# SUPPLEMENTARY AGENDA

**NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE**

Friday 25 June 2021, 10:00 a.m.
MS Teams (watch it here)

Contact: Fiona Rae / Robert Mack

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**Councillors:** Alison Cornelius and Linda Freedman (Barnet Council), Larraine Revah and Paul Tomlinson (Camden Council), Christine Hamilton and Derek Levy (Enfield Council), Pippa Connor **(Chair)** and Khaled Moyeed (Haringey Council), Tricia Clarke **(Vice-Chair)** and Osh Gantly (Islington Council).

**Support Officers:** Tracy Scollin, Sola Odusina, Claire Johnson, Robert Mack, and Peter Moore.

**Quorum:** 4 (with 1 member from at least 4 of the 5 boroughs)

**AGENDA**

**5. DEPUTATIONS / PETITIONS / PRESENTATIONS / QUESTIONS (PAGES 1 - 4)**

To consider any requests received for deputations, petitions, presentations, or questions.

**8. GP SERVICES (PAGES 5 - 50)**

To receive a report on GP Services.

**9. COVID-19 PANDEMIC UPDATE (PAGES 51 - 72)**

To receive an update on the Covid-19 pandemic.

**11. WORK PROGRAMME (PAGES 73 - 136)**

This paper provides an outline of the 2020-21 work programme for the North Central London Joint Health Overview and Scrutiny Committee.

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Tuesday, 22 June 2021

# Agenda Item 5

**JHOSC June 25th 2021**
**Deputation on the White Paper -integration and innovation and primary care post - Centene**

Since our delegation to the March JHOSC, more details about the White Paper have been released which confirmed our concerns.

The Government plans to put the Bill formally establishing the ICSs across England before Parliament in the next few days. As this will happen shortly before the end of the Parliamentary Session, there will be no effective scrutiny of the Bill its provisions. We feel this is deliberate on the part of the Government and NHSE to avoid thorough examination of their proposals. This makes it even more important that JHOSC does that scrutiny.

We have looked more closely at some of the underlying issues for primary care (Item 6 below).

As was noted previously, some of the stated goals of the White Paper are laudable -e.g., promoting integration, reducing competitive tendering, partnership, collaboration, and tackling health inequalities. If the implementation of ICSs, and the context had been different, the proposals could have been very positive. However, as it stands, the White Paper does not address the real keys to improving health outcomes and reducing health inequalities i.e., workforce and funding in health, relative to comparable countries, (fewer beds, doctors, and nurses), Investing in social care and public health, and council cuts and reduced responsibilities.

- Ideally there would be a full public consultation involving all stakeholders, with implementation delayed till after the worst of the pandemic, as suggested by NHS Providers.

- The key concerns remain the same and we strongly recommend that the JHOSC raise these with NLP, the mayor, local government bodies and MPs and their own voters.

1.*Unequal partnership* between NHS and local authorities. The new ICS design framework details for ICS NHS board membership are a chief executive, nursing director, medical director, and a minimum of two other independent executive directors. NHSE also expects that boards will have three additional partner members, including one from the local NHS, one from general practice and one from social care. The ICS NHS board controls plans and budgets for the whole system.

There is no mention of representation for patients and public. There is no requirement that ICS boards meet in public, that board papers and minutes are published, nor that they be the subject to FoI requests, which given that private providers can be members of both the ICS NHS as well as Partnership Boards, is unsurprising, but retrograde for a public body.

As an example, the Bath, North East Somerset, Swindon and Wiltshire ICS has a Virgin Care director on their Partnership Board. Virgin Care was not prepared for any information to be shared with the public. In response the other board members agreed that the ‘open book approach would need to be amended to protect providers’ corporate and commercial interests.

- *JHOSC should press NCL to ensure councils and primary care have parity of representation and voting rights on main ICS board or at the very least, increased voting representation.*
- *Measures need to be in place to ensure ICSs are fully accountable to LAs, public, and patients, meetings to be held, and papers/minutes etc to be made, public, and ICSs be subject to FoIs.*
- *Independent providers should be excluded from membership on decision-making/resource allocation ICS board and committees.*

- ***We also urge JHOSC to seek assurances from the NCL CCG that the role and remit of JHOSC will continue if and when an ICS is formally constituted in NCL***

**2**. The White Paper will repeal ***competition law*** as it applied to procurement, in section 75 of the Health and Social Care Act 2021 and exempt the NHS from the Public Contract Regulations safeguards for compliance with environmental, social, and labour law (ILO). Also with independent providers permitted on both ICS boards, there is potential for major conflicts of interest as highlighted by the BMA, *'the White Paper takes the first step to abolishing these wasteful rules, but unless it goes further -making the NHS the default option for delivering NHS services -there is a risk that contracts will be awarded without scrutiny to private providers at huge expense to the taxpayer, as was seen with the procurement of PPE and Test & trace during the pandemic'.*
The new ***Provider Selection Regime*** (PSR) consultation document permits contracts to be continued, directly selected or tendered - the former creating opportunities for private companies, e.g. Centene to be 'locked in'. There is also a developed, private health care sector of 200 plus pre-approved companies in NHS England's Health Support Service Framework.

- ***We urge the JHOSC to press the ICS to agree that the NHS organisations be the preferred providers in NCL***
- ***We strongly recommend that the JHOSC press the ICS to use the provisions in the PSR to continue or directly select existing NHS, and some not for profit providers, when contracts come for renewal, as these are better value for money with no funds diverted to profit and contracting costs, and all funds reinvested in the service.***

**3**.Major ***social care*** *(SC)* proposals are deferred again. The Discharge to Assess model will be updated, with assessments taking place *after* discharge from acute care, with an estimated 80% not receiving an assessment. Councils' responsibilities for SC have already been eroded by the Care Act Easements 2020, and now the Secretary of State (SoS) will be given powers to make direct payments to SC providers, and the CQC will gain new powers to assess councils' delivery of SC. The plans for ***Public Health*** (PH) are sparse and mainly relate to restrictions on food advertising and labelling, to tackle obesity.

- ***Press for increased investment in public health and social care, with wholesale reform of the latter, to deliver significant improvement to health outcomes and inequalities.***

**4.** The Secretary of State can remove a ***profession from regulation,*** and abolish regulators; this opens the way for employment of a less skilled, lower paid workforce with poorer health outcomes for patients.
***There appears no merit to these proposals which should be scrapped.***

**5.** ***Digitalisation*** and technology are central to ICSs, to reimagine care pathways, with little acknowledgement that the huge shift to virtual and remote consultations, erodes the doctor patient relationship and continuity, key to better patient outcomes, not least to reducing mortality. The emphasis on data driven planning between NHS and councils, using Population Health Management (PHM), and data sharing, with poor safeguards, and actuarial health targets for the whole population, within a capped budget, is likely to result in further rationing and delays to healthcare.

- ***Urge NCL to agree Face to face consultations are enshrined as a right, not a rationed/delayed exception - Patient First not Digital First.***
- ***Introduction of capped budgets to be delayed or preferably scrapped -*** there has always been the ability to roll over deficits and seek bailouts – but coming after years of lower level percentage annual funding increases, the impact of Covid 19, and NHSE's latest demand for savings, increased productivity and efficiency, and the restoration of 'normal financial disciplines', capped budgets will result in even more serious delays and rationing.

- ***Press for government to increase funding to meet the backlog that existed before the pandemic, but exacerbated by it, and restore annual funding increases of 4%, and abolish the remaining components of the expensive and wasteful private market tendering provisions.***

***6. Primary care***

*Primary care is under severe pressure and at breaking point, with patient satisfaction declining as a result because of the difficulties making contact with practices, getting appointments, long waits, telephone triage, and then long waits for referrals to secondary care.*

Funding and workforce – These problems are unsurprising given that primary care provides 90 % of patient contacts but receives only 10 % of NHS funding. There was a 10% vacancy rate in the NHS pre-Covid which is now much worse, and for many years there have been Insufficient GP training places to cope with replacement needs and increased demand.

If general practice fails, so will the NHS, with patients diverting to emergency departments (ED) and other unscheduled care provision, but still the workload increases without concomitant funding. It is worth noting that a year's worth of GP care per patient costs less than two trips to EDs.

Pressures A range of pressures have resulted in early retirement, heavy workloads, demoralisation, difficulties for partners to buy in, and lack of career structure for salaried GPs. Because of these difficulties, many GPs both salaried and partners are vulnerable to leaving, giving up practices, which if they had received greater support, e.g. helped to merge or partner, gain economies of scale by sharing back office specialists e.g. HR, IT, complaints, compliance and premises management, and collaborate on service development, may well have continued.

Contracts NHSE made clear by 2014, that all new GP practices should be on Alternative Provider Medical Services contracts (APMS), i.e. contracts held by private companies or third sector organisations, other than GP partnerships. This has opened the door to the Centene type takeover. One of the difficulties for GP partnerships or even GP Federations when bidding for contracts, is that large multinationals have teams for contracting and can put in glossy, deceptively polished tender documents. They have threatened or actually sued, if they fail to win contracts - so tendering is not a level playing field.

KONP have put in an FoI to NLP requesting details of when contracts will come for renewal and are awaiting a response. There is also currently a Judicial Review pending on the Centene takeover.

Action –

1. We strongly recommend that the JHOSC **raise these concerns about funding, workforce and the use of APMS contracts with NLP, the mayor, local government bodies and MPs.**
2. **We urge the JHOSC to make clear to the NCL ICS that primary care on the standard GMS contract and the less common PMS one, should be supported and that APMS contract should not be used for primary care.**
3. **The JHOSC should explore with the ICS, the options for increasing support to GP practices, beyond that currently available from the Federations and PCNs.**
4. **They should also ensure primary care contracts remain within the NHS, perhaps with GP Federations, PCNs or local Trusts, and explore salaried GP practice options, rather than private APMS ones.**
5. We urge JHOSC to seek assurances from the NCL CCG that the role and remit of JHOSC will continue if and when an ICS is formally constituted in NCL.

Brenda Allan & Alan Morton NCL NHS Watch

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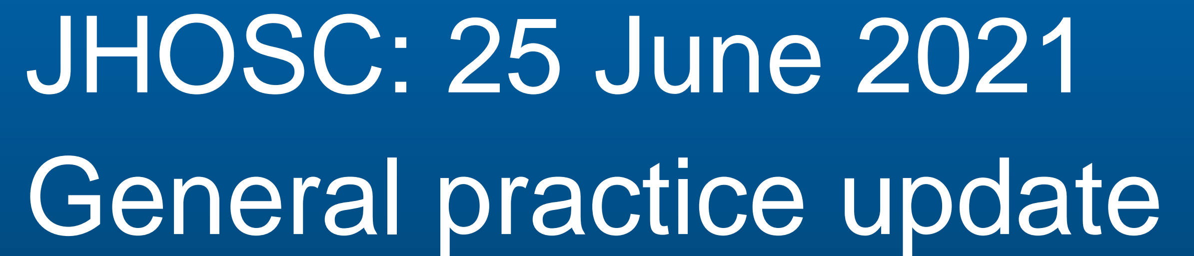


Agenda Item 8

# Contents

NHS
North Central London
Clinical Commissioning Group


- Primary care in North Central London
- Commissioning of primary care services
- Performance and monitoring
- Primary care's achievements during Covid-19
- Primary care Covid-19 vaccination programme
- Pressures in general practice
- Workforce
- Digital inclusion: Haringey pilot
- Primary care organisations
- Integrated Care System
- General Practice Data for Planning and Research

# Primary care in North Central London

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**Barnet**
Population: 434,778
Practices: 51
Primary Care Networks: 7
Clinical Directors: 10
Federation: Barnet Federated GPs

**Camden**
Population: 307,618
Practices: 33
Primary Care Networks: 8
Clinical Directors: 11
Federations: Haverstock Healthcare and Camden Health Evolution

**Enfield**
Population: 352,077
Practices: 32
Primary Care Networks: 4
Clinical Directors: 6
Federation: Enfield GP Federation

**Haringey**
Population: 327,360
Practices: 35
Primary Care Networks: 8
Clinical Directors: 8
Federation: Federated 4 Health

**Islington**
Population: 274,748
Practices: 32
Primary Care Networks: 5
Clinical Directors: 5
Federation: Islington GP Federation

**Dr Katie Coleman: Clinical Lead for primary care development in North Central London**

With 200 practices across North Central London, these range from single-handed practices to super-partnerships (groups of practices who have come together formally)

A strong history of practices working together has seen the development of Care and Health Integrated Networks in 2017/18 and the establishment of Primary Care Networks in 2019/20.

# Commissioning primary care services

NHS North Central London Clinical Commissioning Group

There are three types of contracts for commissioning primary medical services.

A practice can hold either a GMS or PMS contract with the latter being phased out.

New contracts are commissioned through an open procurement process. This involves surveying patients and stakeholders on the delivery of services and what changes and improvements they would like to see in the future.

A range of methods are used to notify patients such as letters, text messages, messages on a practice website and forums held in the GP practice itself.

| Contract type | Summary |
| --- | --- |
| General Medical Services (GMS) | • Nationally agreed contract for essential primary medical services<br>• Contract can be with a single GP, a GP partnership (two or more individuals of whom at least one must be a GP) or a company limited by shares |
| Personal Medical Services (PMS) | • A locally agreed contract of essential services and additional locally agreed services |
| Alternative Provider Medical Services (APMS) | • A contract for fixed period, usually five years following a procurement<br>• Often held with limited companies such as GP Federations for specific services e.g. walk-in centre, extended access hub, GP practice for homeless patients etc. |

# Commissioning primary care services

North Central London
Clinical Commissioning Group

There are several services that are commissioned from general practice, many defined at a national level with an allocated budget. However local commissioners have responsibility for contracting additional services from general practice, often tailored to meet a specific need of the local population.

| Service type | Service requirements |
|---|---|
| Essential (core) | Service provided within core hours for the management of the contractor's registered patients and temporary residents. |
| Additional (optional) | Provided to registered and temporary patients as part of the national contract and can be opted out of by providers (affecting their payments).<br><br>Includes services relating to cervical screening, contraception, vaccination and immunisations, child health surveillance, maternity and minor surgery. |
| Enhanced (optional) | There are three types of enhanced service: Directed Enhanced Services, Locally Commissioned Service (CCG) and Locally Commissioned Service (Public Health).<br><br>Locally Commissioned Services are often developed to meet a specific need of the local population with input from GP providers, CCG clinical leads, Local Medical Committees, and if appropriate, with input from Healthwatch or other patient representation. |

# Performance and monitoring

North Central London
Clinical Commissioning Group

**Contract management**

The management of GP contracts is delegated from NHS England to CCGs. In North Central London this is managed by the CCG's contracts team and the Primary Care Commissioning Committee.

**Primary Care Commissioning Committee**

Performance and contract decisions are referred to this committee which meets in public.

A broader quality report is also supplied to the committee and made publicly available.

**Contract management levers**

Ways in which contracts can be managed include contract breach and remedial notices, sanctions and the termination of contracts.

**Monitoring**

A range of quality indicators are monitored, these include:

- Quality and Outcomes Framework (long-term condition disease registers)
- Vaccinations, immunisations and screening
- Access, patient experience and complaints
- Care Quality Commission ratings
- Workforce
- Premises

# Performance and monitoring

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**Patient and stakeholder engagement**
Engagement with patients and stakeholders takes place when there is a service change or a practice is relocated to ensure their views are taken into account.

Equality Impact Assessments are also carried out to review the impact of the change.

Stakeholders' views and Equality Impact Assessment findings are taken into consideration by the Primary Care Commissioning Committee before decisions are taken.

**Londonwide and Local Medical Committees**
The CCG has a statutory duty to liaise with LMC on most matters, particularly practice remuneration or requests and communications to practices.

Practices also receive representation and support from the Local Medical Committee with contractual and other matters.

# Primary care's achievements

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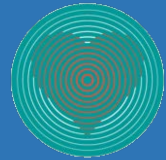
Clinical Commissioning Group



**559,811** Covid-19 vaccines delivered
**62%** of all Covid-19 vaccines in North Central London

**50,000** online consultations
(October - December 2020, average/month)

**52.5%** of appointments via telephone
**47.5%** of appointments face-to-face
**91%** attendance rate
(October - December 2020)

Page 12

**13,071** referrals to social prescribing
**12,500** personalised care and support plans (target)

| | |
|---|---|
| NCL GP annual appointments | 6.7m |
| Annual referrals to secondary care | 339,086 |
| Annual learning disability health checks | 3,000+ |

% of North Central London 2016-20 mortality

Data as of April 2021

# Covid-19 vaccination programme

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The primary care Covid-19 vaccination programme has been delivered through high levels of collaboration both within primary care and with the wider health and care system.

**General practice**

Practices have collaborated across North Central London, putting in place formal agreements spanning Primary Care Networks and boroughs.

Collaboration has seen the sharing of workforce, clinical and operational leadership, infrastructure such as fridges, freezers and IT equipment, best practice, learning and estates.

**North Central London CCG**

There has also been increased collaboration between general practice and the CCG with the sharing of clinical and operational leadership, workforce and collaborative population management to tackle health inequalities.

**Wider health and care system**

General practice has also worked closely with a number of partners in the wider health and care system.

- Care homes: collaboration with local authority, public health and community services
- Voluntary sector: utilisation of community assets, volunteer drivers, marshals, stewards and more
- Local community: Engagement to tackle health inequalities
- Acute Trusts: Sharing of resources through mutual aid

**Over 60% of Covid-19 vaccinations in North Central London have been delivered by primary care**

# Pressures in general practice

NHS North Central London Clinical Commissioning Group

There is currently significant pressure on general practice, as with the wider health and care system.

**Key pressures for general practice (within the context of wider system recovery):**

- A tired workforce
- Pent-up patient demand and a backlog of routine work
- A significant volume of online consultations
- Increased workload and flow to general practice from secondary care
- More advice and guidance managed in primary care
- Continued management of chronic and complex conditions

**Appointment levels**

National data shows that across North Central London, GP appointment levels are already exceeding pre-pandemic levels.

Prior to the pandemic approximately 16% of GP appointments were conducted by telephone, video or online.

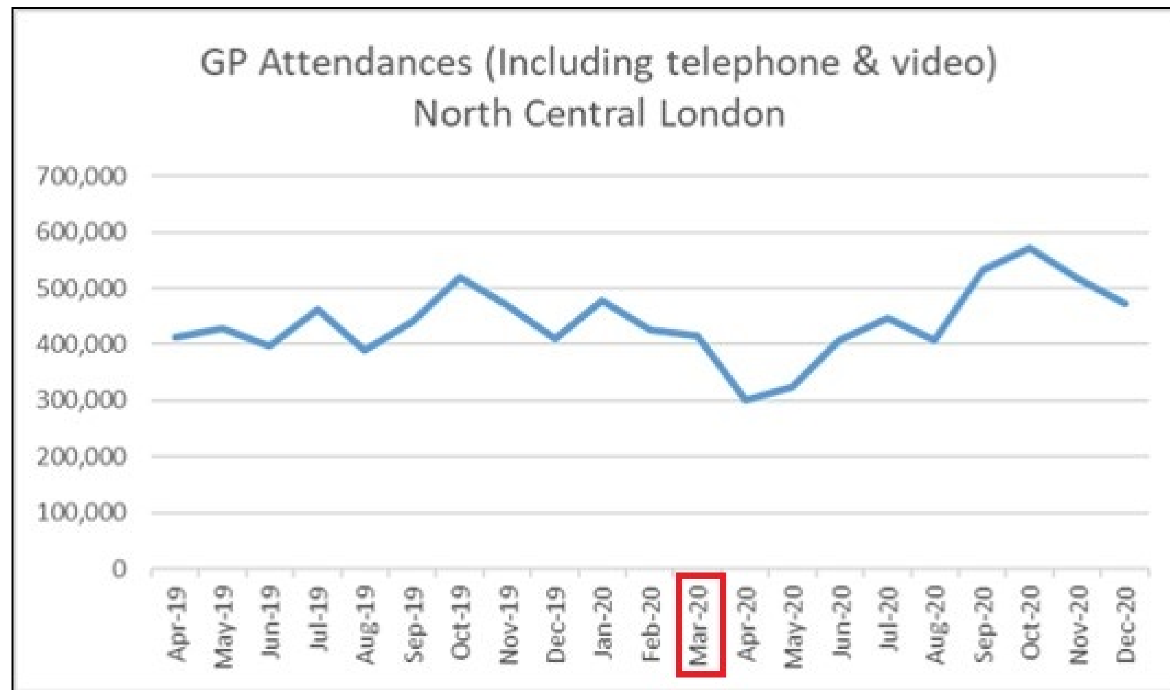
Following the introduction of the total triage model (March 2020), the proportion of non-face-to-face appointments increased to 66% by April 2020.

