Integrated Care Board – Meeting in Public

10.00 to 11.00 on 16 November 2022

Room 5&6 The Foundry, 17 Oval Way, London SE11 5RR

Chair: Richard Douglas, ICB Chair

Agenda

No.	Item	Paper	Presenter	Timing
	Opening Business and Introduction			
1.	**Welcome** Apologies *To receive apologies from members unable to attend.* Declaration of Interest *To declare relevant interests not recorded on the register or declare any conflict of interest in relation to items on the agenda.* Minutes of previous meeting actions and matters arising *To receive the minutes of the meeting on 12 October and review any actions and matters arising.*	**A** **B**	RD RD RD	10.00
	Items for decision			
3.	**Delegation of Pharmacy and Optometry** *For the Integrated Care Board to accept delegated responsibility for Pharmaceutical Services, General Ophthalmic Services, and Dental (Primary, Secondary and Community) Services.*	**C**	SC	10.10
	Closing Business and Public Questions			
9.	**Any other business**	-	RD	10.40
10.	**Public questions and answers** *An opportunity for members of the public present to submit questions*	-	-	10.45
	CLOSE 11.00			

Presenters

Richard Douglas (RD)	ICB Chair
Sarah Cottingham (SC)	ICB Deputy CEO and Executive Director of Planning

NHS
South East London

NHS South East London Integrated Care Board
Register of Interests declared by Board members
Date: 16/11/2022

Name	Position Held	Declaration of Interest	Type of interest	Date interest commenced	Date interest ceased
Board members					
Richard Douglas, CB	Chair	1. Senior Counsel for Evoke Incisive, a healthcare policy and communications consultancy 2. Trustee, Place2Be, an organisation providing mental health support in schools 3. Trustee, Demelza Hospice Care for Children, non-remunerated role.	Financial interest Non-financial professional interest Non-financial professional interest	March 2016 June 2022 August 2022	Current Current Current
Andrew Bland	Chief Executive	1. Partner is an NHS Head of Primary Care for Ealing (a part of North West London ICB)	Indirect interest	1 April 2022	Current
Peter Matthew	Non executive director	None	n/a	n/a	n/a
Paul Najsarek	Non executive director	1. Non-executive director for Richmond Fellowship mental health charity 2. Advisor to Care Quality Commission on their approach to local authority assurance 3. Non-executive director for What Works Centre for Wellbeing 4. Policy spokesperson for health and care for the Society of Local Government Chief Executives	Non-financial professional interest Non-financial professional interest Non-financial professional interest Non-financial professional interest	April 2022 April 2022 2017 2017	Current Current Current Current
Anu Singh	Non executive director	1. Non-executive director on Camden and Islington FT Mental Health Board 2. Non-executive director for Barnet, Enfield and Haringey NHS Trust 3. Non-executive director on Board of Birmingham and Solihull ICS. 4. Independent Chair of Lambeth Adult Safeguarding Board. 5. Member of the advisory committee on Fuel Poverty. 6. Non-executive director on the Parliamentary and Health Ombudsman.	Non-financial professional interest Non-financial professional interest Non-financial professional interest Non-financial professional interest Non-financial professional interest Non-financial professional interest	2020 2020 March 2022 April 2021 2020 April 2020	Current Current Current Current Current Current

Name	Position Held	Declaration of Interest	Type of interest	Date interest commenced	Date interest ceased
Dr. Angela Bhan	Director of Place, Bromley	1. UKHSA- Undertake professional appraisals for consultants in public health 2. Faculty of Public Health - Very occasional assessor for CESR applications for GMC, on behalf of Faculty of Public Health	Non-financial professional interest Financial Interest	1 April 2020	Current
David Bradley	Partner member, mental health	1. Unpaid advisor to Mindful Healthcare, a small start up providing digital therapy 2. Wife is an employee of NHS South West London ICS in a senior commissioning role 3. Chief Executive (employee) of South London and Maudsley NHS Foundation Trust	Non-financial profession interest Indirect interest Financial interest	April 2019 July 2019	Current Current Current
Andrew Eyres	Director of Place, Lambeth	1. Director of Lambeth, Southwark and Lewisham LIFTco, representing the class B shares on behalf of Community Health Partnerships Ltd for several LIFT companies in the boroughs. 2. Married to Managing Director, Kings Health Partners AHSC 3. Strategic Director for Integrated Health and Care – role spans ICB and Lambeth Council.	Financial interest Indirect interest Non-financial professional interest	1 April 2013 1 April 2021 1 October 2019	Current Current Current
Mike Fox	Chief Finance Officer	1. Director and Shareholder of Moorside Court Management Ltd 2. Spouse is employed by London Regional team of NHS England	Financial interest Indirect interest	May 2007 June 2014	Current Current
Dr. Toby Garrood	Medical Director	1. Shareholding in Serac Healthcare 2. Consultant rheumatologist at Guy's and St Thomas' NHS Foundation Trust (GSTT) 3. In my role at GSTT I have received research and service development grant funding from Versus Arthritis, Guy's and St Thomas' Charity, Pfizer, Gilead and NHSx 4. I undertake private practice at London Bridge Hospital 5. Honorary Treasurer for British Society for Rheumatology	Financial interest Financial interest Financial interest Financial interest Non-financial professional interest	April 2020 2009 2018 2012 July 2020	Current Current Current Current Current
Dr. Jonty Heaversedge	Medical Director	1. Sessional GP at Crowndale Medical Centre in Lambeth 2. Clinical director, Imperial College Health Partners	Non-financial professional interest Non-financial professional interest	1 March 2017 1 November 2019	Current Current

Name	Position Held	Declaration of Interest	Type of interest	Date interest commenced	Date interest ceased
		3. Director, Vitality Ltd – a wellbeing communication consultancy	Financial interest	1 March 2015	Current
Angela Helleur	Chief Nurse	1. Member of Kings Fund Council	Non-financial professional interest	May 2021	Current
Ceri Jacob	Director of Place, Lewisham	None	n/a	n/a	n/a
Prof. Clive Kay	Partner member, Acute	1. Fellow of the Royal College of Radiologists 2. Fellow of the Royal College of Physicians (Edinburgh) 3. Chief Executive (employee) of Kings College Hospital NHS Foundation Trust	Non-financial professional interest Non-financial professional interest Financial interest	1994 2000 April 2019	Current Current Current
James Lowell	Director of Place, Southwark	1. Chief Operating Officer (employee) of South London and Maudsley NHS Foundation Trust	Financial interest	January 2021	Current
Sarah McClinton	Director of Place, Greenwich	1. Director, Health & Adult Services, employed by Royal Borough of Greenwich 2. Deputy Chief Executive, Royal Borough of Greenwich 3. President and Trustee of Association of Directors of Adult Social Services (ADASS) 4. Co-Chair, Research in Practice Partnership Board	Financial interest Non-financial professional interest Non-financial professional interest Non-financial professional interest	November 2019 May 2021 April 2022 2016	Current Current Current Current
Dr. Ify Okocha	Partner member, Community	1. Chief Executive (employee) of Oxleas NHS Foundation Trust 2. Director, Dr C I Okocha Ltd, providing specialist psychiatric consultation and care 3. Director, Sard JV Software Development 4. Director, Oxleas Prison Services Ltd, providing pharmacy services to prisons and Kent and South East London 5. Holds admitting and practicing privileges for psychiatric cases to Nightingale Hospital 6. Fellow of the Royal College of Psychiatrists	Financial interest Financial interest Financial interest Financial interest Financial interest	2021 1996 2011 27/09/16 1992	Current Current Current Current Current Current

