Public Document Pack

GATESHEAD HEALTH AND WELLBEING BOARD AGENDA

Friday, 22 January 2021 at 9.00 am via Microsoft Teams
Live Stream available via: https://www.youtube.com/user/GatesheadMBC

From the Chief Executive, Sheena Ramsey

Item	Business
1	**Apologies for Absence**
2	**Minutes** (Pages 3 - 10)
3	**Declarations of Interest** Members of the Board to declare an interest in any particular agenda item.
	Items for Discussion
4	**Homelessness and Rough Sleeping Update - Kevin Scarlett** (Pages 11 - 14)
5	**Covid-19 Response & Vaccine Update - Alice Wiseman & Lynn Wilson / All**
6	**Children's Social Care - Service Update on Impact of Pandemic - Andrea Houlahan**
7	**Gateshead System Response to NHSE Consultation on Next Steps for ICSs - John Costello & Mark Dornan** (Pages 15 - 30)
8	**Gateshead Health & Care System Update - Mark Dornan / All**
	Items for Information
9	**NHSE/I Change of Opening Hours Notifications - John Costello**
9a	**L Rowland & Co: Former Five Star Batteries, Meresyde, Leam Lane** (Pages 31 - 32)
9b	**L Rowland & Co: Saltwell Road** (Pages 33 - 34)
9c	**Boots Pharmacy at the Metrocentre: temporary change of opening hours** (Pages 35 - 36)
10	**Updates from Board Members**
11	**A.O.B.**

Contact: Melvyn Mallam-Churchill, Tel: 0191 433 2149,
Email: melvynmallam-churchill@gateshead.gov.uk, Date: Thursday, 14 January 2021

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GATESHEAD METROPOLITAN BOROUGH COUNCIL

GATESHEAD HEALTH AND WELLBEING BOARD MEETING

Friday, 11 December 2020

PRESENT	Councillor Lynne Caffrey	Gateshead Council
	Councillor Leigh Kirton	Gateshead Council
	Councillor Bernadette Oliphant	Gateshead Council
	Councillor Gary Haley	Gateshead Council
	Councillor Michael McNestry	Gateshead Council
	Councillor Paul Foy	Gateshead Council
	Caroline O'Neill	Care Wellbeing and Learning
	Dr Mark Dornan	Newcastle Gateshead CCG
	James Duncan	Cumbria, Northumberland Tyne and Wear NHS Foundation Trust
	Alice Wiseman	Gateshead Council
	Lisa Goodwin	Connected Voice
	Siobhan O'Neil	Healthwatch
	Ian Warne	Tyne & Wear Fire and Rescue
IN ATTENDANCE	John Costello	Gateshead Council
	John Robinson	Gateshead Council
	Anya Bramich	Gateshead Council
	Andy Graham	Gateshead Council
	Andrew Beeby	Gateshead Health NHS Foundation Trust
	Steph Downey	Gateshead Council
	Lynn Wilson	Gateshead Council
	Michael Brown	Healthwatch

HW214 APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Martin Gannon, Councillor Ron Beadle, Andrea Houlahan, Lewis Atkinson, Mark Adams and Richie Rickaby.

HW215 MINUTES

The minutes of the last meeting held on 23 October 2020 were agreed as a correct record.

The Board also received an update on items contained within the Action List; it was noted from the list that the Board will continue to receive updates on Covid-19 as required. It was further noted that the update report on Childhood Immunisations would be presented at a Board meeting in the summer.

HW216 DECLARATIONS OF INTEREST

Siobhan O'Neil declared an interest in Item 4 as a board member of the North East

Poverty Trust.

HW217 ADDRESSING POVERTY IN GATESHEAD: AN OVERVIEW - ALISON DUNN (PRESENTATION)

The Board received a presentation from Alison Dunn providing an update on reducing inequalities and supporting residents during Covid-19.

From the presentation, the Board received information relating to the following:

- Community hubs
- Food provision
- Holiday activity programmes
- Support for businesses and the self employed
- Support for people looking for work
- Support for individuals through welfare and grants

The Board acknowledged that the pandemic has had huge implications for partners around the table; a comment was made noting that throughout the pandemic organisations have had to have a more reactive approach to dealing with poverty and deprivation.

It was noted that challenges ahead remain in terms of addressing inequalities; it was further noted that whilst the current 'sticking plasters' are needed, investment in narrowing the gap in inequalities for the future must remain a key priority.

The Board agreed that partnership work and communication had been outstanding but that whilst reactive work has been taking place to support communities during the pandemic, future planning and other tasks were not being taken forward as they would have under normal circumstances. The Board acknowledged that the 'day job' of partners, including those in the voluntary sector needed to continue to prevent issues in the future.

On the topic of the voluntary sector, the Board were advised that providers are nearing a 'cliff edge' in terms of access to funding leading up to March 2021. It was agreed that Alison Dunn and Lisa Goodwin would provide the Board with an update on work being done within the community and voluntary sector at a future meeting.

The Chair thanked Alison for the presentation.

RESOLVED:

(I) The Board noted the contents of the presentation.

(II) The Board agreed to receive a further update on work being done within the community and voluntary sector at a future meeting.

HW218 OLDER PERSONS CARE HOME MODEL - BARRY NORMAN (PRESENTATION)

Barry Norman delivered a presentation to the Board providing an update on the Older Persons Care Home Model.
From the presentation, the Board were provided with an overview of Gateshead care

home provision; it was noted that the sector had been faced with challenges before the pandemic and that these have been exacerbated since then. It was further stated a project team is in place to explore the future requirements for Gateshead and to look at future market investment.