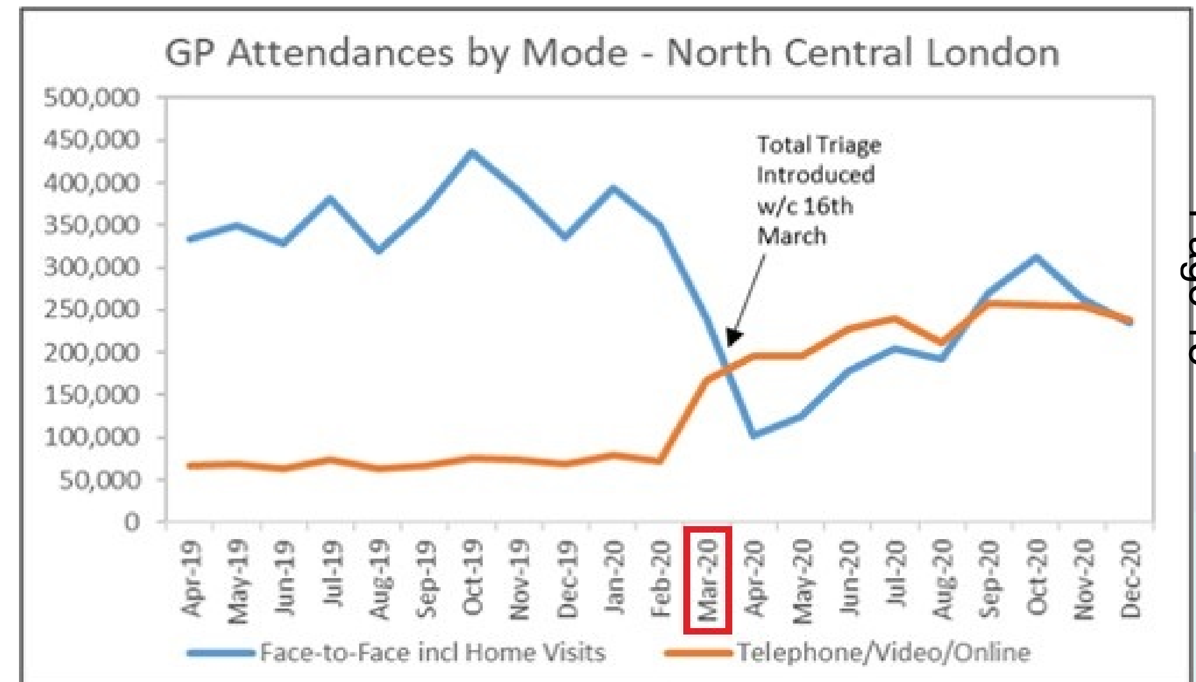
Although the proportion has decreased since, as of December 2020 at least 45% of total appointments were non-face-to-face.

# Pressures in general practice

North Central London
Clinical Commissioning Group

The following charts show rolling appointment capacity (overall and split by modality).




Page 15

# Workforce

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**Impact on staff**

The general practice workforce is exhausted. Practices have changed both how they operate and how patients access care, adapted to new ways of working and continued to deliver face-to-face care throughout the pandemic.

The last 14 months have been exceptionally difficult for staff. Some have experienced personal loss as a result of Covid-19, whilst some are finding it difficult to cope with the rapid changes to how they work.

**What general practice staff have told us in recent local engagement (April 2021)**

"I'm more stressed than I've ever been"

"I'm working the longest days I've ever worked"

"Staff are having meltdowns"

"The workload is becoming unsustainable"

"One of the main issues is…how an exhausted workforce manages increased GP work whilst also managing Covid-19 vaccinations etc."

# Workforce

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North Central London
Clinical Commissioning Group

**New and hidden pressures**

The total triage model (telephone, video, online consultation) has kept patients and practice staff safe but is an intensive way of working, with some reporting professionally feeling isolated e.g. where working from home.

Practices have also received a significant volume of enquiries regarding Covid-19 vaccination, particularly in response to high-profile media coverage of issues such as changes in national guidance.

Pent-up demand has also seen a surge in online consultations and telephone queries. One practice with a list size of 12,000 recently recording 7,000 phone calls in and out over a week in April this year.

**Existing pressures**

Pressures on the GP workforce which existed prior to the pandemic continue to provide a challenge such as a shortage of GPs and practice nurses and a high number of retiring or close to retiring GPs.

A recent workforce survey by Londonwide LMC indicated that of the 74 North Central London practices that completed the survey, 41% reported having a GP planning to retire in the next three years.

# Digital inclusion: Haringey pilot

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The CCG and GPs in Haringey have been working to develop a programme to help all patients access primary care in new ways, so as not to develop further inequality.

The patients we wanted to support have multiple needs and other health organisations faced similar challenges.

The pilot was developed with Barnet, Enfield and Haringey Mental Health Trust, North Middlesex University Hospital, Whittington Health and Haringey Council was involved as a key partner in our social inclusion initiatives.

To help build a model for wider implementation the initiative was developed as “action research”.

**Progress update**

Going live on 14th January, we have since received 53 referrals and the following case studies highlight the positive patient outcomes, value and impact the service is already delivering.

**Case study: Patient A**

Patient A was referred for a loaned device and access to an AttendAnywhere video consultation. This enabled the patient to attend two support sessions, receive an assessment from a clinical psychologist and attend future online GP and physiotherapy appointments.

They expressed immense gratitude in being able to access multiple appointments to better manage their physical and mental health.

**Case study: Patient B**

Patient B was referred for a loaned phone and has been supported in learning how to access Microsoft Teams.

They have since attended a hub appointment with a Turkish speaking interpreter and are able to attend weekly group therapy sessions for Turkish patients. Supporting this patient efficiently has also meant that the therapy group has been able to start and avoided delaying other patients’ treatment.

# Primary care organisations

NHS North Central London Clinical Commissioning Group

## Primary Care Networks

To help meet our population's changing needs GP practices are working together with community, mental health, social care, pharmacy, hospital and voluntary services in groups of practices known as Primary Care Networks.

Typically based on GP registered patient lists these networks serve communities of between 30,000 to 50,000 people (with some flexibility). They are small enough to provide the personal care valued by both people and GPs, but large enough to have impact and economies of scale through better collaboration.

Building on existing primary care services the networks enable more proactive, personalised, coordinated and more integrated health and care services.

## GP Federations

The NHS Five Year Forward View (2009) confirmed the need for practices to come together to explore new, innovative ways of delivering primary care at scale.

A GP Federation is a formal or informal alliance of practices or practices and other community primary care providers, coming together to develop and deliver primary care services.

Organisations such as Primary Care Networks and GP Federations are not intended to replace practice, or diminish practice autonomy but should reduce waste, enhance efficiency and support a number of vital functions that can best be achieved at differing scales.

# Integrated Care System

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**The role of primary care in an Integrated Care System**

General practice has a unique and critical role and sits at the heart of integrated care.

The current pandemic has reiterated the value, skill, importance and flexibility of primary care.

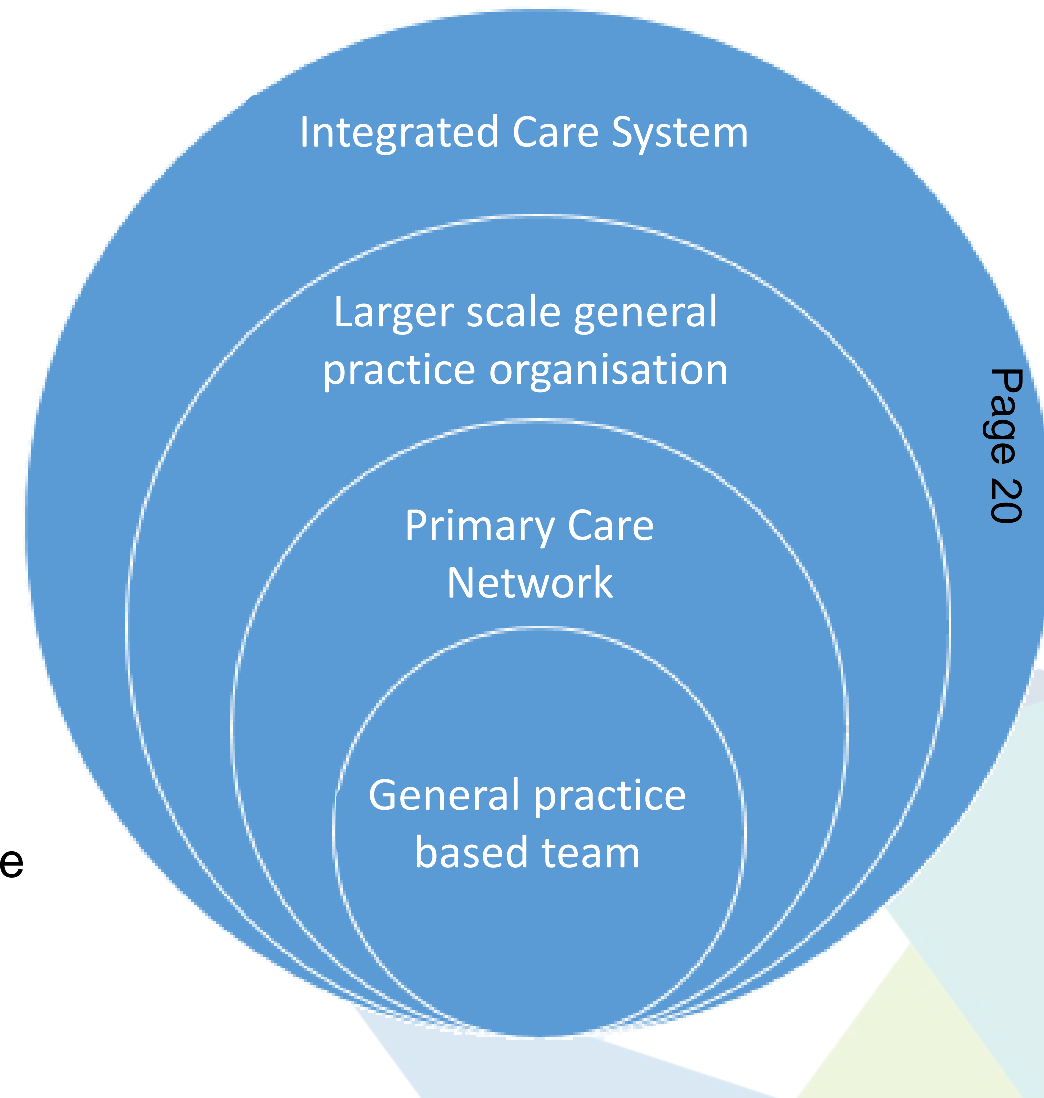
**How will primary care be represented?**

With clinical leadership remaining at the heart of the future Integrated Care System, there will be a continued need for primary care clinical leadership.

Proposed legislation outlines some of the formal decision making forums which will include GPs.

We are working with primary care leaders locally to ensure primary care is engaged in forums both at borough and North Central London levels as we move into 'shadow form' as an Integrated Care System.

Our elected Governing Body members and clinical leads will continue in post during 2021/22.



# Integrated Care System

NHS
North Central London
Clinical Commissioning Group

**What could integration look like for primary care on a day-to-day basis?**

Borough-based Integrated Care Partnerships and integrated care meetings already involve GPs alongside representatives from across health, the voluntary and community sector and partners such as the police and council.

This integration allows GPs and other health and care professionals to input into conversations and to highlight to partners the need to consider health factors in discussions that go beyond health and care.

Future integration could see this develop further into specific pathways for conditions that involve health and care partnerships, colleagues from the council and police just as much as it does a hospital specialist.

# Integrated Care System

NHS North Central London Clinical Commissioning Group

**GP Provider Alliance**

As health and care providers come together at an Integrated Care System level across North Central London, they are forming alliances to ensure representation.

To ensure primary care representation providers are forming a GP Provider Alliance, enabling it to:

- Unify its voice
- Influence and challenge decision making in the commissioning and provider system
- Create an awareness of the culture of primary care

**Next steps**

With Primary Care Networks and GP Federations coming together across North Central London, a GP Alliance reference group has been formed and signalled the intention to join the wider NCL Provider Alliance formed of acute, community and mental health trusts.

Having established a terms of reference and purpose statements, work is underway to develop a process that formalises function, structure, the type of organisation and more.

# General Practice Data for Planning and Research

North Central London
Clinical Commissioning Group

**Overview**

You will have seen information recently about changes to the way NHS Digital will access and use GP data.

This section provides an update about what this means for our residents and what we are doing to ensure that our partners, health and care professionals, residents and patients understand what this means for them.

**What is NHS Digital?**

NHS Digital is the organisation responsible for standardising, collecting, analysing, publishing and sharing data and information from across the health and social care system, and has been collecting data from general practice for some time.

**What are the changes being announced?**

NHS Digital recently announced plans to simplify and update the way it collects data from GP practices, and to introduce a new way to use data, known as General Practice Data for Planning and Research (GPDPR).

Data is requested from GP practices by Data Provision Notices; GPs are legally required to comply.

For GPDPR, data is pseudonymised, so not directly identifiable. It doesn't include information like detailed GP notes, but can be used to identify patients if needed, and will be used for:

- Managing and planning demand for services, e.g. how many people are diagnosed with particular illnesses
- Analysing the outcomes of services to ensure the health service delivery is getting results
- Recently, managing the pandemic

# General Practice Data for Planning and Research

North Central London
Clinical Commissioning Group

**When will this happen?**

National data extraction has now been delayed to 1 September 2021 to allow time to address concerns about the change; residents weren't aware or able to opt out in time.

**Can patients opt out of GPDPR and how do they do this?**

Patients can use a Type 1 opt-out to make sure that their data is not shared. This is currently the only opt out process that covers the pseudonymised data used by GPDPR.

This is a different process to the National Data Opt-Out which only applies to confidential patient data.

As there are two opt out processes, this may be confusing for residents and patient. We want to make sure that everyone understands how their data is being used and have the choice to opt out.

**Is there any disadvantage in opting out?**

If residents opt out, then their data won't be included in research and guidance studies which might affect NHS planning and mean services don't meet the needs of the local population.

**What information has been made available to residents and patients?**

We are concerned that these national changes have not been widely communicated.

We want to ensure that residents are informed and we will be making information available on our website and via GP practices in the next week or so. Information will include details of how residents can opt out should they choose to.

**What are the next steps?**

With the data extraction now delayed to 1 September 2021, we are taking time to develop communications materials which set out the changes and how data will be used clearly for residents and patients.

healthwatch

# Locked out:

# Digitally excluded people's experiences of remote GP appointments

June 2021

# Executive summary

**In this qualitative research project, we wanted to speak to groups traditionally more likely to experience digital exclusion to understand why and how this can impact their healthcare experiences, especially during the pandemic. These groups included older people, people with disabilities, and people with limited English.**

We found that people can be digitally excluded for various reasons including digital skill level, affordability of technology, disabilities, or language barriers. Participants often mentioned that they weren't interested in accessing healthcare remotely, even if they could. However, our experience at Healthwatch has taught us not to take such statements at face value, and the system needs to continue exploring why people feel reluctant to take up remote offers.

The stories we heard about using GP services during the pandemic were mixed. Some people who traditionally experienced barriers to accessing care, like carers or people with mobility issues, found the shift to remote care beneficial. In general, people understood the benefits of remote and digital care and appreciated the need to shift to these methods during the pandemic rapidly. However, we found that services frequently overlooked individual support requirements, and digital health systems had little means of anticipating them. Not knowing how to seek alternatives to remote booking systems or appointments meant some people became entirely reliant on their families for accessing healthcare, received poorer quality care or abandoned attempts to seek healthcare altogether.

Those who experienced multiple barriers to accessing care found it even more difficult to seek alternatives independently.

People experienced significant difficulties booking an appointment via e-consult or reception. This part of the booking process was by far the main point where people felt excluded and gave up trying to access care. In particular, people with low digital literacy or language barriers struggled to use e-consult systems and sometimes felt discouraged from seeking an appointment in another way. People who tried to call their GP instead frequently complained of long waits on phone lines or difficulty getting an appointment at all.

We also interviewed staff at GP practices as part of this project. While staff wanted to retain the added efficiency of remote care where possible, they acknowledged that the total shift to remote methods had excluded some people from care, and a better balance between face-to-face and remote methods is needed.

As we transition out of the pandemic, primary care needs to rebuild based on a hybrid system, doing everything possible to reduce barriers to accessing care remotely while giving people the agency to decide what kind of appointment is right for them. However, in the long-term, people – particularly those who are more vulnerable, like our research participants – need to be supported to develop their digital skills and facilitated to go online. Our analysis points to the need for a bold programme of investment in digital literacy and online access while emphasising the importance of maintaining face-to-face methods to ensure no one falls through the gaps.

# Background

**Digital transformation has been a long-term strategic goal for the NHS, even before the pandemic. In January 2019, the NHS Long Term Plan committed that every patient will have the right to digital-first primary care by 2023/24. At the time, our research bringing together 40,000 people's views on the future of the NHS highlighted concerns that technological advancements could prevent certain people, such as those without the internet, from accessing care.**

A **five-year framework** for GP contract reform published in 2019 set out ambitions for digital improvements in IT infrastructure and access to digital services for patients. These changes were already in motion, but the COVID-19 pandemic forced GP services to switch to remote appointments overnight to prevent the spread of infection.

Guidance issued by NHS England last year advised GP practices to **adopt a 'total triage' model** so that every patient is triaged remotely by telephone or through an online consultation system before being given an appointment. Practices were encouraged to only book face-to-face appointments where clinically necessary and provide care for people via a telephone or online consultation wherever possible.

As a result, the proportion of appointments taking place via phone or online/video calls skyrocketed. The Nuffield Trust estimates that in April 2020, nearly 1 in 2 (48%) appointments in general practice were carried out remotely via telephone or online/video calls[1]. By comparison, between January and March 2020, only 1 in 10 (10%) GP appointments had been remote[2].

This digital revolution means that people will never access primary care in quite the same way again. To understand people's initial perceptions of remote appointments, we carried out research and, in July 2020, published a report, **The Dr Will Zoom You Now** with **Traverse** and **National Voices**. Our findings showed that there is no one size fits all solution when it comes to using remote consultations. While remote consultations can offer a convenient option for the public to speak with their healthcare professional, some people experience barriers or frustrations. Based on these findings, we also published **top tips** to enable professionals and patients to get the most out of their virtual healthcare experience.

The Dr Zoom report provided useful insight which was well-received by NHS professionals and policymakers. However, we wanted to understand the issues faced by specific groups of people who feel excluded from remote care. The general feedback we have received over the last year shows that while remote consultations can be positive, they don't always work for everyone. Alongside this, our review of existing literature concluded that people living in social deprivation are more likely to be digitally excluded than the general population. This could be economic deprivation due to low income, people living in remote areas, or people who experience a poorer quality of care due to other characteristics like language barriers or living with a disability.

We decided to work with five local Healthwatch to uncover how the shift to remote care had affected people at greater risk of digital exclusion.

1 The Nuffield Trust: **The remote care revolution during Covid-19**

2 Ipsos MORI: Experiences of remote appointments: **What does 2020 GP Patient Survey data tell us?**

# Project timeline

- We received 30 expressions of interest after the project was put out to tender in September 2020.
- Healthwatch England's project group evaluated the proposals and finalised which five local Healthwatch would be grant funded to carry out engagement and collect data. A representative from NHSX also took part in our selection process.
- Local Healthwatch selected for this project were:
  - Healthwatch Darlington
  - Healthwatch Dudley
  - Healthwatch Haringey
  - Healthwatch Swindon
  - Healthwatch Wigan and Leigh (supported by Healthwatch Salford)

# Methodology

Local Healthwatch partnered with GP practices or Primary Care Networks (PCNs) in their community to reach people who are socially deprived. They recruited research participants and carried out semi-structured interviews with the following groups:

- Older people – people aged 65+ years.
- Disabled people – especially people with sensory impairments, learning disabilities or dexterity/mobility issues.
- People with language barriers, i.e., people who had limited proficiency in the English language. Local Healthwatch identified non-English languages widely spoken in their area and used an interpreter for their engagement work.
- Local Healthwatch also carried out interviews with professionals working in a primary care setting to contextualise people's experiences from a clinical perspective.

To ensure everyone interviewed had the same level of care and digital services offer, we asked local Healthwatch to recruit all participants from a single GP practice or a PCN. An interview guide was created by the project group, made up of local Healthwatch and Healthwatch England, to guarantee that data collected was as comparable as possible.

We wanted to understand the experiences of people who live in relative social and economic deprivation. Due to lockdown restrictions, local Healthwatch found it more difficult to recruit participants from lower-income households or those completely digitally excluded. Lockdown measures also meant that we carried out all interviews remotely.

These were by phone, but Zoom calls were also used in a small number of cases when requested by participants, usually to facilitate interpreters being present. Online and telephone surveys were also used to gather information from some professionals and patients, respectively. We recognise that remote methods are not ideal for reaching those at greater risk of digital exclusion, but the circumstances left us with no other option.

# Participant profiles

**Local Healthwatch gathered evidence from 86 patients and 26 members of staff. More than a quarter of the patients (27%) were people from a minority ethnic background.**

## Older people aged between 60-89 years old

34 people were part of the older age bracket group.

This group included:

- 21 women and 13 men.
- Several people with common age-related conditions such as arthritis and hearing or sight impairment.
- Two participants who identified as full-time carers for their partners.
- Family members gave interviews on behalf of two elderly participants.
- Whilst not all participants consented to collect their ethnicity data, most identified as White British. Only one individual said they were of Asian heritage.

## Disabled people

Local Healthwatch interviewed 31 disabled people.

This group included:

- 18 men and ten women from those who provided data about their gender.
- People with physical disabilities, mobility and sensory impairment, learning disabilities, mental health issues and long-term conditions.
- Those who shared their ethnicity were all White British, with one exception who identified as Asian.

# Participant profiles

## People who experienced language barriers

21 participants had English as their second language.

This group included:

- People with varying levels of English proficiency. An interpreter was requested in some cases when required.
- People who spoke Arabic, Bengali Sylheti (Bengali Spoken Dialect), Farsi, Polish, Punjabi and Urdu.
- People from Nepalese and Somali backgrounds.

## Staff interviews

We also interviewed staff in various roles within GP practices for this project.

This group included:

- GPs – two of whom were Clinical Directors at their respective practices.
- Nurses and Nurse Practitioners, including those who carry out triage duties.
- Practice managers.
- Administrators.
- Reception staff.
- Healthcare assistants.
- A practice-based pharmacist.

# People find it difficult to use remote methods for many reasons

**The reasons why participants felt digitally excluded are described below in order of how frequently they were reported.**

## Limited interest in technology

Some participants preferred not to use technology to access healthcare as a matter of personal choice. Primarily this was due to a lack of interest in developing digital skills, which we found in all our research groups.

> I do not really understand all this technology and not interested in learning."

Limited interest in technology can stem from a lack of confidence in using online services for some people. Others know how to use technology (for example, through work) but were not keen to continue using it for personal matters, especially after retirement. Some older participants do not prioritise learning new skills and want to get away from it. In general, participants felt that technology is time-consuming and it's far easier to talk to someone over the telephone or face-to-face. For them, online communication is impersonal – a feeling of "being trapped in a bubble of non-communication" – and is not appropriate for consulting with their doctor.

