North East Lincolnshire Clinical Commissioning Group

Agenda Item: 13

Report to:	**Governing Body**
Date of meeting:	**11/03/2021**
Date paper distributed:	**11/03/2021**
Subject:	**ICS Development**
Presented by:	**Rob Walsh / Dr Peter Melton / Helen Kenyon**
Previously distributed to:	**NA**

STATUS OF THE REPORT ***(auto check relevant box)***

Decision required	☐
For Discussion to give Assurance	☐ *(Only if requested by Committee member prior to meeting)*
For Information	☐
Report Exempt from Public Disclosure	☐ No ☐ Yes

PURPOSE OF REPORT:	**To provide an update to the Governing Body with an update following the publication of the White Paper - Integration and innovation: working together to improve health and social care for all on 11th February, on the work taking place locally regarding the development of the ICS, and the development of the place based arrangements that will need to continue post 2022**
Recommendations:	**The Board are asked to:** • **note the work taking place around the development of the Humber Coast and Vale ICS and** • **Endorse the work taking place across the CCG, Council and the NEL health and care provider partners to establish local arrangements that will support the continuation of the integrated working locally within the context of the white paper proposed changes**
Clinical Engagement	Ongoing dialogue and discussion is taking place as part of the work at place and Humber / ICS level, through local dialogue and through the clinical and professional leaders groups that are already in existence. At a local level it is taking place through council of Members, as part of the Health and Care Partnership and via direct linkages the PCN and CCG clinical leads
Patient/Public Engagement	As part of the development of the white paper the government has sought views from various groups including patient representative groups. Within NEL engagement is taking place through the Health and Care provider partners membership engagement processes and with the community forum via regular updates. This will need to continue to be worked on as the year progresses
Committee Process and Assurance:	**An oversight group has been established comprising of the CCG Chair and Accountable Officer, plus the Leader and Portfolio Holder for Health and wellbeing from the NELC, and the Joint Chief Executive to oversee the work on an ongoing basis and ensure that it meets the needs of both the council and NHS**

Link to CCG's Priorities	• Sustainable services • Empowering people	☒ ☒	• Supporting communities • Fit for purpose organisation	☒ ☒
Are there any specific and/or overt risks relating to one or more of the following areas?	• Legal • Finance • Quality • Equality analysis (and Due Regard Duty)	☒ ☒ ☐ ☐	• Data protection • Performance • Other	☒ ☒ ☐

Provide a summary of the identified risk

The White paper proposes legislative change that would result in the creation of Integrated Care Systems as a legal NHS body, which would incorporate within it the functions and allocations of CCGs, therefore resulting in CCGs ceasing to exist.
If the CCG ceases to exist, then the longstanding section 75 agreement between the CCG (NHS locally) and the Council would cease to exist which if no alternative solution to enable the place based partnership between the NHS and the council can be found would result in the CCG and Council needing to unwind all of the integration that has taken place over the years, and the current joint arrangements separated and passed back to the respective statutory bodies.

The new arrangement could lead to a reduction in the allocation received for NEL and therefore reduce the level of statutory NEL pound available for investment locally.

It could have a destabilizing effect on provision locally as many of the providers currently hold NHS contracts that cover health and social care and are jointly funded.

There are also a number of CCG staff who work across Health and Adult social care so identifying who would need to transfer into the Council and who would need to be included in the future NHS arrangements would also need some working though. Despite this being very unsettling for staff, if could also result in a loss of knowledge and expertise across health and social care locally, which would have a detrimental effect on service transformation locally.

The time taking to undertake all of the above would also be significant and therefore would pull staffing resource away from the restoration work required as we hopefully move out of the covid pandemic lockdown arrangements.

Whilst the developing ICS is committed to building its arrangements from the 6 places in its area, there is still a risk in the dilution of local community engagement and involvement in service planning and transformation.

The Council and CCG are therefore working together to determine whether there is a proposition that could enable the current integration to continue and built upon where it makes sense to do so and retain a strong place leadership and focus across health and care.

Executive Summary

On the 11th February the Government published a White paper - Integration and innovation: working together to improve health and social care for all, which sets out the Department of Health and Social Care's legislative proposals for a Health and Care Bill.