The Board received information relating to care homes challenges during the pandemic. It was noted that there have been many pressures within the sector which have included Covid-19 related deaths in addition to staffing and resourcing pressures.

An overview of the 'Gateshead Approach' was provided, it was highlighted that financial support had been agreed to ensure providers were able to deliver safe services during the pandemic. From the presentation the Board also noted that the pandemic has forced through changes within the sector which included strengthening the 'person centred focus' such as same day discharges to support NHS partners.

The Board were advised that occupancy levels have reduced in Gateshead from 93% to 82%. It was also acknowledged that the 'Home First' strategy has been a success resulting in fewer admissions to long term care. It was noted that the roll-out of the vaccine has provided a light at the end of the tunnel for residents and care workers.

The Board were also made aware that by early summer, new models of care delivery within care homes will be proposed and consulted on with new contracts put in place. It was agreed that Barry should attend a future Board meeting to provide an update on the new models of care delivery.

The Board agreed that further work needed to be done to improve the sector; it was also felt that the data on Covid-19 related deaths needed to be unpicked to identify areas for improvement. A discussion also took place on how care homes are managing the challenges of allowing family visits safely; from this discussion it was highlighted that work is ongoing regionally to introduce lateral flow testing to allow for increased visits to residents.

RESOLVED:

(I) The Board noted the contents of the presentation.

(II) The Board agreed that an update on new models of care delivery be presented at a future meeting.

HW219 COVID-19 VACCINE UPDATE - LYNN WILSON / ALL

The Board received a verbal update on the roll out of the Covid-19 vaccination programme.

From the update, the Board were advised that five primary care networks are working together to roll out delivery of the vaccine. It was also noted that deliveries of the Pfizer vaccine are expected imminently in addition to equipment to support staff and administration such as laptops and 4G trackers. It was also stated that logistically there is still work to do to ensure that the vaccines are stored at the

appropriate temperature.

An overview of staffing was provided; it was highlighted that across the system staff are being deployed or redeployed to support the vaccination programme. It was also stated that resource will be put in place to support with car parking and the marshalling of waiting areas at vaccination sites.

A brief overview of priority groups was provided which highlighted that those over the age of 80 would be first to be invited for a vaccine. It was also noted that following the first dose of the vaccine, the second dose is to be administered 21 days later. The Board were advised that there will be four vaccination sites across the borough, each located to provide convenient coverage for residents to attend.

The Board were advised that a huge task is underway to ensure the roll-out of the vaccine is successful and that the whole system was involved.

A question was asked as to whether transport would be made available to those who are not able to make their own way to a vaccination site. The Board were advised that such plans are being developed, it was noted that partners and voluntary sector providers may also support in this effort.

Concern was raised about the recent allergic reactions to the vaccine that have been reported in the press. The Board were assured that these instances were very rare but that no vaccine can promise no side-effects; it was also highlighted that the individuals reported to have had an adverse reaction to the vaccine have now recovered.

The Board were also advised that it is important to get the message out to residents that they should not contact their GP or hospital to request a vaccine. It was noted that individuals would be contacted directly.

RESOLVED:

(I) The Board noted the verbal update

HW220 GATESHEAD HEALTH & CARE SYSTEM UPDATE - MARK DORNAN / ALL

Dr Mark Dornan advised the group that a thank you message has been produced to express gratitude to services and residents for their support and effort during a very challenging time. The Board were advised that links to the video would be circulated following the meeting.

The Board were advised that work is ongoing between the LA7 to encourage residents to continue to follow Covid guidance over the upcoming Christmas holidays, it was also noted that plans are being rolled out across the system for a third wave of the virus which is a massive undertaking.

A discussion took place on the impact on the mental health of children during the pandemic, it was noted that the lack of social interaction and uncertainty around schooling will have had an adverse impact on children. The Board noted that this issue is recognised and affects children both locally and nationally, it was further

noted that the wider impact of social isolation will affect all age groups.

It was highlighted that the backlog of cancelled hospital appointments and screenings will impact upon both patients and services. The Board were assured that work is ongoing to manage appointments, it was stated that weekly and daily calls are taking place with operational groups to manage the situation.

It was highlighted that services are very much focussed on maintaining and improving patient care on the frontline. Additional discussions took place on digital inclusion for residents, it was highlighted within the discussion that inequalities throughout the borough mean that some residents are excluded from digital engagement due to not having the infrastructure or a device to use.

It was noted that challenges remain across the system, both in terms of business continuity but with additional pressures as a result of the pandemic.

RESOLVED:

(I) The Board noted the update.

HW221 GATESHEAD SAFEGUARDING CHILDREN PARTNERSHIP ANNUAL REPORT 2019-20 - SAIRA PARK

Saira Park provided the Board with a summary of the Gateshead Safeguarding Children Partnership Annual Report.

The Board requested an additional update from Saira on the impact of Covid on services.

RESOLVED:

(I) The Board noted the contents of the report.

(II) The Board requested a further update on the impact of Covid on children's services at a future meeting.

HW222 NHSE/I NOTIFICATION OF CHANGE OF OWNERSHIP: BEWICK ROAD PHARMACY - JOHN COSTELLO

RESOLVED:

(I) The Board noted the report.

HW223 UPDATES FROM BOARD MEMBERS

Cllr Haley raised the issue of secondary school children not attending school due to anxiety. It was also noted that school admissions have currently suspended home visits due to the pandemic. It was suggested that this matter should be picked up via the Community Hub network.