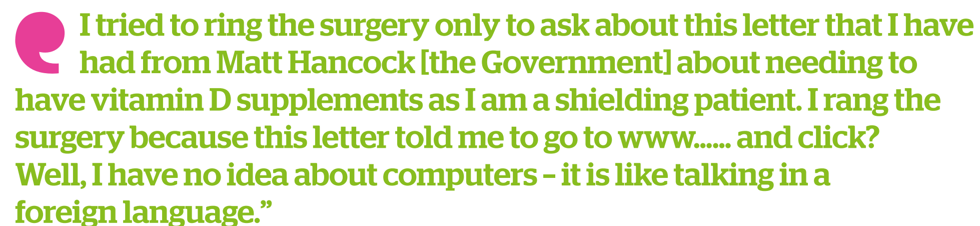
> I don't want to use computers and I don't feel I should have to be forced to do this. I am a hands-on bloke and expect a hands-on approach...I think you should have a relationship with your doctor – I prefer to see the same doctor as I like that personal touch."

## Lack of digital skills

Many participants remain digitally excluded because they are unfamiliar with technology. Older participants were more likely to have never used the internet or a mobile phone. They were worried about damaging expensive devices because they don't know how to use them properly, and weren't sure how to start using them.

People struggle to develop their digital skills because they lack the facility and resources. Specific disabilities, such as sight impairment, can be an added disadvantage. People can't read the resources to improve their skills and don't know how to access training materials in accessible formats.

People without adequate digital skills felt flustered by technology. Even when they have access to the internet and digital devices, they aren't comfortable using them. Messages about using digital services can also be challenging to understand, and people felt that providers do not consider their limited comprehension when drafting critical healthcare communications. As a result, people can't follow these instructions as it felt like reading a "foreign language".



> I tried to ring the surgery only to ask about this letter that I have had from Matt Hancock [the Government] about needing to have vitamin D supplements as I am a shielding patient. I rang the surgery because this letter told me to go to www...... and click? Well, I have no idea about computers – it is like talking in a foreign language."

Limited digital skills have also confused participants using online platforms and discouraged them from using these services. For example, when accessing GP websites online, people were unaware that web content could look differently on mobile phones, tablets, and laptops. It was not clear that they might need to scroll down to find the relevant information.

Some participants depended on family to help them use online and telephone services, such as booking GP appointments. These people were particularly vulnerable during the COVID-19 lockdown as family members could not be there to help them physically. While turning to family can be a great support, some people find it uncomfortable to discuss sensitive issues with their doctors, such as those related to mental health or sexual health, with a family member involved. Lacking digital skills can put people off getting any help if their only choice is remote consultation.

## Age and disability

Our interviews showed that old age and disability can impact people's confidence and prevent them from accessing technology and digital healthcare platforms. For example, one older person had tried to learn to use technology but couldn't remember what to do later, reducing their confidence in using technology next time. Even when keen to learn, some people do not get adequate support, and depending on family members can be tricky and might not be an option for everyone.

I've thought about it [learning digital skills] before and asked my grandchildren for help but they move so quickly I get confused and I lose confidence. When I ask my son for help he gets frustrated with me and we argue. It would be good if there was somewhere we could learn that would move at our pace... but I'm too old to go back to the classroom."

On the other hand, some people are comfortable depending on family to help them access digital healthcare services, so they don't feel the need to learn digital skills. However, as highlighted above, this caused problems during the pandemic when people couldn't meet their family due to the lockdown restrictions and struggled to get online.

Sensory impairments, such as hearing and sight loss, can prevent people from using online services, making them reluctant to try digital healthcare services, so they prefer face-to-face interaction. For example, participants using hearing aids said they struggled to communicate over the phone or a video call. People with sight impairments are unable to read instructions unless they're in Braille. This makes them reluctant to try digital healthcare services and as a result they prefer face-to-face interaction.

Physical disabilities can also be a barrier to online healthcare. For example, people with disabilities affecting their arms cannot use a computer or touch screen phone. Holding the phone for a long time to get through to a GP practice, can be equally uncomfortable.

For repeat prescriptions you use an online app which I struggle with because I can only use one hand as my left arm is disabled and my shoulders are weak."

## Lack of trust

Several participants feared that their privacy and confidentially would be compromised online and preferred to stay digitally excluded. Online scams were a concern; many people were also uncomfortable sharing private medical information via online platforms as they didn't know who could access their details. For example, one concern was that GP receptionists might see the photographs people submit for online consultation with their doctor. Some people find technology invasive and feel uneasy about using technology that could identify them, such as video calls.

I have no one to ask to help me with this. I am a little bit worried about fraud and less interested in learning about this as I am getting older."

Others remain wary of what they perceive to be a rush to adopt new ways of working remotely. In general, people seek reassurance from healthcare services about the quality of care and that it will not be compromised on digital platforms.

## Language barriers

People with limited English proficiency, especially the elderly, struggle to express their needs over the phone. They tend to rely on body language and facial expressions to communicate with their doctors during in-person appointments, making remote appointments difficult.

People with language barriers often depend on family to translate their issues during remote consultations, which can be an issue when sharing private medical information and can put people off using digital services.

As most online information is in English, people with language barriers, including those who use British Sign Language, find it hard to understand. For example, trying to book or confirm an appointment on an English-based website is a problem and prevents them from downloading and using online GP applications, such as **AskmyGP**.

**"Before it was much easier, I would go to my GP in person, and the receptionist understood what I needed. My GP was also patient with me, and face to face, it was easier to talk about my health. Now it's different, I know they do telephone consultations, but it is not suitable for people like me. My English is weak, and I am not sure I would be able to explain myself on the phone."**

# How does affordability impact digital exclusion?

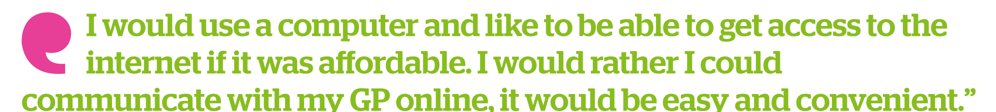
**Most of our participants could afford technology, such as the internet and a broadband connection, allowing them to engage with online healthcare services. However, for a minority, affording computers, smartphones, and an internet connection is difficult. Our analysis below highlights the issues they face because of this.**

## When people can afford technology and an internet connection:

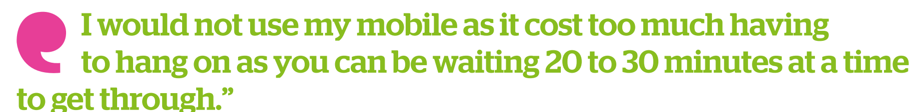
- Affordability is not a guarantee of digital inclusion, but it is essential to engaging with digital health. We found that when people can afford the technology and have digital literacy, they tend to use online services and are more willing to engage with digital healthcare.
- Many participants were confident using online applications, such as ordering repeat prescriptions, having remote consultations with their GPs and sending pictures to their doctor.
- We have also noted that people who can afford to access technology and have the right skills appreciate the advantages of digital healthcare and are more likely to invest in developing their digital capacity. For example, we heard from a disabled person with motor and mobility issues who had upgraded their broadband package for a faster connection and bought a webcam that could recognise speech – making digital interactions much easier.

## When people are unable to afford technology

- People unable to afford technology are primarily digitally excluded – our data suggests that these people cannot use digital healthcare facilities, even when they want to or are willing to learn the relevant technical skills. In some cases, it can impact their willingness to engage with services altogether, which is especially relevant for those who are on a low income and for disabled people who have additional living costs.



- Our data also suggests that financial constraints can impact the choices people make. For example, a person living in accommodation with limited space felt that they didn't have enough room for a computer and remained digitally excluded. Others might be unable to afford technical accessories, such as webcams, or assistive technology, such as screen-readers for people with sight impairments, making it easier for them to use online platforms. Consequently, this discourages them from using online services.
- People on low incomes were put off by the extra charge of a broadband contract as they felt that they had enough bills to pay already. Some opted for phones with only basic features because they couldn't afford more expensive smartphones, which prevented them from using certain healthcare applications available only on smart devices.
- People who own older versions of mobile phones and computers said that they aren't helpful for digital interactions with healthcare services. As affordability is an issue, they can't upgrade to newer devices and consequently become digitally excluded.
- Access to the internet is not the only barrier – it can be difficult for people to afford to call their GPs using a telephone if they are on a pay-as-you-go phone contract or a contract with limited call allowances. While unlimited data or phone contracts work out cheaper per unit cost, the comparatively high initial cost excludes people from using phone services altogether. People also avoid phoning their GP as they worry about the cost of long wait times getting through.



**I would not use my mobile as it cost too much having to hang on as you can be waiting 20 to 30 minutes at a time to get through."**

- People on low-cost phone contracts tend not to have enough data allowance to send large files like pictures to their GP. Their contracts can also limit the type of digital platforms they can access to share images.
- People on cheaper internet deals have reported poor connection and slow internet speed making remote communication difficult. This becomes more challenging for those with language barriers and needing additional interpreter services when communicating with their doctor online.
- People who depend on others to have digital access may lack the freedom to access remote care. For example, one of our research participants said they rely on their family members to afford technology. They could also quickly become digitally excluded if the person they depend on is unable to pay.

**I've got a landline and mobile contract which my son pays for to help me to stay connected; otherwise it would be a struggle."**

- People who cannot afford and access technology have said that they feel left out and unable to keep up with the latest healthcare information. This could make them feel isolated and less confident about using online services.

# People found it more difficult to access face-to-face appointments during the pandemic

- People were usually able to access face-to-face appointments eventually if they felt they needed one or could not use other remote systems, but this often required persistence and repeated escalation by patients or their family members.
- Usually, people go through a triage process using an e-consult system or practice reception before they are offered an appointment. They are asked to have a phone appointment first before a face-to-face appointment can be booked at the clinician's discretion.
- People felt they required face-to-face appointments for a variety of reasons. Some preferred the option, whereas others believed that the lack of face-to-face appointments hindered an effective diagnosis, particularly when waiting for triage and then follow up.
- People generally felt safe attending surgeries with social distancing and other COVID-19 safety measures in place. However, there were several examples where people felt communication from staff about COVID-19 arrangements could have been better. For example, people were asked to queue outside in the cold or were unclear which entrance to use.
- People who are regular visitors to their GP practice were frustrated at the lack of proactive communication about how visiting arrangements would change. For example, using different doors and confusion around where to put requests for repeat prescriptions. For older or disabled patients, this caused confusion and distress, and they would have liked a letter or phone call to explain how things were changing. Staff interviews also reiterated that repeat prescriptions were one of the main reasons people came to surgeries in person during the pandemic. Proactive communication and reassurance about alternative arrangements could help to cut down unnecessary visits and give people greater confidence in their care.

# Remote care removes obstacles for some and creates barriers for others

- Those with mobility issues said remote care made it easier for them to avoid difficult trips to the practice. People with caring roles also found it easier to talk to their doctors remotely without worrying about leaving their loved ones alone.
- The most common complaint we heard was around the difficulty of getting an appointment in the first place. Many reported that phone lines were busy, or appointments were fully booked when they rang first thing in the morning. Long automated messages with different options were complex for those with limited English or hearing impairments. On some occasions, people listening to a pre-recorded message didn't hear the right option, so they gave up. This echoes the findings of **our GP access report**, which also highlighted rising problems with booking appointments during the pandemic.

**Every time I rang up, for a whole fortnight, I was told that all of the appointments had gone. I was asked to ring back again tomorrow at 8am but I was just told the same thing again every day. I waited over a month to get an appointment."**

- At one practice, implementation of a 'total triage' model led receptionists to direct people to book appointments through the AskMyGP app, but participants who struggled to use the app were not offered support to book on the phone, and as a result abandoned attempts to seek care.

**You must go through 'Ask My GP'. My dad would want a face to face; but there was no offer of that. I rang the surgery (for my dad) but no appointments as two doctors were off self-isolating. They said use the online link. They didn't ask if my dad had a computer/a smart phone. My dad is panic stricken about using this app."**

- As might be expected, many older people, people with limited English, people with sight impairments and deaf people shared how they felt less comfortable or struggled with remote bookings and appointments and would much prefer face-to face. However, remote appointments also worked well for some people in these groups, particularly those that could draw on support from family.

**The GP was refusing to talk to me over the phone about my child... I just feel some medical issues are not right for the app and I wanted to speak with a GP about my son's problems. If I could have spoken to someone it could be dealt with more appropriately. I had to send pictures of my disabled child's genitals over the 'Ask MY GP' app before the GP would talk to me."**

- Whereas interpreters can usually be present during a face-to-face consultation, booking apps and phone appointments present a more significant challenge for people who speak little English.
- A staff comment highlighted that bringing people in for appointments with an interpreter wasted GP time as many issues could otherwise have been dealt with remotely. However, some GP practices relayed that they used interpreters for phone or video consultations rather than just face-to-face appointments.

**I had a letter for a review in June for my pacemaker and it told me to phone, so I went through Type Talk. I asked if it was possible to have a Zoom and they refused, so in the end they delayed the appointment till September, but I haven't heard from them and no new appointment has come through."**

- The three groups of people we spoke to, reiterated similar frustrations regarding telephone appointments and not knowing exactly when a doctor will call within a wide time slot. But for people in these three groups, the challenge was exacerbated because they often needed an interpreter, carer, or family member to help them with the appointment.
- Some older people or people with hearing impairments said they found it difficult to hear the doctor on the phone but didn't feel confident to say anything (or did say something but experienced no improvement). One person told us they said "yes" to everything without understanding what was being said.

People also experienced a range of challenges accessing care specific to their conditions or demographics, or to do with their digital skills or literacy, including:

- Not being able to register a family member on remote consultation platforms using a common email address.
- Finding it difficult to navigate registration requirements, e.g. creating or knowing a required password.
- People with language barriers struggling to get a repeat prescription as they could not spell or pronounce the name of the medication over the phone.

Some issues related to the accessibility or functionality of the online platforms, including:

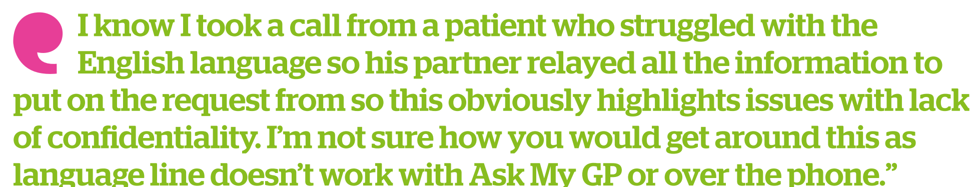
- Not knowing if online requests were successful as people did not always receive notifications, e.g. having to chase the pharmacy to ensure the prescription requests had gone through.
- Missing information in text messages, such as a link to upload requested photographs.
- Not understanding how to request their preferred doctor on online forms led to people completing forms multiple times – this was particularly an issue with elderly/sight impaired.
- Wi-Fi breaking up causing poor quality video consultations.

# People want choice over what kind of appointment they have

- Overwhelmingly, people expressed the desire for choice over what kind of appointment works best for them. Some people (especially full-time carers and those with mobility issues) said remote appointments worked well because they saved time and avoided travel costs and inconvenience.
- Many who did not experience significant barriers accessing care remotely and had their needs met did not see their experience as significantly different from face-to-face appointments and would be happy to continue receiving healthcare remotely.
- We frequently heard people say that they understood the need to shift to remote methods during the pandemic and felt remote solutions had been "good enough" given the circumstances. However, they were concerned that this would become the only option. They felt something would be lost from their care in the long term if they couldn't return to face-to-face appointments in the future.
- People who spoke about a specific remote consultation were more likely to be satisfied with the quality of care. However, when talking about the shift to remote care in general terms, people were more likely to be unsatisfied. This was often to do with a feeling that they would be more confident in managing their health in the long term if given the option to attend face-to-face appointments. For many, the human interaction adds to their trust and confidence in diagnoses and empowers them to ask follow-up questions or clarify anything they did not understand.

# Staff support remote care but want a hybrid model

- Most staff interviews expressed broadly positive views about the shift to remote care, saying that they felt it was a valuable addition and had allowed them to accelerate a change that was already in progress.
- In many cases, remote consultations enabled GP practices to work more efficiently, saving time and helping with forward planning (e.g. triaging online requests at the start of the week allows for the arrangement of locum doctors according to demand). They felt that many of the practice population, especially young people, are grateful for having remote appointments that fit better around their lives.
- However, most staff also acknowledged that the pace of the changes had been swift, with several saying they had to implement the remote systems "overnight" with little support, which meant that some people's needs weren't met. Many staff (including nurses, healthcare assistants and practice managers) recognised that older people and non-English speakers particularly struggled with the shift to remote care, and this might have prevented people from getting help, and in some cases avoiding their GP altogether.



"I know I took a call from a patient who struggled with the English language so his partner relayed all the information to put on the request from so this obviously highlights issues with lack of confidentiality. I'm not sure how you would get around this as language line doesn't work with Ask My GP or over the phone."

- All staff interviewed emphasised the importance of being able to see people face-to-face if clinically necessary, for example, if they need to physically examine someone to diagnose them or if communication is difficult over the phone. They also stressed that it was essential to maintain face-to-face appointments as an option for those who struggle to access care remotely.
- Several felt that at the start of the pandemic, the "balance wasn't right", and they missed some diagnoses due to the lack of face-to-face appointments. Some staff also found remote working was both alienating and uncomfortable. However, as time has gone on and they have been able to re-introduce more face-to-face appointments, they believe a hybrid model works well and strikes the right balance.
- Most staff want to maintain the use of remote appointments in a hybrid model. However, many wanted to review the proportion of remote vs face-to-face appointments: suggesting that the number of face-to-face appointments should be higher than during the pandemic.

- The immediate shift to remote care at the start of the pandemic meant that some preventative care programmes, including screenings, smears, and immunisations, were paused or scaled back. Many of these have now restarted, but take-up is lower since people are reluctant to attend surgeries in person for non-essential needs. Asthma and diabetic checks are taking place remotely, but staff are not always confident they will pick up symptoms. New patients are not receiving health checks. However, staff felt this was due to the pandemic rather than the shift to remote care. They hoped these issues would improve as we transition out of the pandemic and toward a hybrid model of care.

**All our new patients used to have a health check. They are not getting that nowadays, that's a real shame. We are missing opportunities to diagnose new diabetics, people with high blood pressure. Smoking cessation as well."**

- Staff mentioned that remote consultations, even where video is an option, aren't always clinically appropriate – e.g. they can't see a rash well enough to diagnose it.
- Staff at several practices told us that online booking and triage systems significantly increased the volume of consultation requests. In some cases, this is positive as people ask for help with issues they wouldn't feel comfortable speaking about over the phone. However, in other cases, unnecessary requests around minor conditions manageable at home were being submitted. There was the perception that the ease of submitting an e-consult request was exacerbating these issues, whereas with face-to-face appointments, people would only request one if they felt they needed it. In smaller practices, the time required to process e-consult requests created significant staff capacity issues. This echoes **reports of similar issues in the Health Service Journal**.

**For the elderly or people that are not really tech-smart, it's had quite an impact. A few people are really, really hit. They will say "The GP is avoiding seeing me". They are used to face to face, and they just want you to see them, even if it's something that can be dealt with over the phone, and sometimes it's kind of hard to say no. With people like that, it's been quite hard on them."**

# Better support could help some people access care in different ways

- People wanted more proactive communication from GPs about changes in working practices. For example, one person said they hadn't been aware that the surgery was now offering face-to-face appointments again after a period of being remote.
- Another was worried that her mother (who was shielding) had not been contacted and would miss out on preventative care like having a flu jab or blood pressure taken. There were also positive examples of where proactive communication led to a better experience.

**"When I came home from the hospital, my GP wrote me a letter, which had a telephone number I could call. Because of my disability, I prefer to call them If I need to ring them for my prescriptions, I can talk to the receptionist and she can provide me with the medicine I need. I have no complication in that way because they know me well."**

- Despite staff at one practice saying they could only source interpreters for face-to-face appointments, language needs can be supported remotely where this works for the patient. In one PCN, staff described how they previously used Language Line for face-to-face appointments, which meant an interpreter would be in the room. Now they also use Word 360, a service which provides translation services for remote phone and video calls. Other PCNs also reported that they successfully use Language Line for telephone calls.
- Both patients and staff suggested that it would be helpful to make notes on patient records regarding communication needs or level of digital skills. Staff could then be more proactive about offering them the most appropriate consultation type or be more understanding about requests for adjustments.
- Some practices have produced supporting guidance, like YouTube videos, demonstrating how to use their e-consult system. Another practice set aside specific time slots for older and more vulnerable people to call up and book to ensure they can get an appointment.
- In some practices, which encourage people to book appointments through an app or online system, staff told us that if people do not feel confident filling out the form themselves, they can call the practice. A receptionist will talk them through the questions and submit the form on their behalf. This allows the practice to maintain a total online triage model so that all requests go through the online system. Everyone has an equal chance of getting an appointment while ensuring those who are digitally excluded can still book an appointment. However, it was unclear whether those unable to use the online system would receive an appointment straight away or whether they would have to wait for a call back or email.

## Helping people access digital healthcare in Haringey

The Digital Support Project in Haringey aims to improve access to care for patients by mobilising a team of volunteers to provide tailored technical support, helping the public access GP and hospital appointment systems like e-Consult and Attend Anywhere. So far, the pilot project has enabled over 60 people to access appointments, but demand is growing as in-person meetings become possible.

A small team of dedicated staff train Healthwatch volunteers to support people use remote systems. GPs, hospital trusts, and social prescribers can refer people who may benefit from improved digital skills. Those who do not have a mobile phone or tablet can loan one.

Volunteers provide different levels of support depending on individual need. The smartphones also allow volunteers to control the device remotely, demonstrating to users how to access apps or links.

Volunteers can also talk to people about their digital needs over the phone or in-person at libraries and community hubs to support them through their appointment, showing people how to do it themselves next time. As lockdown restrictions lift, volunteers will also meet people in their own homes, providing them with a training session on their device or a device loaned by the support team. Next, the project is looking to train care home staff, who can then support residents use tablets for remote care and to keep in touch with loved ones.

