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Wednesday 10 February 2021

Notice of Meeting

Dear Member

Health and Adult Social Care Scrutiny Panel

The **Health and Adult Social Care Scrutiny Panel** meeting will take place remotely at **2.00 pm** on **Thursday 18 February 2021.**

This meeting will be live webcast. To access the webcast please go to the Council's website at the time of the meeting and follow the instructions on the page.

The items which will be discussed are described in the agenda and there are reports attached which give more details.

Julie Muscroft
Service Director – Legal, Governance and Commissioning

Kirklees Council advocates openness and transparency as part of its democratic processes. Anyone wishing to record (film or audio) the public parts of the meeting should inform the Chair/Clerk of their intentions prior to the meeting.

The Health and Adult Social Care Scrutiny Panel members are:-

Member

Councillor Habiban Zaman (Chair)
Councillor Aafaq Butt
Councillor Vivien Lees-Hamilton
Councillor Alison Munro
Councillor Lesley Warner
Councillor Bill Armer
David Rigby (Co-Optee)
Lynne Keady (Co-Optee)

Agenda
Reports or Explanatory Notes Attached

Pages

1: Minutes of previous meeting

1 - 6

To approve the Minutes of the meeting of the Panel held on 10 December 2020.

2: Interests

7 - 8

The Councillors will be asked to say if there are any items on the Agenda in which they have disclosable pecuniary interests, which would prevent them from participating in any discussion of the items or participating in any vote upon the items, or any other interests.

3: Admission of the public

Most debates take place in public. This only changes when there is a need to consider certain issues, for instance, commercially sensitive information or details concerning an individual. You will be told at this point whether there are any items on the Agenda which are to be discussed in private.

4: Deputations/Petitions

The Committee will receive any petitions and hear any deputations from members of the public. A deputation is where up to five people can attend the meeting and make a presentation on some particular issue of concern. A member of the public can also hand in a petition at the meeting but that petition should relate to something on which the body has powers and responsibilities.

In accordance with Council Procedure Rule 10 (2), Members of the Public should provide at least 24 hours' notice of presenting a deputation.

5: Public Question Time

Due to current covid-19 restrictions, Members of the Public may submit written questions to the Panel.

Questions should be emailed to richard.dunne@kirklees.gov.uk no later than 10.00 am on Wednesday 17 February 2021. In accordance with Council Procedure Rule 51(10) each person may submit a maximum of 4 written questions.

In accordance with Council Procedure Rule 11(5), the period allowed for the asking and answering of public questions will not exceed 15 minutes.

6: Independent analysis of the future size and shape of the older persons' care home market

9 - 16

The Panel will be presented with the findings of the independent analysis of the older persons' care home market and the steps that will be taken to address the findings.

Contact: Helen Severns, Service Director Integrated Commissioning Tel: 01484 221000

7: Covid-19 Update

17 - 30

The Panel will receive an update on the local position and response to the Covid-19 pandemic.

Contact: Emily Parry-Harries Consultant in Public Health / Head of Public Health Kirklees and Jane O'Donnell Head of Health Protection – Tel: 01484 221000.

8: Future Configuration of Kirklees Clinical Commissioning Groups (CCGs)

31 - 76

Representatives from Greater Huddersfield and North Kirklees CCGs will be in attendance to discuss the future configuration of Kirklees CCGs.

Contact: Richard Dunne, Principal Governance Officer, Tel: 01484 221000

9: Work Programme 2020/21

77 - 84

The Panel will review its work programme for 2020/21 and consider its forward agenda plan.

Contact: Richard Dunne, Principal Governance Officer Tel: 01484 221000.

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Contact Officer: Richard Dunne

KIRKLEES COUNCIL

HEALTH AND ADULT SOCIAL CARE SCRUTINY PANEL

Thursday 10th December 2020

Present:	Councillor Habiban Zaman (Chair) Councillor Alison Munro Councillor Lesley Warner
Co-optees	David Rigby Peter Bradshaw Lynne Keady
In attendance:	Chris Lennox - Deputy Director of Operations, South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) Sue Sutcliffe – General Manager, SWYPFT Melissa Harvey - General Manager, SWYPFT Becky Smith - Senior Advanced Clinical Practitioner SWYPFT Emily Parry-Harries – Head of Public Health Kirklees Jane O'Donnell - Head of Public Protection, Kirklees
Observers:	Councillor Elizabeth Smaje, Chair of Overview and Scrutiny Management Committee
Apologies:	Councillor Vivien Lees-Hamilton

1 Minutes of previous meeting

That the minutes of the meeting held on the 5 November 2020, be approved as a correct record.

2 Interests

Dave Rigby declared an interest as he is an ordinary member of South West Yorkshire NHS Partnership Foundation Trust

Cllr Lesley Warner declared an interest as she is one of the governors of Calderdale and Huddersfield NHS Foundation Trust

Lynne Keady, declared an interest as she is a volunteer with South West Yorkshire Partnership NHS Foundation Trust and a volunteer with Healthwatch Kirklees ad Healthwatch Calderdale

3 Admission of the public

All agenda items were considered in public session.

4 Deputations/Petitions

No deputations or petitions were received.

5 Public Question Time

No questions were asked.

6 Impact of Covid-19 on Mental Health Services

The Panel welcomed representatives from South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) to the meeting. Chris Lennox, Deputy Director of Operations, supported by colleagues provided the Panel with a summary of the information contained in the appended report. The Panel was advised that the report outlines:

- the operational challenges faced from March 2020, at the start of the pandemic and the early response in setting up the gold, silver and bronze command structures
- the work undertaken to maintain the continuity of services and how cohorting procedures were developed for the inpatient units
- the ongoing resource challenges, in terms of staff absence, keeping staff wellbeing at the forefront and keeping people well, while meeting the needs of service users
- the recovery and how services could be delivered, particularly using technology
- the demand for services for example the core and enhanced teams and how demand had fluctuated and current caseloads
- how outbreaks on the wards were dealt with
- how contact methods are balanced for example, face to face, telemedicine, and telephone
- the carers passport that was launched at the end of November for both unpaid carers and staff
- Partnerships with all sectors in terms of local recovery for Kirklees
- Manging to maintain services to people throughout this period who need crisis care

The Panel asked what the overall trends in incidence referrals had been and whether had there been a difference in the volume of referrals during the pandemic. In response, Sue Sutcliffe General Manager advised that she manages the Enhanced Teams which supports people with the most complex of mental health needs. With regard to the trends from a referrals perspective there was quite a marked drop round about March/April time and this was sustained for approximately 2/3 months. There was then a rise in referrals and at the times the referrals were higher than the previous year.

The Panel further asked whether there had been any feedback from service users with regard to the method of contact ie phone or telemedicine and what they felt about those methods. This was particularly in relation to the change in the way contact has been made and whether that has had any effect on response times to initial inquiries.

In response, Melissa Harvey, General Manager advised the Panel that different groups and cohorts of service users have different experiences with telephone contacts. It has become clear that for some people or groups of people, digital provision does not work and for them this is not an appropriate method. It has also become clear that for assessments it is much better to do those face to face as it enables a much better understanding of what people are experiencing and going through. With other groups such as the IAPS service users for example, a survey was undertaken with service users who use primary mental health care who actually indicated that they much prefer digital methods as they find it easier because they don't have to travel, park their cars or leave their homes in some circumstances. For the IAPS group they were the early up takers of digital methods using Teams and WhatsApp and all sorts of CBT therapy to reach out to people.

A question and answer session followed that covered a number of issues that included:

- in relation to IAPS, the current waiting time is 8 weeks to receive support, how is it working and has there be greater take up, what is the usual waiting time during the year, how do you know the telephone support is successful and how is that measured
- how significant has telemedicine been in the diagnosis of those acute people, for example the acute young psychotics
- is there a date in which face to face contact will resume?
- is there a contingency plan for ensuring services are maintained in the face of staff absences?
- is there a possibility that there are people with serious mental health issues who have not been in contact with any services for support?
- what use is made of volunteers who may be able to provide support people for example those who are in isolation for example training volunteers to be useful listening ears

An example was shared by a Panel member who explained the circumstances of a service user currently on the Kirklees Enhanced Pathway with a long-term complex potentially unstable mental health diagnosis who has not been seen face to face by her Care Co-ordinator since the middle of March 2020.

The Panel welcomed the information presented and thanked the representatives from South West Yorkshire Partnership NHS Foundation Trust for their comprehensive response to questions asked.

RESOLVED

1. That the report be noted
2. That representatives from South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) be thanked for attending the meeting

7 Covid-19 Update

Emily Parry-Harris, Head of Public Health and Jane O'Donnell, Head of Public Protection, Kirklees provided the Panel with an update on Covid-19.