RESOLVED:

(I) The Board noted the update.

HW224 A.O.B.

There was no other business.

Item 2.2

GATESHEAD HEALTH AND WELLBEING BOARD
ACTION LIST

AGENDA ITEM	ACTION	BY WHOM	COMPLETE or STATUS
Matters Arising from HWB meeting on 11th December 2020			
Addressing Poverty in Gateshead: An Overview	To provide the Board with an update on work being done within the community and voluntary sector at a future meeting	A Dunn & L Goodwin	To feed into the Board's Forward Plan
Older Persons Care Home Model	To bring back an update on the progression of the model to a future Board meeting	B Norman	To feed into the Board's Forward Plan
Gateshead Safeguarding Children Partnership Annual Report 2019-20	To bring a service update from Children's Social Care on the Impact of the Pandemic	A Houlahan	On the Agenda of 22nd January meeting
Matters Arising from HWB meeting on 23rd October 2020			
Covid-19 Presentation	The Board to receive further updates on the local response as required. This should include an update on the impact of Covid on the mental health of children and young people.	A Wiseman / All	Standing item on agenda
Matters Arising from HWB meeting on 6th March 2020			
Integrated Care Partnership (ICP) Suicide Prevention	The Board agreed to receive an update on the matter in 6	I Miller	To feed into the Board's Forward Plan

AGENDA ITEM	ACTION	BY WHOM	COMPLETE or STATUS
Developments	months.		
Matters Arising from HWB meeting on 17th January 2020			
Childhood Immunisations	The Board to receive an update report in the summer (to include details of the immunisations programme for 2020/21).	R Chapman & F Neilson, NHS England	To feed into the Board's Forward Plan

Gateshead Council

HEALTH AND WELLBEING BOARD
22 January 2021

TITLE OF REPORT: Homelessness and Rough Sleeping Strategy Update

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Purpose of the Report

1. To seek the views of the Health & Wellbeing Board regarding homelessness workstreams currently underway, their scope and the expected outcomes.

Background

2. Under the broader Housing Review currently underway in Gateshead, which will see the reintegration of services from The Gateshead Housing Company back into the Local Authority, we are developing a new strategy for Homelessness, with a vision of ending Homelessness in Gateshead.

   This will result in the following key outcomes:

   - A new, co-produced, Homelessness and Rough Sleeping Strategy
   - The remodeling and potential re-provision of homelessness accommodation and support services for all those aged 16+, which will include (but not be limited to) any external provision we commission.
   - A new, 'Connected Services' delivery model with multi-disciplinary locality-based working and a new 'Gateway' for accommodation and support.

3. Work has started to develop our Homelessness and Rough Sleeping Strategy. Based on feedback so far this is likely to include the following:

   - Vision
     - To end homelessness, in all forms, in Gateshead
   - Values
     - Delivering on the rights and needs of those who are homeless or at risk of homelessness
     - Listening to those with experience of homelessness
     - Enabling a personalised approach
     - Providing high standards of communication, co-ordination and consistency in decisions
     - Being fair and transparent
   - Principles
     - Seeing potential working with strengths
     - Listening, learning and responding through co-production
     - Working together, inclusively

- It's all about people

- 4 Strategic Aims

    1. Make homelessness a rare occurrence

    2. Homelessness to be as brief as possible and result in positive outcomes

    3. No-one sleeping rough or in unsuitable accommodation

    4. Homelessness is a one-off occurrence

- Strategic Action Plan

    - This will provide a delivery plan, which will be made up of plans for each of the 4 strategic aims outlined above.

4. We have started the process of consulting with both internal and external services on the emerging Homelessness and Rough Sleeping Strategy and will continue to do so as we develop the content further. Feedback so far from both the Internal and External Homelessness Working Groups we have set up, has been constructive and positively received.

5. Whilst developing the Homelessness and Rough Sleeping Strategy we have also started a review of accommodation and support provision for those who are homeless or at risk of homelessness. This review will feed in work already underway by Commissioning Colleagues to review related commissioned provision. The broader review will be an all age (16+) holistic review of all relevant accommodation and support provision, internal and external, commissioned and non-commissioned including but not limited to the following:

    - Accommodation with Support.
      (This will include accommodation such as Supported Housing, Semi-Supported and Dispersed Accommodation)

    - Advice and Support Only.
      This will include drop in facilities, advice, assessments, prevention support, move on support and outreach/floating support.

6. To progress this review, we have developed an accommodation and support, mapping template in order to take an evidence-based approach to consider any gaps in accommodation and/or support provision within Gateshead. We have begun populating this template in partnership with TGHC and Commissioning colleagues, with any known relevant service information. This template will be further developed with contributions from external providers with a view that we have gain a full understanding of what is already out there within the borough, which will inform both the strategy and this review.

7. In addition to mapping provision we have also begun analysing related Homelessness Data to better understand need(s) and demand. This has so far included analysing recent data from the Supported Housing Portal, which is the central route for all commissioned homelessness accommodation in addition to detailed recent data from our Government Homelessness Data Returns. Additional

data and reports to consider and feed in also include Gateshead's Homelessness and Multiple and Complex Needs Health Needs Assessment 2017 and the recent Gateshead Multiple and Complex Needs Transformation Initiative findings. We will continue to further develop our evidence base over the next month to inform both the strategy and the review.