Healthwatch Haringey run the project in partnership with three local hospital trusts and the CCG. The project is currently in a 6-month pilot phase, funded by the CCG and local hospital trusts, with scope to recommission for next year.

# Recommendations for practices, PCNs, and commissioners on better supporting patients

- Practice websites should contain clear information about all the possible ways to book an appointment. Links to any supporting information (e.g. a YouTube video showing how to use the e-consult system) and information on what to expect after the booking request is submitted should also be available. Commissioners should request that e-consult system providers create guidance videos in different languages. Consider asking your Patient Participation Group to review this information and feedback on how it is displayed.
- Carefully consider whether a remote or face-to-face consultation would be more appropriate for each patient. The RCGP has produced **a guide** to support clinicians when choosing a consultation type.
- Can the practice be more proactive in supporting patients who have additional support needs for accessing care? When offering a remote appointment, ask people whether they need any support accessing the appointment. Make notes on records so that patients are offered support every time they contact the service (e.g. if an interpreter is required). When patients are referred onwards, these notes should also be shared with other services.
- Seek opportunities for partnership with the voluntary and community sector to offer support to patients in accessing care. **National Voices' report** contains a wide variety of case studies on community support initiatives for remote care.
- When implementing a 'total triage' model, train reception staff to support patients who cannot access digital tools during booking requests. People can be encouraged to book online, but no one should be told that the only way to book an appointment is through the e-consult system, without offering them support in making the booking. This is in line with **NHS guidance on total triage**.
- Make patients aware of their rights to access care in a way that works for them. For example, display the **Knowing your choices poster** endorsed by Healthwatch, alongside National Voices and the RCGP.
- Make use of existing tools and guidance to support high quality remote and video consultations, including:
  - **Principles for supporting high quality consultations by video in general practice during COVID-19**
  - **Key principles for intimate clinical assessments undertaken remotely in response to COVID-19**
  - **Advice on how to establish a remote 'total triage' model in general practice using online consultations**
  - General Medical Council (GMC) – **Ethical guidance for remote consultations**

# Five principles for post-COVID digital healthcare

## 1 Maintain traditional models of care alongside remote methods and support patients to choose the most appropriate appointment type to meet their needs

We know that remote care has worked well for many and has even removed barriers to accessing care for some who would otherwise find it challenging. For many, retaining the option to access care remotely will be an essential improvement to services.

Our research, and similar work conducted by National Voices, clearly shows that some people find it more difficult to access care through digital or remote methods for a variety of reasons, including affordability of technology, digital skill level and language barriers. For some people, remote methods aren't an option, and a lack of alternatives can mean they don't receive vital healthcare.

As lockdown measures lift, it is vital that GP practices offer in-person appointments and that appointment bookings can be made by phone or by coming into reception, with practices open to the public.

Practices should respect patient preferences for face-to-face care unless there are good reasons to the contrary (e.g. the patient has COVID-19 symptoms). Giving people the agency to say what is right for them is not about giving people what they 'want', but a vital way for the system to manage people's varying needs more effectively. This is in line with the most recent standard operating procedure for general practice issued by NHS England to support the restoration of general practice services as lockdown is lifted.

At the same time, we also support the ongoing digital transformation of the NHS and recognise the need for continued investment into IT infrastructure and digital innovations – enabling all practices and PCNs to offer remote care for those who want it.

As we move out of the pandemic, the NHS must support the effective and safe use of remote consultations and different triage models while offering a mix of remote and in-person appointments. This would be based on shared decision-making between GPs and patients.

## 2 Invest in support programmes to give as many people as possible the skills to access remote care

While not everyone will have the capacity or desire to access remote or digital care, we know that the proper training and support can help people who were previously digitally excluded from getting online.

A report by National Voices contains a wide variety of case studies on community support initiatives for remote care. Through the NHS Widening Participation Programme, the Good Things Foundation has also shown how community interventions can help improve digital literacy and suggests a 'digital health hubs' model to build skills and enable people to access health services online.

There are many examples of successful local initiatives, including the case study featured in this report. But ultimately, such initiatives should not be left up to local discretion – the NHS must commit to improving digital literacy central to its post-pandemic recovery strategy.

## 3 Clarify patients' rights regarding remote care, ensuring people with support or access needs are not disadvantaged when accessing care remotely

Currently, national policy regarding remote methods in primary care is fragmented across various operational documents. We have previously called on NHS England to undertake a formal review of the ways people access General Practice services to make sure they work for everyone.

Part of this should include developing a code of practice clarifying patients' rights to receive services online or offline, alongside the kinds of support they are entitled to both on and offline, like access to an interpreter. Ultimately, this should become a core part of the NHS Constitution.

Our research showed that there is currently a wide variation in local practice regarding how practices integrate remote appointments with the support which people are legally entitled to (e.g. foreign language or BSL interpreter, information available in accessible formats). These approaches need to be standardised – for example, making clear that the NHS should be commissioning telephone interpreters – to ensure that no one with additional support needs has a worse experience because of receiving care remotely.

More broadly, NHS England should produce a single vision statement setting out national expectations for the role remote care plays in transitioning out of the pandemic.

## 4 Enable practices to be proactive about inclusion by recording people's support needs

The NHS must understand people's individual support needs, removing all barriers to accessing services.

In our research, both patients and staff suggested that practices should code patient records with information regarding a patient's language and communication needs or level of digital skills. Staff can then be proactive about offering people an appropriate consultation type or pre-empt requests for adjustments in future.

The system should investigate how patient record systems can support this. We are not suggesting that GPs conduct an audit of all patients' support needs, but rather that these are noted when initially come up.

As increasing proportions of secondary care appointments are delivered remotely, this information should follow a patient referred to other services.

## 5 Commit to digital inclusion by treating the internet as a universal right

Digital and remote methods will play an increasingly important role in how people access the NHS going forwards. We support the long-term ambition to make 'digital first' models accessible to everyone to save time and create efficiency without sacrificing quality.

But if the NHS is going digital, there can be no excuse for allowing cost to create a permanent barrier to accessing vital public services. In its **report 'Beyond Digital'**, the House of Lords Covid-19 Committee argues that the internet should now be considered an essential utility in the same way as water or electricity. The Committee recommended that the Government consider introducing a legal right to internet access, giving people a ringfenced benefits entitlement to access affordable internet.

We agree that the national ambition to provide digital-first primary care to everyone should be underpinned by a universal right to internet access, ensuring the NHS remains genuinely free at the point of use.

This principle is already gaining recognition, with some broadband providers creating new low-cost tariffs for those on Universal Credit, but this should be taken further by the Government to ensure people can always access vital public services.

Additional interim solutions could include:

- Ensuring all GP practices are reachable by a freephone number.
- Arrangements with telecoms firms that no data charges will incur when accessing any NHS services.
- Including access to the internet in social prescribing schemes, funded by the NHS for those whose health may benefit from it.

# About us

## Healthwatch is your health and social care champion.

If you use GPs and hospitals, dentists, pharmacies, care homes, or other support services, we want to hear about your experiences. As an independent statutory body, we have the power to make sure NHS leaders and other decision makers listen to your feedback and improve standards of care. Last year, we helped nearly a million people to get the support and information they deserve.

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# Learning from Covid-19

JHOSC – June 2021

# Summary

During the first wave of the Pandemic we had to respond rapidly to a very challenging situation and unprecedented demand for services.

Learning from the first wave informed preparations for wave 2 over autumn/winter 2021 and has helped us build strong foundations as an integrated care system (ICS).

This report provides an overview of the approach employed by NCL system partners to respond to and learn from the COVID pandemic. The report further sets out how system partners worked together, developed innovative system solutions and key achievements that have been delivered as a result.

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# Contents


1. Introduction and context
2. System working and governance
3. Key learning from wave 1
4. Approach to planning for second wave
   - Critical Care
   - Emergency Care
   - Local Care
   - Support for care homes
   - Specialist care
   - Children and Young People's Services
   - Mental Health
5. Elective recovery
6. Key Achievements

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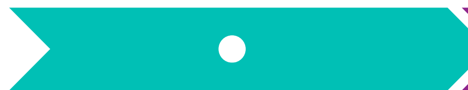
# Introduction and context

During the pandemic, NCL has faced unprecedented challenges for the health and care system. We have worked as a system to strategically plan our response, within the context of a level 4 national incident. We have continually reviewed and refined our approach during the different phases of the pandemic. We made sure we learnt, were flexible and able to adapt to the different situations we faced to ensure we could continue to deliver services that meet the needs of local people.

**March – June 2020**



### Wave 1

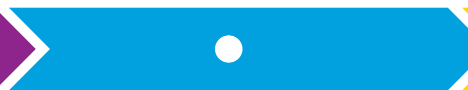
We rapidly responded to the emerging situation, making temporary changes to services and redeploying staff at short notice.

**July – Nov 2020**

### Recovery and Review

We carried out after action reviews, planned service recovery and explored how to build on successful collaborative response to ensure future benefits for the ICS.

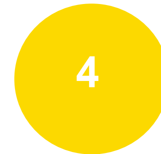
**Dec – March 2021**



### Wave 2

Having prepared for a potential second wave were able to respond to significant increase in demand for services due to Covid and maintain more essential services

**April 2021 - present**




### Recovery and Review

Now we are focusing on recovery of electives, primary care, community and mental health services while planning for any further waves, the longer term future and ambitious ICS plans.

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# System working and governance

Over the course of 2020, NCL we established cross system governance structures and ways of working that have allowed us to adapt to the changing demands of the pandemic. Operating within a level 4 national incident required different ways of working, including governance arrangements, with increased oversight from NHS England and NHS London GOLD level and NHS London Clinical Advisory Group (CAG):

- System leadership provided through the System Recovery Executive and Partnership Executive Group
- Senior clinical and operational leadership provided by NCL's Clinical Advisory Group (CAG) and Operational Implementation Group
- Oversight provided by the Partnership Board and NHS England and NHS London GOLD/CAG
- We established NCL's People Board to provide professional leadership
- We formed clinical networks to support areas such as critical care, prioritisation and medical specialties
- The Local care group provided leadership to primary care, mental health and community care
- The Provider Alliance supported collaboration and efficient working between NHS trusts

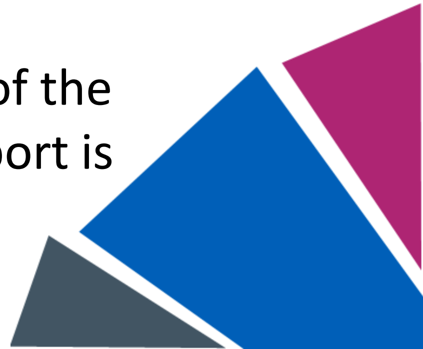
We want to ensure we evolve our leadership structures, accelerate and maximise the benefits of new ways of working, including system collaboration across the NHS, councils and partners. This will enable us to respond to the ongoing pandemic while building the foundations for a better health and care system as we move to become an ICS, including action to tackle health inequalities and the wider determinants of health.

# Learning from first wave

In NCL we found that:

- Impact on NCL's population was broadly in line with national Public Health England's analysis. Identified a need to prioritise tackling health inequalities, in and across boroughs, as central to our recovery planning
- COVID has exposed the impact of inequity and inequality within and between boroughs - there is a real risk of widening of inequalities as some communities fear re-engaging with services.
- Experience and impact of the pandemic is individual to residents and we need to respond appropriately. Need to continue to work closely with communities, councils and community organisations to tackle fear of accessing services, isolation and outbreaks within family and communities. Use principles of:
    - Actively engage with those most impacted by change
    - Make everyone matter, leave no one behind
    - Confront equality head on
    - Strengthening personalised care
    - Value health, care and support equally
- As a system, we need to plan based on local population health needs following the impact of the pandemic. For example, the burden for mental health, long term conditions and social support is continuing to grow, and this requires more collaboration at a system level.





# Learning from first wave

- Data helped us to develop systematic Covid responses across the health and case system. We used triggers and modelling to plan for critical points at which the system took particular actions and responses, and graduated this in line with the rate, prevalence and admissions of cases.
- NCL benefitted from specialist tertiary NHS hospitals shifting their focus and acting as part of the system e.g. Great Ormond Street Hospital and Royal National Orthopaedic Hospital. Continuing to working closely with these world leading centres will support our response and recovery to future waves.
- Future response need to be borough specific and sector coordinated to build on local strengths, respond in an agile way while benefitting from system actions
- We benefitted from new use of data and technology to support primary care to work with other agencies and support shielded and vulnerable residents
- We benefitted from strong local relationships in working with care homes and captured learning
- System actions were required for aspects of NCL's response such as boosting intensive care capacity
- Our workforce is our greatest asset, we need to more to support them and their families. There is an opportunity to address many of the workforce challenges, including a focus on developing, supporting and promoting leaders from our local communities and BAME communities.
- There are some benefit in continuing to work as a system to support capacity issues and constraints in areas such as testing and PPE.

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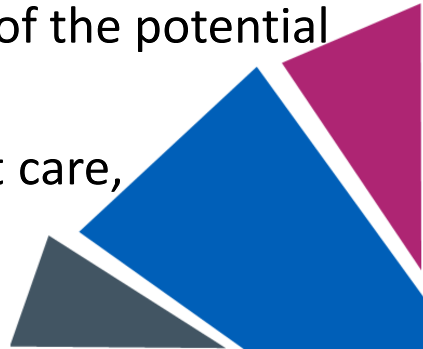
# NCL approach to planning for Wave 2

- To maximise the learning from the first phases of the COVID pandemic, NCL worked on modelling and scenario planning which has guided the system's preparation and response to Wave 2.
- This guided our collective planning and decision-making around trigger points for standing up or down services or flexing capacity at the right point in time. This approach also aligned to the Public Health England and local authority and outbreak response work.
- It allowed us to respond quickly and appropriately to maximise our impact while maintaining health services as long as possible.
- We took also into account key capacity constraints such as personal protective equipment, testing and medicine availability, as well as staff well being and ensuring staff support through an extended response.
- We developed a series of escalation plans to alert us to pressure in the system, factoring in interdependencies.
- We used scenario planning to support a system response to best and worst case modelling of the potential impact of a second wave.
- Our priority was to maintain services, including emergency care, cancer and other specialist care, outpatient, diagnostics and elective care, throughout a second wave as much as possible.



# Critical Care

We learnt a huge amount during wave 1 which supported successful planning for wave 2 –

- System wide surge planning allowed NCL to increase capacity in intensive care by 250% across system from a baseline of 152 beds during the peak of demand in January/February 2021
- UCLH ran a highly effective critical care transfer team and is took a significant number of transfers from other sites
- Royal Free London provided specialist renal services for patients across the system
- Our ongoing approach to critical care:
  - build on our **partnership working** and mutual aid strengthened during the first and second waves of Covid
  - consolidate **learning from our clinical outcomes** and after action reviews to inform our planning
  - increase **staffing resilience through training**
  - consolidate and build on the NCL critical care **patient retrieval/transfer hub** which UCLH will host
  - grow **bed surge plan**. Locate most increased capacity at UCLH and the Royal Free Hospital **creating hubs** to support the network
  - protect **specialist work** and maintain specialist elective work, such as cancer, through future peaks or Covid surges
  - develop our **staff wellbeing plans** in line with wider London principles and ICS plans
  - develop **Oxygen resilience** to support increase in ventilated and non-invasive ventilation beds

# Urgent and emergency care

- We experienced a surge in **NHS 111 activity** during both wave one and two.
  - During wave one we introduced service advisors and this was continued during wave two, to maintain call answering performance.
  - A Clinical Assessment Overflow Service was introduced during wave two to support the 111 service at a regional level to be used when demand increased.
  - Closer working between 111 and primary care with ability to book GP appointments introduced (in hours).
  - Out of hours pulse oximetry home management for Covid patients delivered by 111 to complement the in-hours primary care led service.
- During summer 2020 we introduced new ability for NHS 111 to directly **book A&E or urgent treatment centre appointments** following clinical assessment to determine both level of urgency and most appropriate service.
- We have also recently introduced hospital pathways for **same day emergency care** via clinician to clinician hand over for areas such as stroke and falls
- Although we initially closed the Edgware Walk in Centre, this is now scheduled for re-opening in October, recognising the surge in demand for walk in appointments.

# Local care

Hospitals having seen a huge demand for their services and many residents have been very anxious about spending time in hospital it has been really key to make sure patients are cared for in the most appropriate setting including in their own homes, or community beds where possible. Before the pandemic there was variation in discharge arrangements:

- In March 2020 we created **integrated discharge teams i**n each acute hospital to reduce the variation in discharge arrangements, support collaborative working and reduce delayed discharge of medically optimised patients. The teams facilitated very positive changes such as P2 capacity bed sharing, and local authority capacity for step down bed, helping to reduce excess admissions and stranded patients. We have continued to refine our approach across NCL introducing consistent processes and operational tools
- **Pulse oximetry at home/Virtual wards** - working closely with primary and secondary care pulse oximetry led by primary care and virtual wards led by secondary care to avoid Covid patients' admission to hospital and early discharge where appropriate
- **Additional community step down** – 24 bedded nurse and Allied Health Professional (AHP)/Multidisciplinary Team (MDT) led unit facilitating patient discharge from North Mid.
- NCL has an existing **Rapid Response** (Urgent Community Response) 'core offer', including consistent opening hours, cross-border eligibility and clinical conditions accepted. There is a single NCL Rapid Response LAS Appropriate Care Pathway (ACP) and referral protocol for 111/IUC

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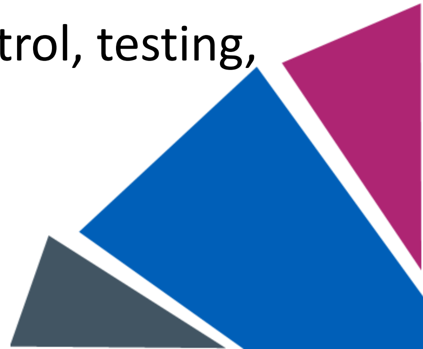
# Support for care homes

- As per previous paper to JHOSC in September 2020, we have been developing our support to care homes during the pandemic
  - Following the huge impact covid-19 had on residents that receive care services during wave one, we developed a robust **After Action Review** to explore how we had responded as a system and what we could learn.
  - We agreed that as a system we will formally implement a joint programme of work between NHS and Councils to continue strengthening **integrated work with care providers** at a borough and NCL level.
  - This will support **continuous improvement and learning** as well as implementation of the action plan from the review.
  - We worked closely together, particularly across adult social care, public health and NHS partners. We formed new joint programmes of work and **enhanced relationships with care providers** to help us respond.
  - We have increased **support to care homes** in areas such as infection prevention and control, testing, staff training and access to clinical support.





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# Specialist care

- **Cancer**
  - Between wave 1 and 2 we learnt, from data published by the surgical hub at UCH at Westmorland St along with private hospitals, that it was possible to carry on services safely with the right infection control measures and it was possible to keep patients safe.
  - We managed to encourage people to still attend services, meaning a much smaller drop in attendance at services and a smaller drop in suspected cancer referrals. (about drop 70% in April 2020 vs 30% in Jan 2021), largely through a combination of local and national public awareness work.
  - The early stages of the pandemic led to some of changes in clinical management of patients, such as increasing gaps between chemo cycles or avoiding chemo alongside surgery. In some cases we think that these changes will lead to long term improvements and NCL Cancer Alliance is sponsoring a project to collect detailed data to evaluate how changes to pathways have benefitted patient care.

- **Stroke**
  - High Acuity Stroke Unit relocating to Queens Square has seen improvements in number of patients admitted to stroke unit within four hours and in time to see both consultant and trained stroke nurse
  - NCL has started a pilot with LAS to link patient, paramedics and stroke consultant by video link

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# Specialist care

- **Cardiology** - during wave one St Barts acted as a 'Cardiac Hub'

- **Renal**
  - We have an ongoing ambulance divert in place for dialysis patients to the free from the sector. This was confirmed and supported by a pan London CAG paper.
  - We selectively transfer patients with AKI to the renal unit to avoid ITU bed use in sector hospitals when clinically appropriate
  - We provided  renal ward rounds at n district hospital iTU during the pandemic to optimise management
  - We contributed to the national guidance for the management of AKI  in ITU in COVID.

- **Neuro-rehab centre**
  - temporarily closed in December 2020, and reopened in February 2021.

# Children and young people's services

During wave one, changes were made to paediatric services at short notice, when all inpatient care moved to GOSH. This was disruptive for staff, children and young people and their families. To prepare for future increases in demand over winter/autumn 2020/21, we proposed temporary changes to allow paediatrics to continue to deliver safe, high quality emergency, inpatient and specialist care:

- **Whittington Health** Southern Hub created with temporary expanded capacity for paediatric emergency and inpatients
- **University College London Hospitals' (UCLH)** paediatric emergency department temporarily closed. UCLH specialist inpatient and day-case services, e.g. cancer haemato-oncology and complex adolescents, stayed open.
- The **Royal Free Hospital's** paediatric emergency department and majority of inpatient beds temporarily closed. A small number of low volume specialist services remained open for: Plastics trauma; Gastro infusions; food challenges; tongue ties; MRI ; hydrogen breath tests; urgent ophthalmology; and plastics.
- **Barnet Hospital** paediatric emergency department and inpatient unit reopened in August 2020
- **North Middlesex University Hospital** paediatric emergency department remained open with additional capacity. Inpatient paediatric provision temporarily moved to GOSH Dec 2020 - early Feb 2021
- **Great Ormond Street Hospital** provided urgent elective inpatient and some – but not all – day surgery.
- In addition, paediatric gastroenterology temporarily moved from Royal Free to GOSH

# Children and young people's services

- The temporary changes were only ever designed to provide resilience over autumn/winter 2020/21 and emergency departments and inpatient beds at the Royal Free Hospital and UCLH **reopened in April 2021**.
- NCL committed when the temporary changes were made that we would carry out an in-depth evaluation of the temporary changes, which will cover:
  - Did we meet the aim of the recommendations, which was to have a resilient, clinically safe and quality service over autumn/winter 2020/21
  - What is the learning for the system in terms of both the both the change process and operational implementation?
  - What are the strengths, areas for improvement and opportunities in the model?
  - Drawing from the temporary model are there further recommendations that can inform future planning for paediatric services in north central London?
- The evaluation draws on service data, patient experience surveys and feedback from staff, stakeholders and the wider community
- The evaluation will publish a summary report in the summer this year and we would welcome and opportunity of presenting the evaluation to the JHOSC in due course.