The Panel was informed that with regard to testing, services for extra care and supported living both residents and staff now have access to testing following the pilot roll out. Staff and residents will be tested on a weekly basis and this includes ancillary staff within these settings.

Ms O'Donnell informed the Panel that a proposal was submitted for targeted testing. This was successful, and the swabs have now been received. The aim is to test people who are in contact with vulnerable people for example, people who work within drug and alcohol services, individuals in children's residential care, children's and adult social workers, staff within special school settings and those within high risk work places. The initial proposal also included care home visitors, however that was superseded by the national rollout of the Department of Health and Social Care doing direct access to care homes for their visitors and friends to access testing.

Work will be undertaken with services who are in contact with vulnerable people to see if they would be willing to be a part of targeted testing called a lateral flow test. The lateral flow test is where individuals do a self-swab and if that is positive, it then requires them to have a confirmatory PCR either at a walk-up site or at a local testing centre. If a person is positive, it links into test and trace and they will receive support. A submission will then be made for wider community testing.

The Panel asked how much reliance is being place on lateral flow tests given the reports about its sensitivity and lack of specificity. In response the Panel was advised that lateral flow tests should be seen as part of control measures to identify individuals with a high viral load at an early stage before they become symptomatic. While no test is 100% accurate and the lateral flow test is not the panacea it should be seen as part of a suite control measures to try and identify people with a high viral load.

The Panel asked a further question in respect of care homes testing update, and the discharge of people from hospital. If people for example, who have had a positive Covid-19 test but are ready for discharge from hospital, what is the criteria to decide whether they are ready for discharge or not. In addition, with regard to step down care homes which have recently been set up how are they operating and what kind of challenges have they faced?

In response, the Panel was advised that if an individual is medically fit to be discharged from hospital and they have had a positive PCR test in hospital, if they have come from a care home and the care home is willing to have them back and can meet their needs, that individual will complete their isolation within the care home. If the care home is not willing to have the individual back, then this is why there are designated care home beds to receive patients who are PCR positive.

The Panel asked a number of further questions including:

- How many step-down care homes are there across Kirklees and how many residents with Covid can they each take? The care homes that are willing to take patients with Covid can assurance be given that they can adequately cope particularly if the patient deteriorates, and are they covered by insurance

- Have all the sites been designated for vaccinations and will the people administering the vaccines be medically trained or will lay people have to be trained in giving the vaccines

Ms O'Donnell advised the Panel that the questions in relation to step-down care homes would require information from adult social care and agreed to get the information and provide the Panel with a future update.

The Panel was informed that regarding contact tracing there has been one full week of rollout and contact has been made with 50% of cases. These are cases previously stated as being hard to reach. The Panel commented that it was positive that the new local tracing service was in place and noted the difficulty tracing contacts who are in patients in hospital. The Panel asked for feedback on whether the issue had been resolved before the next panel meeting.

With regard to the vaccination programme this is an NHS led programme supported by the local authority. Potential sites are being looked at and will have to be signed off by NHS England. The designation of sites is not a local authority decision and they are likely to be sites where there are a number of GP practices and where Primary Care Networks can come together and deliver collaboratively.

Emily Parry-Harries provided the Panel with a brief summary of the numbers in relation to Covid as follows:

- In the last week there has been 75 hospital admissions which is significantly down on the previous week and there are currently 154 inpatients 24% of whom are aged over 80
- The cases are down 26% on the previous week, there have been 921, that takes the numbers below the level of October
- Kirklees is now 28th in the country, having previously been 4th or 5th which is lower than Calderdale and Bradford but continue to be higher than Leeds and Wakefield in terms of the West Yorkshire picture
- There are cases in all wards, although there appears to be a greater concentration in North Kirklees, although it is not to say there are not significant numbers across all of Kirklees
- It is generally looking like a much more positive picture

The Panel was advised that it is important that people do not become complacent and remember social distancing, the use of face covering and washing of the hands.

RESOLVED

a) That the information be noted
b) That Jane O'Donnell and Emily Parry-Harries be thanked for providing the Panel with an update on Covid
c) That further information on the step-down care homes be provided at a future meeting
d) That an update on the immunisation and rollout programme be provided at a future meeting

e) That feedback on the challenges of tracing inpatients be circulated to Panel members prior to the next meeting

8 Work Programme 2020/21

The Panel will hold a workshop session in January 2021 which will look at:

- Re-setting of NHS and care services
- Re-evaluation of work programme
- Managing the agenda plan
- Approach to how the Panel reviews and scrutinises issues

KIRKLEES COUNCIL			
COUNCIL/CABINET/COMMITTEE MEETINGS ETC **DECLARATION OF INTERESTS** Health & Adult Social Care Scrutiny Panel			
Name of Councillor			
Item in which you have an interest	**Type of interest (eg a disclosable pecuniary interest or an "Other Interest")**	**Does the nature of the interest require you to withdraw from the meeting while the item in which you have an interest is under consideration? [Y/N]**	**Brief description of your interest**

Signed: …… **Dated:** ……

NOTES

Disclosable Pecuniary Interests

If you have any of the following pecuniary interests, they are your disclosable pecuniary interests under the new national rules. Any reference to spouse or civil partner includes any person with whom you are living as husband or wife, or as if they were your civil partner.

Any employment, office, trade, profession or vocation carried on for profit or gain, which you, or your spouse or civil partner, undertakes.

Any payment or provision of any other financial benefit (other than from your council or authority) made or provided within the relevant period in respect of any expenses incurred by you in carrying out duties as a member, or towards your election expenses.

Any contract which is made between you, or your spouse or your civil partner (or a body in which you, or your spouse or your civil partner, has a beneficial interest) and your council or authority -

- under which goods or services are to be provided or works are to be executed; and
- which has not been fully discharged.

Any beneficial interest in land which you, or your spouse or your civil partner, have and which is within the area of your council or authority.

Any licence (alone or jointly with others) which you, or your spouse or your civil partner, holds to occupy land in the area of your council or authority for a month or longer.

Any tenancy where (to your knowledge) - the landlord is your council or authority; and the tenant is a body in which you, or your spouse or your civil partner, has a beneficial interest.

Any beneficial interest which you, or your spouse or your civil partner has in securities of a body where -
(a) that body (to your knowledge) has a place of business or land in the area of your council or authority; and
(b) either -

the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body; or

if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which you, or your spouse or your civil partner, has a beneficial interest exceeds one hundredth of the total issued share capital of that class.

Name of meeting: Health and Adult Social Care Scrutiny Panel

Date: Thursday 18th February 2021 - 2.00 pm

Title of report: Independent analysis of the likely future size and shape of the older persons' care home market.

Purpose of report: To share with Scrutiny members the findings of recent independent analysis of the local care home market, and to outline the opportunities for the council to work alongside the sector to address the findings.

Key Decision - Is it likely to result in spending or saving £250k or more, or to have a significant effect on two or more electoral wards?	Not Applicable
Key Decision - Is it in the Council's Forward Plan (key decisions and private reports)?	Not Applicable
The Decision - Is it eligible for call in by Scrutiny?	Not Applicable
Date signed off by Strategic Director & name **Is it also signed off by the Service Director for Finance?** **Is it also signed off by the Service Director for Legal Governance and Commissioning?**	Richard Parry 09/02//2021 Not Applicable Not Applicable
Cabinet member portfolio	Cllr Musarrat Khan

Electoral wards affected: Not Applicable

Ward councillors consulted: Not Applicable

Public or private: Public

Has GDPR been considered? No personally identifiable data has been included in this report.

1 Summary

1.1 The care home market nationally, regionally and locally in Kirklees has been in a state of change over the past few years. The COVID19 pandemic has resulted in significant challenges for the sector with reduced admissions, increased death rates and increased business costs.

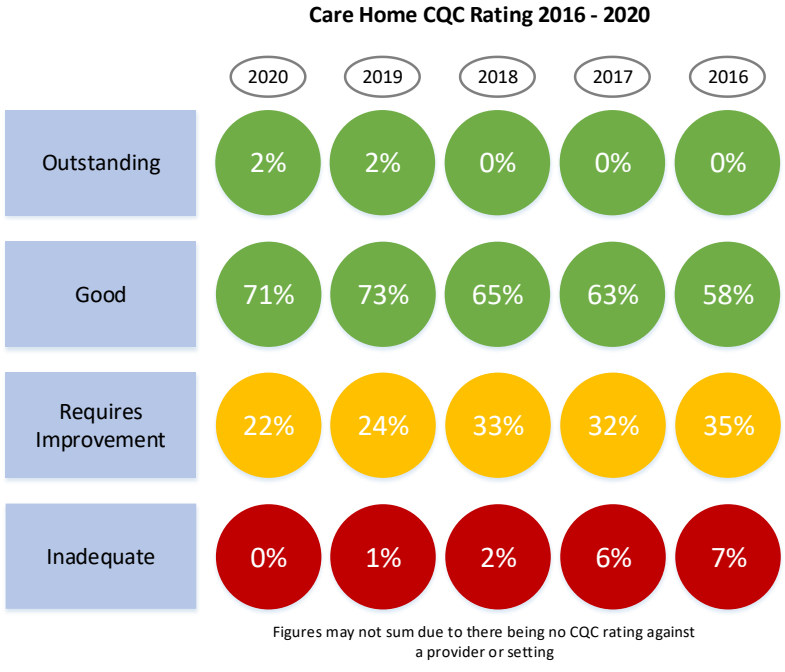
1.2 The impact of COVID19 has exacerbated issues that were already affecting how the market operates. There are likely to be continued changes in care homes as the sector moves towards a 'future normal' state in the coming months and years and there is significant effort required to make this shift as safe and effective as possible for the long-term.