In January 2019, the NHS published its Long Term Plan which set out the priorities for health and care over the next ten years. The long term plan suggested targeted legislative proposals that would help with implementation of its objectives and recommended that legislation be designed around 3 key principles:

- any legislation should solve practical problems;
- avoid a disruptive top down reorganisation; and
- have broad consensus within the system.

The white paper builds on these recommendations and sets out legislative proposals for a Health and Care Bill. It aims to build on the collaborations we have seen through Covid and shape a system that's better able to serve people in a fast-changing world.

The paper therefore sets out to achieve 3 things:

1. remove the barriers that stop the system from being truly integrated with Integrated Care Systems playing a greater role, delivering the best possible care, with different parts of the NHS joining up better; and the NHS and local government forming dynamic partnerships to address some of society's most complex health problems
2. remove much of the transactional bureaucracy that has made sensible decision-making harder. The reforms will help enable use technology in a modern way, establishing technology as a better platform to support staff and patient care. It will maintain the distinct responsibilities between those who fund services and those who provide care but set out a more joined-up approach built on collaborative relationships, so that more strategic decisions can be taken to shape health and care for the decades to come. It's about population health: using the collective resources of the local system, NHS, Local Authorities, the voluntary sector and others to improve the health of local areas.
3. a system that is more accountable and responsive to the people that work in it and the people that use it. Ministers are accountable for NHS performance, but this proposal will ensure NHS England, in a new combined form, is accountable to Government and the taxpayers that use it while maintaining its clinical and day-to-day operational independence. It will introduce measures to enhance quality and safety in the NHS, including the creation of an independent statutory body to oversee safety investigations.

The white paper proposes a number of legislative changes which are summarized at appendix 1, but the main one that directly affects the council and CCG is the proposal to establish integrated Care systems in law, and incorporate into them the functions of CCGs, which will have a significant impact on the longstanding arrangements that exist locally between the NHS (CCG) and Local Authority. If the CCG ceases to exist, then the section 75 agreement will cease to exist.

Whilst an alternative arrangement could be established between the ICS and the council, the council would not want that arrangement to be at a distance, i.e. an arrangement held at ICS level, as it would feel too remote from place. The ICS is however that its starting point for building its architecture is the 6 places based on the 6 Local Authority areas. That gives NEL an opportunity to shape and influence how the place based arrangements are established within the ICS and hopefully will enable the integration that local NHS leaders and the Local Authority have been working to achieve to be further enhanced.

Within the ICS structure 2 geographic partnerships have been created, one for Humber and one for North Yorkshire and York. Interim appointments to geographic leads have been made to support the establishment of the systems and processes that will be required at the Humber / NYY level and to support the further development of the governance structure of the ICS.

Detailed within this paper is an infographic that seeks to show the work that will be delivered at 5 differing levels within the new NHS architecture. This clearly shows that most of the work is expected to be delivered at place or neighborhood / PCN level within Place.

The CCG, Local Authority and health and care partners are working closely with the Humber geographical partnership lead to help shape those arrangements and ensure that only those activities that need to be undertaken at a humber / ICS level are.

The CCG, Local Authority and local health and care provider partners are working together to develop local governance and leadership that will meet both the needs of place and its communities, and provide assurance to the ICS that we would be able to receive a NHS delegated responsibility for planning and delivery within a place based budget.

A steering group comprising of the CCG Chair, Accountable Officer, Local Authority Leader, Portfolio Holder for Health and Wellbeing, and the Joint Chief Executive has been established to oversee the work taking place locally.

A programme group has been established for the ICP specific work requirements, which the CCG and Local Authority are both part of.