# Mental Health

The system pandemic response across both waves for mental health, children and young people's mental health and children's community services included:

- Mutual aid between Adult mental health providers to create a shared bed base to reduce out of area placements. Commissioned additional beds at The Oakes to ensure we were able to meet infection prevention and control guidelines while maintaining inpatient bed capacity;
- Brought forward plans to establish a 24/7 all age crisis line
- Established a mental health clinical assessment service on a non-acute site to take the pressure off of emergency departments in the South of the patch
- Established children and young people's hubs at the Northern Health Centre and Edgware Hospital to divert children and young people away from emergency departments for both physical and mental health where appropriate to do so
- Bolstered capacity with children and young people's mental health through additional staff in the out of hours and eating disorders teams at Royal Free London.
- Community teams adopted digital approaches to delivering care, particularly in children and young people's community services.

**We will be providing a fuller paper to JHOSC on mental health services at the meeting in September**

# Elective recovery

2020-21 has had a huge impact on elective surgery for our patients and the majority of elective care had to be paused

- This has led to an increase in the number of patients on waiting lists, currently with 18,800 people (down from 22,000 at the beginning of the year), waiting more than 52 weeks for treatment
- We are planning ahead, working across NCL to reduce waiting lists
- It will take some time before we see an improvement in the number of people on waiting lists.
- Objectives are to:

Work with GPs to encourage referrals, following lower numbers during the peak of the pandemic

Make sure that patients on waiting lists are treated fairly, that we are addressing inequality, with the most urgent patients seen first

Use resources effectively to reduce the number of people waiting for care, with focus on those waiting for cancer treatment

Work to lower the number of patients waiting more than 52 weeks for treatment/care

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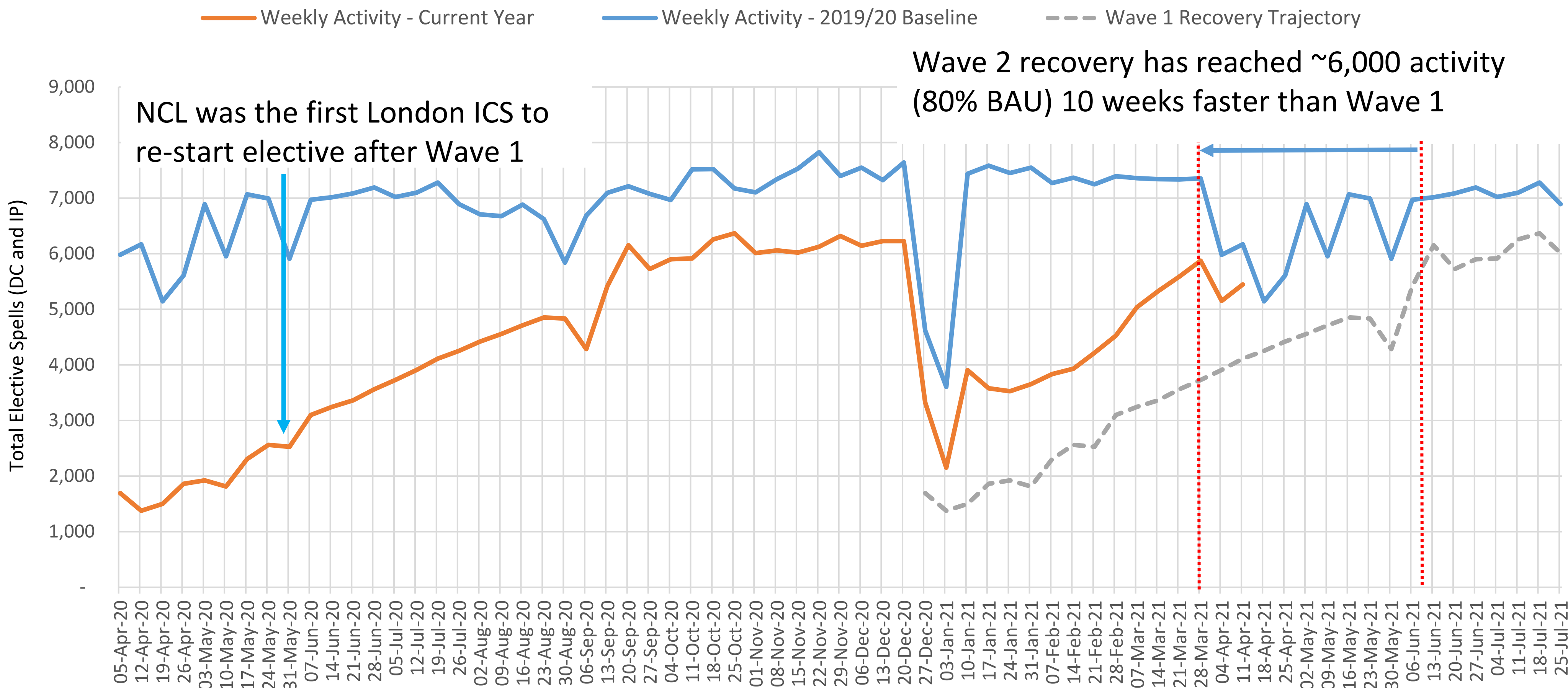
# ‘Accelerated system’ plan

- NCL has been selected as an ‘**accelerated system for elective recovery**’ with additional funding made available to trial ways to see more patients safely and faster with ambitious targets for increasing elective activity.

1. **Moving to an extended hours working including weekends and evenings and adding additional outpatient clinics**
2. **Outsourcing within our NCL NHS hospitals through mutual aid and surgical hubs run by clinical networks**
3. **Improving our use of Independent Sector capacity where possible**
4. **Using all available space and resources, including accelerating expansion into our new state-of-the-art facilities in UCLH’s Grafton Way Building for specialties such as orthopaedics and ENT**
5. **Creation of a ‘one system’ patient tracking list to allow fair and equitable prioritisation and management of demand**

# Recovery progress to date




During the first wave of this pandemic, NCL proactively and rapidly set up an elective recovery programme built on the **principles of system wide collaboration, data driven decision making and addressing variation in care**.

Our robust and thorough planning led to NCL being approved as the **first London ICS to restart elective work**.

Through our recovery programme and **mantra of continuous improvement** we applied a number of learnings from wave 1 recovery to our current recovery plan leading to a **10 weeks improvement in recovery pace**.

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# What have we achieved? – impact of Covid

- **Accelerated collaboration**
  - ❑ single point of access for speedier and safe discharge from hospital to home or care homes
- **Mutual planning and support**
  - ❑ system able to respond quickly to a significant increase in demand for intensive care beds
- **Smoothing the transition between primary and secondary care**
  - ❑ increased capacity for community step-down beds to ease pressure on hospitals
- **Sharing of good practice**
  - ❑ Clinical networks to share best practice and provide learning opportunities
- **Innovative approaches to patient care**
  - ❑ pulse oximetry at home led by primary care and virtual wards led by secondary care to avoid Covid patients' admission to hospital and early discharge where appropriate
- **Clinical and operational collaboration**
  - ❑ Ensuring consistent prioritisation across NCL so most urgent patients are treated first
- **Innovative approach to pathways of care**
  - ❑ New Cancer pathways have improved patient outcomes and experiences
- **Ongoing development of integrated care partnerships**
  - ❑ Borough or 'place' based partnerships with strong community focus and local government leadership

# What have we achieved? – impact of Covid

- **Shared health data for direct care and for system management**
  - Joined-up health records to support primary and secondary care clinicians providing direct care of patients
  - A population health management system allowing analysis of patient waiting lists to ensure we are being fair, equitable and not increasing health inequalities
- **Building workforce capacity and resilience through multi-disciplinary teams**
  - Development of post-Covid Syndrome multi-disciplinary teams to support patients
- **Collaborative after action reviews**
  - Care homes got care providers, local authorities, social care working together to capture collective learning, which has led to greater learning and better decision making
- **GPs forming strong Primary Care Networks**
  - GPs working together to develop resilience and deliver projects, e.g Covid Vaccine programme
- **Greater engagement with communities through the pandemic,**
  - Development of links and strong relationships with NCL's communities, voluntary organisations, volunteers and faith groups
- **Support of specialist trusts and academic institutions in NCL**
  - NCL's world-class specialist trusts and academic institutions have been a vital part of our pandemic response

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# Integrated Care Systems: design framework

Version 1, June 2021

# Contents

**Introduction and summary** 2

**Context** 6

**The ICS Partnership** 8

**The ICS NHS body** 12

**People and culture** 16

**Governance and management arrangements** 19

**The role of providers** 27

**Clinical and professional leadership** 33

**Working with people and communities** 35

**Accountability and oversight** 37

**Financial allocations and funding flows** 40

**Data and digital standards and requirements** 47

**Managing the transition to statutory ICSs** 49

**Conclusion** 54

## Introduction and summary

Everyone across the health and care system in England, in the NHS, local authorities and voluntary organisations, has made extraordinary efforts to manage the COVID-19 pandemic and deliver the vaccination programme while continuing to provide essential services.

We still face major operational challenges: tackling backlogs; meeting deferred demand, new care needs, changing public expectations; tackling longstanding health inequalities; enabling respite and recovery for those who have been at the frontline of our response; and re-adjusting to a post-pandemic financial regime. The intensity of the incident may have abated, but we are still managing exceptional pressure and uncertainty, with differential impacts across the country.

As we respond, Integrated Care Systems (ICSs) will play a critical role in aligning action between partners to achieve their shared purpose: to improve outcomes and tackle inequalities, to enhance productivity and make best use of resources and to strengthen local communities.

Throughout the pandemic our people told us time and time again that collaboration allowed faster decisions and better outcomes. Co-operation created resilience. Teamwork across organisations, sectors and professions enabled us to manage the pressures facing the NHS and our partners.

As we re-focus on the ambitions set out in the NHS Long Term Plan, it is imperative we maintain our commitment to collaborative action, along with the agility and pace in decision-making that has characterised our response to the pandemic.

We want to do everything we can to support this nationally and give you the best chance of making effective and enduring change for the people you serve.

This means seizing the opportunities presented by legislative reform to remove barriers to integrated care and create the conditions for local partnerships to thrive. And it means asking NHS leaders, working with partners in local government and beyond, to continue developing Integrated Care Systems during 2021/22, and preparing for new statutory arrangements from next year.

We know this is a significant ask. This document sets out the next steps. It builds on previous publications[1] to capture the headline ambitions for how we will expect NHS leaders and organisations to operate with their partners in ICSs from April 2022. It aims to support you as you continue to deliver against the core purpose of ICSs and put in place the practical steps to prepare for their new arrangements that we expect to be enabled by legislation in this Parliamentary session.

The ambition for ICSs is significant and the challenge for all leaders within systems is an exciting one. Successful systems will align action and maintain momentum during transition, with systems continuing to make progress in improving outcomes and supporting recovery while embedding new arrangements for strategic planning and collective accountability across partners. The collective leadership of ICSs and the organisations they include will bring teams with them on that journey and will command the confidence of NHS and other public sector leaders across their system as they deliver for their communities. The level of ambition and expectation is shared across all ICSs – and there will be consistent expectations set through the oversight framework, financial framework national standards and LTP commitment – with ICSs adjusting their arrangements to be most effective in their local context.

It is important that this next year of developing ICSs and implementing statutory changes, if approved by Parliament and once finalised, builds on progress to date and the great work that has already taken place across the country. Effective transition will see high performing systems taking their existing ways of working and creatively adapting these to the new statutory arrangements. It is an acceleration, in the current direction.

This document begins to describe future ambitions for:

- the **functions of the ICS Partnership** to align the ambitions, purpose and strategies of partners across each system[2]
- the **functions of the ICS NHS body**, including planning to meet population health needs, allocating resources, ensuring that services

[1] Integrating care: next steps to building strong and effective integrated care systems and
Integration and innovation: working together to improve health and social care for all
NHS Operational Planning and Contracting Guidance

[2] Guidance on the Partnership will be developed by DHSC with local government, NHS and other stakeholders. Expectations described here are based on the proposals set out in the Government's White Paper and initial discussions with local government partners.

are in place to deliver against ambitions, facilitating the transformation of services, co-ordinating and improving people and culture development, and overseeing delivery of improved outcomes for their population

- the **governance and management arrangements** that each ICS NHS body will need to establish to carry out those functions including the flexibility to operate in a way that reflects the local context through place-based partnerships and provider collaboratives
- the opportunity for **partner organisations** to work together as part of ICSs to agree and jointly deliver shared ambitions
- **key elements of good practice** that will be essential to the success of ICSs, including strong clinical and professional leadership, deep and embedded engagement with people and communities, and streamlined arrangements for maintaining accountability and oversight
- the key features of the **financial framework** that will underpin the future ambitions of systems, including the freedom and mechanisms to use resource flexibly to better meet identified needs and to manage financial resources at system level
- the roadmap to **implement new arrangements** for ICS NHS bodies by April 2022 to establish new organisations, appoint leadership teams to new statutory organisations and to ensure that people affected by change are offered a smooth transition that allows them to maintain focus on their critical role in supporting recovery from the pandemic.

**Further information or guidance, developed through engagement with systems and stakeholders, will be made available to support detailed planning. Where relevant, this will follow the presentation of proposed legislation to Parliament.**

We have heard a clear message from systems that they are looking for specificity about the consistent elements of how we will ask them to operate, alongside a high degree of flexibility to design their ways of working to best reflect local circumstances. This document aims to achieve both: to be clear and specific on the consistent requirements for systems and to define the parameters for the tailoring to local circumstances which is key to success. It goes beyond likely minimum statutory requirements and sets out the ambition from NHS England and NHS

Improvement[3] on what will be necessary for systems to be successful as they lead our recovery from the pandemic and the wider delivery of the Long Term Plan.

The Framework does not attempt to describe the full breadth of future ICS arrangements or role of all constituent partners but focuses on how we expect the NHS to contribute. For non-NHS organisations, we hope this document will provide helpful framing on how the NHS will be approaching the proposed establishment of ICS NHS bodies, and inform broader discussions on the creation of system-wide and place-based partnership arrangements.

From the outset, our ambition for ICSs has been co-developed with system leaders, people who use services and many other stakeholders. We will continue this approach as we develop guidance and implementation support, based on feedback and ongoing learning from what works best.

**The Framework is based on the objectives articulated in Integrating Care: next steps, which were reflected in the Government's White Paper.[4] But content referring to new statutory arrangements and duties, and/or which is dependent on the implementation of such arrangements and duties, is subject to legislation and its parliamentary process. Systems may make reasonable preparatory steps in advance of legislation but should not act as though the legislation is in place or inevitable.**

[3] In this document we use 'NHS England and NHS Improvement' when referring to the functions and activities of both NHS England and NHS Improvement prior to April 2022, and NHS England only from April 2022 (subject to legislation).

[4] This document uses the terminology of the White Paper (ICS Partnership and ICS NHS Body). The final legal terms to be adopted for the new statutory components of each ICS will be determined by the legislation.

## Context

In November 2020 NHS England and NHS Improvement published *Integrating care: Next steps to building strong and effective integrated care systems across England*. It described the core purpose of an ICS being to:

- **improve outcomes** in population health and healthcare
- **tackle inequalities** in outcomes, experience and access
- **enhance productivity** and value for money
- help the NHS support broader **social and economic development**.

It emphasised that the next phase of ICS development should be rooted in underlying principles of subsidiarity and collaboration. It described common features that every system is expected to have and develop, as the foundations for integrating care, with local flexibility in how best to design these to achieve consistent national standards and reduce inequalities, as:

- decisions taken closer to, and in consultation with, the communities they affect are likely to lead to better outcomes
- collaboration between partners, both within a place and at scale, is essential to address health inequalities, sustain joined-up, efficient and effective services and enhance productivity
- local flexibility, enabled by common digital capabilities and coordinated flows of data, will allow systems to identify the best way to improve the health and wellbeing of their populations.

Reflecting insight drawn from local systems, the document outlined the key components to enable ICSs to deliver their core purpose, including:

- **strong place-based partnerships** between the NHS, local councils and voluntary organisations, local residents, people who access service their carers and families, leading the detailed design and delivery of integrated services within specific localities (in many places, long-established local authority boundaries), incorporating a number of neighbourhoods
- **provider collaboratives**, bringing NHS providers together across one or more ICSs, working with clinical networks and alliances and other partners, to secure the benefits of working at scale.

In February 2021 NHS England and NHS Improvement made recommendations to Government to establish ICSs on a statutory basis, with strengthened provisions to ensure that local government could play a full part in ICS decision-making. These proposals were adopted in the Government's White Paper *Integration and Innovation: working together to improve health and social care for all*, and we expect legislation to be presented to Parliament shortly. This document is based on our expectations as to the content of that legislation, describing how new arrangements would look if the proposals were implemented, while recognising that the legislation is subject to Parliament's amendment and approval.

Subject to the passage of legislation, the statutory[5] ICS arrangements will comprise:

- an ICS Partnership, the broad alliance of organisations and representatives concerned with improving the care, health and wellbeing of the population, jointly convened by local authorities and the NHS
- an ICS NHS body, bringing the NHS together locally to improve population health and care.

This ICS Design Framework sets out in more detail how we expect NHS organisations to respond in the next phase of system development, including the anticipated establishment of statutory ICS NHS bodies from April 2022. It describes the 'core' arrangements we will expect to see in each system and those we expect local partners to determine in their local context; depending on their variation in scale, geography, population health need and maturity of system arrangements.

Its purpose is to provide some 'guide rails' for NHS organisations as they develop their plans - reflecting the best ways of serving communities and patients in their specific local context - to give them the best chance of delivering on the four core purposes, in the urgent context of COVID recovery.

[5] ICSs will comprise a much wider set of partnership arrangements supported by this statutory framework.

## The ICS Partnership

**Each ICS will have a Partnership at system level established by the NHS and local government as equal partners. The Partnership will operate as a forum[6] to bring partners – local government, NHS and others – together across the ICS area to align purpose and ambitions with plans to integrate care and improve health and wellbeing outcomes for their population.**

**The Partnership will facilitate joint action to improve health and care services and to influence the wider determinants of health and broader social and economic development. This joined-up, inclusive working is central to ensuring that ICS partners are targeting their collective action and resources at the areas which will have the greatest impact on outcomes and inequalities as we recover from the pandemic.**

We expect the ICS Partnership will have a specific responsibility to develop an 'integrated care strategy' for its whole population using best available evidence and data, covering health and social care (both children's and adult's social care), and addressing the wider determinants of health and wellbeing. This should be built bottom-up from local assessments of needs and assets identified at place level, based on Joint Strategic Needs Assessments. We expect these plans to be focused on improving health and care outcomes, reducing inequalities and addressing the consequences of the pandemic for communities. We expect each Partnership to champion inclusion and transparency and to challenge all partners to demonstrate progress in reducing inequalities and improving outcomes. It should support place- and neighbourhood-level engagement, ensuring the system is connected to the needs of every community it includes.

The Government has indicated that it does not intend to bring forward detailed or prescriptive legislation on how these Partnerships should operate. Rather the intention is to set a high-level legislative framework within which systems can develop the partnership arrangements that work best for them, based on the core principles of equal partnership across health and Local Government, subsidiarity, collaboration and flexibility.

[6] The ICS Partnership will be a committee, rather than a corporate body.

To support this process, formal guidance on ICS Partnerships will be developed jointly by the Department of Health and Social Care (DHSC), NHS England and NHS Improvement, and the Local Government Association (LGA), and consulted on ahead of implementation, including on the role and accountabilities of the chair of the Integrated Care Partnership. This document gives an overview of the type of information that we expect to be included in that guidance.

## Establishment and membership

The Partnership will be established locally and jointly by the relevant local authorities and the ICS NHS body, evolving from existing arrangements and with mutual agreement on its terms of reference, membership, ways of operating and administration. Appropriate arrangements will vary considerably, depending on the size and scale of each system.

Members must include local authorities that are responsible for social care services in the ICS area, as well as the local NHS (represented at least by the ICS NHS body). Beyond this, members may be from health and wellbeing boards, other statutory organisations, voluntary, community and social enterprise (VCSE) sector partners, social care providers and organisations with a relevant wider interest, such as employers, housing and education providers and the criminal justice system. They should draw on experience and expertise from across the wide range of partners working to improve health and care in their communities, including ensuring that the views and needs of patients, carers and the social care sector are built into their ways of working. The membership may change as the priorities of the partnership evolve.

To facilitate broad membership and stakeholder participation, Partnerships may use a range of sub-groups, networks and other methods to convene parties to agree and deliver the priorities set out in the shared strategy.

## Leadership and accountability

The ICS NHS body and local authorities will need to jointly select a Partnership chair and define their role, term of office and accountabilities.

Some systems will prefer the Partnership and ICS NHS body to have separate chairs. This may, for instance, provide greater scope for democratic representation. Others may select the appointed NHS ICS body chair as the chair for both the NHS

Board and the Partnership to help ensure co-ordination. This will be a matter for local determination.

We expect public health experts to play a significant role in these partnerships, specifically including local authority directors of public health and their teams who can support, inform and guide approaches to population health management and improvement.

Partnerships will need clear and transparent mechanisms for ensuring strategies are developed with people with lived experience of health and care services and communities, for example including patients, service users, unpaid carers and traditionally under-represented groups. These mechanisms should draw on best engagement practice; for example, by using citizens' panels and co-production approaches, including insights from place and neighbourhood engagement. Partnerships should build on the expertise, relationships and engagement forums that already exist across local areas, building priorities from the bottom up, to ensure the priorities in the strategy resonate with people across the ICS.