1.3 As a result of this changing environment Kirklees commissioned a review of the local care home market, working with the local sector, the Kirklees Care Association and partners to develop a Care Home Market Development and Sustainability Delivery Plan for Kirklees.

1.4 The final report will identify the opportunities and risks for the sector, the council and partners and a range of potential interventions that can be implemented to ensure the level of good quality provision is in place to meet the needs of Kirklees people in the short, medium and longer term. It will also identify the risk and benefits for existing and prospective care home operators and owners.

2 The local care home market

2.1 As of 1st February 2021, there are 131 Care homes operating in Kirklees, with approximately 3,500 beds, 73% (95 homes) are rated by the Care Quality Commission (CQC) as being good or outstanding, the remaining require improvement, there are no inadequate care homes locally. The diagram below shows the change in quality in the care home sector over the past few years.



2.2 Care homes play a critical role in supporting people who cannot be cared for at home and those with complex health and care needs. However, in line with our Vision for Social Care there has been great deal of change in recent years in the care home sector. Locally and nationally there has been a gradual shift away from people choosing to move into care homes. People are choosing to stay at home longer as an increased range of community-based care and support has been developed.

2.3 Care homes have also not been immune to wider changes in health, social care and housing and there are significant challenges ahead. Financial pressures, technological change and changing expectations of end users have resulted in a need to re-think the way care home provision operates and is commissioned locally. It is nationally recognised that the increasingly short term or ring-fenced nature of social care funding means that it is difficult for both commissioners and providers to plan for the long term.

3 Summary Impact of COVID19 on the care home sector

3.1 The care home market has been significantly impacted by COVID-19 and what was a fragile market in some areas of provision is now suffering from reduced volumes of new entrants or respite cases and a higher number of deaths. There have also been a number of operational and financial pressures such as insurance costs, staff sickness and staff isolation. Initially, the cost of PPE was also an issue for the sector.

3.2 The impact of COVID-19 has seen an acceleration in the health and social care system working to support admission avoidance and rapid discharges from hospital and this presented an opportunity to the sector. However, the infection prevention and control issues around C19 positive residents being discharged has been an issue.

3.3 The move to deliver more personalised care in people's own homes, supported through increased collaboration, and the use of technology and equipment solutions, has also meant that people who historically may have gone into care homes are being supported in the community.

4 Rationale for Commissioning of the Care Home Market Development Sustainability Work

4.1 Whilst the market engagement, analysis and options could have been developed internally, it was felt that an external view would bring a rigour to the work, allow comparisons across the country and utilise specialist expertise and knowledge that was not available locally. A service specification was developed and through a competitive process Cordis Bright in partnership with LaingBuisson were selected. They are well respected subject matter experts that could bring both expertise and impartiality to the work.

4.2 The commission was undertaken in partnership with Rotherham Council who have identified a need for a similar market exercise. Each authority has received its own report but where cross-cutting work can be developed and delivered together the authorities will look to work collaboratively to achieve this.

5 Key Findings of Cordis Bright work to date

- There has been a gradual decline in bed and placements numbers over the past few years, this alongside occupancy level reductions has accelerated during the past 12 months.
- Between 2012 and 2020 there was an overall reduction in the number of residential care and nursing care beds per 100 of the population aged 75+ in Kirklees of 12.5 in 2012 to 10.2 in 2018 (slightly above the 10.1 Yorkshire and Humberside average and the 9.6 England average), this shows the long-term trend away from care home provision in the older adult population which grew by 16% over the same period (75+ age group).
- In line with our Vision the "Home First" approach has resulted in the development of the local domiciliary care market over the past 12-18 months.
- There is a need to re-baseline the bed base to achieve desired occupancy levels in the older people sector.
- The predicted future demand for care homes is for people with more complex support needs who will stay for a shorter period of time.
- This predicted change has an impact on Skills, Buildings and Care management.
- There is no generic response that fits all the market and a range of options will be required to support different parts of the market and providers.
- Kirklees is not an outlier in trends around care homes, nationally both LA and self-funder placements have reduced and changed over the past few years and not kept pace with population changes in the 75+ age group.

6 Summary of proposed options for the future

6.1 There are a range of interventions that will be proposed for the care home market locally. These will be based on examples of where such an intervention has been used in other local authority areas. It is recognised that different responses will need to be developed for the different parts of the local market.

The Draft Report covers the following options:

6.2 Minimal Intervention (as-is)

6.2.1 This is very much a continuation of current market management practices such as publishing broad commissioning intentions, common price controls, quality improvement work, regular support and communication with the sector. The report makes clear this is common practice and functioned to a certain degree for all parties prior to COVID19. There is a recognition that both the LA and providers would have to review the risks and impact attached to this level of intervention.

6.3 Medium Level Intervention

6.3.1 It is suggested a much more detailed demand and commissioning plan is developed. There is also greater collaboration with the sector to develop service and pricing specifications. There is also a proposal to support providers in exiting the market where provision does not meet the needs or demand is less than the current available capacity.

6.4 High Level Intervention

6.4.1 This option suggests the need for capital investment in services. This describes options where the local authority changes contracting timeframes and operates elements of the market more directly. There are also suggestions of much closer diversification support for the sector from the LA.

7 Importance of co-production and delivery of options with the sector

7.1 As the report is in a draft format further work is required to consider the above interventions and the implications of each for the LA. Crucially developing and working with the sector on the interventions to support the market in the future is key. The nascent Kirklees Care Association is key to developing the options moving forward. Working with the Care Association and providers from across the provision spectrum is the only way future interventions will develop sustainably.

8 The Vision for Adult Social Care

8.1 The Vision for Adult Social Care is woven throughout the options suggested and will continue to form a key measure of success as the work evolves.

9 Information required to take a decision

9.1 This report is to update on progress and key findings, no decision is being sought.

10 Implications for the Council

10.1 Working with People

Delivering the outcomes for the people living in care homes and their carers is at the centre of this work. The changing shape of case complexity and when people enter care homes has been changing over a number of years.

10.1.1 We want to remove barriers so those requiring support in care homes and providers can develop solutions together and build relationships based on trust to create positive outcomes, with a greater emphasis on tailoring care home options to meet the requirements of a range of individuals, groups and communities.

10.1.2 As part of the wider work, we are developing different ways to help people live independent lives for as long as possible, especially by enabling people to stay

well and healthy in their own home and communities. This means that as people get older, they can continue to remain at home using more of the support already available to them in their community. An important part of our work is preventing problems before they happen and helping people get back to living the way they want after a period of illness or injury.

10.2 Working with Partners

10.2.1 Care home businesses, their staff as well as partners across the statutory and voluntary health and social care market all have a role to play in ensuring the actions outlined are delivered effectively. The recently formed Kirklees Care Association is a key partner in representing and leading the sector wide change working with the LA and the CCGs.

10.3 Place Based Working

10.3.1 The age profile of our local population and the expected needs moving forward will mean a local approach will be required in aspects of this work. There are a cohort of people that may require care home support who will want to remain very local to where they live now, keeping local support networks active as people move into a care setting is very important. The report outlines where over time this demand is expected to manifest, which will have modelling and strategic planning implications for the care market.

10.3.2 Adult social care is increasingly working in a place-based way, the different locality hubs and the work with primary care networks has led to strong relationships with partners and local providers and led to case level outcome improvements across the range of our provision.

10.3.3 A further aspect of place-based working that is core to the work moving forward is making the most of local assets be that land, existing buildings, staff resource or specialist services which will all be important in delivering sustainability in our local care market.

10.4 Climate Change and Air Quality

10.4.1 Connected to place-based working as more local care provision is developed there should be less travel by families and carers, some of whom maybe travelling outside Kirklees to visit someone if current models do not adapt.

10.4.2 The clearer picture of demand at a local level should mean providers can make better investment in buildings, it is expected new developments would be significantly more efficient than some current assets.