8. This review will also consider the availability of resources to deliver the Homelessness and Rough Sleeping Strategy. This will include using resources from both our commissioned provision and our internally provided services/schemes. We will aim to offer greater value for money by using both resources. Following the completion of the review we will remodel all related accommodation and support provision, which may involve:

- Commissioning new provision
- Recommissioning
- Developing new provision
- Changing existing internal provision

9. Letters have been sent to external commissioned providers notifying them of the review and the potential recommissioning and/or decommissioning of services. Providers have also been invited to attend our External Homelessness Working Group where a review progress update was provided at the group's first meeting in December 2020.

10. In addition to developing the strategy and reviewing provision we will also be developing a 'connected services' model. This will result in the development of a new holistic central 'gateway' for all homelessness accommodation and support referrals in Gateshead. Through an existing Supported Housing Referral Portal, we only have a limited referral route, for some commissioned accommodation referrals which doesn't include a route for any of our internal provision. It is spreadsheet reliant, under resourced and does not cover the broader scope required to deliver the needs of the Homelessness and Rough Sleeping Strategy.

11. We therefore need to develop an holistic gateway that covers all accommodation and support for those aged 16+, with the necessary system and staffing resources to ensure we are best meeting the needs of those who are homeless or at risk of homelessness and delivering on our strategic objectives. Key aims for the development of a new 'gateway' will include:

- One referral form for all related accommodation and support
- A database which can collate data on demand/need as well as outcomes information
- 'Connection' to other related services i.e. health and social care – both through referral pathways and aligned or joint systems
- The ability to co-ordinate referrals where there are multiple and complex needs
- Providing advice, signposting and referring on (i.e. to locality based support services)
- Feeding into related strategic housing and homelessness groups.

12. The following projects and transformational programmes currently underway will also support and inform the Homelessness and Rough Sleeping Strategy and its associated strategic action plan:

    - Homelessness Prototype Casework and Development
    - Mental Health Locality Based Community Model
    - Gateshead's Multiple and Complex Needs Transformation Initiative
    - Changing Futures Potential MHCLG Bid
    - New Domestic Abuse Bill Requirements
    - MHCLG Next Steps Accommodation Programme

13. We will work together with internal and external partners to ensure the projects and programmes outlined above support, inform and deliver on the objectives within the Homelessness and Rough Sleeping Strategy, through our Working Groups and with the broader support of the newly developed Strategic Housing Partnership. By working together, we have the opportunity to deliver the broader system change which will be required in order to develop a new 'connected services' delivery model with multi-disciplinary locality-based working and a new 'Gateway' for accommodation and support. It should also improve outcomes for people and offer greater value for money.

Proposal

14. In terms of next steps, we will:
    - Continue to work with partners and co-produce a Homelessness and Rough Sleeping Strategy. Timescale - 1st April 2021.
    - Progress the holistic review of accommodation and support for those who are homeless or at risk of homelessness. Timescale – 30th September 2021.
    - Further develop a 'connected services' delivery model, with multi-disciplinary locality-based working. Timescale – 30th September
    - Develop a 'Gateway' for homelessness accommodation and support. Timescale – 30th September

Recommendations

15. The Health and Wellbeing Board is asked to note the update provided and share any views, particularly in relation to:

    - The 4 key aims of the newly developing Homelessness and Rough Sleeping Strategy
    - The scope of the review of accommodation and support for those who are homeless or at risk of homelessness
    - The development of a 'connected services' delivery model with a central 'Gateway' for homelessness accommodation and support.

Contact: Vicky Sibson, Strategic Housing Lead, vickysibson@gateshead.gov.uk

Gateshead Council

HEALTH AND WELLBEING BOARD
22nd January 2021

TITLE OF REPORT: **NHSE/I Consultation on Next Steps for ICSs – Gateshead System Response**

Purpose of the Report

1. To seek the endorsement of the Health & Wellbeing Board to the Gateshead Health & Care System response to the consultation by NHS England/Improvement on the Next Steps for ICSs.

Background

2. NHS England/Improvement (NHSE/I) issued a consultation document before Christmas 'Integrating Care: Next steps to building strong and effective integrated care systems across England' with a very short timescale to respond – the deadline for responses was the 8th January.

3. The document sets out a proposed direction of travel for ICSs as well as options for giving ICSs a firmer footing in legislation, likely to take affect from April 2022. A summary of the main proposals are set out at Appendix 1 to this report.

4. A response to the consultation was quickly prepared by the Gateshead Health & Care System and submitted to NHSE/I. A copy of the full response is attached at Appendix 2. Issues highlighted within the response include:

The timing of the consultation

- The frustration and disappointment of partners regarding the very short timescale for responding to the consultation, during a busy Christmas period. Also, the approach to the consultation has not demonstrated that local areas are regarded as valued partners in the development of the proposals.

Focus on health and inequality

- The need to focus on addressing health and other inequalities, which have been exacerbated by the pandemic.
- The lack of references to the broader aspects of wellbeing (i.e. the wider determinants of health) or the role of partners councils in progressing social value and community wealth building approaches.

The importance of Place and influencing broader geographies (ICPs and ICS)

- The importance of the primacy of 'Place' and subsidiarity principle, whereby decisions should be taken as close to communities as possible, not by distant organisations.
- Consideration needs to be given to what can be commissioned at Place in conjunction with local health and care partners, including local authorities, in line with the subsidiary principle.