As a key forum for convening and influencing and engaging the public, the Partnership will need to be transparent with formal sessions held in public. Its work must be communicated to stakeholders in clear and inclusive language.

## Partnership principles

The ICS Partnership will play a key role in nurturing the culture and behaviours of a system. We invite systems to consider these 10 principles:

1. Come together under a distributed leadership model and commit to working together equally.
2. Use a collective model of decision-making that seeks to find consensus between system partners and make decisions based on unanimity as the norm, including working though difficult issues where appropriate.
3. Operate a collective model of accountability, where partners hold each other mutually accountable for their shared and individual organisational contributions to shared objectives.
4. Agree arrangements for transparency and local accountability, including meeting in public with minutes and papers available online.

5. Focus on improving outcomes for people, including improved health and wellbeing, supporting people to live more independent lives, and reduced health inequalities.
6. Champion co-production and inclusiveness throughout the ICS.
7. Support the triple aim (better health for everyone, better care for all and efficient use of NHS resources), the legal duties on statutory bodies to co-operate and the principle of subsidiarity (that decision-making should happen at the most local appropriate level).
8. Ensure place-based partnership arrangements are respected and supported, and have appropriate resource, capacity and autonomy to address community priorities, in line with the principle of subsidiarity.
9. Draw on the experience and expertise of professional, clinical, political and community leaders and promote strong clinical and professional system leadership.
10. Create a learning system, sharing evidence and insight across and beyond the ICS, crossing organisational and professional boundaries.

# The ICS NHS body

**ICS NHS bodies will be established as new organisations that bind partner organisations together in a new way with common purpose. They will lead integration within the NHS, bringing together all those involved in planning and providing NHS services to take a collaborative approach to agreeing and delivering ambitions for the health of their population. They will ensure that dynamic joint working arrangements, as demonstrated through the response to COVID-19, become the norm. They will establish shared strategic priorities within the NHS and provide seamless connections to wider partnership arrangements at a system level to tackle population health challenges and enhance services at the interface of health and social care.**

## Functions of the ICS NHS body

The ICS NHS body will be a statutory organisation responsible for specific functions that enable it to deliver against the four core purposes:

- **Developing a plan** to meet the health needs of the population within their area, having regard to the Partnership's strategy. This will include ensuring NHS services and performance are restored following the pandemic, in line with national operational planning requirements, and Long Term Plan commitments are met.
- **Allocating resources** to deliver the plan across the system, including determining what resources should be available to meet the needs of the population in each place and setting principles for how they should be allocated across services and providers (both revenue and capital). This will require striking the right balance between enabling local decision-making to meet specific needs and securing the benefits of standardisation and scale across larger footprints, especially for more specialist or acute services.
- **Establishing joint working arrangements** with partners that embed collaboration as the basis for delivery of joint priorities within the plan. The ICS NHS body may choose to commission jointly with local authorities, including the use of powers to make partnership arrangements under section 75 of the 2006 Act and supported through the integrated care strategy, across the whole system; this may happen at place where that is the relevant local authority footprint.

- **Establishing governance arrangements** to support collective accountability between partner organisations for whole-system delivery and performance, underpinned by the statutory and contractual accountabilities of individual organisations, to ensure the plan is implemented effectively within a system financial envelope set by NHS England and NHS Improvement.
- **Arranging for the provision of health services** in line with the allocated resources across the ICS through a range of activities including:
  - Putting contracts and agreements in place to secure delivery of its plan by providers. These may be contracts and agreements with individual providers or lead providers within a place-based partnership or provider collaborative. They will reflect the resource allocations, priorities and specifications developed across the whole system and at place level. We expect contracts and agreements to be strategic, long-term and based on outcomes, with providers responsible for designing services and interventions to meet agreed system objectives.
  - Convening and supporting providers (working both at scale and at place) to lead[7] major service transformation programmes to achieve agreed outcomes, including through joining-up health, care and wider support. In addition to ensuring that plans and contracts are designed to enable this, the ICS NHS body will facilitate partners in the health and care system to work together, combining their expertise and resources to deliver improvements, fostering and deploying research and innovations.
  - Working with local authority and VCSE partners to put in place personalised care for people, including assessment and provision of continuing healthcare and funded nursing care, and agreeing personal health budgets and direct payments for care. This may be delegated to individual place partnerships and delivered through integrated teams working in neighbourhoods or across local places, further supporting the integration of planning and provision with adult social care and VCSE organisations.
- **Leading system implementation of the People Plan** by aligning partners across each ICS to develop and support the 'one workforce', including through closer collaboration across the health and care

[7] It is expected that the ICS NHS body will be able to delegate functions to statutory providers to enable this.

sector, and with local government, the voluntary and community sector and volunteers (See ‘People and culture’ section below).

- **Leading system-wide action on data and digital**:  ICS NHS bodies will work with partners across the NHS and with local authorities to put in place smart digital and data foundations to connect health and care services and ultimately transform care to put the citizen at the centre of their care (see ‘Data and digital’ section below);
- Using joined-up data and digital capabilities to **understand local priorities, track delivery of plans, monitor and address variation and drive continuous improvemen**t in performance and outcomes.
- Working alongside councils to **invest in local community organisations and infrastructure** and, through joint working between health, social care and other partners including police, education, housing, safeguarding partnerships, employment and welfare services, **ensuring that the NHS plays a full part in social and economic development and environmental sustainability**.
- **Driving joint work on estates, procurement, supply chain and commercial strategies** to maximise value for money across the system and support these wider goals of development and sustainability
- **Planning for, responding to and leading recovery from incidents** (EPRR), to ensure NHS and partner organisations are joined up at times of greatest need, including taking on incident coordination responsibilities as delegated by NHS England and NHS Improvement.
- **Functions NHS England and NHS Improvement will be delegating** including commissioning of primary care and appropriate specialised services.

We expect that all clinical commissioning group (CCG) functions and duties will transfer to an ICS NHS body when they are established, along with all CCG assets and liabilities including their commissioning responsibilities and contracts.

Relevant statutory duties of CCGs regarding safeguarding, children in care and special educational needs and disabilities (SEND) will apply to ICS NHS bodies. We will clarify in guidance how these statutory duties will transition to ICS NHS bodies. ICSs should support joint working around responsibilities such as safeguarding through new and existing partnership arrangements; and health and

care strategies and governance should account for the needs of children and young people.

The board of the ICS NHS body will be responsible for ensuring that the body meets its statutory duties. We expect these duties will include supporting achievement of the triple aim, improving quality of services, reducing inequalities, ensuring public involvement, obtaining clinical and public health advice, promoting innovation and research, and other duties that may be defined in law.

We are reviewing our own operating model - including how our functions and activities will be carried out in future and how associated resources will be deployed -in the context of the expected creation of statutory ICS NHS bodies. We are committed to ensuring that the principle of subsidiarity is applied in considering our own functions, that resources are devolved accordingly, and that the creation of ICS NHS bodies does not lead to duplication or create additional bureaucracy within the NHS. We will co-design our new arrangements with the sector and our partners.

## People and culture

**Better care and outcomes will be achieved by people – local residents, service users, carers, professionals and leaders – working together in different ways. Successful ICSs will develop a culture that attracts people to work in and for their community and supports them to achieve their full potential.**

The NHS People Plan sets out the ambition of having 'more people, working differently, in a compassionate and inclusive culture'. Although individual employers remain the building blocks for delivering the People Plan, ICSs have an important role in leading and overseeing progress on this agenda – including strengthening collaboration among health and care partners – and have already developed their own local People Plans setting out how they will achieve this ambition in their area. These plans should be aligned with the ICS Partnership's Strategy as it is developed and be refreshed annually, taking account of national priorities.

From April 2022, ICS NHS bodies are expected to have specific responsibilities for delivering against the themes and actions set out in the NHS People Plan and the people priorities in operational planning guidance. ICS NHS bodies will play a critical role in shaping the approach to growing, developing, retaining and supporting the entire local health and care workforce. While the People Plan sets out specific objectives and responsibilities for NHS organisations, we expect ICS NHS bodies to adopt a 'one workforce' approach and develop shared principles and ambitions for people and culture with local authorities, the VCSE sector and other partners.

Those planning and delivering health and care services are employed by a range of different organisations (including the ICS NHS body in future). Each will have strategies for attracting, retaining and developing the people they need to deliver the services and functions they are responsible for. To deliver against the ICS's four core purposes and to make the local area a great place to work and live, the ICS NHS body – working with the ICS Partnership – will help bring these partners together to develop and support the 'one workforce' which contributes to providing care across the system. This includes supporting the expansion of primary care and integrated teams in the community and closer collaboration on workforce development across the health and care sector, and with local government, the third sector and volunteers.

The ICS NHS body will be expected to establish the appropriate people and workforce capability to discharge their responsibilities, including strong local leadership. In particular, the ICS NHS body will need to:

- have clear leadership and accountability for the organisation's role in delivering agreed local and national people priorities, with a named SRO with the appropriate expertise (registered people professional (CIPD accredited) or with equivalent experience)
- demonstrate how it is driving equality, diversity and inclusion. It should foster a culture of civility and respect, and develop a workforce and leadership that are representative of the population they serve.

To support local and national people priorities for the one workforce in the system, the ICS NHS body should work with organisations across the ICS to:

- Establish clear and effective governance arrangements for agreeing and delivering local strategic and operational people priorities. This will include ensuring there are clear lines of accountability and streamlined ways of working between individual organisations within the system, with other ICSs and with regional workforce teams
- Support the delivery of standardised, high-quality transactional HR services (eg payroll) across the ICS, supported by digital technology. These services should be delivered at the most effective level within the ICS footprint, based on the principle of subsidiarity, but proactively taking opportunities for collaboration and securing the benefits of delivering at scale. Local arrangements for delivering these services should be agreed by relevant employers across the system, facilitated by the NHS ICS Body, to support standardisation and remove duplication to allow for the reallocation resources to deliver on the strategic people agenda across the ICS
- Ensure action is taken to protect the health and wellbeing of people working within the ICS footprint, delivering the priorities set out in the 2021/22 planning guidance and in the People Promise, to improve the experience of working in the health and care system for all
- Establish leadership structures and processes (including leadership development, talent management and succession planning approaches) to drive the culture, behaviours and outcomes needed for

people working in the system and the local population, in line with the Leadership Compact[8]

- Undertake integrated and dynamic workforce, activity and finance planning based on population need, transformation of care models and changes in skills and ways of working – reflected in the system people plan and in the ICS Partnership's Strategy
- Plan the development – and where required, growth – of the one workforce to meet future need. This should include agreeing collaborative recruitment and retention approaches where relevant, planning local educational capacity and opportunities, and attracting local people into health and care employment and careers (including creating long-term volunteering opportunities)
- Develop new ways of working and delivering care that optimise staff skills, technology and wider innovation to meet population health needs and to create flexible and rewarding career pathways for those working in the system. This should be enabled by inclusive employment models, workforce sharing arrangements and passporting or accreditation systems
- Contribute to wider local social and economic growth and a vibrant local labour market, through collaboration with partner organisations, including the care home sector and education and skills providers.

To support ICS NHS bodies to discharge these responsibilities and deliver national and local people and workforce priorities, we will work with Health Education England to publish supplementary guidance and implementation support resources for ICSs on developing their strategic People capabilities, including a People operating model.

[8] The NHS Leadership Compact will set out the compassionate and inclusive behaviour we want all our leaders to show towards people. It will require every leader, at every level, to recognise, reflect and bring to life every day six core principles focused on: equality and diversity; continuous improvement; kindness, compassion and respect; trust; supporting people and celebrating success; and collaboration and partnership. The Compact will be published in due course.

## Governance and management arrangements

**Strong and effective governance and management arrangements are essential to enable ICSs to deliver their functions effectively. The pandemic has shown the success of partnership approaches that allow joined-up, agile and timely decision-making underpinned by common objectives. ICSs will build from this to establish robust governance and management arrangements that are flexibly designed to fit local circumstances and that bind partners together in collective endeavour.**

**This guidance provides an overview of our expectations for ICS governance and management arrangements. We will provide further resources throughout the year that share learning on the different approaches ICSs are developing.**

### The ICS NHS board

The statutory governance requirements for the NHS ICS body will be set out in legislation and NHS England and NHS Improvement will provide further guidance on the constitution of the board and process for this being agreed prior to establishment. This section provides an overview of our current expectations which will be developed, through engagement. As a new type of organisation, the governance arrangements for ICS NHS bodies will be different to those of existing commissioner and provider organisations in the NHS. They will need to reflect the different ways of working that will be required for ICS NHS bodies to effectively deliver their functions - as independent statutory NHS bodies, that bring together parties from across the NHS. The minimum requirements we set out are designed to provide a common framework for effective leadership and governance in this context.

The ICS NHS body will have a unitary board. The board will be responsible for ensuring the body plays its role in achieving the four purposes of the wider ICS and should be constituted in a way that ensures this focus on improving outcomes in population health and healthcare; tackling inequalities in outcomes, experience and access; enhancing productivity and value for money; and contributing to broader social and economic development.

All members of the ICS NHS board (referred to below as “the board”) will have shared corporate accountability for delivery of the functions and duties of the ICS

and the performance of the organisation. This includes ensuring that the interests of the public and people who use health and care services remain central to what the organisation does. The board will be the senior decision-making structure for the ICS NHS body.

The statutory minimum membership of the board of each ICS NHS body will be confirmed in legislation. To carry out its functions effectively we will expect every ICS NHS body to establish board roles above this minimum level, so in most cases they will include the following roles:

- Independent non-executives: chair plus a minimum of two other independent non-executive directors (as a minimum required to chair the audit and remuneration committees). These individuals will normally not hold positions or offices in other health and care organisations within the ICS footprint.
- Executive roles (employed by the body): chief executive (who will be the accountable officer for the funding allocated to the ICS NHS body), director of finance, director of nursing and medical director.
- Partner members: a minimum of three additional board members, including at least:
  - one member drawn from NHS trusts and foundation trusts who provide services within the ICS's area
  - one member drawn from the primary medical services (general practice) providers within the area of the ICS NHS body
  - one member drawn from the local authority, or authorities, with statutory social care responsibility whose area falls wholly or partly within the area of the ICS NHS body.

We expect all three partner members will be full members of the unitary board, bringing knowledge and a perspective from their sectors, but not acting as delegates of those sectors.

We expect the partner members from NHS trusts/foundation trusts and local authorities will often be the chief executive of their organisation or in a relevant executive-level local authority role.

The process of appointing the partner members, and the rules for qualification to be a member, will be set out in the constitution of the body.

The final composition of the board and the process of appointment of partner members will need to be consistent with any requirements set out in primary legislation and is therefore subject to Parliamentary process.

ICS NHS bodies will be able to supplement these minimum board positions as they develop their own ICS NHS body constitution, which will be subject to agreement with NHS England and NHS Improvement.

We expect all members of the board will be required to comply with the Nolan Principles of Public Life and meet the Fit & Proper Persons test, and boards must have clear governance and board level accountability for discharging the associated regulations.

Boards of ICS NHS bodies will need to be of an appropriate size to allow effective decision making to take place. Through a combination of their membership, and the ways in which members engage partners, the board and its committees should ensure they take into account the perspectives and expertise of all relevant partners. These should include all parts of the local health and care system across physical and mental health, primary care, community and acute services, patient and carer representatives, social care and public health, with directors of public health having an official role in the ICS NHS bodies and the Partnership.

It will be important that boards have strong leadership on issues that impact upon organisations and staff across the ICS, including the people agenda and digital transformation.

The ICS NHS body will be expected to promote open and transparent decision-making processes that facilitate finding consensus, drawing on agreed decision-making processes to manage areas of disagreement to ensure that the statutory duties of the ICS NHS body continue to be met. The board and its committees will have to make decisions transparently, holding meetings in public and publishing the papers.

NHS England and NHS Improvement will publish further guidance on the composition and operation of the board, including a draft model constitution. We will also provide guidance on the management of conflicting roles and interests,

ensuring partners can work together effectively and that the public can have confidence decisions are being made in their best interests as taxpayers and service users (see below for new provider selection regime).

## Committees and decision-making

All ICS NHS bodies will need to put arrangements in place to ensure they can effectively discharge their full range of duties and functions. This is likely to include arrangements for committees and groups to advise and feed into the board, and to exercise functions delegated by the board. Boards may be supported by an executive group including, for example, other professional and functional leads, to manage the day-to-day running of the organisation.

These arrangements should address the cross-cutting functional responsibilities of the body including finance and resources, people, quality, digital and data performance and oversight. They should enable full involvement of clinical and professional leaders, leaders of place-based partnerships and providers, including relevant provider collaboratives. We expect the ICS NHS body will have arrangements that bring all relevant partners together to participate in decision-making.

We expect that each board will be required to establish an audit committee and a remuneration committee. The board may establish other decision-making committees, in accordance with its scheme of delegation. The board may also establish advisory committees to advise it on discharging certain duties, such as public and patient engagement.

The legislation is expected to give ICS NHS bodies flexibility in how they establish and deploy such committees. In particular, they will have the power to:

- appoint individuals who are not board members or staff of the ICS NHS body to be members of any committee it has established
- establish joint committees with NHS Trusts/FTs to which they may delegate responsibilities (decision making) in accordance with those bodies' schemes of delegation.

As ICSs will have significant flexibility in how and where decisions and functions are undertaken, every ICS NHS body should maintain a 'functions and decision map' showing its arrangements with ICS partners to support good governance and

dialogue with internal and external stakeholders. This should include arrangements for any commissioning functions delegated or transferred by NHS England and NHS Improvement.

The boards of ICS NHS bodies, and their committees, should conduct their business in a way that builds consensus, and should seek to achieve consensus on decisions. They should foster constructive challenge, debate and the expression of different views, reflecting the scope of their remit and their constituencies. They should have agreed processes for resolving differences in the first instance, if consensus cannot be reached; for example, through referencing the principles and behaviours set out in the ICS NHS body's constitution and by assessing the decision for consistency with overarching objectives (including the triple aim) and plans already agreed. The chair may make decisions on behalf of the board where there is disagreement. Where necessary boards may draw on third party support such as peer review or mediation by NHS England and NHS Improvement.

The ICS NHS body's constitution may provide for a vote to be taken where consensus cannot be reached and to set out how the vote will be conducted (for example, the chair having the casting vote). However, voting should be considered a last resort rather than a routine mechanism for board decision-making.

## Place-based partnerships

Partnerships between organisations to collectively plan, deliver and monitor services within a locally defined 'place' have a long history. These place-based partnerships have typically been established by local agreement according to their context and this bottom-up approach has been an important enabler to meaningful collaboration. However, as part of the development of ICSs, we now expect that place-based partnerships are consistently recognised as key to the coordination and improvement of service planning and delivery, and as a forum to allow partners to collectively address wider determinants of health.

We have asked each system to define its place-based partnership arrangements, covering all parts of its geography, agreed collaboratively between the NHS, local government and other system partners working together in a particular locality or community.

There is no single way of defining place or determining a fixed set of responsibilities that a place-based partnership should hold. All systems should establish and

support place-based partnerships with configuration and catchment areas reflecting meaningful communities and geographies that local people recognise. In the smallest ICSs, the whole system may operate as a single place-based partnership. The arrangements for joint working at place should enable joined-up decision-making and delivery across the range of services meeting immediate care and support needs in those local places but should be designed flexibly to reflect what works in that area.

The ICS NHS body will want to agree with local partners the membership and form of governance that place-based partnerships adopt, building on or complementing existing local configurations and arrangements such as Health and Wellbeing Boards. At a minimum, these partnerships should involve primary care provider leadership, local authorities, including directors of public health, providers of acute, community and mental health services and representatives of people who access care and support.

The ICS NHS body will remain accountable for NHS resources deployed at place-level. Governance and leadership arrangements for place-based partnerships should support safe and effective delivery of the body's functions and responsibilities alongside wider functions of the partnership. Each ICS NHS body should clearly set out the role of place-based leaders within the governance arrangements for the body.

An NHS ICS body could establish any of the following place-based governance arrangements with local authorities and other partners, to jointly drive and oversee local integration:

- consultative forum, **informing** decisions by the ICS NHS body, local authorities and other partners
- committee of the ICS NHS body with delegated authority to take decisions about the use of ICS NHS body resources[9]
- joint committee of the ICS NHS body and one or more statutory provider(s), where the relevant statutory bodies delegate decision making on specific functions/services/populations to the joint committee in accordance with their schemes of delegation

[9] Contracts would be awarded and held, and payments made, by the ICS NHS body as the legal entity.

- individual directors of the ICS NHS body having delegated authority, which they may choose to exercise through a committee. This individual director could be a joint appointment with the local authority or with an NHS statutory provider and could also have delegated authority from those bodies
- lead provider managing resources and delivery at place-level under a contract with the ICS NHS body, having lead responsibility for delivering the agreed outcomes for the place.

Effective leadership at place level is critical to effective system working, but the specific approach is to be determined locally. The roles of place-based leaders will include convening the place-based partnership, representing the partnership in the wider structures and governance of the ICS and (potentially) taking on executive responsibility for functions delegated by the ICS NHS body CEO or relevant local authority.

## Supra-ICS arrangements

There are some functions where ICS NHS bodies will need to work together; for example, commissioning more specialised services, emergency ambulance services and other services where relatively small numbers of providers serve large populations, and when working with providers that span multiple ICSs or operate through clinical networks. In many areas, multiple providers and ICS NHS bodies will need to work together to develop a shared plan for cancer services, with existing Cancer Alliances[10] continuing to use their expertise to lead whole-system planning and delivery of cancer care on behalf of their constituent ICSs, as well as providing clinical leadership and advice on commissioning. Similarly, provider collaboratives, including those providing specialised mental health, learning disability and autism services, will span multiple ICS footprints where this is right for the clinical pathway for patients.

The governance arrangements to support this will need to be co-designed between the relevant providers, NHS ICS bodies clinical networks or alliances and, where relevant, NHS England and NHS Improvement regional teams. In smaller ICSs it will be particularly important to establish joint working arrangements at the appropriate scale for the task, joining up planning for services across a wider

[10] Service Development Funding for cancer will continue to be provided to Cancer Alliances to enable them to continue to deliver their existing functions on behalf of their constituent ICS(s).

footprint where that makes sense to establish provider collaboratives at the appropriate scale to support service transformation across wider clinical networks.