Name	Position Held	Declaration of Interest	Type of interest	Date interest commenced	Date interest ceased
		7. Fellow of the Royal Society of Medicine 8. International Fellow of the American Psychiatric Association 9. Member of the British Association of Psychopharmacology 10. Member of the Faculty of Medical Leadership and Management 11. Advisor to several organisations including Care Quality Commission, Kings Fund, NHS Providers and NHS Confederation.	Non-financial professional interest Non-financial professional interest Non-financial professional interest Non-financial professional interest Non-financial professional interest Non-financial professional interest	1985	Current Current Current Current Current
Stuart Rowbotham	Director of Place, Bexley	1. Director of Adult Social Care and Health, London Borough of Bexley	Financial interest	16 January 2017	Current
Debbie Warren	Partner member, local authority	1. Chief Executive (employee) of Royal Borough of Greenwich. 2. Lead London Chief Executive on Finance, also contributing to the London Councils lobby on such matters including health.	Financial interest Non-financial professional interest	December 2018 (acting in role from July 2017) March 2020	Current Current
Dr. George Verghese	Partner member, primary care	1. Lambeth Healthcare GP Federation - Shareholder on behalf of Waterloo Health Centre 2. Lambeth Together Training and Development Community Interest Company - Director along with other primary care colleagues	Non-financial professional interest Non-financial professional interest	2022 2019	Current Current

Integrated Care Board meeting in public

Minutes of the meeting on 12 October 2022

Ground Floor W160 Tooley Street, London SE1 2TZ

Present:

Name	Title and organisation
Richard Douglas	ICB Chair
Anu Singh	Non-Executive Director
Peter Matthew	Non Exec Director
Paul Najsarek	Non Exec Director
Debbie Warren	Partner Member Local Authorities
Prof Clive Kay	Partner Member Acute Care
Dr Ify Okocha	Partner Member Community Care
Dr George Verghese	Partner Member Primary Medical Services
Andrew Bland	ICB Chief Executive Officer
Angela Helleur	ICB Chief Nursing Officer
Dr Jonty Heaversedge	ICB Joint Medical Director
Dr Toby Garrood	ICB Joint Medical Director
Mike Fox	ICB Chief Financial Officer
Dr Angela Bhan	Bromley Place Executive Director
Stuart Rowbotham	Bexley Place Executive Director
Sarah McClinton	Greenwich Place Executive Director
James Lowell	Southwark Place Executive Director
Ceri Jacob	Lewisham Place Executive Director

In attendance:

Name	Title and organisation
Sarah Cottingham	ICB Deputy Chief Executive and Executive Director of
Tosca Fairchild	Planning ICB Chief of Staff
Ranjeet Kaile	ICB Director of Communications and Engagement
Julie Screaton	ICB Chief People Officer
Jane Bowie Elliott	Director of Integrated Commissioning Lambeth, SEL ICB
Ward	Programme Lead Bromley Healthcare CIC
Dr Lynette Linkson	Interim Clinical Lead and Respiratory Consultant Kings College London NHS FT
Lorna Redpath	Service Lead Bromley Healthcare
Sabrina Philips	LLWN Alliance Director
Guy Swindell	LLWN Alliance Deputy Director
Ayo Osisami	IAPT team South London and Maudsley NHT FT
Afikha Islam	IAPT team South London and Maudsley NHT FT
Livia Whyte	Head of Special Services and Legacy, Black Thrive

Apologies	Title and organisation
Name	
Andrew Eyres	Lambeth Place Executive Director

David Bradley Partner Member Mental Health Care

1.	**Welcome**
1.01	The Chair welcomed members and those in attendance to the meeting.
	Apologies
1.02	Apologies for absence were noted.
	Receive Register of Interests
1.03	The Board received the register of interests. No additional interests were declared or conflicts of interest in relation to items on the agenda.
	Minutes of previous meeting actions and matters arising
1.04	The Board accepted the minutes of the meeting on 1 July 2022 as a record of the meeting. The action log was reviewed.
2.	**Presentation- Lambeth Living Well Network Alliance – Advancing mental health equalities for black communities**
2.01	The board heard a presentation from Lambeth Living Well Network, an alliance of South east London NHS, Lambeth Council, Certitude London, South London and Maudsley and Thames Reach. • Ayo Osisami outlined the Lambeth Talking therapies and the achievement of an increase in proportion of referrals for Black clients, of whom in 2021-22 50% reached recovery. Learning and actions to improve outcomes included talking about race and culture in sessions, regularly auditing the experience of service users, reflection and use of supervision and an additional session to Black Clients to ensure accurate signposting and socialising to therapy and regular training for staff, as well as reviewing recruitment processes to improve representation. Continued outreach work was intended to increase access rates and referrals. • Livia Whyte presented the Culturally Appropriate Peer Support and Advocacy CAPSA where Lambeth Black Thrive worked with to the LLWN co-produce culturally appropriate support to ensure the voices and lived experience of Black people were recognised in co-design of services. The board heard an audio clip of feedback a user of the service describing its positive impact. • Emotional Emancipation Circles were set up as an African centred peer support group approach to support the wellbeing were set up in partnership with the Black Cultural Archives as an opportunity for Black people to learn about Black History and a safe space to share daily challenges including experiences of racism and learn and apply emotional wellness skills. EECs were an opportunity to signpost to other services and rebuild trust.
2.02	Richard Douglas asked noted that co-delivery was as important as co-producing services and noting CAPSA was a pilot asked about its future. Livia Whyte noted that a key lesson for co-delivery was to continue to obtain feedback and not to regard problems as fixed, asking people who used services. Jane Bowie noted

	that pilots as part of a partnership helped to amplify the work as well as testing approaches.
2.03	Dr Jonty Heaversedge asked how more capability could be built in each borough on co-design as an approach. Noting work on 'Spread and Scale' he pointed to the need to develop small pilots into wider approaches. He asked about approaches to ensure better representation of communities in the workforce.
2.04	Dr Toby Garrood asked what lessons from the work could be applied in secondary care settings to provide better care for those from Black communities.
2.05	Dr George Verghese noted the overriding importance of going out and making sure underserved communities were welcome. Metrics of success needed to be developed that adequately captured the rebuilding of trust achieved by these approaches, which was not captured in traditional access metrics.
2.06	Sabrina Philips noted that working with service users from the start helped to build capability rather than at the end of a process. In relation to workfoce entry level posts such as apprenticeships and work experience to help generate interest.
2.07	Anu Singh described the work as bold and praised the anti-racist stance being taken, which should be more widely adopted in the system. She commented on the necessity of data to help measure outcomes, and how to help those with both mental and physical health conditions. It was important when considering spreading ideas to remember that work in one place may not work but similar approaches may be useful.
2.08	Julie Screaton asked about differences between access for Black African and Black Caribbean communities. She offered to discuss using resources for apprenticeships across the system to help with developing new talent, as well as discussing synergies around proving mental health support to staff.
2.09	James Lowell described work in Lambeth as key in helping South London and Maudsley NHS FT to commit to becoming an anti-racist organisation. He commented that trust was increasingly being shown as a determinant of health, and asked for advice on how local boroughs
2.10	Tosca Fairchild emphasised the value of people receiving care from those who looked like them and shared lived experience.
2.11	Guy Swindell noted the lack of trust between communities and the establishment, and suggested it was important to go to communities rather than expecting them to access the establishment. It was important to provide evidence of impact and value for money but the long term relationship was important.
2.12	Livia Whyte noted that the Black Thrive research institute and observatory working alongside Kings College London and Sheffield Hallam University to help measure success while continuing to develop and improve services. Working in partnership there was an opportunity to make a difference.
2.13	Richard Douglas summed up the lesson that successful approaches were build from a local level based on trust. The board should consider how to give sufficient certainty and remove disincentives. Co-production and co-delivery were key, as well as ensuring the workforce reflected the community it served.