10.5 Improving outcomes for children

10.5.1 While this work is focussed on adult provision, there should be outcomes that improve for young carers as provision is developed reducing the care burden on this cohort.

10.6 Other (eg Legal/Financial or Human Resources)

10.6.1 The report sets out our long term shaping options around care homes and market development locally. At this stage it does not commit to specific spending requirements.

11 Consultees and their opinions

11.1 The work of Cordis Bright is still being finalised. They have engaged through interviews and questionnaires around 80% of owners, operators and managers of care homes in Kirklees. They have also engaged a large number of health and social care commissioning and service leads to understand local issues and inform the shape of the options proposed.

11.2 The Care Home Provider forum and Kirklees Care Association have been consulted throughout the project and received regular updates and initial findings. The opinion of the forum and Association in the work has highlighted the long-standing issues and provides the evidence base to move the sector forward in a sustainable and supportive manner.

12 Next steps and timelines

12.1 The overall approach to change mirrors the Adult Social Care vision and will be developed with the sector and Care Association.

The work produced by Cordis Bright has highlighted a number of tasks that need to be completed to support the sustainability of the sector. As final reports are produced by Cordis Bright we will develop a joint delivery plan which highlights Urgent, Short Term, Medium Term and Long-Term tasks that need to be completed and the resource requirements across all partners to deliver.

13 Governance

13.1 The future plan of work will be overseen by the Kirklees Care Home Programme Board which is led by the Strategic Director for Adults at Kirklees Council and the Chief Quality and Nursing Officer for the Clinical Commissioning Groups (CCGs). Membership includes senior representation from across partner and provider organisations. The Board is responsible for the strategic development and short term operational delivery of care home support.

14 Officer recommendations and reasons

14.1 That the Panel considers the information provided and determines if any additional information is required.

15 Cabinet Portfolio Holder's recommendations

15.1 Not Applicable

16 Contact officer

Simon Baker
Head of Commissioning Partnerships and Market Development
simon.baker@kirklees.gov.uk
Ext - 71960

17 Background Papers and History of Decisions

17.1 Not Applicable

18 Service Director(s) responsible

Helen Severns
Service Director – Integrated Commissioning
helen.severns@kirklees.gov.uk
Ext - 75320

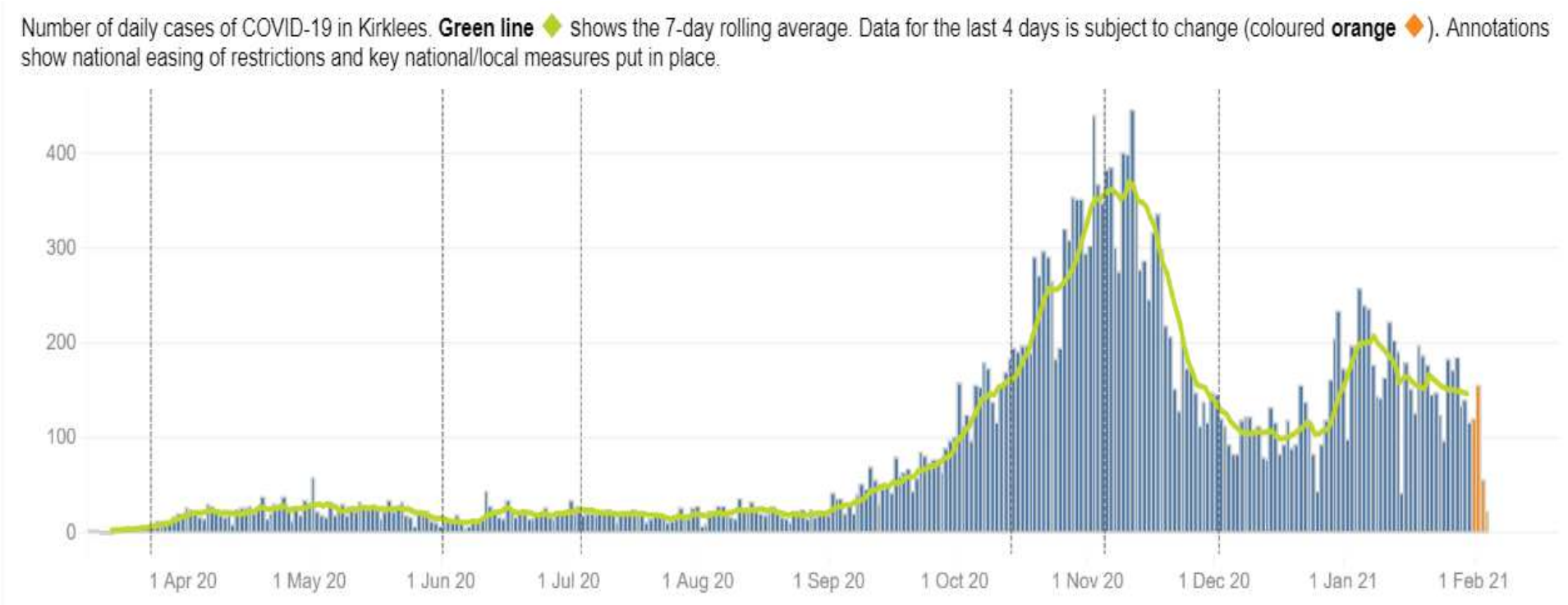
Kirklees COUNCIL

Covid-19 Update: Health and Adult Social Care Scrutiny Panel

Jane O'Donnell
Emily Parry-Harries

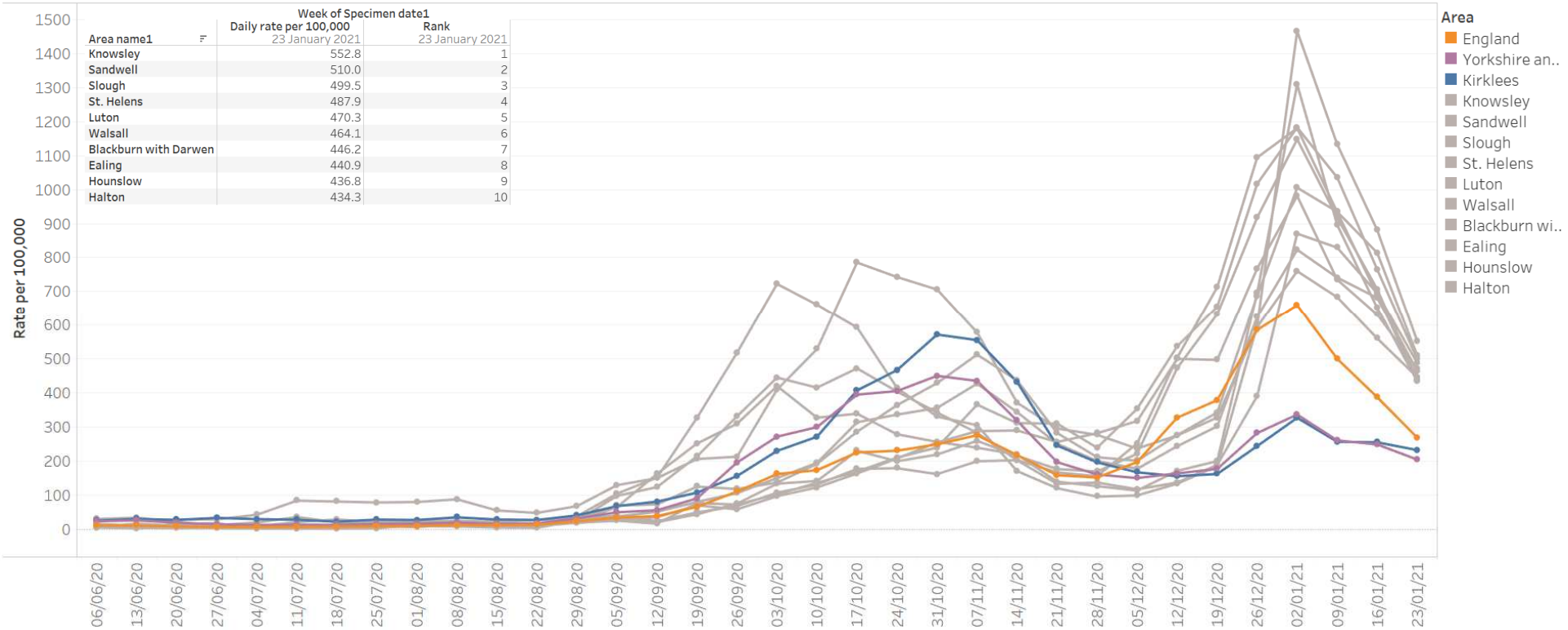
Cumulative Position

- Number of all-time confirmed cases in Kirklees: 27,915
- Cases in the last week: 231
- Latest weekly rank: 94/149
- Note: these are correct as of 05.02.2021

