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Humber, Coast and Vale Health and Care Partnership
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Dear Colleagues

RE: Integrating Care: Next Steps for Integrated Care Systems

Thank you for the opportunity to share our views on the document you published on the 24th November 2020 on Integrating Care: Next Steps for Integrated Care Systems (ICSs) and the proposed legislative changes aimed at removing barriers to integration across health bodies and with social care.

The following views represent a collective response from the partner organisations of the Humber, Coast and Vale Health and Care Partnership which already holds integrated care system status.

As a partnership that has been and continues on a development journey, we are very supportive of the direction of travel set out in the document and welcome the opportunity to build on and make the appropriate adjustments that need to be made to reflect the policy changes set out.

We agree that giving ICSs a statutory footing from 2022, alongside other legislative proposals, provides the right foundation for the future. There has been broad agreement and a preference through our discussions to option 2.

We believe this model will provide greater encouragement for collaboration and flexibility to establish arrangements that suit the needs of our population, alongside strengthening lines of accountability most importantly, to our patients.

We welcome the clarity of purpose rooted in creating health and care systems that will be better placed to:

- Improve population health
- Improve access and address health inequalities
- Drive better quality and value
- Directly engage the NHS with wider social and economic development.

The partners in Humber, Coast and Vale also felt we needed to ensure that other proposals in the document were drawn out as key tests for a successful integrated care system, these include:

- Operating as an equal partner with local government and the voluntary and community sectors
- Co-producing strategies, plans and outcomes with patients, citizens and their representatives.

On improving population health and health inequalities we would like to see a strengthening of strategic planning to support this and feel a longer term outlook (5-10 years) is required to make changes to population outcomes.

Place

The emphasis on 'place' in the document is universally seen as positive and we will ensure decisions and resources are devolved as close to communities as possible. It remains a main focus for strengthening local leadership, increasing integration and developing primary care in its broadest sense as both a foundation and as an equal partner in transforming services. We see 'place' as the key enabler to continuing to improve the overall health and wellbeing of people living in our area in equal partnership with local government.

Having said that, for a large geographical area such as Humber, Coast and Vale there is logic to an approach that brings a number of places together on a footprint which is smaller than the ICS, but is through the functions of the ICS. This would enable partnership working, strategic leadership and planning of integrated care to meet the needs of populations greater than a single place, to drive better value, address health inequalities and the wider determinants. In doing so, we would not envisage additional formal governance or accountability of the ICS, but instead flexible and dynamic arrangements for the practical delivery of outcomes and services across 'places'. The partnership arrangements already established in Humber, Coast and Vale are demonstrating this through the strength and depth of the managerial, clinical, professional and lay leadership. They have contributed complementary views as set out in annex one.

We feel the approach set out in the document is permissive and pragmatic enough to enable governance arrangements to be established that make sense in the context of our geography and arrangements we already have in operation but also to develop further ways of working and developing clear accountabilities with arrangements such as Health and Wellbeing Boards, we welcome this. We would encourage in any further considerations this flexibility remains so that ICSs are able to strengthen integration and reduce bureaucracy.

Provider Collaboration

We are supportive of the changes proposed for provision, based on duties of collaboration at place within provider collaborations and across an ICS within provider collaboratives, where patient pathways need to rely on services of more than one trust or organisation due to the specialist nature of treatment. We acknowledge for the sector specific collaboratives the value is in designing and delivering specialist and other services at scale that meet the needs of our population, where it makes sense to do so. There are some highly specialised services where we feel it might be beneficial to still consider whether they should be delivered on a multiple ICS or even a national basis e.g. Deaf Services for CAMHS to ensure patient safety is maintained and workforce expertise is available.

We also need to continue to recognise the value of diversity in our providers particularly for areas such as Humber, Coast and Vale where we have a vibrant Voluntary, Community and Social Enterprise Sector that focus on delivering care closer to home as we increasingly shift resources into the community. They also play an important strategic role at an ICS and multi-ICS level, with many community providers working across systems and in at scale provider collaboratives. This is an important point for community providers as the landscape of provision varies greatly across the country. While some ICSs have large community providers, others such as Humber, Coast and Vale will have a more mixed collection of varying sized providers delivering a myriad of services. The proposals also only reflect community providers' relevance at place which we fully support, however, there is a role at an ICS level where they bring together primary and

community care into a collaborative network, developing plans to deliver more care at home and in the community to improve population health outcomes. We feel it is important that the leadership role that community providers' play at place and system level is emphasised and the changes need to ensure parity of esteem across mental and physical health, and care in the community and in hospital.