- The important role that local government has to play at both at place and broader geographies. This needs further work to involve Social Care and Public Health within local authorities, adopting a co-production approach.
- The need to strengthen the important role that Health & Wellbeing Boards play and the need to support place-based leadership arrangements generally.
- Clarity is needed on how the commitment to delegate significant budgets to place level will be done in practice and on what basis decisions will be made.
- The need to evolve the NENC ICP North (within our ICS) building upon existing relationships. Also, the need to explore how it can best work with local authority collaboration (e.g. our LA7) so that we can maximise the national and local influence of our partnerships.
- The importance of a permissive approach to the development of ICSs so that they support and enable place-based working.
- The need to ensure that the voice of individual local areas is not lost within the ICS.

Relationships

- The need to protect existing relationships that have been developed, particularly at Place, so that the focus on delivering for local people is not lost. Local systems have benefited significantly from the input of CCGs, including their commissioning and clinical expertise, which have helped to shape local priorities and plans to address them. This expertise must be retained in any new arrangements.
- That local areas must be enabled to build upon the progress that has been made in recent years, through bringing together service provision, strategic commissioning and clinical leaders to address the needs of their communities.
- The importance of Provider collaboration and mutual co-operation, rather than competition.

Accountability

- The need to ensure that there are locally accountable place-based arrangements to oversee the full range of resources for the populations they serve.
- The need for clarity on the role of Health & Wellbeing Boards in ensuring there is appropriate accountability.
- The need to ensure there is true (and equal) partnership at all levels, including Local Authority, Primary care, Specialist providers, Education providers, Healthwatch & VCS.
- The need to address the democratic deficit at ICS and to avoid a two-tier hierarchical system.

Lack of detail

- References are made to the many areas where there remains a lack of clarity on what future arrangements may look like and the need for more detail on this.
- Asks that local areas are fully engaged and consulted by NHSE/I on the future development of any proposals relating to ICSs, their implications for Place arrangements, and how issues raised in our response will be addressed.

5. The Board may wish to note that responses to the consultation have also been submitted by the LA7, the Joint OSC for the North East & North Cumbria ICS &

North & Central ICPs and the North East & North Cumbria ICS itself. Many of the themes within the Gateshead System response have also been captured by these responses.

Proposal

6. Given the short timescale set by NHSE/I for responding to the consultation, the endorsement of the Board is now sought to the Gateshead System response.

Recommendations

7. The Health and Wellbeing Board is asked to endorse the response of the Gateshead Health and Care System to the NHSE/I consultation paper set out at Appendix 2.

Contact: John Costello (0191) 4332065

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NHS England/ Improvement Consultation on Next Steps for ICSs

Introduction

NHS England/ Improvement (NHSE/I) have published a consultation paper on the next steps for ICSs 'Integrating care: Next steps to building strong and effective integrated care systems across England'. This note provides a summary of the content of the consultation paper.

Place

"Place": is identified as an important building block for health and care integration. For most areas, this will mean long-established local authority boundaries (par 1.14).

There are various references to Governance at a Place Level. The document states that the place leader on behalf of the NHS will work with partners such as the local authority and voluntary sector in an inclusive, transparent and collaborative way. They will have four main roles:

- to support and develop primary care networks (PCNs) which join up primary and community services across local neighbourhoods;
- to simplify, modernise and join up health and care (including through technology and by joining up primary and secondary care where appropriate);
- to understand and identify – using population health management techniques and other intelligence – people and families at risk of being left behind and to organise proactive support for them; and
- to coordinate the local contribution to health, social and economic development to prevent future risks to ill-health within different population groups (Par 2.18).

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

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

Where partnership working is truly embedded and matured, the ability to accelerate place-based arrangements for local decision-making and use of available resources (such as delegated functions and funding), maximises the collective impact that can be achieved for the benefit of residents and communities (Par 2.23).

Later on in the document there is further reference to 'place' leadership arrangements.

Good partnership working must be underpinned by mutually-agreed governance arrangements, clear collective decision-making processes and transparent information-sharing (Par 2.28).

Place leadership arrangements should consistently involve:

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

They may flexibly define:

i. the configuration, size and boundaries of places which should reflect meaningful communities and scale for the responsibilities of the place partnership;
ii. additional membership of each place partnership that is likely to include acute providers, ambulance trusts, the voluntary sector and other partners;
iii. the precise governance and decision-making arrangements that exist within each place; and
iv. their voting arrangements on the ICS board. Providers of community and mental health services are "core" Place members whereas acute providers are "additional members" (Par 2.31).

The greater development of working at place will provide an opportunity to align decision-making with local government, including integrated commissioning arrangements for health and social care, and local responsiveness through health and wellbeing boards (Par 2.34).

ICSs

ICS governance should seek to minimise levels of decision-making and should set out defined responsibilities of organisations, partnerships at place, provider collaboratives and the core ICS role (Par 2.31).

The document acknowledges that the more levels of hierarchy in a system, the more likely it is that bureaucracy will exist and grow. It states that ICSs have the potential to reduce bureaucracy through increased collaboration, leaner oversight through streamlined assurance structures and smarter data-sharing (Par 1.7).

Devolving Power

The paper states that there is a need to devolve more functions and resources from national and regional levels to local systems, to develop effective models for joined-up working at "place (Par 1.8).

There is scope to shift national or regional resources and decision making so that these are closer to the people they serve e.g. to devolve a greater share of primary care funding and improvement resource to this more local level (Par 1.11).

Provider collaboration

Some services such as hospital, specialist mental health and ambulance needs to be organised through provider collaboration that operates at a whole-ICS footprint – or more widely (Par 1.19).