3.	**ICS Strategy update**
3.01	Ben Collins updated on work to deliver an initial strategy for the ICS. The ambition was not to replicate all the work in the system, but to work with staff, communities, local authorities and the voluntary, community and social enterprises to focus on opportunities for cross system change. The paper would set out a mission and vision for the ICS, opportunities that would be prioritised for the next five years, and enablers which would be required to deliver. Based on wide engagement in the first phase a draft vision had been produced, and a structured process to identify strategy priorities had reviewed previous strategy work to identify seven areas to discuss with staff, partners and the public. This engagement had led to a longlist of strategic priorities and an analysis based on size of opportunity, need for collaboration and feasibility produced overarching themes: health and wellbeing, children and young people, adult mental health and primary care, long term conditions and complex needs.
3.02	Anu Singh commented that the focus of the strategy was limited to care delivery and asked if the strategy should be more ambitious in addressing factors underlying people's health from employment to housing and wellbeing.
3.03	Paul Najsarek asked how the strategy would deliver the objectives set nationally for the ICB in a sustainable way.
3.04	Debbie Warren noted that local authorities had built up knowledge of local communities, particular during the pandemic, and should be involved to build on this when engaging on the strategy.
3.05	Clive Kay pointed out that the strategy along with other strategies local and national would succeed only if those caring for people on the frontline found it meaningful for their work.
3.06	Andrew Bland stated that reaching the level of ambition to involve other services such as education and the police would need to be phased, there were a number of strategies and it would be important to ensure the strategy provided additionality and was clear where it linked on other areas it was also important to continue limited financial and other resources.
3.07	Dr Jonty Heaversedge advised that the majority of work on wider determinants of health would need to happen at Place and was in progress in many areas already. It would be important to articulate priorities for south east London where system working was necessary to deliver additional benefit, and which were simple enough to be meaningful to those working in healthcare in south east London.
3.08	Sarah Cottingham proposed setting ambitions for progress in the next five years but testing them against the four purposes of the ICS, for example without a sustainable health and care system other ambitions would not be possible. The strategy and five year view would need to be linked together and form a coherent whole that was feasible to deliver.
3.09	Stuart Rowbotham commented that engagement in Place was ongoing work. Through the pandemic there had been good progress to engage seldom heard groups locally, and a risk that south east London level would overreach and miss these groups. It would be important to understand the relationship between a local health and wellbeing strategies and between the ICS strategy and the role of political leaders, and to work on this to achieve alignment.

3.10	The Board **noted** progress with the development of the ICS Strategy
4.	**Chief Executive Officers report**
4.01	Andrew Bland referred members to the Chief Executives report, pointed out the interdependence of all the work described in it, given a limited set of resources, and the role of the Board to manage this interplay across the system rather than individual areas dealt with by organisations, places and collaboratives.
4.02	Anu Singh noted a theme of inequalities across the different areas of the report and asked if there were data systems across south east London that would help individual boroughs build their capability to manage population health. Andrew Bland suggested a that a report from the population health and equity executive should be received by the board.
4.03	**Action: A report from the Population Health and Equality group to be presented to the board**
4.04	The Board **noted** the Chief Executives report.
5.	**ICB Committee & Provider Collaborative Reports** i. **Overall report of ICB committees and provider collaboratives** ii. **Report of Quality and Performance Committee** iii. **Report of Planning and Finance Committee** **Overall report of ICB committees and provider collaboratives**
5.01	Tosca Fairchild noted that the committees had met and the board were asked to approve changes to terms of reference detailed in the paper.
5.02	The Board **approved** the terms for the Audit committee. The Board **approved** the terms for the Quality and Performance committee. The Board **approved** the Board assurance framework noting the discussion later in the agenda. **Report of Quality and Performance Committee**
5.03	Prof Clive Kay referred members to the report of the Quality and Performance committee and invited executive to update on key quality and performance measures being monitored by the committee.
5.04	Angela Helleur noted in relation to quality that • IT failures affecting GSTT and a separate incident affecting services including 111 had been managed through incident control processes, and a review of any harm to patients underway as well as learning. • A CQC report had been published on Orpington hospital with a rating of 'requires improvement'. Reports were awaited from maternity services at King's College Hospital NHS FT at Denmark Hill and Princess Royal University Hospital sites, Guys and St Thomas NHST FT maternity services and Oxleas NHS FT community mental health services.

- There was a national focus on maternity services from Ockenden and Kirkup reports, and work as underway on actions in south east London.

5.05

Sarah Cottingham noted challenged performance across urgent and emergency care, but in line with London averages.

- There were challenges on demand because of Covid and mental health, capacity constraints in hospitals and in discharge, and workforce.
- There was concerted work to plan for winter and improvements had been agreed across the sites as part of winter, overseen by the committee. A winter plan had been submitted and commitments would be monitored by the quality and performance committee and concerns about delivery reported to the board.
- Hospital ambulance handovers were an area of intense focus and learning from work in North Bristol was being applied in Princess Royal University Hospital and Queen Elizabeth Hospital who were most challenged on handover performance.
- Good progress had been made against targets to eliminate 104 week waits for elective care by end of July and 78 week waits by the end of March. Although there were risks to the sustainable delivery of this trajectory.
- Performance against Cancer continued to be challenged but there were plans to reduce the backlog of those waiting over 62 days for a diagnosis.
- In relation to IAPT a key goal was to increase referrals and meet access targets, which current performance fell slightly short of.
- A spike in demand had been met with good progress in meeting urgent demand, and work on routine waiting time now needed attention.
- There were good results from a drive to recover numbers of SMI physical healthchecks after a significant reduction in these checks during pandemic.
- Out of Area placement performance reflected pent up demand during the pandemic.
- The system was doing well to reduce reliance on inpatient care working with local authorities.

Report of Finance Committee

5.06

Dr George Verghese noted that as well as the role of the committee in overseeing strategic, operational and financial planning, the committee had engaged with discussions on development of integrated care strategy, mental health planning, pharmacy and delegation of specialised services, pharmacy, optometry and dentistry. It had also received reports from ICB information governance sub-committee and a rich discussion about the board assurance framework. The financial position of the ICB was currently in deficit but forecasting a break even position and would be discussed as part of an associated risk on the board assurance framework.

5.07

The Board **noted** the committee reports.

6.	**Board Assurance Framework** Executives updated the Board on the highest rated risks to the organisation.
6.01	In relation to risk SELICS_17 Mike Fox noted the ICS reported a £50m deficit with a forecast breakeven position accompanied by heightened risks. Pressures included operational pressures in addition to winter demand such as the effect of increased levels of Covid both on patients and staff sickness, affecting the ability to deliver savings and to recover elective waiting lists. The effect of inflation was largely felt via non-domestic utilities costs while a government announcement was awaited, but it may not be possible to continue to resist inflationary pressure in other areas such as procurement.
6.02	In relation to risk SELICS_09 Sarah Cottingham noted that the urgent and emergency care pathways were already challenged in a context of usual winter pressures and facing uncertainty with rising covid cases as well as the potential impacts in flu. Work was underway to try to match capacity with demand to support flow and to address workforce challenges but this work would not deliver quickly, leading to the high risk scoring.
6.03	Paul Najsarek suggested that in future focus on could include reviewing some of the amber rated risks where intuitively the risks might be expected to be higher, for example on workforce and inequality.
6.04	Sarah McClinton asked if the risks took into account the wider impact on social care, especially in the context of the introduction of charging reform. She also suggested mitigations to the workforce risk needed to explore opportunities for integration more broadly across the system. She
6.05	Dr Ify Okocha suggested the Audit committee may wish to challenge some of the ratings in order to avoid rating those issues that preoccupied the organisation more highlight than other key concerns which the ICS should be addressing.
6.06	Julie Screaton suggested that there was opportunity to create an ICS aggregated workforce position as with finance, and that the rating of the risk reflected risks to the delivery of the workforce programme rather than the risk posed by workforce issues generally.
6.07	Tosca Fairchild thanked members for the comments and suggestions on the board assurance framework, noting that the BAF was subject to change and had been the subject of development prior to the start of the ICB, but could be developed in light of the comments and used as a tool to direct the attention of the board. There would also be an opportunity to take best practice approaches from other organisations.
6.08	Andrew Bland suggested improvements to the process and content should be made simultaneously, suggesting that the ICB executive might be a forum to provide more regular challenge from a wider group. Improving the content would require changing the organisations objectives, and the current BAF reflected those objectives agreed as initial objectives following the transfer of the CCG which could now be reviewed.
6.09	Richard Douglas suggested the board should have time on the agendas of its meetings to discuss mitigations for each of the highest risks. Each risk should also