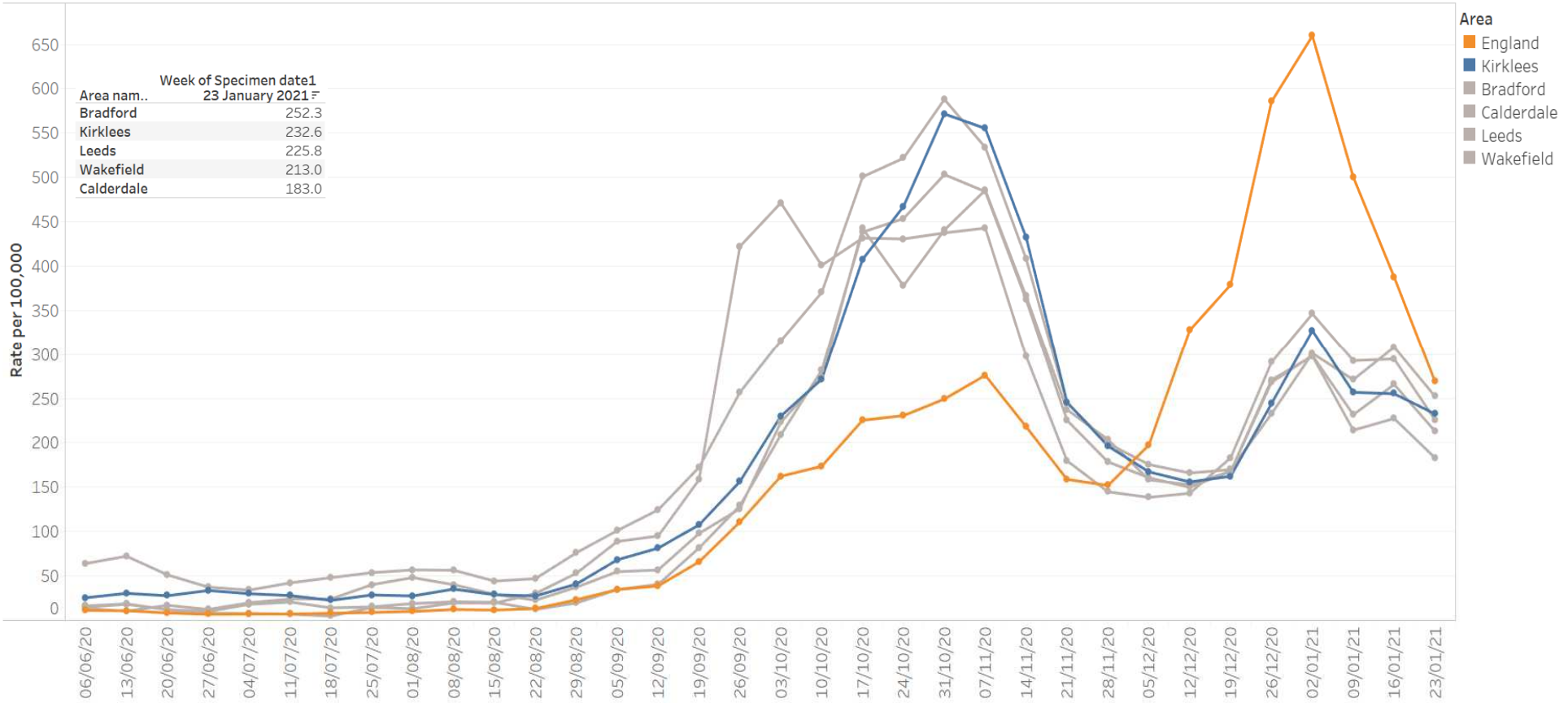


Weekly rates per 100,000 population

- Comparison between Kirklees and top ten ranked Upper Tier Local Authorities
- Ranking based on figure for week commencing 23/01/21; Kirklees ranked 97th (latest rate: 233 per 100,000)

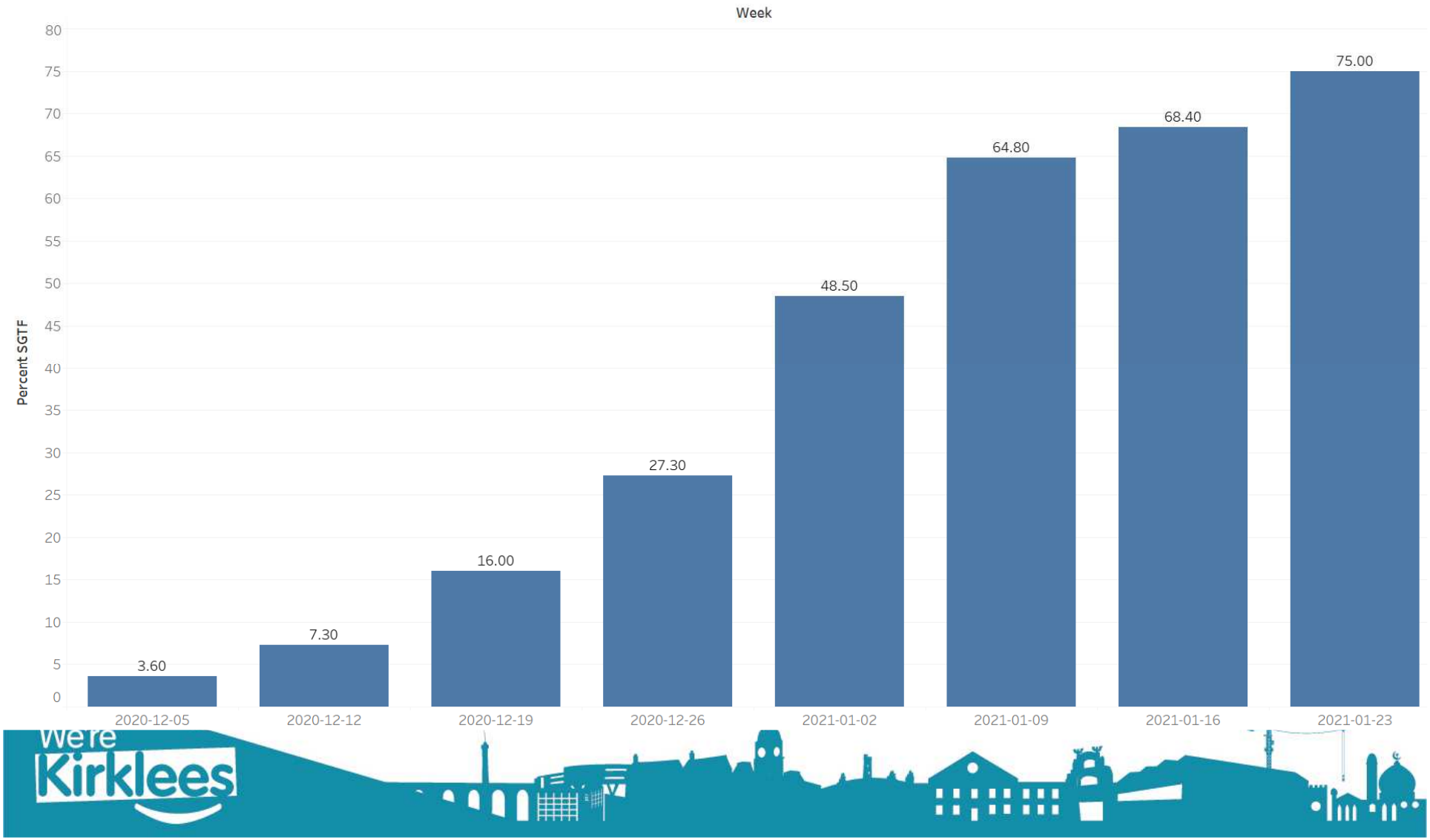


Weekly rates per 100,000 population, West Yorkshire



UK/Kent Variant in Kirklees

Three quarters of tested samples in Kirklees were the UK/Kent variant in the latest week



COVID-19 Communications

- Continue to encourage the hands, face and space messages reinforcing these throughout vaccine roll out and beyond.
- Encourage flu vaccination to ensure flu vaccination is administered at least 7 days before Covid-19 vaccination takes place
- Ensure National messages are tailored locally
- Expect National campaign messages:
    - Key message will be to encourage take up of vaccine (information on safety trials etc.)
    - Information about how to get vaccine (timings, bookings, locations)

Covid-19 Testing Update

The DHSC has approved care home staff to conduct self-test Lateral Flow Devices (LFDs) from their own homes. This means care home staff are now able to take and register their twice weekly LFD tests at home, before they arrive at the care home to start work. If staff test positive a confirmatory Polymerase Chain Reaction (PCR) test will be required.

Community Testing Update

There are currently four community testing sites across Kirklees for:

- **Critical workers who cannot work from home**

Individuals **must** be asymptomatic and consent to share their data with the national test and trace programme.