ICSs and ambulance providers, which typically provide services to a population across multiple ICSs, should agree their working relationships carefully to ensure that, where appropriate, there is a joined-up dialogue between ICSs and their relevant ambulance provider, avoiding unnecessary variation in practice or duplication of communication. Alongside this, ambulance providers should consider how they can play their role effectively as part of individual systems, provider collaboratives and place partnerships, for example supporting the implementation of an effective integrated urgent care offer.

## Quality governance

Quality is at the heart of all that we do. Each NHS organisation has individual responsibilities to ensure the delivery of high quality care. ICS NHS bodies will also have statutory duties to act with a view to securing continuous improvement in quality. We expect them to have arrangements for ensuring the fundamental standards of quality are delivered including to manage quality and safety risks and to address inequalities and variation; and to promote continual improvement in the quality of services, in a way that makes a real difference to the people using them.

ICSs are expected to build on existing quality oversight arrangements, with collaborative working across system partners, to maintain and improve the quality of care. ICS NHS bodies will need to resource quality governance arrangements appropriately, including leading System Quality Groups (previously Quality Surveillance Groups) and ensuring that clinical and care professional leads have capacity to participate in quality oversight and improvement. Operational support will also be provided through NHS England and NHS Improvement regional and national teams in line with National Quality Board's guidance, namely the refreshed *Shared Commitment to Quality* and the *Position Statement*. These key documents set out the core principles and consistent operational requirements for quality oversight that ICS NHS bodies are expected to embed during the transition period (2021/22) and beyond.

## The role of providers

Organisations providing health and care services are the frontline of each ICS. They will continue to lead the delivery and transformation of care and support, working alongside those who access their services and the wider communities they serve. As ICSs have developed, providers have increasingly embraced wider system leadership roles, working with partners to join up care pathways, embed population health management, reduce unwarranted variation and tackle heath inequalities.

The arrangements put in place by each ICS Partnership and ICS NHS body must harness the expertise, energy and ambition of the organisations directly responsible for delivering integrated care.

As constituent members of the ICS Partnership, the ICS NHS body and place-based partnerships, providers of NHS services will play a central role in establishing the priorities for change and improvement across their healthcare systems and delivering the solutions to achieving better outcomes.

We expect the contracts health service providers hold (NHS Standard, or national primary care[11] supplemented locally) to evolve to support longer term, outcomes-based agreements, with less transactional monitoring and greater dialogue on how shared objectives are achieved.

### Primary care in Integrated Care Systems

All primary care professionals have a fundamental role to play in ensuring that ICSs achieve their objectives. The success of efforts to integrate care will depend on primary care and other local leaders working together to deliver change across health and care systems.

Primary care should be represented and involved in decision-making at all levels of the ICS, including strategic decision-making forums at place and system level. It should be recognised that there is no single voice for primary care in the health and care system, and so ICSs should explore different and flexible ways for seeking primary care professional involvement in decision-making. In particular, primary care should have an important role in the development of shared plans at place and

[11] Primary care contracts will continue to be negotiated nationally

system, ensuring they represent the needs of their local populations at the neighbourhood level of the ICS, including with regards to health inequalities and inequality in access to services.

ICSs should explore approaches that enable plans to be built up from population needs at neighbourhood and place level, ensuring primary care professionals are involved throughout this process.

## The role of primary care networks

Primary care networks (PCNs), serving the patients of the constituent general practices, play a fundamental role improving health outcomes and joining up services. They have a close link to local communities, enabling them to identify priorities and address health inequalities. PCNs will develop integrated multi-disciplinary teams that include staff from community services and other NHS providers, local authorities and the voluntary, community and social enterprise (VCSE) sector to support effective care delivery. Joint working between PCNs and secondary care will be crucial to ensure effective patient care in and out of hospital.

PCNs in a place will want to consider how they could work together to drive improvement through peer support, lead on one another's behalf on place-based service transformation programmes and represent primary care in the place-based partnership. This work is in addition to their core function and will need to be resourced by the place-based partnership.

ICSs and place-based partnerships should also consider the support PCN clinical directors, as well as the wider primary care profession, may need to develop primary care and play their role in transforming community-based services. Place-based partnerships may also wish to consider how to leverage targeted operational support to their PCNs, for example with regard to data and analytics for population health management approaches, HR support or project management.

## Voluntary, community and social enterprise partners

The VCSE sector is a vital cornerstone of a progressive health and care system. ICSs should ensure their governance and decision-making arrangements support close working with the sector as a strategic partner in shaping, improving and delivering services and developing and delivering plans to tackle the wider determinants of health. VCSE partnership should be embedded as an essential part

of how the system operates at all levels. This will include involving the sector in governance structures and system workforce, population health management and service redesign work, leadership and organisational development plans.

We expect that by April 2022 Integrated Care Partnerships and the ICS NHS body will develop a formal agreement for engaging and embedding the VCSE sector in system level governance and decision-making arrangements, ideally by working through a VCSE alliance to reflect the diversity of the sector. These arrangements should build on the involvement of VCSE partners in relevant forums at place and neighbourhood level. A national development programme is in place to facilitate this in all areas.

## Independent sector providers

All providers, including independent providers to the NHS and local authorities, will need to be engaged with other relevant partners in the ICS, through existing or newly formed arrangements, to ensure care meets the needs of the population and is well co-ordinated.

## NHS trusts and foundation trusts

NHS trusts and foundation trusts will play a critical role in the transformation of services and outcomes within places and across and beyond systems.

As now, they will work alongside primary care, social care, public health and other colleagues in each of the places or localities they serve, to tailor their services to local needs and ensure they are integrated in local care pathways. They will also be more involved in collectively agreeing with partners how services and outcomes can be improved for that community, how resources should be used to achieve this and how they can best contribute to population health improvement as both service providers and as local ‘anchor institutions’. The most efficient and appropriate ways of doing this will vary for different types of providers and in different local contexts. ICS NHS bodies will need to work with providers that span multiple ICSs and cross ICS boundaries, including ambulance and community trusts, to agree arrangements that ensure they are fully engaged.

In future, we expect the ICS NHS body could ask NHS trusts and foundation trusts to take on what have been ‘commissioning’ functions for a certain population,

building on the model that NHS-led provider collaboratives for specialised mental health, learning disability and autism services have been developing.

The success of individual trusts and foundation trusts will increasingly be judged against their contribution to the objectives of the ICS, in addition to their existing duties to deliver safe and effective care. This will include delivering their agreed contribution to system financial balance, improving quality and outcomes and reducing unwarranted variation and inequalities across the system as a whole, in the context of the new 'triple aim' duty to promote better health for everyone, better care for all and efficient use of NHS resources.

## The new provider selection regime

NHS England and NHS Improvement has recommended that Parliament legislates to remove the current rules governing NHS procurement of healthcare services; and these are replaced by a new regime specifically created for the NHS.

This regime would give decision-makers greater discretion in how they decide to arrange services, with competition and tendering a tool to use where appropriate, rather than the default expectation. We want to make it straightforward for local organisations to continue with existing service provision where the arrangements are working well and there is no value in seeking an alternative provider. Where the system wants or needs to consider making changes to service provision, we want there to be a flexible, sensible, transparent and proportionate process for decision-making that allows shared responsibility to flow through it, rather than forcing the NHS into pointless tendering and competition.

The central requirement of the proposed new regime is that decisions about who provides NHS services must be made in a transparent way, in the best interests of patients, taxpayers and the population. The regime would need to be applied by NHS bodies (NHS England and NHS Improvement, ICS NHS bodies, NHS trusts and foundation trusts) and local authorities when making decisions about who provides healthcare services (the new regime will not apply to other local authority services).

The regime sets out the steps that decision-making bodies should take when seeking to justify continuing existing arrangements with an existing provider; how to select the most suitable provider when a service is new or changing substantially, but a competitive procurement is not appropriate; and how to run a competitive

procurement where this is considered appropriate. The regime sets out some key criteria decision-makers need to consider when arranging services, as well as requirements around transparency and scrutiny of decisions. Further details can be found at www.england.nhs.uk/publication/nhs-provider-selection-regime-consultation-on-proposals/

## Provider collaboratives

Provider collaboratives are partnership arrangements involving two or more trusts (foundation trusts or NHS trusts) working across multiple places to realise the benefits of mutual aid and working at scale. The response to COVID-19 has demonstrated both the need for and potential of this type of provider collaboration. During 2021/22 the dynamic management of capacity and resources, greater transparency and collective accountability seen during the pandemic must be continued and developed. Specifically, providers are expected to work together to agree and deliver plans to achieve inclusive service recovery, restoration and transformation across systems, and to ensure services are arranged in a way that is sustainable and in the best interests of the population.

From April 2022 trusts providing acute and/or mental health services are expected to be part of one or more provider collaboratives. Community trusts, ambulance trusts and non-NHS providers (eg community interest companies) should participate in provider collaboratives where this is beneficial for patients and makes sense for the providers and systems involved.[12]

The purpose of provider collaboratives is to better enable their members to work together to continuously improve quality, efficiency and outcomes, including proactively addressing unwarranted variation and inequalities in access and experience across different providers. They are expected to be important vehicles for trusts to collaboratively lead the transformation of services and the recovery from the pandemic, ensuring shared ownership of objectives and plans across all parties.

[12] Community trusts, ambulance trusts and other providers may need to maintain relationships with multiple provider collaboratives, and/or focus on relationships within place-based partnerships, in ways they should determine with partners.

Provider collaboratives will agree specific objectives with one or more ICS, to contribute to the delivery of that system's strategic priorities. The members of the collaborative will agree together how this contribution will be achieved.

Provider collaboratives will help facilitate the work of alliances and clinical networks, enabling specialty-level plans and decisions to be made and implemented in a more coordinated and systematic way in the context of whole system objectives. For example, Cancer Alliances already work with the providers in their local systems to lead a whole system approach to operational delivery and transformation, and in future Alliances will work with their relevant Provider Collaboratives.

It will be up to providers, working with partners, to decide on the specific model and best governance arrangements for their collaboratives.

ICS NHS bodies will contract with NHS trusts and foundation trusts for the delivery of services, using the NHS Standard Contract. For services delivered through collaborative arrangements, ICS NHS bodies could:

- contract with and pay providers within a collaborative individually. The providers would then agree as a provider collaborative how to use their respective resources to achieve their agreed shared objectives
- contract with and pay a lead provider acting on behalf of a provider collaborative (whole budget for in-scope services). The lead provider would agree sub-contracting and payment arrangements across the collaborative. The existing mental health provider collaboratives have been successfully based on lead provider arrangements.

The ICS NHS body and provider collaboratives should define their working relationship, including participation in committees via partner members and any supporting local arrangements, to facilitate the contribution of the provider collaborative to agreed ICS objectives.

Further guidance on provider collaboratives will be published in due course.

## Clinical and professional leadership

All ICSs should develop a model of distributed clinical and care professional leadership, and a culture which actively encourages and supports such leadership to thrive. This includes ensuring professional and clinical leaders have protected time and resource to carry out system roles, and are fully involved as key decision-makers, with a central role in setting and implementing ICS strategy.

These arrangements should support and enhance those of the organisations within the ICS footprint, which are responsible for the professional and clinical leadership of their people and services.

They should reflect the learning and experience gained from CCG clinical leadership, building out from this to reflect the rich diversity of clinical and care professions across the wider ICS partnership, including health, social care and the VCSE sectors, embedding an inclusive model of leadership at every level of the system.

Specific models for clinical and care professional leadership will be for ICSs to determine locally and we recognise that ICSs are at different stages of development in this regard. We will provide further resources describing the features of an effective model, informed by more than 2,000 clinical and care professionals and illustrating case studies from systems with more advanced approaches. These features include:

- effective structures and communication mechanisms to connect clinical and care professional leaders at each level of the system
- a culture which systematically embraces shared learning, supporting its clinical and care professional leaders to collaborate and innovate with a wide range of partners, including patients and local communities
- protected time, support and infrastructure for clinical and care professional leaders to carry out their system leadership roles
- clearly defined and visible support for clinical and care profession leaders, including support to develop the leadership skills required to work effectively across organisational and professional boundaries
- transparent approaches to identifying and recruiting leaders, which promote equity of opportunity and a professionally and demographically diverse talent pipeline which reflects that community it serves.

We will expect ICSs to use the resources to support self-assessment of their clinical and professional leadership model and implement mechanisms to measure their progress and performance. We encourage systems to consider how they could use a peer review approach to support their development in this area, buddying with other systems to undertake their assessment and develop subsequent plans.

For the NHS ICS body, the clinical roles on the Board, described in the ‘Governance and management arrangements’ section, are a minimum expectation, ensuring executive-level professional leadership of the organisation. Individuals in these roles are expected to ensure leaders from across clinical and care professions are involved and invested in the purpose and work of the ICS.

The ICS NHS board will be expected to sign off a model and improvement plan for clinical and care professional leadership that demonstrates how this will be achieved, and to ensure that the five guiding principles described above are reflected in its governance and leadership arrangements.

## Working with people and communities

The parties in an ICS, including those of the ICS Partnership, the NHS ICS body and place-based partnerships will be expected to agree how to listen consistently to, and collectively act on, the experience and aspirations of local people and communities. This includes supporting people to sustain and improve their health and wellbeing, as well as involving people and communities in developing plans and priorities, and continually improving services.

As part of the ICS-wide arrangements, we expect each ICS NHS body to build a range of engagement approaches into their activities at every level and to prioritise engaging with groups affected by inequalities. The solutions to reducing inequalities will often be found by engaging with communities through relational and strengths-based approaches drawing on the experience of local authority, VCSE and other partners with experience and expertise in this regard.

We expect that this will be supported by a legal duty for ICS NHS bodies to make arrangements to involve patients, unpaid carers and the public in planning and commissioning arrangements, and by the continuation of the existing NHS trust and foundation trust duties in relation to patient and public involvement, including the role of foundation trusts governors.

Working with a range of partners such as Healthwatch, the VCSE sector and experts by experience, the ICS NHS body should assess and where necessary strengthen public, patient and carers' voice at place and system levels. Places are an important component, as they typically cover the area and services with which most residents identify. We are working with ICSs, Healthwatch England and others to identify and disseminate some of the most effective place-based approaches, for example through place-level citizens' panel work.

Arrangements in a system or place should not just provide a mechanism for commentary on services but should be a source of genuine co-production and a key tool for supporting accountability and transparency of the system. Where decision-making affects communities, groups or specific services, these arrangements (including any formal consultation) should fully engage those affected, including populations, patients and carers across health and social care.

We have previously set out seven principles for how ICSs should work with people and communities. These are:

1. Use public engagement and insight to inform decision-making
2. Redesign models of care and tackle system priorities in partnership with staff, people who use care and support and unpaid carers
3. Work with Healthwatch and the voluntary, community and social enterprise sector as key transformation partners
4. Understand your community's experience and aspirations for health and care
5. Reach out to excluded groups, especially those affected by inequalities
6. Provide clear and accessible public information about vision, plans and progress to build understanding and trust
7. Use community development approaches that empower people and communities, making connections to social action.

Each ICS NHS body should use these principles as a basis for developing a system-wide strategy for engaging with people and communities, building on the existing relationships, good practice and networks across system partners.

As part of this strategy, the body should work with its partners across the ICS to develop arrangements for:

- ensuring the ICS Partnership and place-based partnerships have representation from local people and communities in priority setting and decision-making forums
- gathering intelligence about the experience and aspirations of people who use care and support, together with clear approaches to using these insights to inform decision making and quality governance.

More detailed information will be made available to systems in guidance on membership and governance of ICS NHS bodies and in the implementation support for how ICSs work with people and communities.

## Accountability and oversight

The ICS NHS body will be a statutory organisation. The members of its unitary board will have collective and corporate accountability for the performance of this organisation and will be responsible for ensuring its functions are discharged. NHS England and NHS Improvement through its regional teams, will agree the constitutions and plans of ICS NHS bodies and hold them to account for delivery through the chair and chief executive.

ICSs more broadly bring together NHS, local government and other partners, who each retain formal accountability for the statutory functions they are responsible for. Building on the relationships and ways of working they have developed to date, these partners will need to maintain a working principle of mutual accountability, where, irrespective of their formal accountability relationships, all partners consider themselves collectively accountable to the population and communities they serve, and to each other for their contribution the ICS's objectives.

Providers of NHS services will continue to be accountable:

- for quality, safety, use of resources and compliance with standards through the provider licence (or equivalent conditions in the case of NHS trusts) and CQC registration requirements
- for delivery of any services or functions commissioned from or delegated to them, including by an NHS ICS body, under the terms of an agreed contract and/or scheme of delegation.

Executives of provider organisations will remain accountable to their boards for the performance of functions for which their organisation is responsible. Where an executive of an NHS provider organisation sits on the board of an NHS ICS body, they will in their capacity as a member of that board also be accountable – collectively with other board members – for the performance of the ICS body and ensuring its functions are discharged. And when acting as an ICS body board member, they must act in the interests of the ICS body and the wider system, not those of their employing provider. NHS England and NHS Improvement will provide guidance to support ICS NHS bodies to manage conflicting roles and interests of board members.

## Approach to NHS oversight within ICSs

The oversight arrangements for 2022/23 will build on the final 2021/22 System Oversight Framework (SOF) reflecting the statutory status of ICS NHS bodies from April 2022. We expect these arrangements to confirm ICSs' formal role in oversight including:

- bringing system partners together to identify risks, issues and support needs and facilitate collective action to tackle performance challenges
- leading oversight and support of individual organisations and partnership arrangements within their system.

While ICS NHS bodies will, by default, lead local oversight and assurance, NHS England and NHS Improvement's future statutory regulatory responsibilities will be similar to its existing ones. This means that any formal regulatory action with providers will, when required, be taken by NHS England and NHS Improvement.

We will work with each ICS NHS body to ensure effective and proportionate oversight of organisations within the ICS area, with arrangements that reflect local delivery and governance arrangements and avoid duplication. In particular, where additional assurance or intervention is required, NHS England and NHS Improvement will work with the ICS partners to ensure such action is informed by the perspective of system stakeholders, and that any recovery plans agreed align with system objectives and plans.

NHS England and NHS Improvement and ICS NHS bodies may, over time, decide to take the role of provider collaboratives and place-based partnerships into account when determining how to address issues identified through system oversight. This may, for instance, include looking to these arrangements (and the partners involved) for support where poor performance is identified; or considering the effectiveness of collaborative working arrangements when considering whether systems/providers have an effective plan for improvement/recovery.

Systems will also benefit from existing local authority health overview and scrutiny committees reviewing and scrutinising their work. Scrutiny provides a mechanism for local democratic accountability through local government elected members. It enables valuable connections to be made between the experience and aspirations of residents and ICS governance, via the relationships that local councillors have with their constituents.

Accountability and transparency in ICSs will also be supported via:

- clearly agreed and articulated arrangements for how the system works with people and communities
- public meetings, published minutes, and regular and accessible updates on the ICSs' vision, plans and progress against priorities.

We are working with colleagues from the Care Quality Commission (CQC) and DHSC to agree the process and roles for reviewing and assessing systems. The aim is that this would complement the role of NHS England and NHS Improvement, avoiding duplication and overlap, and support the delivery of integrated care across system partners.

The proposed principles for NHS system oversight are:

- working with and through ICSs, wherever possible, to provide support and tackle problems
- a greater emphasis on local priorities and on system performance and quality of care outcomes alongside the contributions of individual organisations to system goals
- matching accountability for results with improvement support, as appropriate
- greater autonomy for ICSs and organisations with evidence of collective working and a track record of successful delivery of NHS priorities, including tackling inequality, health outcomes and access
- compassionate leadership behaviours that underpin all oversight interactions.

## Financial allocations and funding flows

Systems are currently funded under the COVID financial regime through a system funding envelope for each ICS, which includes system top-up and COVID fixed allocation arrangements. In due course, system funding allocations will move back towards the population-based distribution and funding quantum allocated as part of the Long Term Plan funding settlement, taking account of subsequent funding allocations and the outcome of the Spending Review.

### ICS allocations

NHS England and NHS Improvement will make financial allocations to each ICS NHS body for the performance of its functions. Decisions about spending will be devolved to ICS NHS bodies.

This will include the budgets for:

acute, community and mental health[13] services (currently CCG commissioned)
primary medical care (general practice) services (currently delegated to CCGs)
running cost allowances for the ICS NHS body.

This may also include the allocations for a range of functions currently held by NHS England and NHS Improvement, including:

- other primary care budgets
- relevant specialised commissioning services suitable for commissioning at ICS level (for example, excluding highly specialised services)
- the allocations for certain other directly commissioned services
- a significant proportion of nationally held transformation funding and service development funding
- the Financial Recovery Fund
- funding for digital and data services.

[13] Every ICS will be required to continue to meet the mental health investment standard and as such a minimum level of mental health funding remains ringfenced (ICSs are free to invest above this level).

Funding will continue to be linked to population need. Allocations will be based on longstanding principles of supporting equal opportunity of access for equal needs and contributing to the reduction of health inequalities. NHS England and NHS Improvement's approach will continue to be informed by the independent Advisory Committee on Resource Allocation (ACRA).[14] Allocations will be set in a way that avoids large swings in funding that would risk destabilising local health economies.

NHS England and NHS Improvement will allocate funding to ICSs, continuing to take into account both the need of their population ('the target allocation') and how quickly ICSs move towards their target allocations (known as pace-of-change). We would not make a centrally set allocation to 'place' within the ICS. Existing allocations tools can be adapted to support ICS NHS bodies in making decisions about how to deploy resource to places.

An open book relationship between providers of NHS services, supported by improved cost data (PLICS), will give further transparency for stakeholders that the NHS is meeting its commitment to deploy resource according to need and tackle inequalities.