	be owned by one of the ICB's committees as well as the responsible director and the audit committee could provide oversight. **Action: The ICBs board assurance process and risk management processed be discussed and developed in the light of comments by the board and its committees. Lead Tosca Fairchild** **Action: To create an opportunity to refresh the ICBs organisational objectives better reflect the concerns of the new organisation and to provide assurance through the BAF on the management of any risks to the delivery of these refreshed objectives.**
6.10	The board **noted** the risks against the delivery of its 16 corporate objectives for the financial year 22/23.
7.	**ICS Delivery of Virtual Ward Services**
7.01	Dr Toby Garrood introduced the work on virtual wards, building on a history of delivering hospital at home using multidisciplinary teams, virtual wards were intended to include other initiatives such as Home Oximetry and to be complementary to existing community services. NHS England had provided funding (£6m in 2022/23) to develop 40-50 'beds' per 100,000 population by December 2023. As well as reporting on availability and occupancy, SEL ICB would wish to collect other data on the effectiveness of these approaches. It was important to consider not just costs to healthcare but also societal cost and potential inequalities that could be created particularly reflecting the current cost of living. There was commonality across the boroughs but also diversity in the approaches used. This was positive as it allowed learning from multiple approaches. In assessing this approach the experience of the patient would be key. There was an opportunity to build on the strong foundation of work already done to transform pathways. The board received a presentation on the hospital at home work in Bromley
7.02	Elliott Ward advised the Board that: • in Bromley 18% of the population were over 65 and lived 17 years in poor health. Exacerbations in chronic conditions drove 38% of demand for emergency care. There was currently no centre for sub-acute care, or hospital at home equivalent, leading to an over-reliance on beds. • Work had been taking place on links between acute and community services including children's Hospital at Home and delivering IV antibiotics in community. • Service design had been based on data on acute exacerbation, statistics on acute infection responsible for 1500 bed days per month, and a literature review. Rounds of Delphi engagement involving clinicians professionals and patients helped develop the service.
7.03	Dr Lynette Linkson noted that • strong existing relationships with One Bromley provided a basis for growth. • The intention was to build places to hold patients safely for a period of acute care with consultant led multidisciplinary teams, with a seamless

transfer of care from hospital – engagement had noted concerns from people about responsibility and accountability and what happened when things went wrong.

- Support from a hierarchy and clear escalation procedures would be important for this new model of care, as well as developing ways of demonstrating competency and qualifications to deliver in this way to allow people to take this qualification across the system with their career.
- An additional 30 virtual and hospital at home beds would establish the model and maximise national pump-priming funding to facilitate growth.

7.03 Lorna Redpath outlined benefits for patients compared to a hospital stay. The home was more realistic place to assess needs and hear the patient voice, as well as reducing the chance of infection and falls because of a familiar environment and allowing better opportunity for physical activity and the comfort of home and friends and family.

7.04 Julie Screaton asked if there was a clear sense of what areas investment of would be needed in relation to education training and movement or passporting and staff. Elliott Ward noted work to engage with London wide consideration on passporting for staff, as well as work with clinicians to develop a specification for the training and development that would be needed.

7.05 Prof Clive Kay noted that in previous experience of similar projects it had not been possible to reduce the number of hospital beds needed but some success in reducing the need to increase bed capacity. It would be important to ensure that staff were empowered and had the appropriate skill mix but to avoid unintended consequences if staff were attracted to the programme from areas of need. There may be a need for some standardisation across south east London.

7.06 Dr Lynette Linkson explained that limited numbers of people had the skills for the support needed. It was proposed to create hybrid roles for people to rotate from placements in hospital at home and other settings as part of a more rewarding career path.

7.07 Angela Helleur commented on the change in culture on the nursing workforce which would be required to deliver this and there could be liaison with LMC and colleges pre-registration training. She commented there was a risk of inequality if poor housing meant this option was not available to people.

7.08 Dr Jonty Heaversedge emphasised the importance of retaining the original ambition for virtual wards to accelerate discharge from hospital beds by using technology to help staff look after people in their homes. There was a need to find cohorts of patients who could be supported with the use of technology to allow the limited workforce to be used more efficiently; frailty and respiratory patients may not be best suited for this approach. There was also a need to balance capability and resource in order not to increase unwarranted variation and consider the practicalities for acutes working with different systems teams across multiple boroughs to provide consultant support.

7.09 Stuart Rowbotham agreed a south east London overview was necessary to understand variation and share learning. There should be a robust understanding of the outcomes to be delivered, and consideration that in some cases accelerated discharge had led to poorer outcomes where there been sufficient involvement of therapists to assist people with reablement as with traditional

	discharge. There also needed to be an understanding of any implications for cost for patients.
7.10	Dr Toby Garrood noted that the 200 virtual beds already in place and the variety of approaches across the boroughs provided a strong foundation to review the most successful approaches and take the programme forward. It would be important to work with partners to ensure there was no additional burden placed on social and primary care. He pointed out that the various services were delivered in many cases by a similar team.
7.11	Dr Angela Bhan commented that a proactive care pathway helped to look over patients who were known to services and look after them. Dr Lynette Linkson added that the board for the hospital at home programme included involvement of pharmacy, voluntary sector; many patients were on multiple pathways for various conditions, and the offer was intended to be flexible to meet the need.
7.12	The Board **noted** the update on virtual wards.
8.	**2021-22 Annual Report and accounts**
8.01	The Board **noted** the annual report and accounts from south east London CCG.
9.	**Any other business**
9.01	There was no other business
10	**Public Questions and Answers**
10.01	There were no questions from members of the public.

Quality and Performance Committee
NHS South East London Integrated Care Board
ACTION LOG

REFERENCE	DATE ACTION AROSE	ACTION DESCRIPTION	STATUS	ACTION OWNER	DATE FOR COMPLETION	UPDATE/NOTES
ICB 001	27 July 2022	A report from the Population Health and Equality group to be presented to the board	open	Andrew Bland	18-Jan-23	A report will be prepared for a forthcoming full meeting of the board.
ICB 002	27 July 2022	The ICBs board assurance process and risk management processed be discussed and developed in the light of comments by the board and its committees.	open	Tosca Fairchild	18-Jan-23	The development of a new board assurance and risk process is underway and an initial proposal agreed by the ICB executive team.
ICB 003	27 July 2022	To create an opportunity to refresh the ICBs organisational objectives better reflect the concerns of the new organisation and to provide assurance through the BAF on the management of any risks to the delivery of these refreshed objectives.	open	Andrew Bland	01-Apr-23	The development of objectives will take place informed by the ICS Strategy and Five Year view which is being developed.

Integrated Care Board

Item: 3
Enclosure: C

Title:	**Delegation of commissioning and contracting of Pharmacy, Optometry and Dental services from NHS England to the South East London Integrated Care Board**
Meeting Date:	**16 November 2022**
Authors:	Sarah Cottingham, Executive Director of Planning and Deputy CEO Holly Eden, Director of Commissioning Improvement Sam Hepplewhite, Director of Primary Care
Executive Lead:	Sarah Cottingham, Executive Director of Planning and Deputy CEO

Purpose of paper:	The purpose of this paper is to support the Integrated Care Board's consideration of and decision upon accepting delegated responsibility for commissioning of Pharmacy, Optometry and Dental services from NHS England from the 1 April 2023	Update / Information	
		Discussion	
		Decision	***x***
Summary of main points:	The paper provides: • The national context and regional background to the proposal. • An overview of the work that the London's ICBs have completed together with the NHS England (London) Team to develop and agree the future operating model to deliver the delegated functions. • An overview of the objectives, opportunities, and implications of taking on the delegated functions of the services • A consideration of key risks and mitigations.		
Potential Conflicts of Interest	None advised		

Relevant to the following Boroughs	**Bexley**	**X**	**Bromley**	**X**
	Greenwich	**X**	**Lambeth**	**X**
	Lewisham	**X**	**Southwark**	**X**