Providers will join up services across systems: within places (for example, between primary, community, local acute, and social care, or within and between primary care networks) through place-based partnerships and between places at scale (Par 2.5). All NHS provider trusts will be expected to be part of a provider collaborative (Par 2.6).

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

NHSE/I will set out further guidance in early 2021, describing a number of potential models for provider collaboratives (Par 2.13).

Primary care networks in neighbourhoods and thriving community networks are also provider collaboratives, and for integration to be successful there will be a need for primary care to work with community, mental health, the voluntary sector and social care as close to where people live as possible (Par 2.20).

Financial Framework

The finances of the NHS will increasingly be organised at ICS level and allocative decisions put in the hands of local leaders. ICSs are to be key bodies for financial accountability and financial governance arrangements will need to reflect that (Par 2.39). A single pot will be created that brings together different budgets (Par 2.40).

ICS leaders will be expected to delegate significant budgets to 'place' level, which might include resources for general practice, other primary care, community services, and continuing healthcare.

Decisions about the use of all of these budgets will usually be made at the lowest possible level, closest to those communities they serve and in partnership with their local authority. New powers will make it easier to form joint budgets with the local authority, including for public health functions (Par 2.43).

Workforce

From April 2022, this will include:

- developing and supporting a 'one workforce' strategy;
- enabling employees to have rewarding career pathways that span the entire system, by creating employment models, workforce sharing arrangements and passporting or accreditation systems that enable their workforce to be deployed at different sites and organisations across (and beyond) the system, and sharing practical tools to support agile and flexible working (par 2.16).

Clinical and other frontline staff have led the way in working across professional and institutional boundaries, and they need to be supported to continue to play a significant leadership role through systems (Par 2.24).

Data

Systems will need:

- A system-wide digital transformation plan that outlines the journey to digitally-driven, citizen-centred care, and the benefits that digital and data will realise for the system and its citizens.
- To develop or join a shared care record joining data safely across all health and social care settings.
- To build the tools to allow collaborative working and frictionless movement of staff across organisational boundaries (Par 2.51).

The document also states that NHHE/I would support legislative change that clarifies that sharing data for the benefit of the whole health and care system is a key duty and responsibility of all health and adult social care organisations (Par 2.51).

Legislative Proposals

The document sets out options for giving ICSs a firmer footing in legislation likely to take affect from April 2022. Two possible options are set out for enshrining ICSs in legislation, without triggering a distracting top-down re-organisation (Par 3.9):

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

- It would establish a mandatory, rather than voluntary, statutory ICS Board through the mechanism of a joint committee and enable NHS commissioners, providers and local authorities to take decisions collectively (Par 3.11).
- There would be one aligned CCG only per ICS footprint under this model, and new powers would allow that CCGs are able to delegate many of its population health functions to providers (Par 3.13).
- This option retains individual organisational duties and autonomy and relies upon collective responsibility (Par 3.14).
- However, current accountability structures for CCG and providers would remain (Par 3.15).

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

- ICSs would be established as NHS bodies partly by “repurposing” CCGs and would take on the commissioning functions of CCGs (Par 3.18).

- The CCG governing body and GP membership model would be replaced by a board consisting of representatives from the system partners (Par 3.19).

Both models offer a basis for planning and shaping services across healthcare, social care, prevention and the wider determinants of health. Both would allow for the delegation of functions and money to place-based statutory committees involving NHS bodies and local government. Both would enable NHS and local government to exploit existing flexibilities to pool functions and funds (Par 3.25).

NHSE/I believe that Option 2 is a model that offers greater long-term clarity in terms of system leadership and accountability. It states that it provides:

- A clearer statutory vehicle for deepening integration across health and local government over time.
- Enhanced flexibility for systems to decide who and how best to deliver services by both taking on additional commissioning functions from NHS England but also deciding with system colleagues (providers and local councils) where and how best service provision should take place (Par 3.26).

The consultation document can be accessed at https://www.england.nhs.uk/wp-content/uploads/2020/11/261120-item-5-integrating-care-next-steps-for-integrated-care-systems.pdf

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Response of Gateshead Health & Care System to NHSE/I Consultation