A number of working groups have also been established across the CCG/Local Authority and Health and Care provider partners to undertake the detailed work to develop the new architecture, these working groups are covering the following areas:

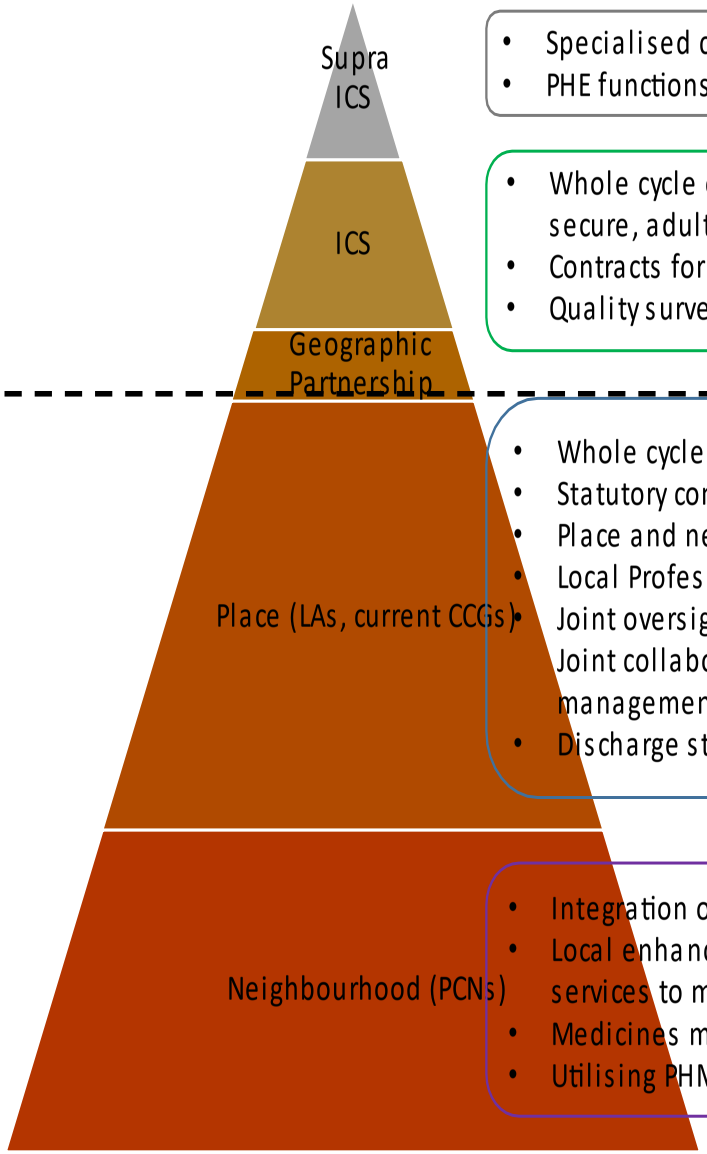
- Governance and accountability
- Operating model and business processes including Performance and BI
- Workforce & OD
- Contracting and commissioning
- Finance & funds flow
- Comms and engagement
- IT and Infrastructure technology

Over the coming weeks this work will create a structure and route map through to April 2022, when the legislative changes are anticipated to be fully enacted.

integration-and-in
novation-working-t

Extract from regional work - Fig 1. Building from the neighbourhood up – aligning CCG and NHSE commissioning

What will be done at neighbourhood, unless it's better done at place/ICS, or at place unless it's better done at ICS level.



- Specialised commissioning for c.49 services (c.80 national)
- PHE functions aligned to NHS E services
- Primary care performer list
- Screening and Immunisation
- Ambulance

- Whole cycle of speciality care including (a.) 18 Specialised services (see Product 3 Appendix B) (b.) adult secure, adult eating disorder and CAMHS Tier 4 Non-custodial community facing health and justice
- Contracts for General Practice (Core), Optometry (Core), Dental (Contract), Pharmacy (Contract)
- Quality surveillance Oversight and Assurance (Service Quality and Population Health)

- Whole cycle of urgent and emergency H&SC
- Statutory committees responsible for Place Pound, partnership development of place and PCNs
- Place and neighbourhood reporting through to the ICS
- Local Professional Networks and GP Leadership
- Joint oversight, QI, allocation of place pound to care homes, community beds, home care, hospices,
- Joint collaboration with other health determinants e.g. education, employment, communities, weight management, screening
- Discharge statutory responsibilities on behalf of ICS
- Essentially A&E, general inpatient care, ambulance
- one version of the truth
- SEND, child death reviews, safeguarding