	Equality Impact	Dental, optometry and pharmacy services are key components of general health and wellbeing, with deep rooted connections and synergies to prevention, primary care and community services. Formal delegation will allow ICBs to have more control and influence over the development of local services and greater flexibility in how these services are planned and delivered. Collaborative working across London's ICBs,

		whist managing contractual and practice issues locally, has the potential to lead to greater understanding of the population health needs and to support more robust and sustainable service offers and support targeted action to reduce health inequalities
	Financial Impact	The ICB will assume related budgetary responsibility for the contracts as detailed in the paper and is continuing to work to understand the financial implications of delegation as a priority including putting in place a Finance Working group.
Other Engagement	Public Engagement	The ICB Board will receive the current paper at its public meeting. After assuming responsibility for the services ICBS will be able to embed experience of care in improvement and transformation programmes including coproduction with people with lived experience; enabling engagement and coproduction; staff surveys and feedback
	Other Committee Discussion/ Engagement	The Board received an initial briefing on the delegation on 12 October 2022. The ICB's planning and Finance Committee also discussed the delegation.
Recommendation:	The Board is asked to consider the contents of the paper including the objectives, opportunities and risks associated with delegation and the proposed operating model that supports it; and: • **Agree** to accept the delegated functions of the Pharmacy, Optometry and Dental Services commissioning from NHS England on the 1 April 2023 in the event that NHS England agrees that proposal • **Note and endorse** the approach, timescales and proposed operating model • **Note and accept** the implications of delegation including resources and finance and the work that is on-going to test and plan for these.	

Delegation of commissioning and contracting of Pharmacy, Optometry and Dental services from NHS England to the South East London Integrated Care Board

ICB Board 16 November 2022

1. Purpose

1.1 The purpose of this paper is to support the Integrated Care Board's consideration of and decision upon accepting delegated responsibility for commissioning of Pharmacy, Optometry and Dental services from NHS England from the 1 April 2023, noting that NHS England would also need to approve this delegation. The paper also articulates the proposed approach, timescales and operating model that is being developed and that will support ICB's in delivering their delegated responsibilities.

1.2 The paper provides:

- The national context and regional background to the proposal.
- An overview of the work that the London's ICBs have completed together with the NHS England (London) Team to develop and agree the future operating model to deliver the delegated functions.
- An overview of the objectives, opportunities, and implications of taking on the delegated functions of the services
- A consideration of key risks and mitigations.

2. Background

2.1 From 1 April 2023 NHS England plan to delegate responsibility to all ICBs for all pharmaceutical, general optometry and primary, secondary and community dental services (PODs). This means that there is an agreement between NHS England and each ICB that enables the ICB to take on the responsibility for delivering NHS England functions for their population. The ICB becomes the operational and legal owner of the commissioning function, being both responsible and liable for its delivery, with NHS England retaining accountability to Parliament.

2.2 A number of functions will be retained by NHS England under the planned delegation model, such as national contract development and negotiations, performers list management, wider aspects of professional regulation and national transformation programmes.

2.3 In south east London the delegation agreement would relate to the following number of contracts and related budgetary responsibility:

		No of contracts	Value of contracts (£)
Dentistry	Acute Dentistry	2	57,494,695
	Community Dentistry	2	6,782,419
	Dentistry/ Orthodontics	216	94,677,083
	Total	**220**	**158,954,197**
Ophthalmology	General Ophthalmic	191	15,194,000
	Total	**191**	**15,194,000**
Community Pharmacy		43	30,966,000
	Total	**43**	**30,966,000**
Grand Total		**454**	**205,114,197**

2.4 Across England more broadly, some ICBs took on the delegation of PODs services in the Summer of 2022, however, none were in London. Due to the nature of the small single regional PODs team working across London to support PODs services commissioning, London's ICBs have agreed to work collectively across their five systems in relation to this delegation, to ensure the best use of that limited resource is secured alongside working together on key aspects of our delegation preparation.

2.5 In September 2022 the South East London ICB, along with the other four London ICBs, submitted a pre-delegation assessment framework (PDAF) to NHS England. The framework was developed in collaboration across London and provided an assessment of readiness to receive delegation by each system. This was considered and approved at the NHS England moderation panel on the 13 October 2022. Briefings were held with Board members and a copy of the framework was shared with board members at the time of submission.

2.6 The sections that follow provide further information for Board members on the delegation, culminating in a recommendation that the delegation of these services to the ICB from 1 April 2023 be agreed alongside the adoption of and further work on the proposed operating model of the London ICBs in support of that delegation.

3. The objectives, opportunities, and implications of transitioning responsibility for PODs services commissioning to the ICB

3.1 The rationale behind the delegation of PODs services commissioning functions to ICBs, is to improve the scope to commission these services in the context of managing local population health needs, tackling inequalities and addressing fragmented pathways of care. It is hoped that, through delegation, ICBs will be able to support approaches to designing services and pathways of care that better meet local population health need and priorities. Delegation should also provide greater flexibility to integrate services across care pathways, supporting improved continuity of care for patients, improved health outcomes for the local population and optimised use of resources.

3.2 In the first instance and whilst recognising the opportunities for improved integration, transformation in outcome and service offer for patient and citizens, London's ICBs are focused on achieving a safe landing for the transfer of PODs services commissioning, both business as usual functions and the PODs commissioning team. Later sections of this paper aim to set out the importance of this safe landing, the future opportunities that could be realised through successful transformation and the implications on ICBs for taking on the delegation of this service. In summary, however, the delegation of these responsibilities is aligned to both the purpose of ICBs and of our SEL ICB ambition for service and pathway integration and population health improvement and the recommendation that the Board agrees the delegation reflects this, with the operating model designed to secure a safe landing and effective on going commissioning function for the ICB.

4. Opportunities for transformation following the delegation of PODs Services commissioning

4.1 It is recognised that dental, optometry and pharmacy services are key components of general health and wellbeing, with deep rooted connections and synergies to prevention, primary care and community services. Through this delegation it is hoped that ICBs will have the flexibility to join up key pathways of care, leading to better outcomes and experiences for patients, and less bureaucracy and duplication for clinicians and other staff.

4.2 We will need to balance the ambitions for transformation against the restraints created by a national contract which, by its nature, has less opportunity for local adjustments. There should however still be scope to commission more flexibly, particularly when it comes to prevention, oral health promotion and other aspects of dental care, for example.

4.3 This section aims to set out the general opportunities that could feature as ambitions within a future transformation programme, alongside those opportunities that are specific to addressing the needs of the SEL population.

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4.4 Formal delegation will allow ICBs to have more control and influence over the development of local services and greater flexibility in how these services are planned and delivered. Collaborative working across London's ICBs, whist managing contractual and practice issues locally, has the potential to lead to greater understanding of the population health needs and to support more robust and sustainable service offers and support targeted action to reduce health inequalities.

4.5 With the triple aim in mind of improved health for everyone, better care for all patients and efficient use of NHS resources, the opportunities offered through local commissioning of Pharmaceutical Services, General Ophthalmic Services, and Dental services include:

- **Patient benefits:** The opportunity for more joined up care, increased focus on prevention, early intervention, right care, right time, right place, a holistic, multi-disciplinary approach to care and better step down care.
- **Equity:** ICBs are well placed to directly tackle health inequalities, reducing and removing organisational constraints and barriers and tackling variation and supporting targeted action.
- **Better value:** The scope for improved management of patient demand, a more holistic and integrated approach to care, protecting and building workforce resilience, improved budgetary management and use of resource.

The above could be achieved by:

- Strengthening links with integrated neighbourhood teams, primary care networks, population health management and public health.
- Fully aligning and localising approaches, advice and communications relating to staying well, through all primary care providers, particularly promoting the wider services offered by Community Pharmacies.
- Using data and intelligence to develop local initiatives to improve patient access and experience.
- Embedding professional and clinical leadership of the three areas of commissioning in local areas.
- Establishing local services to support partner collaboration across health, social care and public health to help address health inequalities and support more joined-up working.