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

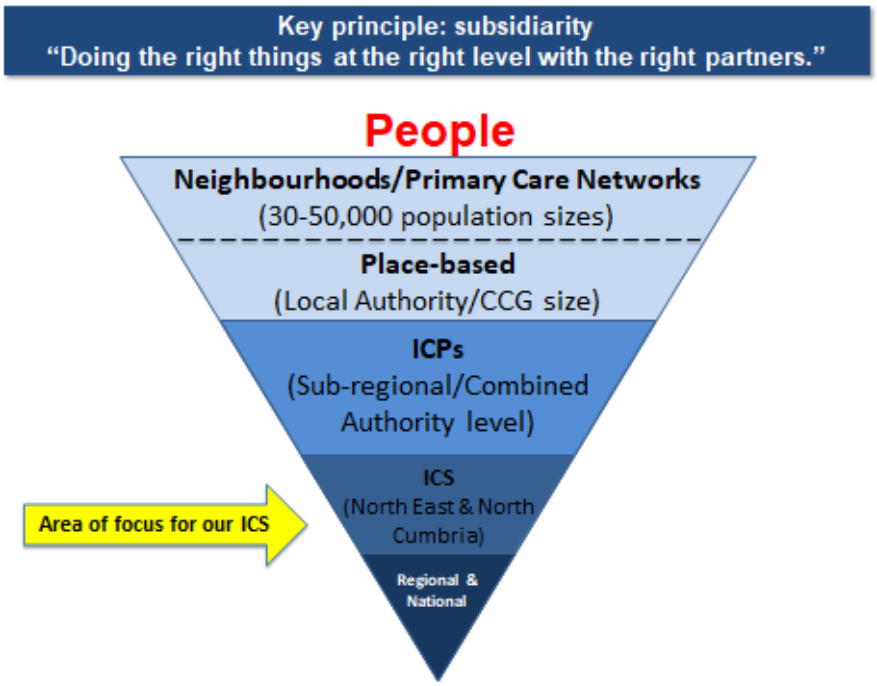
Timing of the Consultation

We would like to express our disappointment at the timing of this consultation over the Christmas period and the short timescale for responding. We note that the consultation highlights the importance of working in partnership, but the approach to the consultation is not demonstrating that local areas are regarded as valued partners in the development of the proposals.

It is all the more important, therefore, that there is full and substantive engagement with local areas on the development of the proposals and how issues raised in this response will be addressed. It is crucial that local areas can shape not only their own local Place based arrangements but also how they interface with the ICS, as well as the roles and the accountability arrangements within the ICS itself. Any arrangements that impact upon local communities need to be co-produced with those communities and the organisations that serve those communities.

1. **Our Focus is on serving our communities and the primacy of 'Place':**

We are all here to serve the people of Gateshead, our patients and our service users. In order that we are best placed to do so, we wish to keep decision making as close the public (and place) as possible and wish to keep our principles of subsidiarity as set out in the illustration that we have championed:



The focus must remain on delivery and transformation with any structural changes being least disruptive to care delivery and happening in the background. They should also respect the primacy of

place as a guiding principle and be streamlined in ways that will not to add bureaucracy at place and broader geographies.

2. **Relationships:**

We also wish to protect existing relationships so that our focus on delivering for our public and patients is not lost, especially with the health inequalities and levels of poor health and wellbeing we have. The strength of relationships at Place have been demonstrated during our response to the Covid pandemic – relationships that pre-date the health reforms of 2013.

Since 2013, strong relationships have been developed with CCGs and significant work has been undertaken across the patch not only in aligning and taking forward integrated commissioning arrangements with local authorities, but also in articulating a vision for Place in conjunction with health and care provider organisations. Local systems have benefited significantly from the input of CCGs, including their commissioning and clinical expertise which have helped to shape local priorities and plans to address them.

It is imperative, therefore, that local relationships that have been built up over the years can continue to thrive so that the people of Gateshead can also 'thrive'. That means that whatever proposals are taken forward for ICSs (and their knock-on implications for CCGs), specific assurances and more information is needed on how those relationships, as well as the expertise that those relationships have brought, can continue to form a key component of future working arrangements at Place.

3. **Leadership – Clinical, Primary Care & System Leadership – and Accountability:**

We want to maintain strong primary care and clinical representation and retain leadership and capacity in commissioning and system working at all geographies from Place, ICP and ICS. As PCN leadership focuses on smaller geographies, systems must also ~~to~~ continue to support PCNs to ensure that they have sufficient capacity to fulfill their important roles within communities and maximise their future potential.

If option 2 is progressed, there is a good case for some form of statutory oversight arrangement that would include health and care representatives (including primary care) to which ICSs would be accountable. This oversight body/committee could also advise the ICS Board on integrated commissioning and the application of the subsidiarity principle. As part of these arrangements, there would also be a need to address the democratic deficit that would otherwise exist at ICS level, through appropriate political representation, supported at Place level by existing statutory Health & Wellbeing Boards.

4. Commissioners and Providers working together:

We would welcome the contractual and quality assurance relationships between commissioners and providers to be invested in Place. This would also lead to a more integrated, sensitive responsive and impactful relationship between commissioners and providers and more appropriately enable co-production on priorities and improving outcomes. This would include acute and community providers.

The NHS legislative framework has been centred around the notion that competition between organisations is the way to improve the quality of services. This has been demonstrated not to be the case as competition has bred inefficiency and inequality in the health system.

Some provider needs may now be better served in provider partnerships at sub-ICS levels (ICPs).

How providers are enabled to collaborate in ways that meet the needs of people served by local systems will need to be explored further. The paper tips the balance away from competition and towards collaboration and a key focus going forward should be the removal of barriers to joint working.

Greater clarity is needed on what accountability framework will be in place to ensure that organisations across provider collaboratives are jointly accountable for the decisions that they make whilst retaining their own accountability as single provider organisations.

Local NHS organisations, local authorities and the VCS have been seeking better ways of working together for a number of years despite the existing legal framework. It is imperative that local areas are enabled to build upon the progress that has been made in recent years as well as the working arrangements that have been established at Place - bringing together service provision, strategic commissioning and clinical leaders to improve the health and wellbeing of the communities they serve.

5. **Local Authority as a Key Partner:**

Local authority input is key - both political and executive leadership. Although the national paper has been health driven, it does make references to the important role that local government has to play at both at place and broader geographies. This needs further work to involve Social Care and Public Health within local authorities, adopting a co-production approach. There is a need to build upon existing relationships with local Health & Wellbeing Boards as the statutory bodies that oversee working at Place. Recognition is also required of the role of Overview & Scrutiny Committees, both at Place level and broader geographies (such as the Joint OSC for the North East & North Cumbria ICS & North & Central ICPs). More detail is also needed on how the commitment to build upon existing arrangements at Place will be taken forward.