Full capital allocations will be made to the ICS NHS body, based on:

- the outcome of the 2022/23 capital settlement for operational capital, building on the arrangements initially implemented in 2020/21
- capital budgets being a combination of system-level allocations (operational capital), nationally allocated funds (for large strategic projects) and other national programmes
- the methodology being kept under review to ensure available capital is best allocated against need. We hope future allocations can be set over a multi-year, subject to the outcome of the next Spending Review.

## Distribution of funds by the ICS NHS body

The ICS NHS body will agree how the allocation will be used to perform its functions, in line with health and care priorities set at a local level.

[14] An independent committee of academics, public health experts, GPs and NHS managers that makes recommendations on the preferred, relative, geographical distribution of resources for health services.

Money will flow from the ICS NHS body to providers largely through contracts[15] for services/outcomes, which may be managed by place-based partnerships or provider collaboratives.

The existing provider collaboratives for specialised mental health, learning disability and autism services have paved the way in taking on budgets through lead provider arrangements. In conjunction with ICS leaders, we will consider supporting provider collaboratives to take on further responsibility for use of resources to deliver population health outcomes.

The ICS NHS body will be able to commission jointly with local authorities under a section 75 joint commissioning arrangement, as CCGs can.

Spending will be part of a plan to deliver financial balance within a system's financial envelope, which would also be set by NHS England and NHS Improvement. This envelope covers expenditure across the whole system, including spending by NHS trusts/foundation trusts for services delivered for commissioners from outside the system.

Each ICS will have an agreed framework for collectively managing and distributing financial resources to address the greatest need and tackle inequalities in line with the NHS system plan, having regard to the strategies of the Partnership and the Health and Wellbeing Board/s. This is in line with the duty we expect to remain for the system to have regard for reducing health inequalities.

Financial rules will apply to ensure delivery of key national commitments, such as the Mental Health Investment Standard and the primary medical and community health services funding guarantee.

Based on these local priorities and national rules (including the National Tariff Payment System), the ICS NHS body will agree:

- priorities and outcomes to be achieved in plan against NHS budget (with clinical advice and with regard to ICS Partnership plan)
- the distribution of the NHS revenue allocation (both total financial value and service lines) to:

[15] The ICS NHS body will also be able to make grants to VCSE organisations and to NHS Trusts/FTs. In future, the ICS NHS body may wish to use its expected power to delegate its functions to statutory providers.

- each place-based partnership as appropriate
- each NHS provider (individually contracted or via a lead provider contract, including where operating as part of a provider collaborative)
- contracts with other service providers
- other collaboratives partnerships.

- A capital plan including how capital spend should be prioritised locally (developed through collective decision making across NHS providers, and with ability to co-ordinate with the estates and assets managed by local authorities).

The ICS NHS board and chief executive (AO) will be ultimately responsible for services under delegation arrangements with place-based partnerships or through lead provider contracts. They will need to put in place proportionate mechanisms to provide assurance on the spending of public money.

## Setting budgets for places

The ICS NHS body will have the freedom to set a delegated budget for place-based partnerships to support local financial decisions to spend ICS NHS resources. However, it must adopt the principle of equal access for equal need and the requirements to reduce health inequalities. The ICS NHS body should engage local authority partners on the ICS NHS resources for the NHS services to be commissioned at place and support transparency on the spending made at place level. It should explain any variation from previous CCG budgets and enable the shared planning or pooling of NHS and local authority budgets, including stated minimum NHS contributions to Better Care Fund arrangements.

Budget allocated to and managed within a place (under the agreed schemes of delegation) might include:

- primary medical care
- other primary care as delegated/transferred from NHS England and NHS Improvement – dental, pharmaceutical, ophthalmology services
- community services
- community mental health including IAPT
- community diagnostics
- intermediate care

- any services subject to Section 75 agreement with local authority
- any acute or secondary care services that is has been agreed should be commissioned at place-level.

## Financial and regulatory mechanisms to support collaboration

ICS NHS bodies will have a duty to co-operate with other NHS bodies, including NHS trusts and foundation trusts, and local authorities. They also have a duty to promote integration. These duties, combined with the new triple aim duty, should be a key driver for ensuring NHS ICS partners work together to meet the four purposes of the ICS with the resources available.

Collaboration in the NHS has accelerated in recent years and this is already supported by a wide range of enablers to ensure a shared investment in system objectives and plans.

Enablers already established, or expected to be established, through NHS England and NHS Improvement's system-by-default approach include:

- Setting system financial envelopes, which describe the funding available to spend in an ICS, including CCG allocations and national sustainability funding. These budgets will be based on population need and will support systems to work together to free up resources, which can be spent elsewhere in the system
- Proposals to establish an aligned payment and incentive (API) approach, in which fixed payments are set for an agreed level of planned activity; variable payments would also be agreed for activity above or below these plans. This should give the ICS NSH body, NHS trusts and foundation trusts greater certainty over payments and the agreed level of activity these payments will cover
- Inclusion of a System Collaboration and Financial Management Agreement in the NHS standard contract, which is a collaborative document aimed to ensuring NHS system partners work together to deliver shared financial objectives. The ICB, NHS trusts and foundation trusts will agree in advance ways of working and the risk management approach to dealing with unplanned pressures

- Change in oversight focus in the System Oversight Framework (SOF) which works with and through the system to tackle problems with an emphasis on system performance and greater autonomy for organisations with evidence of effective joint working.
- Guidance to be issued on provider governance to support providers to work collaboratively as part of ICSs to deliver system objectives. This will include an updated Code of Governance for NHS provider trusts, updated guidance on the duties of foundation trust governors, and updated memorandums for accounting officers of foundation trusts and NHS trusts. New guidance will be issued under the NHS Provider Licence that good governance for NHS providers includes a requirement to collaborate.

In addition to these policy developments, further enablers to support system collaboration are expected from the proposed legislation and policy, including:

- A common duty for ICS NHS bodies, NHS trusts and foundation trusts in relation to the triple aim, which requires them to have regard to the wider effect of their decisions in each of the three strands of the triple aim improving population health, quality of care and the use of resources
- Imposition of duties on the ICS NHS body to act with a view to ensuring system financial balance and to meet other financial requirement and objectives set by NHS England and NHS Improvement. This would also apply to NHS trusts and foundation trusts. This should mean that ICS NHS bodies, NHS trusts and foundation trusts have shared investment in the delivery of system financial balance and strong reason to collaborate to agree a system plan for meeting this; supported by a review of the NHS provider licence
- Powers to ensure organisational capital spending is in line with system capital plans. A review of the NHS provider licence in light of the new legislation and policy developments and specifically to support providers to work effectively as part of ICSs to deliver system objectives.

**Services currently commissioned by NHS England and NHS Improvement**

The legislation will enable the direct commissioning functions of NHS England and NHS Improvement to be jointly commissioned, delegated or transferred at an appropriate time to ICS NHS bodies.

NHS England and NHS Improvement is considering how it might shift some of its direct commissioning functions to ICS NHS bodies. Subject to discussions with systems and our Regions and further work on HR, our intention is to enable ICS NHS bodies to take on responsibility as soon as they are ready to do so after the enactment of legislation.

Commissioning of primary medical services is currently delegated to CCGs and will transition immediately into ICS NHS bodies when they are established. ICS NHS bodies might also take on primary dental services, general ophthalmic and pharmaceutical services commissioning.

Further work is taking place at national and regional levels to explore how the commissioning model for specialised services could evolve , in line with the safeguards and four principles set out in *Integrating Care: Next steps to building strong and effective integrated care systems across England*.

NHS England and NHS Improvement has a range of other direct commissioning functions including health and justice, armed forces and aspects of public health. Engagement with ICSs will continue to establish how they could take on greater responsibility for these services in future.

## Data and digital standards and requirements

The standards and requirements for digital and data will be centred around the What Good Looks Like framework, which will set out a common vision to support ICS leaders to accelerate digital and data transformation in their systems with partner organisations. Based on consultation with a wide range of NHS and care stakeholders, the framework identifies seven success measures and will be published in the first quarter of 21/22.

We expect digital and data experts to have a pivotal role in ICSs, supporting transformation and ensuring health and care partners provide a modern operating environment to support their workforce, citizens and populations.

From April 2022, systems will need to have smart digital and data foundations in place. The way that these capabilities are developed and delivered will vary from system to system. Systems will locally determine the right way to develop these capabilities and to ensure they are available at system and place level, and across provider collaboratives.

Specifically, ICS NHS bodies are expected to:

- Have a renewed digital and data transformation plan that is embedded within the ICS NHS body plan and details the roadmap to achieve 'What Good Looks Like'; and enables a cross system approach to transformation, so that changes to models of care and service redesign involve digital and data experts working with partners from all relevant sectors.
- Have clear accountability for digital and data, with a named SRO with the appropriate expertise, (registered professional or with equivalent experience), underpinned by governance arrangements that have clear oversight and responsibility for digital and data standards and requirements for the ICS and enabling partner organisation programmes and services.
- Invest in levelling-up and consolidation of infrastructure, linked to the future ICS reference target architecture and data model, adopting a simplified cloud-first infrastructure that provides agility and frictionless cross-site working experience for the workforce.

- Implement a shared care record, that allows information to follow the patient and flow across the ICS to ensure that clinical and care decisions are made with the fullest of information.
- Ensure adherence by constituent partners to standards and processes that allow for interoperability across the ICS, and alignment to forthcoming national guidance.
- Enable a single co-ordinated offer of digital channels for citizens across the system and roll out remote monitoring technologies to help citizens manage their care at home.
- Cultivate a cross-system intelligence function to support operational and strategic conversations, as well as building platforms to enable better clinical decisions. This will require ICSs to have linked data, accessible by a shared analytical resource that can work on cross-system priorities.
- Agree a plan for embedding population health management capabilities and ensuring these are supported by the necessary data and digital infrastructure, such as linked data and digital interventions. Online PHM support can also be found at https://future.nhs.uk/populationhealth/grouphome and here Population Health Management - e-Learning for Healthcare (e-lfh.org.uk).

Arrangements should be co-ordinated across the NHS and local government, as well as between NHS organisations.

## Managing the transition to statutory ICSs

We will work in partnership with systems, individual organisations affected, trade unions, voluntary organisations and central and local government to ensure the opportunities for improved outcomes for populations and improvements for our people are realised. We aim to create an environment that enables this change to take place with minimum uncertainty and employment stability for all colleagues who are involved.

The change and transition approach is guided by our Employment Commitment and a set of core principles designed to inform the thinking and actions of all colleagues throughout the process, acknowledging the wide variation in circumstances across systems.

> **The Employment Commitment**
>
> *"NHS people within the wider health and care system (below board level) affected directly by these legislative changes, including CCGs, NHS England and NHS Improvement and NHS providers, will receive an employment commitment to continuity of terms and conditions (even if not required by law) to enable all affected colleagues to be treated in a similar way despite a variety of contractual relationships. This commitment is designed to provide stability and remove uncertainty during this transition."*

The Employment Commitment is designed to minimise uncertainty and provide employment stability for people who will transfer directly from their employment or engagement directly into the statutory ICS NHS body. During the transition period the Employment Commitment asks affected organisations not to carry out significant internal organisational change and not to displace people. The commitment does not apply to those people in senior/board level roles who are likely to be affected by the new ICS Board structure and will have to go through organisational change as part of the abolition and establishment process.

## Core Principles

**People Centred Approach – in line with the People Promise**

- Thinking about the needs of patients and the impact on our people as a first step and amending plans if necessary
- Taking a supportive talent based approach with colleagues impacted by the changes
- Seeking to provide stability of employment/ engagement
- 'One NHS workforce' inclusive change approach supported by the employment commitment
- Working in partnership with trade union colleagues

**Compassionate and inclusive**

- Openness and transparency of process and actions
- Taking action to increase the diversity of the new ICS workforce and particularly the leadership
- Co-creation at the appropriate level
- Individual behaviours
- Supportive change approach

**Minimum disruption**

- Taking the minimum position to enable the change to happen and setting the direction for future evolution by the new ICS NHS Bodies
- Keeping policy as simple as possible and testing thinking against these principles
- Working together to avoid unnecessary duplication of effort and achieve greatest value – based on the principle of subsidiarity
- Implementing the employment commitment

**Subsidiarity**

- Functions and accountability move based on the principle of where the work should be carried out to ensure the enablement of continuous improvement and partnership responsibility to the ICS ambitions, through a population health management approach across all functions
- People follow the function in line with the employment commitment for people below board level
- Organisation design at national and regional level should mirror the legislative approach and be as minimally prescriptive as possible

Accountability for managing the change process will be with the current ICS and CCG leadership, with increasing involvement of the new leaders (eg chair, chief executive and others at board level) who may be appointed on a shadow or designate basis, pending the legislation.

Each ICS should make initial arrangements to manage the transition and ensure that there is capacity in place ready for implementation of the new ICS body. Plans should be agreed with regional NHS England and NHS Improvement teams.

Each ICS should ensure that planning adequately addresses the implications of organisational development implications as operations evolve from the current into the future configuration. This should be explicitly based in the local context.

It is important to note that any plans are subject to the passage of the legislation. Systems cannot pre-empt the decision of Parliament on whether to approve a bill or how it is to be amended. While plans can be made, systems should not take decisions or enter into arrangements which presume any legislation is already in place or that it is inevitable it will become law, before the Parliamentary process has been completed.

The overarching aim is to ensure and enable:

- the safe transfer of functions into the ICS NHS body (ie existing statutory functions that are to be exercised by the ICS NHS body) and prepare for the ICS body to take on new functions as appropriate
- the smooth transition of our people (ie legally compliant, with minimum disruption).

The indicative outputs expected in every ICS over the course of the transition period in 2021/22 are set out below. This is subject to legislation and other factors (including pending decisions on ICS boundaries in some areas).

| | |
|---|---|
| By end Q1<br>Preparation | • Update System Development Plans (SDPs) against the key implementation requirements (functions, leadership, capabilities and governance) and identify key support requirements.<br>• Develop plans in preparation for managing organisational and people transition, taking into account the anticipated process and timetable, and any potential changes to ICS boundaries and the need to transform functions to support recovery and delivery across the ICS. |
| By end Q2<br>Implementation | • Ensure people currently in ICS Chair, ICS lead or AO roles are well supported and consulted with appropriately.<br>• Carry out the agreed national recruitment and selection processes for the ICS NHS body chair and chief executive, in accordance with guidance on competencies and job descriptions issued by NHS England and NHS Improvement. This will reflect the expected new accountabilities and responsibilities of ICS NHS bodies.<br>• Confirm appointments to ICS Chair and chief executive. Subject to the progress of the Bill and after the second reading these roles will be confirmed as designate roles.<br>• Draft proposed **new** ICS NHS body MoU arrangements for **2022/23**, including ICS operating model and governance arrangements, in line with the NHS England and NHS Improvement model constitution and guidance.<br>• Plan for CCG teams to only operate at sub-ICS level where the SDP confirms that the ICS plans to establish a significant place-based function at that footprint.<br>• Begin due diligence planning. |
| By end Q3<br>Implementation | • Ensure people in impacted roles are well supported and consulted with appropriately. |

| | |
|---|---|
| | • Carry out the recruitment and selection processes for designate finance director, medical director, director of nursing and other board level role in the NHS ICS body, using local filling of posts processes.<br>• Confirm designate appointments to ICS NHS body finance director, medical director and director of nursing roles and other board and senior level roles.<br>• ICS NHS bodies and ICS Partnerships to be ready to operate in shadow form.<br>• Engagement on local ICS Constitution and governance arrangements for ICS NHS body and ICS Partnership. |
| By end Q4 Transition | • Ensure people in affected roles are consulted and supported.<br>• Continue the recruitment and selection processes for all other designate ICS NHS body senior roles, including place-level leaders and non-executive roles, using local filling of posts processes.<br>• Confirm designate appointments to any remaining senior ICS roles (in line with our relevant guidance) so that as much of the ICS NHS executive board and other senior leadership is ready (subject to formal decisions on appointments after the legislation is in place/in force).<br>• Complete due diligence and preparations for staff and property (assets and liabilities, including contracts) transfers from CCGs and other NHS staff transfers to new ICS NHS body in line with our guidance.<br>• Commence engagement and consultation on the transfer with trade unions.<br>• Complete preparations to shift our direct commissioning functions to ICS NHS body, where this is agreed from 1 April 2022.<br>• Ensure that revised digital, data and financial systems are in place ready for 'go live'.<br>• Submit the ICS NHS body constitution for approval and agree the 2022/23 ICS MoU with NHS England and NHS Improvement, setting out key elements of how the new ICS NHS body and ICS Partnership will operate in the future, in accordance with guidance to be issued by NHS England and NHS Improvement. |

NHS England and NHS Improvement is working with a range of stakeholder groups, including a newly formed ICS Transition Partnership Group, which is a sub-group of the national Social Partnership Forum, to make available a range of resources and guidance to support the transition. The following document will be published in support of this:

- Employment Commitment Guidance – which builds on the commitment made in the FAQs published on 11 February 2021 and sets out what ‘board level’ means in this context. This also sets out the national support and senior level support that is available for colleagues affected by these changes.

After the legislation is introduced, we will publish further resources and guidance to support people transition planning and implementation.

## Conclusion

As we move into the next phase of system development, we must capture and build on the spirit and practice of partnership now embedded across the NHS local councils, the VCSE sector and beyond. We continue to face an unprecedented challenge as a health and care system, but ICSs offer a clear way forward.

Strengthening local partnerships through ICSs is one of the most important and exciting missions in the public sector today.  We would like to thank colleagues in every part of every system for your continued efforts to pursue it. This is an opportunity to deliver better care and population health; to ensure services treat us all as individuals and respond to our increasingly complex health and care needs. It is also an opportunity to work in partnership with local residents in new ways, removing even more of the traditional barriers to joined-up, personalised care and support.

Building on the achievements of system leaders over several years, the further ‘transformation by necessity’ prompted by the pandemic provides a platform for ongoing improvement of relationships, services and outcomes. Working together through ICSs will allow us to seize these opportunities, ensure our health and care systems are fit for the future and that we achieve world class health outcomes for our whole population.

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NORTH LONDON PARTNERS in health and care

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# NHS Provider Selection Regime

## Consultation on Proposals

**June 2021**

NORTH LONDON PARTNERS
in health and care
North Central London's sustainability and transformation partnership

# Current & Proposed Regime

NHS

**Current Regime**

Current procurements are governed by the Health & Social Care Act 2012 and Public Contract Regulations (PCR) (including historic references to EU Regulations). This creates an expectation that nearly all contracts will be reprocured even where they are working well.

In turn this creates an environment of perpetual competition and uncertainty for providers as well as imposing procurement costs on the NHS.

**Proposed Regime**

Decision Making Bodies would have more flexibility to extend contracts where arrangements are working well and there is no value in seeking alternative provision. A new duty would be created for Decision Making Bodies to demonstrate that services are arranged in the best interests of patients, taxpayers and the population.

Where changes to contracts are required the current processes will be replaced with a transparent but proportionate process for decision making allowing for shared responsibility rather than competitive tendering.

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# Applicability

NHS

**Who does the regime apply to?**
The new regime will apply to all NHS Bodies (NHSE, ICS's, NHS Foundation Trusts) and Local Authorities for certain healthcare services.

**Note:** Healthcare services purchased from the VCS, Independent Sector (including AQP Contracts) are all included in the new regime.

**What is not covered by the new regime?**
The new regime will not apply to Social Care, non NHS Services, non Clinical Services (ie Consultancy, Catering etc), Community Pharmacy nor the Procurement of Goods and Medicines.

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# Considerations in Decision Making

NHS

Decision Making Bodies will need to demonstrate that they have considered all of the following:

- **Quality & Innovation**
- **Value**
- **Integration/Collaboration**
- **Access**
- **Inequalities & Choice**
- **Service Sustainability**
- **Social Value**

Decision Making Bodies must show how they have made decisions in a structured way, been proportionate to reflect the scale, cost and significance of the service and show all criteria have been considered

**Note:** The Patient right to choice for Consultant Led 1st Outpatient Appointments are not affected.

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# Enforcement and oversight

NHS

- The government's approach is to ensure transparency throughout the process and limit remedies as much as possible after the contract has been awarded:
- Intentions as to approach must be published *in advance*; a record must be kept of all decisions and reasoning and notices of the successful provider published again prior to contract award. There will also be requirements to publish a list of awarded contracts and annual audit processes.
- There will be no remedies available, similar to those currently available under the current PCRs but there will be an informal process for making representations to the decision making body.
- NHS England may also use powers of intervention under the NHS Act 2006 but for a claimant, the last resort will be judicial review.

# Scenarios

NHS

## Scenario 1

Is the decision maker looking to continue existing arrangements without a new tender process? If so, continuation will be permitted if:

- there is no reasonable alternative provision; **or**
- the alternative provision is already available to patients through patient choice mechanisms; **or**
- the incumbent is “doing a good job" and delivering against the Key Criteria defined in the regime and the service is not changing; so there is considered no value in seeking another provider.

# Scenarios



## Scenario 2

Are arrangements substantially changing or is a new service needed? Can the incumbent no longer continue? Does the decision maker wish to make a direct award? If so it can now do so without a full tender process if it "reasonably believes" that one or more providers are the most suitable to deliver the service provided that all of the following apply:

- it is transparent about this choice of process;
- it is satisfied that the "key Criteria" will be met. In this regard there will be criteria specified in the legislation but it is not limited and can be applied in any order of priority or weightings;
- it has carefully considered other potential options providers within the geographical footprint;
- it publishes its intention to make an award with a 4-6 week notice period; and
- there are no credible representations/challenges during the notice period.

# Scenarios



## Scenario 3

The decision maker wishes to run a competitive process and/or there is a failure to satisfy the Key Criteria and it would not be possible to identify a suitable provider without a competitive process. In this circumstance, a lightly regulated procurement process must be undertaken which can be structured in accordance with the decision maker's own preferences provided the opportunity is formally advertised and the principles of transparency, openness and fairness are adhered to; as well as any relevant best practice and guidance.

If this route is chosen there will also be a need to advertise the award and allow a notice period for representations as for a direct award.