4.6 Whilst further work is required, ICBs will also consider the benefits that could achieved through linked datasets to drive joined up care and tackle health inequalities, improvements to patient navigation through better provider connections, and opportunities to optimise resources across primary care as services recover from the impacts of the Covid-19 pandemic.

4.7 Specific South East London transformation opportunities that we would wish to explore further include:

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- Maximising the connections that pharmacies have to their local communities to tackle health inequalities. Our experience of working directly with pharmacies as part of an integrated vaccination offer has highlighted the reach that many pharmacies have into communities that are traditionally underserved by mainstream services. We have been building on these connections through the roll-out of new services within pharmacies, such as blood pressure monitoring. There are significant opportunities for maximising the role of pharmacies in reducing health inequalities by further integrating key prevention and Long Term Condition management services into these very local services. This could form part of an integrated partnership approach to delivering action in support of our Core 20 plus 5 population and the Vital 5 risk factors as part of an integrated prevention offer.
- Considering how to bring together work on healthy lives – including weight management, smoking cessation and alcohol use – with oral health promotion at a very local level, using a think family and Making Every Contract Count (MECC) approach. There are evidenced links between tooth decay / poor dental health with broader physical health conditions. By integrating our preventative approach and messaging and using the full range of health and care professionals across our system we would hope to be able to increase our impact.
- Improving the utilisation of local optometry services for minor eye conditions to reduce demand on our urgent and emergency care services. Whilst minor eye condition services are already commissioned across South East London, delegation may support us in improving local relationships between optometry providers and our systems and building optometry providers into work underway within our Local Care Partnerships to design integrated urgent care pathways as part of implementing Fuller Review.

4.8 ICBs will be giving further thought to how transformational work is coordinated and resourced within their structures including across transformation teams, local teams and enabling teams such as quality, workforce, estates, digital and business intelligence functions.

5 Operating model for PODs Services Commissioning in London

5.1 In the event that delegations are made to all ICBs in London an operating model in support of that would need to be established and in place from day one. NHS England (London Region) currently hosts the PODs Services Commissioning Team of twenty-six people. Within the team, individuals operate across all three of the PODs Services and across all areas of London. In the delegation of PODs Services Commissioning, the funding for the current workforce establishment is also transferred to the ICBs.

5.2 The five London ICBs, along with the London Regional Team, worked together to conduct two options appraisals in support of determining proposed delegation arrangements. The first was to agree the operating model for the PODs

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Commissioning Team from 1 April 2023. The second was to agree a "Host" ICB, by which we mean selecting one of the London ICBs to host the commissioning function on behalf of all the ICBs, following a safe landing of the business as usual aspects of PODs services commissioning. The hosted function would enact the plans of the five ICBs in respect of these services alongside providing contract and related management of service provision.

5.3 In the first options appraisal, four options were considered (see Annex One). The option to "do nothing" was immediately discounted, as was the option to disaggregate the team across the five ICBs. This was due to its small size and the nature of the individual team members' portfolios spanning the PODs services and multiple ICSs. The focus therefore was on options for the management of the function at a London level with the following consensus recommendation agreed should delegation proceed:

- **The TUPE transfer of the PODs Team will transfer the team to a single ICB at a point after 1 April 2023. The team's employment will, therefore, remain with NHS England on 1 April 2023:** We recognise that the timeframes are very tight to achieve a TUPE transfer by 1 April 2023, especially the establishment of the ICB governance, agreeing this arrangement across all of the ICBs, due diligence and ensuring sufficient knowledge transfer to the host ICB and other ICBs.
- **The agreed host ICB will work with NHS England London to agree a transfer date for the PODs team's employment into the host ICB within 12 months:** The aim is to achieve this as swiftly as possible (and within 12 months), whilst taking enough time to ensure the right conditions are in place for a successful transfer. These conditions need to balance the importance of providing stability and certainty for the staff in question, with the need to assure that key risks (as identified in the Pre-Delegation Assessment Framework) have been sufficiently mitigated or managed. This proposition recognises a level of due diligence that would need to take place between a future Host ICB, other ICBs and the PODs Team. It also allows time for a period of 'bedding in' for the new governance arrangements and the ongoing mitigation of key risks.
- **The Host ICB and the PODs Team will agree a target date for the future transfer of employment by 1 April 2023:** This will give the staff in the PODs team clarity over their future employer and the date on which that transfer will be made. It will be linked to a workplan that captures clearly what work needs to be completed by this date to mitigate risk and assure ICB Boards.

6.4 The second options appraisal resulted in the recommendation that North East London ICB (NEL ICB) should operate as the Host ICB for London. The details of the second options appraisal process can be found in Annex Two.

7. The Host ICB and the Commissioning Hub

7.1 Following the outcome of the two options appraisals, and the resulting clarity over our aim for 1 April 2023, the five ICBs have come together, under NEL ICB's leadership, to set their ways of working together over the coming months and their ambitions for what they want to achieve by 31 March 2023:

- That NEL ICB are supported as Host ICB and are willing to continue in their leadership with the support from the other London ICBs.
- London's ICBs, under NEL ICB's leadership, will be intelligent and informed commissioners, with a comprehensive understanding of what can and cannot be achieved within the constraints of the national contracts underpinning these services and the current funding of the teams.
- Governance will be in place that will drive decisions based on the evidence of need, enabling London's ICBs, under NEL ICB's leadership, to take decisions collectively and objectively.
- That the PODs Hub, under NEL ICB's leadership, compliments local relationships through joining up ambitions for local pathways with the knowledge about the commissioning and contracting to underpin these.
- Establishment of a process through which we can share, scale and spread innovations and best practice across London.
- Appropriate tolerances for decision making will be set so that our governance is slick and efficient and develop sophisticated principles that ensure all ICBs understand when decisions will be taking once across London and when they will be taken more locally.
- A clear understanding of the roles for quality and improvement across the London ICBs in cases where leadership is required at a local (Place or Neighbourhood) level of the system, utilising leadership across the London ICBs where relevant.
- The PODs team will be acknowledged and credited for the full spectrum of work they do, beyond a 'back office' function.

7.2 Delegation means that there is an agreement between NHS England and an ICB that enables the ICB to take on the responsibility for delivering NHS England functions. Following final approval and signature by each organisation's senior leadership team, the function becomes the responsibility of the ICB. In our proposed operating model for London, we are recommending that we continue to coordinate PODs Services Commissioning at London level, with NEL ICB operating as our Host. As such, in readiness for delegation from 1 April 2023, a Memorandum of Understanding (MoU) will be developed that will describe, in detail, the relationship between NEL ICB and the other London ICBs, and how the delegated functions will be enacted. This document will have the following components:

- Operating Model
- Priorities

- Key Deliverables
- Workforce Model
- Quality Model
- Ways of working
- TUPE
- Points of contact
- Review and monitoring arrangements
- Approval process

8. The role of NHS England as the employment host prior to a TUPE transfer of staff

8.1 NHS England London Region will continue to employ the staff until the ICBs are ready to take forward a TUPE transfer into NEL ICB. This is a model that is mirrored by other regions. A MoU between NHS England London Region and London ICBs will be agreed, and the key elements are summarised below.

8.2 Whist the MoU will be structured in a similar way to the MoU between the ICBs, the purpose of this MoU will be to set out the operating model and ongoing workforce support that is to be provided by NHS England London Region to enable the ICBs to discharge their responsibility for delegated PODs contracting and commissioning functions from April 2023.

8.3 The MoU will also include details on the following:

- **The functions retained by NHS England nationally and regionally.**
- The **ongoing access to the infrastructure surrounding the current PODs Team** required for the continued delivery of the service. This includes clinical expertise within the Region's clinical networks, public health consultants, communication and engagement and staff development, as well as more fundamental infrastructure such as payroll and IT.
- How the PODs Services Commissioning function will operate in the context of **other, connected, delegated functions that may be transitioning at a different pace** (complaints and specialised commissioning).
- The **relationship between NHS England London Region and NEL ICB**, and how this differs from the relationship with the other London ICBs.
- An **employment commitment** that aims to ensure that the continuation of the good work being carried out by the current PODs Team is prioritised by minimising disruption.
- Support for the **future TUPE transfer of the PODs Team** into NEL ICB.

