce, communication and procurement, with oversight through the Strategic Command group. This enabled day-to-day oversight of the key issues that occurred, the mitigating actions taken to address the problems, which inevitably delivered timely decision making.

In line with national Emergency Preparedness, Resilience and Response requirements the Trust is a Category One provider and has continued to work closely with the Cleveland Local Resilience Forum and other partners during the pandemic.

4. Pathway Redesign and Innovation

The consequence of the Covid pandemic has been multi-faceted; resulting in significant changes to service delivery. Examples of this include:

- Impact of Infection Prevention and Control requirements,
- Re-organisation of all clinical areas to accommodate Covid and Non Covid patients, including Critical Care, base wards, outpatient clinics, diagnostic services, urgent and emergency care services, theatres etc.

- Full Personal Protective Equipment (PPE) requirements in clinical areas, physical constraints and additional time to 'don' and 'doff'
- Increase of Oxygen supply to base ward areas to accommodate high consumption.
- Restricted patient family and carers support on clinical areas
- Patients' reluctance to attend hospital face to face
- Multiple releases of clinical guidance to support delivery of pathways
- Increased input by our Community Teams to prevent avoidable admissions to hospital
- High acuity of patients on the base wards, requiring additional nursing care
- Reduced staffing resources
- Significant impact on staff health and wellbeing

The issues outlined above, alongside many others, has required new, innovative ways of working to both reduce avoidable hospital contacts and also support prompt safe discharge, with the key aim to maintain safe, quality pathways at all time.

Examples of some of the work that has taken place to support this includes:

- Revised bed models to accommodate Infection, Prevention and Control (IPS) measures to segregate Covid and Non Covid patients, significantly reducing the risk of nosocomial infections.
- Electronic 'advice and guidance' facility for Primary Care to reduce referrals and admissions.
- Daily calls with local authority partners to support discharge planning processes
- Virtual appointments to reduce the need for patients to attend hospital.
- Utilisation of Lateral Flow testing at front of house for early identification of potential Covid positive patients, enabling appropriate IPC management.
- Revised staffing models to accommodate the high level of acuity of patients on the base wards.
- Roll out of the 'Home First' model, to support early discharge of elderly patients.
- Increased Community support to Care Homes to reduce avoidable admissions, including named matrons as contact for each Care Home
- Training support for Care Homes for Infection, Prevention and Control (IPC)
- Review of available theatre capacity to enable emergency, urgent and cancer procedures to be carried out alongside the expansion of Critical Care
- Recruitment to new role of 'Support workers' to assist in non-clinical activities on the wards, providing patient engagement and support, alongside releasing clinical time to care.
- Temporary redeployment of both clinical and non-clinical staff to acute ward areas to support operational delivery
- Enhanced health and well-being support is being provided, including a dedicated Covid advise line, regular refreshments on clinical areas and the availability of mental health advice and support
- Opening of 'Rainbow' hubs on each site to provide breakout areas for staff, supported through funding from the 'Captain Tom' charitable funds.

Alongside the above pressures and mitigating actions, the Trust has successfully rolled out the Covid vaccination plan, with over 10,500 staff, patients and other frontline care providers vaccinated in the previous 4 weeks.

5. Recovery

In line with the national Emergency Preparedness, Resilience and Response (EPRR) framework, the recovery of 'business as usual' has already commenced.

Good progress was made between Wave 1 of the pandemic, when national guidance committed to reducing all non-urgent activity, and Wave 2, with the reinstatement of the majority of elective routine outpatients, diagnostics, screening and elective programs achieved.

Wave 2 of the pandemic inevitably brought with it some additional challenges, with higher infection rates than the first wave, and subsequently higher numbers of Covid patients admitted to the Trust.

Despite this, as outlined above, the Trust has managed Covid pressures through new ways of working, alongside the delivery of business as usual.

However, unavoidably some elective services have reduced. Revised recovery plans are now in place, with the aim to ensure all postponed routine elective outpatients appointments, diagnostics and procedures are re-appointed as soon as possible, notwithstanding the Covid pressures are still prevalent across the care system.

6. Summary

In summary, the unprecedented Covid pressures have delivered significant challenges to the delivery of health and social care. However, the Trust, as a health provider, has worked tirelessly to ensure services have continued to be deliver to our population, with patient safety and quality at the centre of all decision making.