As providers, Ambulance Trusts are an important part of our provider collaboration both at place and across the ICS. We recognise that this is significantly challenging for them as they tend to span multiple ICSs. Therefore, we feel it would be beneficial for consideration to be given to ambulance collaboratives being coterminous with wider regions ensuring alignment to ICSs within that region to enable them effectively work with systems and places.

What must not be underestimated is the balancing for all providers between place and sector and that they are supported appropriately to do both. Whilst there is some acknowledgement of their role as anchor institutions this could be strengthened to include more around their social and economic value and not just a focus on fair and equal access.

As mentioned above Primary Care is the foundation of delivering better outcomes for the population and specifically the role of Primary Care Networks within this. Whilst there is recognition through development funding that they need to be supported to grow, they are all at different levels of maturity. It would be helpful if further consideration could be given to the capacity and support needs to enable them to be an equal partner alongside the other provider organisations.

Partnership with local government

Whilst our existing arrangements are and any changes to these arrangements will be mindful of the potential reforms to local government and allow for greater alignment and integration in the future, we propose that should there be any further consideration of the model to ensure the flexibility between health, public health and social care is maintained and enables places within systems to build on existing established arrangements between the NHS and local government and create the equal partnership that can address the needs of a population. With the proposed changes to Public Health England and the impact of reduced funding to local authorities on community services and clinical aspects of health improvement / public health services, we also feel there needs to be greater consideration with local authorities of the roles of ICSs in this area.

Clinical and Professional Leadership

There is clear message about the clinical and wider professional community being a powerful force for leadership and governance at every level, as well as the voluntary and community sector and citizens and this has been collectively acknowledged by partners in Humber, Coast and Vale as a positive direction. A specific response from the Clinical and Professional Group is set out in annex two.

Workforce

We are also supportive of the direction in relation to our people as creating a sustainable workforce is key to the delivery of our ambitions. It is vital that there is engagement with other stakeholders, such as Health Education England, Universities, Further Education providers and schools and other public sector organisations to ensure we maximise the opportunities.

Finance, transformation and digital

Whilst we recognise there is further detail to be developed, we welcome the proposals around the financial arrangements set out in the document. This will enable us to ensure resources are more effectively linked through to our places to address health inequalities and improve outcomes for our people and communities and are also available to support delivery of national programmes and transformation change as a system. We also welcome the focus on connecting health and social care, using digital and data to transform care and put the person at the centre of their care. Annex three provides a further response to the digital and data proposals.

Changes to commissioning

The proposals will lead to significant change for commissioning and the document refers to absorbing Clinical Commissioning Group (CCG) functions as core ICS business. We believe to have a successful integrated care system this will only be a small part and that to deliver on the purpose described in the document we will need to ensure the functions are appropriately deployed to place, providers and the system. As we are sure you will be aware, this causes concern for colleagues in our organisations particularly in CCGs. The document suggests 2021/22 will be a transitional year and central to this will be the redeployment of staff with guarantees of employment as we transition to new roles, ways of working are reshaped and changes are made to the current system to enable the new one to be formed and we welcome this. This will be an unsettling time and will cause significant uncertainty and anxiety for all colleagues who have been and continue to work exceptionally hard in response to COVID-19. Whilst as a collective group of leaders we will manage this change and transition, expediency in our requests for support / further national guidance, so that we can give staff the certainty they are looking for would be appreciated.

Link with NHS England and Improvement

The North East and Yorkshire (NEY) region was the first region in England to have 100% ICS coverage, and as a result we believe the ICSs are in a very strong position to take on the statutory role and responsibilities outlined in the proposals. Building on the firm foundations, as ICSs in NEY we work closely with the regional team as part of a “four plus one” approach, with collective leadership from ICS leaders and the Regional Director. Many regional staff are already embedded within, or aligned to, the ICS. NHSEI Locality Director works directly to ICS leader, playing a key role and working as a bridge between the region and the ICS. Working in this “four plus one” way has proved highly effective in managing the response to Covid, in service planning, performance management and development of a commonly agreed framework for deploying staff. This puts the ICS and the region in a strong position to manage any transition process.