9. Our plan for delivering delegation by 1 April 2023

9.1 To oversee the transition of the PODs Services Commissioning to London's ICBs, we have established a Steering Group made up of representatives from across the ICBs, the Regional Primary Care Commissioning Team and the PODs Team, as well as the programme team supporting the work. The Steering Group is accountable to the Collaboration of the London ICSs (CLICS) and to the NHSE London Regional Executive Board. The group is charged with the following key deliverables:

- Develop and implement a **transition plan** to support successful and smooth delegation of POD services to ICBs; Ensure the 'safe landing of the PODs Team as part of the transition.
- The design and delivery of a series of **masterclasses** to educate ICBs about the PODs services, and for the PODs team to learn about the London ICBs.
- Develop and agree the **MoU between NHS England and the London ICBs** to underpin the operating model of a PODs 'Hub' employed by the regional team until such a time as a TUPE transfer can take place.
- Develop and agree the **MoU between the London ICBs and the NEL ICB (as the Host ICB)** to underpin the relationship between the London ICBs in enacting their delegated functions in commissioning PODs services.
- Establish the **required governance forums** through which the London ICBs will deliver the commissioning of PODs services, under the coordinating host role of NEL ICB.
- Develop and agree **the papers to underpin decisions required of the London ICBs and the Regional Team** to ensure consistency across London.
- The preparation and delivery of opportunities to **simulate the governance** in advance of the delegation taking place.

9.3 To support the steering group, technical working groups are being established. A Finance working group is meeting regularly, and there are plans to establish a clinical and quality working group when required.

9.4 To date, the focus of the programme has been on undertaking the necessary options appraisals to gain clarity over the future operating model for PODs Services Commissioning. Following the achievement of this, the programme is concentrating on putting place the foundations required for the MoU documents. This includes the education of the ICBs in PODs Services Commissioning through a number of masterclasses, agreeing the areas that will be required for facilitated negotiation between the relevant parties and developing the detailed operating model that will underpin the functions of the PODs Team's day to day work from a quality, workforce and financial perspective.

9.5 A high-level plan is provided in Annex three, and a detailed plan, including roles and responsibilities, is being developed by the programme team.

10. Securing a "safe landing" for the PODs Commissioning Team

10.1 London's ICBs want to ensure "safe landing" for the POD team and its functions, ensuring that it is able to operate at its current levels of effectiveness under the new leadership of NEL ICB and the associated governance. Through prioritising the safe landing of business as usual activity, the London ICBs will have the opportunity to establish their collective governance of the services, upskill and educate their teams in becoming intelligent and informed commissioners, further research and understand the ways PODs services could support population health locally and design a transformation programme from a position of having experienced the way services are currently commissioned.

10.2 To achieve this safe landing there are a several areas of priority:

- Gaining clarity on the **details underpinning the contracts and services** overseen by the PODs Team. This will include the range, type, quality and performance of the provider contracts that will transition, and information regarding the services, contract models and patient feedback.
- Gaining assurance over the **current commissioning arrangements** including commercial information, the capacity and expertise within the existing team (and any gaps that may exist), financial flows, quality and performance.
- Gaining understanding of the **current financial allocations** and the commitment against this across the PODs services. Our Finance working group is working to transfer knowledge to the ICB finance teams on the financial arrangements, including current year budget, actual spend and forecast outturn and any embedded or future plans for efficiencies.
- Developing the **detail behind the agreed operating model**, that clearly sets out the roles, responsibilities and expectations of all parties.

10.3 To achieve the safe landing, and to address the above areas of focus, a period of due diligence will be essential. Using the Safe Delegation Checklist to guide us, we will work through the domains of Governance, People (impact assessment), Finance (financial governance, accounts and audit, leger, financial and cash management, banking arrangements, assets and liabilities), contracts, IT (assets and record management) and quality.

10.4 Our learning from due diligence will inform our education programme for ICBs by helping to highlight where we need transfer knowledge to the new commissioners, as well as building the detail required for our operating model. This, in turn, will be reflected in the content of the MoU documents between the ICBs themselves and with NHS England.

11 Delegation Implications

11.1 Whilst there are undoubtedly opportunities around how PODs services could improve patient and citizen outcomes, there are implications on the ICBs for taking on the delegation of these functions.

11.2 This section aims to explore these in more detail.

Resource implications resulting from the new operating model

11.3 Over the coming months, we will be considering the following implications for ICB resources, which could result from taking on the commissioning of PODs Services, noting we already do much of this work across other areas of responsibility but will need to ensure expansion to secure the effective coverage of PODs services post delegation:

- **NEL ICB as the Host:** NEL ICB is currently in the process of designing its ICB Primary Care Structure and will be including PODs services within this function. NEL ICB is also developing and strengthening its clinical leadership to support the clinical and professional advisory elements of the commissioning and service quality elements of the PODs function. It is anticipated that this will be enacted via the clinical senates and the provider collaborative. NEL ICB also plans to look at the resources required to administer the provider payments, and how best to ensure all ICBs can review their financial information.
- **Strategic Quality:** This refers to identified board level leadership and expertise in relation to the POD functions. Whilst the nature of this role will need to be agreed between the London ICBs and NEL as the Host ICB, this function has a role in maintaining and improving quality following the delegation of PODs services to ICBs. We will need to ensure that quality and risk issues relating to PODs Services are linked into existing ICB governance and accountability structures; the description of clinical governance arrangements; proposed governance and accountability structure for POD and how this integrates into wider ICB governance and accountability structure and relationship with place based partnerships. We will also need clear oversight of Quality Outcomes Framework (QOF) data / intelligence and any relevant improvement plans including those outlining how the PODs services support addressing health inequalities.
- **Operational Quality:** ICBs will need to ensure that there is grip on the governance arrangements for risk identification, management and escalation for the POD functions as well as being able to deliver their statutory duties for quality and setting up systems and processes to enable effective delivery and oversight.
- **National Screening:** ICBs will provide oversight and assurance regarding any national screening programmes including assurance over failsafe processes (e.g. diabetic eye screening).
- **Experience:** ICBs will embed experience of care in improvement and transformation programmes including coproduction with people with lived experience; enabling engagement and coproduction; staff surveys and feedback.

- **Patient Safety:** This includes the Serious Incident Framework or Patient Safety Incident Response Framework processes; Incident reporting to the Learn from Patient Safety Events service; Support for the commissioning of patient safety incident investigations including arrangement for regional or national escalation as appropriate; Compliance with national patient safety alerts; supporting safety improvement programme; Identifying Patient Safety Specialists and recruiting two or more Patient Safety Partners.
- **Safeguarding:** ICBs must have executive accountability and ownership for the Safeguarding Assurance & Accountability Framework (SAAF), including Child Protection information System (CPIS) which includes all children on a protection plan (CPP) and looked after children (LAC); child death overview process (CDOP); Child Safeguarding Practice Reviews (CSPRs); Domestic Homicide Reviews (DHRs); Female Genital Mutilation (FGM); Prevent & Counter Terrorism and Modern Slavery & Human Trafficking.
- **Transformation and Quality Improvement:** ICBs will lead on identifying and agreeing local transformation and improvement priorities. Following the successful delegation of PODs Services, when the ICBs begin to consider improvement and transformation opportunities, additional capacity and expertise may be required to improve outcomes.
- **Finance Teams:** The transactional work required to process the POD payments through the ICB ledgers is not a significant additional task in relation to ICBs existing contract and Primary Care processes, but the exact implications for ICB Finance teams is not yet known. The Secondary and Community Dental payments will, in the vast majority of cases, require an additional line in the ICB contracts they currently hold, with an increased amount to the monthly payment schedule. The payments to Dental Practices and Pharmacies are managed by the NHS Business Services Authority who provide the information needed to journal the ICB costs to the correct ledger codes. Optometry claims are managed on-line by Primary Care Support England and the monthly transactions will be automatically interfaced into the ICB ledgers. NHSE has limited resource currently undertaking these transactions for all of London plus those relating to retained PC services. ICBs will therefore be required to absorb the POD transactions for delegated services into their existing Primary Care and Contracting finance teams.