- Integration of primary care and the wider neighbourhood offer
- Local enhanced services (GP, Optometry), flexing of Dental and Pharmacy contracts to deliver enhanced services to meet local needs
- Social prescribing and VCS
- Medicines management and prescribing
- Utilising PHM in real time to plan proactive care responses

Appendix 1
Summary of Proposed Legislative changes identified in the White Paper
In order to do this it sets out the following proposals for legislation:

- **establish Integrated Care Systems (ICSs) in law** to give them stronger and more streamlined decision-making authority and to embed accountability for system performance and delivery into the accountability arrangements for the NHS to government and Parliament.
  It is proposed to establish statutory ICSs, made up of an ICS NHS Body and an ICS Health and Care Partnership (together referred to as the ICS).

  The ICS NHS Body will merge some of the functions currently being fulfilled by non-statutory STPs/ICSs with the functions of a CCG with the aim of bringing the allocative functions of CCGs into the ICS NHS body so that they can sit alongside the strategic planning function that the ICS will undertake.

  Each ICS will also be required to establish an ICS Health and Care Partnership, bringing together health, social care, public health (and potentially representatives from the wider public space where appropriate, such as social care providers or housing providers). This body will be responsible for developing a plan that addresses the wider health, public health, and social care needs of the system – the ICS NHS Body and Local Authorities will have to have regard to that plan when making decisions.

- **introduce a new duty to promote collaboration across the healthcare, public health and social care system.**
  This proposal will place a duty to collaborate on NHS organisations (both ICSs and providers) and Local Authorities and also provides the Secretary of State for Health and Social Care with the ability to issue guidance as to what delivery of this duty means in practice

- **implement a shared duty** that requires NHS organisations that plan services across a system (ICSs) and nationally (NHS England), and NHS providers of care (NHS Trusts and FTs) **to have regard to the 'Triple Aim' of better health and wellbeing for everyone, better quality of health services for all individuals, and sustainable use of NHS resources.**

- **implement a reserve power to set a capital spending limit on Foundation Trusts,** which will support the third aim of the Triple Aim duty, in relation to sustainable use of NHS resources.

- **create provisions relating to the formation and governance of joint committees** which will enable NHS foundation trusts, CCGs as art of the ICSs, Local Authorities and other providers of NHS care to be involved in partnership arrangements, that would allow decisions to be jointly delegated to them.

- **remove barriers and streamline and strengthen governance to support collaborative commissioning** to allow**:**

  - NHS England the ability to joint commission its direct commissioning functions with more than one ICS Board,
  - ICSs to enter into collaborative arrangements for the exercise of functions that are delegated to them, enabling a "double-delegation".
  - groups of ICSs to use joint and lead commissioner arrangements to make decisions and pool funds across all their functions (and not just commissioning functions).
  - a greater range of delegation options for section 7A public health services, including the ability for onward delegation of the function into collaborative arrangements, such as a section 75 partnership arrangement; and
  - NHS England to delegate or transfer the commissioning of certain specialised services to ICSs singly or jointly, or for NHS England to jointly commission these services with ICSs if these functions are considered suitable for delegation or joint commissioning subject to certain safeguards

- support closer working between actors in the health and care system, greater clarity is needed to enable **joint appointments** across different organisations

- to address structural, cultural/behavioural and legislative barriers to **data sharing** and a more flexible legislative framework to improve data access and interoperability, including enabling the safe sharing of data in support of individual care, population health and the effective functioning of the system.
  A range of proposals will be set out within the forthcoming Data Strategy for Health and Care, but is expected to include:
    - a requirement for health and adult social care organisations to share anonymised information that they hold where such sharing would benefit the health and social care system.
    - powers for the Secretary of State for Health and Social Care to require data from all registered adult social care providers about all services they provide, whether funded by Local Authorities or privately by individuals; and require data from private providers of health care.
    - changes to NHS Digital's legal framework to introduce a duty on NHS Digital to have regard to the benefit to the health and social care system of sharing data that it holds when exercising its functions; and clarify the purposes for which it can use data.
    - a power for the Secretary of State for Health and Social Care to mandate standards for how data is collected and stored, so that data flows through the system in a usable way, and that when it is accessed/provided (for whatever purpose), it is in a standard form, both readable by, and consistently meaningful to the user/recipient.