Confirmatory PCR test of a positive Lateral flow test, has been temporarily suspended nationally on 27/1/2021.

Targeted Testing

DPH led targeted testing has now merged into the community testing programme.

- The focus is on asymptomatic testing for those who are critical to support communities and who are at greater risk of catching the virus.

The focus reflects the local epidemiological picture.

Covid-19 Schools Update

Primary Schools:

The Medicines Healthcare Regulatory Agency (MHRA) has licensed self testing at home for Primary School staff.

- A confirmatory PCR is required for a positive lateral flow.

Secondary Schools and higher education

- Staff are tested once weekly.
- Students tested only on return, two tests 3-5 days apart.

Special Schools

As part of the “DPH testing offer”, under community testing, Public Health has commissioned Locala to do swabbing on pupils (with parental consent).

Care Home Testing Update

Care Home residents discharged from Hospital

- **Must** ensure only residents who are determined to be COVID-19 **infectious** are discharged to designated settings.
- Most people discharged to a care home will receive a COVID PCR test in the 48 hours prior to discharge. A negative test result should be communicated to care homes as part of the discharge information.

Those people who test **positive** would be required to isolate in a designated care setting for 14 days before transferring to their own care home.

However, a different approach is required for people who have previously tested positive. This is because a person can test positive for a period of time after first contracting the virus, even when no longer infectious to others. The criteria for the direct discharge of these persons to care homes are:

- Have tested positive in the past 90 days
- Have completed their 14-day isolation period
- And have a normal immune response

Kirklees COUNCIL

Covid-19 Vaccination update

Vaccinations taking place at:

- John Smiths Stadium
- Huddersfield Royal Infirmary
- Three community pharmacies
- All PCN's

Continuing to prioritise cohort 1-4 for first dose vaccines

Flu Immunisation Programme Update w/c 1/2/2021

Cohort	Kirklees Population size of Cohort	Kirklees Vaccinated total as at 01.02.21	Kirklees % Vaccinated	Vaccination Target
In clinical at risk groups	73610	41395	56.2%	75%>
Aged 65+	75439	61426	81.4%	75%>
Aged 50 to 65	53181	16285	30.6%	
Pregnant Woman	2295	1091	47.5%	75%>
Children 2 -3 yrs.	10578	4839	45.7%	75%>
All Primary school children	45176	25609	56.7%	75%>
Shielded patients & families	591	211	35.7%	75%>
Carers & families	9471	6543	69.1%	75%>
School year 7 children	5736	2974	51.8%	75%>
CCG staff (incl GB not counted elsewhere)	191	130	68.1%	100% Offer
Locala Staff (inc. Frontline staff and Care closer to Home frontline staff)	2620	2267	86.5%	100% Offer
YAS staff		TBC		100% Offer
LCD staff		TBC		100% Offer
SWYPFT Staff		42.8%		100% Offer
CHFT Staff		TBC		100% Offer
MYHT Staff		67.4%		100% Offer

Kirklees COUNCIL

Flu Immunisation Programme Update w/c 1/2/2021

Additional Groups counted within existing cohorts	Kirklees Population size	Kirklees Vaccinated total as at 01.02.21	Kirklees % Vaccinated	
Aged 80 and Over	19421	16347	84.2%	
Care Home Resident	2449	1912	78.1%	
Learning Disability Register	3315	1886	56.9%	
Dementia Register	3008	2465	81.9%	
SMI Register	4533	1847	40.7%	60%>
White British, Mixed British, Irish, Other White background Ethnic group	138043	99904	72.4%	
Mixed Black, Mixed Asian, Other Mixed Background Ethnic group	3190	1491	46.7%	
Bangladeshi, Indian, Pakistani, Other Asian Background Ethnic group	27608	11839	42.9%	
Total North African, Caribbean Other Black Background Ethnic group	2965	1602	54.0%	
Chinese, Other Background Ethnic group	2572	1293	50.3%	
Ethnicity not recorded	20200	12367	61.2%	

Kirklees COUNCIL

Kirklees Health and Adult Social Care Scrutiny Panel: 18th February 2021

Future configuration of Kirklees CCGs

1.0 Introduction

Since the publication of the NHS Long Term Plan in January 2019, Greater Huddersfield and North Kirklees CCGs have considered whether merging would be in the best interests of the Kirklees population. In accordance with CCG governance, the decision was one for the member practices of each current CCG. On 17th November 2020 the member practices of both current CCGs confirmed their support to create a single Kirklees CCG from 1 April 2021.

Separately, on 26th November 2020, NHS England & Improvement launched an engagement about the future of Integrated Care Systems (ICSs). The engagement ended on 8th January and no formal feedback has yet been published. However, the recommended option engaged upon would involve all CCGs being disestablished from 31 March 2022, with ICSs becoming statutory bodies and taking on CCG functions.

If confirmed, the ICS proposal would mean that Kirklees CCG may only exist for 12 months. The rationale for merger has been revisited in this context to confirm that it remains in the best interests of the Kirklees population; the consistent conclusion is that it does.

This paper describes the background to the ICS proposals, as the context for the Kirklees merger plans. It describes key elements of the merger process, including themes from public engagement. Because the creation of a new CCG is largely about governance and administrative arrangements, it will not have a direct impact on frontline patient services.

2.0 Next steps for Integrated Care Systems.

Integrated Care Systems (ICSs), and before them Sustainability and Transformation Partnerships (STPs), have been developing across England over the last four years. In an ICS, NHS organisations, in partnership with local councils and others, take collective responsibility for managing resources, delivering NHS care, and improving the health of the population they serve.

Currently ICSs do not have a statutory basis. ICS governance is based on voluntary arrangements and is therefore dependent on goodwill and mutual cooperation. There are also legal constraints on the ability of organisations in an ICS to make decisions jointly.

The Integrated Care System that Kirklees is part of is the West Yorkshire and Harrogate Health and Care Partnership, which began as an STP in 2016. The Partnership works with, and for, five places of which ours is Kirklees (alongside Bradford District & Craven, Calderdale, Leeds, and Wakefield). Subsidiarity principles are applied, with work taking place at the appropriate level and as close to people as possible.

On 26th November 2020, NHS England & Improvement published “Integrating care: Next steps to building strong and effective integrated care systems across England”

(https://www.england.nhs.uk/publication/integrating-care-next-steps-to-building-strong-and-effective-integrated-care-systems-across-england/) – A copy of this publication is also attached to these papers

The document sets out the direction of travel for ICSs and proposed options for legislative change to support this. Views on proposed options were invited between 26 November 2020 and 8 January 2021. A response to the consultation is expected in the coming weeks, with a legislative change process likely to run from May to December 2021 and new arrangements coming in to place from April 2022.

Two possible options were described for enshrining ICSs in legislation. The recommended option would mean that CCGs are disestablished from April 2022, with their statutory functions transferring to ICSs, which would be established as statutory corporate NHS bodies.

The direction of travel set out has a strong emphasis on place, provider collaboration and closer partnership working with local authorities and other partners. It recognizes that:

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

The Kirklees CCGs' decision to merge predated the NHSE & I engagement document. If the recommended option is pursued, Kirklees CCG would only exist for 12 months and the decision to merge has therefore been revisited internally and with NHS England to check that it remains in the best interests of the Kirklees population, and the consistent view is that it does. This is because the current, and any future, West Yorkshire & Harrogate structure is dependent on the places that make it up, including Kirklees. Streamlining ourselves as a Kirklees CCG in the short-term is therefore consistent with the direction of travel and will support us in integrating health and social care across Kirklees, making best use of resources, and put the Kirklees place in a strong position ahead of any changes to the NHS architecture from 2022 onwards.

3.0 Creation of NHS Kirklees Clinical Commissioning Group

The merger will legally be enacted by NHS England through a Grant of Merger, which will have the effect that on 1 April 2021:

- Greater Huddersfield CCG and North Kirklees CCG will cease to exist;
- A new Kirklees CCG will be established;
- All employed staff of Greater Huddersfield and North Kirklees CCGs will transfer to Kirklees CCG.
- All assets and liabilities of Greater Huddersfield and North Kirklees CCGs will transfer into the new CCG.

3.1 Case for change

Our Kirklees Health and Wellbeing Plan recognises the health inequalities that exist across our system. The disproportionate impact of COVID-19 has shone an additional light on inequalities and created a catalyst for change. The different financial positions of the two CCGs mean that, if we continue as two organisations, commissioning decisions will need to be influenced by organisational boundaries which may increase rather than decrease inequalities across Kirklees. We must avoid this.

Greater Huddersfield CCG and North Kirklees CCG share a local authority and together form the "Kirklees Place" that is recognised within the West Yorkshire and Harrogate Health and Care Partnership. Our two Kirklees CCGs have a long history of working together to commission health services and this collaborative approach has continued to strengthen over recent years. We share a single Accountable Officer and Chief Finance Officer and have a single Senior Management Team leading integrated teams across all areas (in many cases with the local authority and/or with neighbouring CCGs).