Financial implications

11.4 Understanding the financial implications of the delegation of PODs services is a priority, and a summary of the current financial allocation for delegated services can be found in Section 2. We have established a Finance Working Group across London's ICBs and the Regional NHSE Team to develop and agree a way to deliver the financial accounting elements of delegation, and continue to work together to understand the detail behind the following:

- The financial framework governing the delegation.
- Financial allocations and the basis of calculation and the split by ICB.
- The commitments against this budget including any reserves or contingencies set.

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- The surplus or deficit position for each of the transferring functions.
- Any efficiency requirements.
- Unresolved historic issues, contractual or otherwise with a financial impact.
- Other financial income and expenditure risks inherent in the functions to be transferred and their impact.
- Changes to contractual/ payment terms due to COVID and the impact of reverting to BAU as we enter recovery.

Skills, capabilities, upskilling and educating ICBs and their teams

11.5 To manage this, our 'hub' operating model will ensure that the existing expertise within the PODs team continues to deliver the required functions. Work continues with NHS England London Region to ensure that the current clinical and professional expertise provided to the PODs team from other parts of the Region remain in place from 1 April 2023, and these arrangements will be articulated in the MoU.

11.6 A programme of education for the ICBs will commence to develop a foundation knowledge of PODs services, which will support them to become intelligent and informed commissioners. The three initial foundation sessions are focused on:

- The commissioning cycle and contracting
- Service quality and example scenarios
- Service transformation and pathway redesign.

11.7 Following the delivery of these foundation sessions, the team will be working with ICB leads to identify specific sessions that would be helpful going forward, including sessions tailored to individual ICB needs.

11.8 Finally, there will be a specific requirement around building the necessary skills and capabilities within the ICB Finance Teams to be able to oversee the five ICB legers.

12 Transition Risks

12.1 First and foremost, the recommended operating model reduces the risk of transition to a minimum. The following themes make up the ongoing risks to the transition itself, which will be actively mitigate or manage throughout the programme:

- **Lack of information pertaining to the contractual and commissioning arrangements leading to the ICBs not fully understanding the functions that they are taking on.**

  This risk is being mitigated through the preparations for due diligence. Using the safe delegation checklist, and working with the leads within each ICB, the programme team will clearly articulate the requirements for due diligence and

support NHSE London Region in providing the necessary information. The due diligence will inform the Sender / Receiver Transition plans.

- **Lack of understanding of the requirements on ICBs to enact their role as commissioners of PODs services, leading to ICBs being unable to plan for the necessary resourcing.**

  This risk is being mitigated through a series of masterclasses, taking the ICBs through the responsibilities and role of the existing team, and how this will interact with the commissioner. The detail behind the operating model is being divided into its key components as part of the programme planning and will be worked through with ICBs in the coming weeks, in order to articulate this in the two MoU documents. Finally, following the drafting of the MoUs, we will be running a series of simulations to 'stress test' the arrangements to ensure they are fit for purpose in a safe environment.

- **Disruption over the transition period risks the retention of the experts within the PODs Team. This expertise is in scarce supply, and so the loss of key people could put the delivery of the PODs Services Commissioning at risk.**

  This risk is being mitigated through a close working relationship with the Head of the PODs Team, who sits on the Steering Group, so that information can quickly and easily be passed back to the PODs team. The recent conclusion of the options appraisals has led to more clarity for the PODs Team themselves. Finally, the PODs team participate in the delivery of the Masterclasses, helping to build relationships with ICB colleagues, and a masterclass for the PODs Team on the functions of an ICB is also being planned.

- **The transition itself could lead to an unmanageable volume of enquires about the delegation, with ICBs lacking resource to manage these.**

  This risk will be better understood through speaking to the regions that have already delegated their PODs Services to ICBs, to understand if they saw a significant rise in the number of enquiries received. Plans can then be put in place to resource this if necessary.

12.2 Risks from day one, following a "safe landing"

- **Inefficient or misaligned governance and decision making, or a lack of clarity around roles and responsibilities, leading to delays and non-value adding pressure on system capacity.**

  This risk will be mitigated through the development of the MoU between the ICBs, and the ICBs and NHSE London Region, and building on the learning from regions that have already been through the delegation process. A series of simulations will help to identify scenarios where the governance is not working as well as it could so this can be rectified before delegation takes place.

- **ICBs have not developed a sufficient understanding of the required resources to oversee the commissioning of PODs services, and so are unable to support the PODs team effectively and efficiently, or future ambitions for transformation.**

  This risk will be managed partly through the transition of the PODs Team, as is, and the focus on achieving a safe landing such that they can continue their business as usual activity. The programme team will also develop an analysis of the skills and capacity required on the part of the London ICBs. This will be a key part of the detailed operating model, and the understanding of the relationship between NEL ICB and the other London ICBs.

- **Demand for PODs services increases unexpectedly without increased funding, leading ICBs to be unable to meet demand.**

  This risk will be managed through the finance working group. Through this forum ICBs will understand the flexibility of funding and any changes to contractual or payment terms in response to recovery from the Covid-19 pandemic.

- **A mismatch between the expectations of providers, the public and patients and the ability and speed at which the ICBs can drive improvements to services.**

  This risk will be mitigated through close working with NHS England and ensuring that ICBs are well supported throughout any transition programme. We could also use a London-wide patient forum to get a sense of patient expectations and how we could manage these following the transition.

- **The transition itself, or the future TUPE transfer, severs links with key infrastructure for the PODs team, such as the complaints' function, clinical networks or public health consultants.**

  The development of the MoU between the London ICBs and the NHSE London Region will articulate the necessary infrastructure for the PODs Team, and how this will continue to be provided after 1 April.

13 Recommendations to the Board

13.1 The Board is asked to consider the contents of the paper including the objectives, opportunities and risks associated with delegation and the proposed operating model that supports it; and:

- Agree to accept the delegated functions of the Pharmacy, Optometry and Dental Services commissioning from NHS England on the 1 April 2023 in the event that NHS England agrees that proposal
- Note and endorse the approach, timescales and proposed operating model

- Note and accept the implications of delegation including resources and finance and the work that is on-going to test and plan for these.

Annex One - Operating model options appraisal options and criteria

Four options were considered:

Option 1: Do Nothing. The delegation of POD services does not take place, and statutory responsibility and employment of the POD services remains with the Regional Team.

Option 2: Employment of the POD team remains with NHS England, with London's ICBs building a shared governance structure to oversee their statutory obligations as the delegated commissioners of POD services. This arrangement will be reviewed within six months, in the context of the ambitions of the transformation plan and the longer-term operating model required to achieve this.

Option 3: Employment of the POD team transfers to a single ICB, where it is hosted on behalf of all London's ICBs. London's ICBs build a shared governance structure to oversee their statutory obligations as the delegated commissioners for POD services.

Option 4: Distribute the employment of the POD team across all London's ICBs, setting up five separate delivery and governance structures for POD services, one in each ICB.

Against a set of six criteria:

1) Meets the statutory obligations for the ICBs from 1 April 2023
2) Minimises disruption to business as usual activity of the PODs team
3) Minimises disruption to the workforce and, therefore, the risk of losing key knowledge, skills and expertise
4) Minimises the risk of disrupting links with key infrastructure for the PODs team, such as the clinical and public health networks that support them
5) Minimises or results in no additional running costs or operating costs required of the ICBs
6) Possible within the timeframes available to us

Annex Two - Host ICB options appraisal process

All ICBs were asked to self-assess their ability to take on the Host ICS role for PODs services based on three categories:

- Willingness
- Capacity
- Skills, Capability and Expertise (managerial and clinical).

Following the self-assessment, NEL ICB provided an Expression of Interest submission, answering a series of key lines of enquiry in order to understand the 'Host' offer further.

1. High level project plan