- To preserve and strengthen a patients right to choose **(Patient Choice)** where and who will provide their health and care needs.
  It is proposed to repeal section 75 of the Health and Social Care Act 2012 Act including the Procurement, Patient Choice and Competition Regulations 2013 and replace the powers in primary legislation under which they are made with a new provider selection regime. Under the new model, bodies that arrange NHS Services as the decision-making bodies will be required to protect, promote and facilitate patient choice with respect to services or treatment

- To clarify the central role of **collaboration** in driving performance and quality in the system**, rather than competition**. The proposals would:
    - Remove the powers of the Competition and Markets Authority (CMA) to review NHS mergers including Foundation Trusts and allow NHS England to ensure that decisions can always be made in the best interests of patients. The CMA's jurisdiction in relation to transactions involving non-NHS bodies (e.g. between an NHS Trust/FT and private enterprise) and other health matters (e.g. drug pricing) would be unchanged.
    - Remove NHS Improvement's specific competition functions and its general duty to prevent anti-competitive behaviour.

- To reform the approach to **arranging healthcare services** and create a bespoke regime that will give commissioners more discretion over when to use procurement processes to arrange services than at present, with proportionate checks and balances. Where competitive processes can add value they should continue, but that will be a decision that the NHS will be able to make for itself.

- To enable the **National Tariff** to support the right financial framework for integration whilst maintaining the financial rigour and benchmarking that tariff offers.

- To allow the creation of **new trusts** for the purposes of providing integrated care.

- To amend the Care Act 2014 (which sets out the functions and constitution of HEE and LETBs) to remove LETBs from statute. Removing LETBs from statute with their functions continuing to be undertaken by HEE (and reporting to the HEE Board) will provide HEE with the flexibility to adapt its regional operating model over time.

- To fully **Merge NHS England and NHS Improvement** (which consists of the Trust Development Authority and Monitor) to create NHS England and provide a unified National leadership for the NHS answerable to the Secretary of State for Health and Social Care and Parliament

To broaden the scope for potential ministerial intervention in **reconfigurations**, creating a clear line of accountability, by allowing the Secretary of State to intervene at any point of the reconfiguration process as well as removing the current Local Authority referral process to avoid creating any conflicts of interest.

The Paper also makes proposals to support Social Care, Public Health and Safety and Quality.

In relation to **Social care** the paper proposes:

- legislative measures to encourage joined up care for everyone by ensuring local government and social care stakeholders are at the heart of our ICS proposals,
- by amending the legal framework to enable person-centred approaches to hospital discharge.
- A new power for the Secretary of State to make payments directly to adult social care providers, which will remove a bureaucratic barrier to delivering support to the sector in exceptional circumstances.
- To increase accountability in the delivery of social care through an enhanced assurance framework examining the performance of Local Authorities, and
- a new power to collect data from providers

In relation to **Public Health** the paper proposes:

- the creation of the National Institute for Health Protection (NIHP) and the closure of Public Health England
- to strengthen local public health systems,
- improve joint working on population health through ICSs,
- reinforce the role of Local Authorities as champions of health in local communities,
- strengthen the NHS's public health responsibilities,
- strengthen the role of the Department of Health and Social Care in health improvement, and
- drive more joint working across government on prevention.

The paper also proposes:

Taking measures to intervene in obesity; recognising that there is an opportunity to help people make better informed food choices and to help them improve their health and

Streamlining the process for initiating proposals for new schemes for fluoridation of water in England by moving the responsibilities for doing so from Local Authorities to central government

In relation to **safety and quality** the paper proposes:

- the establishment of an independent Health Services Safety Investigations Body to ensure that openness and accountability is embedded into the structure and culture of the NHS
- introducing a medical examiner system to scrutinise all deaths which do not involve a coroner to improve the accuracy of cause of death and mortality statistics
- changes to professional regulation to ensure that professions protected in law are the right ones and that the level of regulatory oversight is proportional to the risks to the public
- improved NHS food and drink standards for patients, staff and visitors, with mandatory minimum standards for the provision of good hydration and nutrition in the NHS