Much has been achieved through joint working and whilst we remain as separate statutory organisations there are minimal further benefits that can be secured. A merger is the natural next step to remove the barriers that are inherent as two separate statutory organisations and will give us a better ability to work in the best interests of the overall Kirklees population.

3.2 Benefits

The criteria we have used in deciding to apply to merge are:

- What is best for the local population?
- How can we deliver the NHS Long Term Plan most effectively?
- How can we achieve best value from our resources and meet our statutory responsibility to manage within budgets?

Although we have achieved a great deal as separate organisations, creating a single Kirklees CCG will bring further benefits in each of these areas:

3.2.1 Best for local population

- Equitable commissioning across Kirklees to reduce health inequalities.
- Supports integration of health and social care across Kirklees – better holistic services available.
- Able prioritise local voice & reflect diverse groups and communities within Kirklees.
- Emerging from initial phase of COVID-19, will support consistent commissioning decisions for Kirklees people.

3.2.2 Delivery of Long Term plan

- Enables CCG to be strategic and lean, supporting providers and facilitating partnerships.
- Strong voice from Kirklees Place as part of West Yorkshire & Harrogate Integrated Care System.

- Efficient structure now and likely to fit with any future national or regional direction of travel.

3.2.3 Best use of resource

- Enables higher levels of clinical and practice representation
- Reduces duplication of "administrative" tasks, e.g. audit, financial accounts, statutory meetings, websites. More capacity focussed on direct commissioning and support.
- Enhances job satisfaction for our staff and will help us build a Kirklees talent pool and support development to meet the future needs of our system.
- Supports action at the "right" level for different things (e.g. Primary Care Network, Kirklees Place, acute footprint, West Yorkshire & Harrogate)
- Improves financial stability and sustainability.

3.3 Impact

As a single Kirklees CCG:

- Our functions will remain broadly the same but the emphasis will change and our operating model will change.
- Our commissioning operating model will predominantly be concerned with planning, strategic oversight and resource allocation.
- Our commissioning will be done within our partnerships – evolving as we go with West Yorkshire and Harrogate Health and Care Partnership and at place across Kirklees.

The impact of a new CCG on patients and carers:

- Creating a single CCG will not impact on any NHS or associated frontline services received by patients and carers, whether in hospitals, in the community or at GP practices.
- A single CCG will ensure consistency and help make our resources go further, delivering equitable outcomes for patients no matter where they live.
- We will ensure that the move to a larger geographical footprint will not be at the expense of the proposed new CCG's ability to engage with - and consider the needs and voice of - local communities. We will continue to base our engagement approach on the needs and interests of groups of people and communities, rather than on arbitrary geographical boundaries.
- So that people's voices are heard no matter where they live, we will continue to meet our statutory duties to provide information about, and opportunities to influence, our plans, priorities and any future plans to change services.

3.4 Financial position

Pre-Covid 19, CCG allocations were based on population fair share of overall NHS budget. Based on historic positions, Greater Huddersfield CCG had a positive cumulative position and a 20/21 in-year control total of break even. North Kirklees CCG had a historic debt and a 20/21 in-year deficit, which (if achieved) would have attracted support funding to achieve an overall break even position.

As a result of Covid-19, the CCGs had their original financial allocations adjusted and financial control requirements suspended. Both CCGs must now achieve a breakeven position for the current year.

There is expected to be a new financial framework as the NHS emerges from this phase of the Covid-19 pandemic; the details are not yet known. Future processes for allocation of funds between, and within, Integrated Care Systems are therefore uncertain as is the future requirement for repayment of legacy debt.

3.5 Public Sector Equality Duty (PSED)

There are similarities and differences between the populations of the two current CCGs, as well as material variations between neighbourhoods within each existing CCG.

Our Equality Impact Assessment will be reviewed in the context of public engagement feedback now received. So far it has not identified any specific or adverse impact on protected groups. The creation of a new Kirklees CCG will create opportunities to strengthen the voice of its diverse population in a range of CCG processes and more effectively to apply learning from the COVID-19 pandemic.

4.0 Public Communications and Engagement

A CCG merger across Kirklees would not result in a change to commissioned services and it is therefore not a legal requirement for the organisations formally to consult the public. However, both CCGs recognise the high level of interest in our work and acknowledge that such a change could impact on our relationships with local people and stakeholders and on that basis we have sought views.

The purpose of the communications and engagement activity was to tell the general public and key stakeholders about our intention to merge and seek their views about the creation of a single commissioning organisation for Kirklees. The feedback gathered will be used in the development of the new organisation.

We used a range of communication and engagement mechanisms to let people know about our plans and how they could have their say. We received feedback on the engagement via:

- **Engagement event** – 41 people attended with representatives from 17 groups / organisations
- **Discussion groups** – 7 people attended representing 6 groups / organisations
- **PRG Network meetings** – 21 people attended representing 14 GP practices
- **Community Voices** – 7 people attended representing 6 organisations
- **Survey** – 51 people completed the survey

The key themes raised were:

- The majority of people were supportive of the change and felt that it was a natural progression which would give the CCG a stronger voice, provide consistency in commissioning decisions, improve partnership working and would be a better use of resources.
- The main concern expressed was that it could lead to a Huddersfield centric organisation that doesn't meet the needs of all its communities, this was a particular concern expressed by those that live in or represent North Kirklees.

People were also concerned that;

- This is a cost cutting exercise and to achieve equitable provision across Kirklees, rather than levelling up, service provision will be levelled down to save money.
- A bigger overall footprint could lead to a loss of local knowledge and an inability to understand the needs of local communities.
- The challenges of working with two Acute Trust providers that provide services across other areas. And whether this could lead to neighbouring CCGs taking funding provided to Kirklees to support patients in Wakefield/Calderdale/ Leeds/Bradford.
- That the CCG would have a 'one size fits all' approach and would not be able to meet the needs of its diverse population and address health inequalities.
- That it could lead to a reduction in staff which in turn could mean an inability to commission services effectively, and a loss of local knowledge.
- Any changes being made now would support the direction of travel being proposed in the NHSE/I consultation on Integrated Care: next steps to build strong and effective integrated care systems across England.

Suggestions for how to provide assurance were to

- Work and invest in deprived communities to tackle health inequalities
- Make sure that we don't have a one size fits all approach and invest where investment is needed, and recognise that across Kirklees different communities have different needs.
- Ensure that patients aren't expected to travel to Huddersfield for services that they currently access in North Kirklees.
- Hold meetings in locations across Kirklees to show that the CCG represents all of Kirklees
- Ensure that Governing Body and CCG committees include representatives from across Kirklees

Feedback from our PRG Network meeting, discussion groups, and Community Voices was that the response from the public on the engagement would be low as the majority of the public are more interested in GP and hospital services.

Integrating care

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

Contents

Introduction

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

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

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

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

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

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

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

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

1. Purpose

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

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

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

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

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

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

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

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

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

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

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

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

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

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

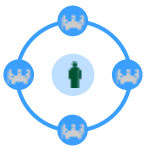
Devolution of functions and resources

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

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

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

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



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

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

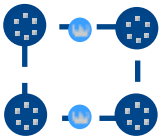
1.15. Our ambition is to create an **offer to the local population of each place**, to ensure that in that place everyone is able to:

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

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

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

Developing provider collaboration at scale



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

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

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

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

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

2. Putting this into practice

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

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

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

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

Provider collaboratives

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2.16. From April 2022, this will include:

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

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

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

Place-based partnerships

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

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

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

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

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

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

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

The NHS's offer to local government

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

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

Clinical and professional leadership

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

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

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

- A primary care perspective at system level.

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

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

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

Governance and public accountability

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

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

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

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

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

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

  They may flexibly define:

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

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

  They may flexibly define:

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

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

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

iv. their voting arrangements on the ICS board.

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

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

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

  It may flexibly define:

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

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

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

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

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

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

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

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

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

Financial framework

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

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

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

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

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

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

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

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

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

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

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

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

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

Data and Digital

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

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

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

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

Build smart digital and data foundations

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

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

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

Connect health and care services

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

Use digital and data to transform care

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

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

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

Put the citizen at the centre of their care

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

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

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

Regulation and oversight

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

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

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

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

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

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

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

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

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

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

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

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

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

How commissioning will change

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

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

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

improving outcomes, rather than managing contract performance between organisations.

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

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

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

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

Specialised commissioning

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

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

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

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

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

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

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

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

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

accountability for tackling inequalities and for improving population health.