To ensure as an ICS, that we have the coherence and capacity to deliver, we would be supportive of an approach that would see the devolution and/or delegation of central and regional NHSEI functions along with the appropriate resources. Recognising that we will work together with the other ICSs in the region, through lead ICS arrangements and building on our “four plus one” approach, we feel that this would put all the ICSs in region in the strongest position to succeed.

We are keen to see an evolutionary approach rather than nationally driven reorganisation, agreeing with the expressed wishes of the Secretary of State that this should be avoided, and learning from previous NHS reorganisations.

Finally, we would like to reiterate our thanks for the opportunity to share our views, we welcome the direction of travel and should you wish to follow up on any points raised then please do get in touch.

On behalf of the Partner Organisation Members of the Humber, Coast and Vale Health and Care Partnership (ICS)

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HCV Independent Chair and System Lead

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Accountable Officer,
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Michele Moran
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HCV Mental Health Collaborative Chair

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Annex One – Supplementary Views from the Geographic Partnerships within Humber, Coast and Vale

Humber

The Humber Partnership is a diverse health and care system comprised of 17 Primary Care Networks, four Local Authorities, four Clinical Commissioning Groups, seven NHS providers and three Community Interest Companies.

Together we work on behalf of the approximately 1 million residents of the Humber to achieve sustained improvements in the health, wellbeing and inequalities experienced by our people and communities through the four places that are aligned with each of the local authorities in the Humber.

We are supportive of the direction of travel set out in the document and agree with the approach to move ICSs to a statutory footing from 2022 (Option 2). We agree that these proposals will provide greater encouragement for collaboration to address health inequalities and improve population health. Whilst we acknowledge that option 2 will provide a longer-term solution to achieving this integration agenda compared to option 1, we have concerns that the arrangement may provide clarity of accountability for Parliament, the clarity of accountability to patients is less evident and more further consideration needs to be given to governance and public accountability.

As a partnership we recognise the potential for the proposals to really strengthen our approach to key enablers, for example:

- *System workforce planning in partnership with Further and Higher Education*

Greater system level workforce planning will enable providers to share expertise, support engagement with further and higher education, and support the development of more flexible training and career choices which encourage people to live, learn and stay local.

- *System intelligence*

True system working will require system intelligence built around individuals, communities and population groups. We recognise the need to bring all organisations and PCNs with us in order to make available linked data sets connecting primary and secondary care data with 999, NHS111, and Local Authority data, to understand and predict service utilisation, identify gaps in provision and target high risk groups.

- *Place at the heart of system health and care provision*

As a partnership we identify PCNs, neighbourhoods and place as key drivers for change. We are looking to align CCG management expertise and clinical leadership to support the rapid development of PCNs and neighbourhood service offers for populations of 30-50,000, which formalise relationships between health, social care and community assets. It is our intention to rapidly develop primary care to form a strong foundation, which is evident through every level of the ICS, and which has the capability to deploy resources at neighbourhood level differentially and disproportionately.

There are areas which are underrepresented in the document where further clarity would be helpful – particularly with regards to accountability (question 2 posed by the document) and governance arrangements (question three) including but not limited to:

- *Discharging quality functions and statutory responsibilities under new arrangements*

Quality (Safety, Outcomes, Patient Experience) should be a clearly defined function within the ICS. We welcome a shift in the focus of Quality Assurance, from individual provider monitoring and improvement, to cross-provider accountability for population outcomes and pathways of care. This should be reflected in a system interface with the CQC. There is opportunity to establish clarity through a Quality Framework which operates at multiple levels, from neighbourhood through to system level, with the ability to establish joint oversight with Local Authorities. We would want to harness the significant expertise of leadership for quality of care, quality assurance, quality improvement, and advocacy for patient experience which exists in CCGs to ensure that those multiple layers, especially at place, feel the benefit and the independence from providers that this brings.