Our staff have worked as a team, at all levels of the organisation, to rise to the challenges, notwithstanding the inevitable impact on personal resilience.

Despite the pressures, the pandemic has released a number of positives, embedding innovative new ways of working and further enhancing a system approach to pathway delivery across local health and social care partners.

Prepared by: Lynne Taylor, Director of Planning and Performance

NHS
Tees Valley
Clinical Commissioning Group

Integrated Care System Consultation

1. Purpose

To update committee members in relation to the Integrated Care System Consultation and CCG approach

2. Background

Integrating Care: Next steps in building integrated care systems across England was published by NHS England in December 2021. It outlines the next steps for developing whole system (as opposed to individual organisation) working. The thinking behind the paper appears to be predicated on building on the successes of partnership working through the Covid19 pandemic. As part of this it suggests options for the formal creation of Integrated Care Systems as bodies in their own right.

3. Consultation document

The document includes:

- Continuation from NHS Long Term Plan and last NHS planning guidance
- Accelerating collaborative ways of working across systems and beyond organisational boundaries
- Developing strategic commissioning and focusing on population health outcomes
- Key components of an ICS including provider collaboratives, place based working
- Proposing legislation to give ICSs a firmer footing
- Inviting views on the way forward – including CCGs' mergers or dissolution.

4. CCG approach to response to the consultation

The CCG undertook staff engagement to ensure all staff were engaged and sighted on the document and were able to provide views to inform the organisational response.

Staff groups included

- CCG employed staff
- CCG Governing Body
- CCG Executive committee
- CCG Council of Practices
- Primary Care Network clinical directors

A corporate CCG response was submitted by the deadline of 8 January 2021. Once the outcome of that national consultation is known, a further update will be provided to system partners.

David Gallagher
Chief Officer
NHS Tees Valley Clinical Commissioning Group
4th February 2021

Integrating care

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

Contents

Introduction

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

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

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

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

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

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

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

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

1. Purpose

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

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

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

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

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

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

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

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

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

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

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

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

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

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

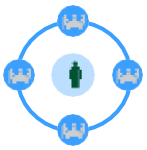
Devolution of functions and resources

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

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

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

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



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

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

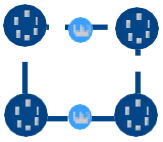
1.15. Our ambition is to create an **offer to the local population of each place**, to ensure that in that place everyone is able to:

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

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

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

Developing provider collaboration at scale



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

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

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

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

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

2. Putting this into practice

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

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

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

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

Provider collaboratives

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2.16. From April 2022, this will include:

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

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

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

Place-based partnerships

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

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

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

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

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

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

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

The NHS's offer to local government

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

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

Clinical and professional leadership

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

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

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

- A primary care perspective at system level.

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

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

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

Governance and public accountability

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

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

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

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

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

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

  They may flexibly define:

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

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

  They may flexibly define:

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

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

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

iv. their voting arrangements on the ICS board.

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

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

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

  It may flexibly define:

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

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

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

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

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

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

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

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

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

Financial framework

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

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

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

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

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

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

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

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

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

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

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

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

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

Data and Digital

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

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

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

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

Build smart digital and data foundations

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

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

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

Connect health and care services

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

Use digital and data to transform care

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

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

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

Put the citizen at the centre of their care

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

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

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

Regulation and oversight

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

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

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

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

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

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

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

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

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

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

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

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

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

How commissioning will change

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

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

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

improving outcomes, rather than managing contract performance between organisations.

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

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

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

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

Specialised commissioning

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

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

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

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

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

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

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

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

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

accountability for tackling inequalities and for improving population health.

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

3. Legislative proposals

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

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

3.3. Recommendations included:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Option 2 – a statutory ICS body

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

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

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

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

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

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

Our approach

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

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

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

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

Questions

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

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

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

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

4. Implications and next steps

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

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

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

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

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

The NHS England and NHS Improvement's operating model

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

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

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

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

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

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

4.10. The new operating environment will mean:

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

against their specific health challenges and population health priorities.

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

Transition

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

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

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

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

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

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

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

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

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

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

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

4.22. Our commitment is:

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

Next steps

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

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

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

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

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

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

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

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

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

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