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

3. Legislative proposals

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

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

3.3. Recommendations included:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Option 2 – a statutory ICS body

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

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

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

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

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

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

Our approach

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

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

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

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

Questions

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

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

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

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

4. Implications and next steps

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

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

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

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

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

The NHS England and NHS Improvement's operating model

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

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

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

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

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

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

4.10. The new operating environment will mean:

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

against their specific health challenges and population health priorities.

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

Transition

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

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

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

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

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

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

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

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

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

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

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

4.22. Our commitment is:

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

Next steps

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

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

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

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

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

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

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

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

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

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HEALTH AND ADULT SOCIAL CARE SCRUTINY PANEL – WORK PROGRAMME 2020/21

MEMBERS: Cllr Habiban Zaman (Lead Member), Cllr Bill Armer, Cllr Aafaq Butt, Cllr Alison Munro, Cllr Vivien Lees-Hamilton, Cllr Lesley Warner, David Rigby (Co-optee), Lynne Keady (Co-optee).

SUPPORT: Richard Dunne, Principal Governance Officer.

FULL PANEL DISCUSSION		
ISSUE	**APPROACH AND AREAS OF FOCUS**	**OUTCOMES**
1. Financial position of the Kirklees Health and Adult Social Care Economy.	Maintain a focus on the finances of the health and social care system in Kirklees to include: • Reviewing any emerging transformation programmes and assessing their contribution to increasing efficiencies and impact on services. • Considering the various Cost Improvement Schemes (CIPs) and their impact on the delivery and commissioning of services. • Impact of COVID-19 on the local health and adult social care economy to include care homes and the implications for their long-term viability.	Panel meeting 24 September 2020 The Panel received an update on the financial position of key organisations from the Kirklees Health and Adult Social Care Economy. The Panel agreed that a further discussion should be arranged to include an update on the financial impact of the pandemic with a focus on services delivered in the community such as domiciliary care.
2. Community Care Services.	To assess the progress and effectiveness of Community Care Services (CCS) in Kirklees to include: • Reviewing progress of the Primary Care Networks (PCNs) to include the impact that COVID-19 has had on patients access to primary medical services. • Looking at the work being done by the networks to assess their local population through a targeted and personalised approach to provide support to people where it is most needed. • Assessing the relationship between the key providers of CCS to include PCNs; Locala; Community Plus; and the Kirklees Wellness Service.	

	• Assessing how well the integration agenda is being implemented through CCCS in Kirklees. • Assessing the impact of CCS in Kirklees in reducing avoidable A&E attendances; hospital admissions; delayed discharges; and reducing avoidable outpatient visits. • Looking at the approach being taken by PCNs to engage with patients in the development of their work programmes and plans.	
3. Kirklees Integrated Wellness Service	To continue monitoring the development of the service and receive a 12-month update on progress of the service following the last discussions with scrutiny in November 2019. To consider the development of the service in conjunction with the work being done through the Kirklees Health and Wellbeing Plan (2018/2023).	
4. Quality of Care in Kirklees	Receive an annual presentation from CQC on the State of Care across Kirklees to include: • A focus on Adult Social Care • The impact of COVID-19 on the quality of care in Kirklees.	
5. Suicide Prevention	Receive an update on progress of the work being done on suicide prevention since the panel meeting in January 2020 to include: • The impact that the pathfinder support workers have had in their work in providing advice, training, and support for men vulnerable to self-harm and suicide. • The impact that the preventative and educational work on mental health that is taking place in schools is having in helping to reduce self-harm and suicide. • The impact of COVID-19.	

6. Kirklees Safeguarding Adults Board (KSAB) 2019/20 Annual Report	To receive and consider the KSAB Annual Report to include consideration of the Impact of Covid-19 on safeguarding adults during periods of lockdown.	Panel meeting 5 November 2020 The Panel received the KSAB Annual Report 2019/20. The Panel noted the report. The Panel also thanked the Board's Independent Chair who was stepping down and look forward to working with the new Chair who will be appointed early 2021.
7. Mid Yorkshire Hospitals NHS Trust (MYHT) Ambulatory Emergency Care (AEC) Services and Services provided at Dewsbury and District Hospital (DDH)	To receive a written update on the closure of the AEC unit at DDH.	
8. Transforming Outpatient Care at Calderdale and Huddersfield NHS Foundation Trust (CHFT) and Mid Yorkshire Hospitals NHS Trust (MYHT)	To receive a written update on: • The programme of change at CHFT. • The work being done by MYHT on its Outpatient Care.	
9. Yorkshire Ambulance Service (YAS) Response Times	To receive a written update on performance and demand across all areas of Kirklees to include: • A focus on response times for categories 1 and 2. • Looking at the variances of performance across Kirklees.	
10. Kirklees Immunisation Programme	To consider the performance of the Immunisation programmes in Kirklees to include: • Details of the local arrangements, structures, and responsibilities for immunisation. • Looking at Kirklees performance compared to national standards.	Panel Meeting 10 December 2020 Immunisation programme update was presented to the Panel as part of the Covid-19 update (see item 14 below).

	• Details of policies that are in place to ensure that those residents that are 'at-risk' and eligible for vaccination are being targeted to include the approach to engagement with the more deprived communities in Kirklees. • An overview of key challenges and/or risks to the delivery of an effective immunisation programme to include the impact of COVID-19.	
11. Update on Winter Planning	Update on winter preparations from the Kirklees Health and Adult Social Care sector to include: • Receiving details from key organisations across the local health and adult social care section on preparations for winter to include the key areas of focus; • lessons learned from the winter period 2019/20; • feedback and experiences of service users from last winter period; • Details of measures that will be put in place to mitigate any additional pressures created by a resurgence of COVID-19.	<u>Panel meeting 5 November 2020.</u> Representatives from organisations across the Kirklees health and adult social care sector presented their winter plans. A detailed discussion took place that included a focus on the additional pressures created by the pandemic. The Panel was supportive of the measures being taken to mitigate the increasing demand particularly in the acute hospital settings. The Panel is keen to monitor closely the situation during the winter period and has requested regular updates on winter pressures.
12. Development of a local Community Care Package (pilot)	Reviewing the outcomes of a local authority pilot initiative to develop a community care package led by Cllr Murgatroyd to include: • Looking at the wider work being done on developing "new models of support in the community" to include reviewing the work on new models of care in people's own home e.g. Colne Valley Care Co-operative, micro enterprises, PAs.	

13. Mental Health Services Workshop	To arrange a mental health services workshop with South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) to look in more detail at the various support services and redesign of services. Format and structure of workshop to be developed by the panel in conjunction with the Trust.	<u>Panel meeting 10 December 2020</u> Representatives from South West Yorkshire NHS Partnership Foundation Trust presented an update on the implications of the Covid-19 pandemic on its service provision. No specific actions were agreed.
14. COVID-19 (To be included as a standing item for the remainder of the 2020/21 municipal year)	To consider the impact of COVID-19 on the local Health and Adult Social Care Economy to include: • Looking at the key challenges; pressures; and measures taken to mitigate them. • Assessing the impact on the workforce. • Understanding the budget implications of dealing with the crisis and the longer-term financial impact. • Assessing the work that was undertaken to safeguarding vulnerable adults. • Lessons learned.	<u>Panel meeting 23 July 2020</u> Representatives from CHFT & MYHT presented details of their response to the COVID-19 virus. Input on the current position locally was also provided by Public Health and Healthwatch Kirklees. No specific actions were agreed. <u>Panel meeting 24 September 2020.</u> Kirklees Public Health presented an update on the local position and response to Covid-19. The Panel agreed that due to importance of this issue that it should continue to be included as an item on future agenda's. <u>Panel meeting 5 November 2020</u> Kirklees Public Health presented an update on the local position and response to Covid-19. The Panel requested that the next update include progress of the local contact tracing service.

		<u>Panel meeting 10 December 2020</u> Kirklees Public Health Presented an update on the local position and response to Covid-19. Actions agreed included: • That further information on the step-down care homes be provided at a future meeting • That an update on the immunisation and rollout programme be provided at a future meeting • That feedback on the challenges of tracing inpatients be circulated to Panel members prior to the next meeting
15. Effectiveness of smoking cessation arrangements in Kirklees.	To review the effectiveness of smoking cessation arrangements in Kirklees to include a review on how people with complex mental ill health are supported.	
16. Kirklees Care Homes Programme Board	To look at the work of the Board to include the support being provided to the care home sector; the approach to infection control; and the long-term look and shape of the care home market.	<u>Panel meeting 24 September 2020.</u> The Panel received an overview of the Kirklees Care Homes Programme that has been developed by the newly established Care Home Board. Actions agreed included: • To receive a further report to follow up on progress of the Board to include: a summary section outlining the key issues and actions taken to address them; and more details of the training and support that will be

		provided to care homes on end of life care plans. • To receive the outcomes of the work that is being done on analysing the care home market.

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