CCGs have statutory responsibilities (alongside other statutory partners) for safeguarding, child death review arrangements, research and the requirement for a SEND Designated Clinical Officer. These responsibilities could be aligned through new legislation to the ICS, with strategic leadership supporting delivery of responsibilities through partnerships operating models. For safeguarding and child death review this could operate effectively through geographic partnerships, and for research through provider collaboratives and PCNs. The SEND DCO role closely aligns to place, defined by Local Authority boundaries. We welcome the opportunity to draw on our local expertise to define accountability and delivery arrangements which fulfil statutory responsibilities through the transition period and beyond.

- *There is a degree of ambiguity in systems shaping their own governance arrangements, particularly given the potential introduction of new geographically-based and sector-based collaborations, and potential implications for individual organisations in managing system performance.*

We welcome the opportunity to develop local financial rules but recognise there is a risk that financial systems will be determined by historic behaviours and practice, which traditionally 'lock-in' resource to sectors and tend not to prioritise preventive and proactive interventions which offer solutions to system problems. This approach cannot continue, particularly when set against the disproportionate impact of Covid-19 on people who are already experiencing disadvantage and discrimination, and will only contribute to rising costs of health and care in the long term.

We welcome the capability as a partnership to target our collective resources to where we have the greatest potential to address inequalities and improve outcomes for our people and communities, although disruptive financial mechanisms are required to support the shift in mindset.

However, it should be noted that in developing existing joint working structures care has been taken to work closely with local government, to establish arrangements through which decisions can be taken together (for example in East Riding, Hull, North and North East Lincolnshire through CCG/Local Authority Committees in Common / place based collaborations). This has enabled

services to be designed and commissioned in collaboration and by the most appropriate local government and / or health partner with a wide range of provider organisations in an integrated contractual form. It is not clear how integrated decision making will be facilitated within the revised arrangements. The focus of the consultation document appears to be primarily upon organisations which are formally part of the NHS. It is not apparent how private sector organisations or the voluntary sector, commissioned by local government to provide much of the integrated delivery chain for the provision of health and social care services, will be integrated into the delivery model.

While the consultation document recognises the importance of the footprint of Health and Wellbeing Boards, there is little reference to their future role. Health and Wellbeing Boards have enabled commissioners and providers to be brought together with other public and key organisations, for example the Police and Crime Commissioner, to provide the framework for development of a co-ordinated response to the wider determinants of health.

The opportunity exists to build on existing structures at place based on the knowledge developed over recent years. Decision making structures will need to respect the role of local government to allow integration with social care to continue and recognise local democratic accountability and wider social care commissioning requirements.

- *Priorities should be set by partnerships with strong clinical, lay member and elected member involvement, enabling disproportionate allocations which target those with the poorest health and support a recurrent shift in resources between sectors and geographies.*

The role of elected member, lay members and foundation trust governors has brought a wealth of experience, professional expertise and objective focus on decision making about local population health priorities. This voice will become distanced in a larger footprint and system governance arrangements will therefore need to reflect the role of place and provide the framework for democratic and community accountability, together with an understanding of people, communities and populations and how this is applied to decisions about priorities and resource allocations.

We are broadly supportive of an approach whereby services currently commissioned by NHSE transfer to ICS bodies. We welcome the opportunity to bring all available resources together to deliver population health care from cradle to grave, across whole cycles of care. We also recognise that there needs to be a multi-layered approach to ensure that value in terms of outcomes and resources is maximised.

There is benefit in moving elements of primary care commissioning to work more locally with PCNs, whilst other primary care services such as performer action lists should continue at scale.

The same is true of specialised services which require a larger population footprint beyond ICSs to maintain service quality and sustainability. Mechanisms will be needed whereby ICSs work through collaborative or hosting arrangements to preserve capacity and capability.

More broadly there are services and strategies which require a regional coordinated approach, for example Yorkshire and Humber Integrated Urgent and Emergency Care Strategic Commissioning and the Yorkshire and Humber Care Record.

As a Humber Partnership we have strength and depth by virtue of our partners and active involvement of managerial, clinical, professional, lay and elected members. The pace of change required to get us to April 2022 presents a significant challenge, recognising the scale and scope of proposed change and the level of ambiguity that remains.

In order to respond to the challenge we are mobilising our local leaders and subject matter experts; to develop and test new arrangements through 2021, learn from and share with other ICSs across the region, and support our members of staff – particularly those in CCGs and NHS EI – to play active roles in our system as it emerges.

North Yorkshire and York

North Yorkshire and York (NY&Y) Partnership has a diverse population of approximately 775,000 residents. It comprises of 76 GP Practices in 19 Primary Care Networks, two Local Authorities (North Yorkshire County Council and City of York Council), two Clinical Commissioning Groups and five NHS providers.

The NY&Y Partnership leaders are supportive of the direction of travel set out in the consultation document and support the approach to move Integrated Care Systems to a statutory footing from 2022 (Option 2). We agree that these proposals will provide greater encouragement for collaboration and will maximise the contribution the NHS makes to the social, economic and environmental conditions that shape good health.

As a partnership we recognise the potential for the proposals to really strengthen our approach to key enablers, and have the following key points to make:

A Strategic and Collaborative Approach to Economic and Social Recovery
We welcome the opportunity to come together as experts to greater influence economic and social recovery, particularly due to the impact of COVID-19 pandemic. We believe that a single, more powerful, voice to represent our regions working closely with other geographic partners will create a sustainable future for our population and our significant workforce. In short, we will work together more effectively so that the people of North Yorkshire and York get the health and social care system they deserve.

System workforce planning in partnership with Further and Higher Education
As detailed within the People's Plan and already embedded within our organisational development plans, we understand the importance of workforce planning, talent management and succession planning through further and higher education and are committed to greater system level workforce development. A flexible approach to workforce planning across wider sectors and geographies will enable a greater level of shared expertise and will encourage talented individuals to come into and remain in the area.

System Intelligence
We support the importance of a strong collaborative approach to system intelligence and for the system to understand how it can aggregate collective effort together at differing levels in the system to make sense of, and deliver on, the specific issue we are addressing. A strong intelligence function

is crucial for the ICS to deliver improved population health and needs to be flexible enough to support local 'place' requirements.

Primary Care at the Heart of System Health and Care Provision

We recognise that PCNs form a key building block of the NHS long-term plan. Bringing general practices together to work at scale is already a priority. We agree that the local voice of our clinicians is paramount in the successful development of PCNs and their sustainability. We agree with our clinicians that we must continue to develop PCNs at pace and for their voice to be heard in order to: improve the ability of practices to recruit and retain staff; to manage financial and estates pressures; to provide a wider range of services to patients and to more easily integrate with the wider health and care system.

Improving Health Outcomes and Reducing Health Inequalities across a Wide Geographical Footprint

We understand the challenges of working across a wide geographical footprint and recognise that the size, scale and reach of the NY&Y Partnership means it can influence the health and wellbeing of the population by aligning core functions to improve health outcomes of local communities. We strongly believe that the notion of place needs to be a flexible concept working closely with communities in order to enable an agile response to improving heath and care outcomes and reducing health inequalities.

Governance Arrangements

As a system that has worked even more closely together over the previous months in response to the pandemic, we have a greater understanding of how our governance models can flex and adapt in light of statutory changes. We have taken the opportunity to embed strong links and working arrangements with our local authorities and would want to see this continue to be strengthened.

As a recently merged CCG, North Yorkshire CCG understands the complexities of joint governance arrangements of multiple statutory organisations. We would therefore welcome decisive authority to act to bring organisations together to act on behalf of consolidated populations and lay aside organisation sovereignty through the transition period towards a single ICS.

We support our ICS formation of two strategic geographical partnerships each with common issues, population needs and aims as a cornerstone of collaborative working both locally and strategically.

We recognise the important principle of subsidiarity and would want to promote the important decisions about health and care being made as close to our local communities as possible.

System Financial Management

We welcome the opportunity to develop local financial rules but recognise there is a risk that financial systems will be determined by historic behaviours and practice. The COVID-19 financial regime has allowed our geographical partnership to have constructive conversations about how to use growth funding which has been refreshing and enabled constructive collaboration across sectors. A return to the previous financial regime could see us return to the requirement of very high levels of efficiency requirements of 3% per annum due to historic recurrent deficit positions of partner organisations. We would like to see recognition of the need for longer term financial recovery period of up to 5 years (setting trajectories locally) to allow challenged financial systems to

make real progress in meeting the financial challenge while also being able to invest in collaborative transformation.

A recognition of the real cost of smaller remote hospitals would also be welcome through national allocations, in particular the hospitals recognised by ACRA.

We would also welcome the continuation and scaling of system performance management and financial performance measures which aid collaboration rather than organisational sovereignty

Annex Two – Humber, Coast and Vale Clinical and Professional Group Response

The following views represent a response from the clinical & professional group of the Humber, Coast and Vale Health and Care Partnership. The clinical and professional group was set up in the response to Covid 19 in April 2020 but has developed over the last 9 months into a wide inclusive group that looks at all areas of health strategy and response.

As a group, we are very supportive of the direction of travel set out in the document and welcome the opportunity to build on the areas we have highlighted over the past months. We have secured agreement across the partnership for a set of principles that establish a focus on shared ownership of care, transparency in communication, shared health demand lists, health access equity, integrated health and care pathways, the prevention agenda and allocation of resources to community solutions.

We agree that giving ICSs a statutory footing from 2022, alongside other legislative proposals, provides the right foundation for the future and will allow us to build on the principles outlined above. We believe option 2 in the document will provide greater encouragement for collaboration and flexibility to establish arrangements that suit the needs of our population, alongside strengthening lines of accountability most importantly, to our residents.

The group welcomes the clarity of purpose rooted in creating health and care systems that will be better placed to:

- Improve population health
- Improve access and address health inequalities
- Drive better quality and value
- Directly engage the NHS with wider social and economic development.

There is clear message about the clinical and wider professional community being a powerful force for leadership and governance at every level, as well as the voluntary and community sector and citizens and we welcome this. We feel that this approach needs to be underpinned by a commitment to a longer term strategy around improving population health and reducing health inequalities. We would like to see a population health management approach embedded in every work stream and strategy going forward.

Primary care networks within our places will be key drivers of integration and collaboration; resource and capacity needs to be liberated for them. We feel option 2 could allow significant resources to flow to place and neighbourhood and drive positive impacts. As key partners within anchor networks and settings we all need to encourage employment in the health and care sector with emphasis on wellbeing and prevention. It is clear that we need to mobilise social justice to build a wellbeing movement and economy.

We are supportive of the changes proposed for provision, based on duties of collaboration at place within provider collaborations and across an ICS within a sector provider collaboratives (acute and mental health). We acknowledge for the sector specific collaboratives the value is in designing and delivering specialist and other services at scale that meet the needs of our population, where it

makes sense to do so. This needs however to be truly cross sector collaboration and we need to recognise and encourage the contribution of the primary care and the VCSE sectors to these forums. All networks and collaboratives within the emerging ICS will need to acquire or grow expertise and provide the people with the skills for 'whole pathway' commissioning and whole pathway quality improvement. This will require some organisational development to be built in across all areas.

We truly agree with and encourage reduction in bureaucracy and hierarchy and understand the need for high trust partnerships and relationships across all sectors; we would not want additional layers of governance and assurance built in via this change for Integrated Care Systems.

Annex Three – Humber, Coast and Vale Digital Response

We welcome the focus on connecting health and social care, using digital and data to transform care and put the citizen at the centre of their care.

We have already completed significant work to join up patient records across our places, for example through the establishment of the Yorkshire & Humber Care Record, with developed capabilities to extend the sharing of patient records via a standard approach across the ICS and wider Yorkshire and Humber. This builds upon our previous success of deploying shared record access to where it's most needed and developing a culture of record sharing as standard rather than by exception e.g. strategic use of the NHS Digital Summary Care Record product, Clinical Systems, GP systems TPP SystmOne and EMIS integration, and use of the Medical Interoperability Gateway solution.

We are invested, at both 'place' and system in building a population health management capability underpinned by more joined up data sets, allowing for improved commissioning and targeted care delivery. This should continue to ensure intelligence-led approaches are the foundation for population planning and improve health outcomes, whilst improving the use of data for research across the system.

We are embracing a "design at system, deliver at place" ethos, via the development of shared strategies, a region wide Digital Charter and a successful Yorkshire and Humber Digital Delivery board. This recognises the continuing importance of all places, but seeks opportunities for further collaboration efficiency gains through working across ICS footprints as we have successfully done over previous years.

We will continue to work in partnership with our peers across Yorkshire and Humber, designing solutions at a system level with delivery at place.