It will be important that any legislative changes that are introduced relating to the NHS does not create a barrier to existing or new joint commissioning arrangements with local government; rather they should be framed in such a way that they support and enhance integrated health and care commissioning at Place.

There is little reference to the broader aspects of wellbeing (i.e. the wider determinants of health) or the role of councils in relation to economic and social drivers of health and wellbeing and how this will interface with the NHS going forward e.g. progressing social value and community wealth building approaches. This is key in responding to the significant health inequality challenges faced by local areas and tackling unequal access to services and opportunities which have been exacerbated by the pandemic.

6. Place based partnership:

Place based partnership arrangements need clear accountability to Health and Wellbeing Boards (mirroring the primacy of place principle) with devolved budgets and teams to address health inequalities. The commitment to delegate significant budgets to place level is welcomed, although greater clarity is needed on how this will be done in practice and on what basis decisions will be made.

Place based working should be led by senior health and social care professionals, and there should be strong primary care clinical representation on Place based statutory committees so that we do not lose the benefits we have had in CCGs.

The pandemic has further demonstrated the value of local partnerships; it is imperative that we build upon these successes. The Gateshead Health and Care System has been the subject of an LGA good practice case study on its collaborative leadership approach during the pandemic and we are currently working on the development of an Alliance Agreement for Gateshead which will set out key deliverables and our future direction of travel for a number of work programme areas.

Further information is needed on how local commissioning and reviews of services would be undertaken in the future arising from the proposals within the consultation document and what input local areas will have in these arrangements to ensure that they are consistent with local priorities and meet the needs of their communities.

7. **Sub ICS localities:**

Although Integrated Care Partnerships (ICPs) are not referenced within the consultation document, we wish to continue and evolve the NENC ICP North (within our ICS) building upon existing relationships which are valued by local partners. We wish to explore how it can best work with local authority collaboration (e.g. our LA7) so that we can maximise the national and local influence of our partnerships. The interface between Place and broader geographies should also be shaped through a co-production process.

8. **ICS:**

Whilst some health, care and wellbeing activity, such as specialist commissioning, can be carried out more effectively at a significantly broader scale, it is not the case for much activity. There is the danger that a large ICS, remote from place, can lead to a model whereby the broader system decides. Full consideration needs to be given therefore to what can be commissioned at Place in conjunction with local health and care partners, including local authorities, in line with the subsidiary principle.

We want to ensure as much budget goes to the frontline as possible so we need to be careful of large regional, ICS and ICP teams when our priority is about planning and delivery at Place. NENC is the largest ICS and we want to enable it to influence the national and regional agenda but because of the distance from place we do feel it needs to be a lean ICS. We would also encourage devolution of regional teams and functions to the ICS or lower levels.

The consultation paper refers to permissive arrangements within ICSs to shape and design their own governance arrangements to best suit population needs. A focus on governance around Place and at ICP level will be key.

As part of these arrangements, it is imperative that the voice of individual local areas is not lost within the ICS. More detail is needed on how this can be achieved in practice and the arrangements that will be put in place to ensure their voices are fully heard.

9. **Wider partnership:**

We want to ensure there is true (and equal) partnership at all levels including Local Authority, Primary care, Specialist providers, Education providers, HealthWatch, VCS and arms lengths bodies. We need to maintain our focus on long term aspirations such as prevention and reducing inequalities, essential in tackling the broader determinants of health and wellbeing. The paper's focus on population health and outcomes is to be welcomed.

Responses to the specific consultation questions

Qn 1: Do you agree that giving ICSs a statutory footing from 2022, alongside other legislative proposals, provides the right foundation for the NHS over the next decade?

This question, as worded, only focuses on the NHS. What is needed are better foundations for the NHS, Social Care and Public Health to work together.

Health and care integration is ultimately about relationships, not structures, and we have seen various changes in structures in the past, sometimes underpinned by legislation. Any further statutory change to structures needs to recognise the importance of ensuring that decision making remains as close to the public and patients as possible. This needs to be supplemented by support to system leaders across health and care to work collaboratively, with a focus on reducing health inequalities, achieving population health outcomes and devolving power and resources to Place where there are opportunities to do so.

The NENC ICS covers a large footprint encompassing thirteen local authority areas and each of these Places within the ICS must continue to have a strong voice and partnerships which are responsive to their population.

The litmus test should be how ICSs will facilitate, support and enable place-based collaboration to address locally identified priorities in response to the needs of local communities.

Qn2. Do you agree that option 2 offers a model that provides greater incentive for collaboration alongside clarity of accountability across systems, to Parliament and most importantly, to patients?

It is important that local government and the VCS are seen as equal partners to the NHS if opportunities and incentives for collaboration are to be maximised. It is not clear how a corporate statutory NHS body can be a partnership body which relates to all constituents in the health and care system. For instance, there is a danger that systems (above place level) will not incorporate the wider perspective from local government and other partners on the role of social care, public health, housing, early years, community wealth building and other local government functions in ICS plans and strategies.

It is imperative that local relationships that have been built up over the years with CCGs and other partners are not lost. That means that whatever proposals are taken forward for ICSs (and their knock-on implications for CCGs), specific assurances and more information is needed on how those relationships, as well as the expertise that those relationships have brought, can continue to form a key component of future working arrangements at Place.

Further information is also needed on how local commissioning and reviews of services would be undertaken in the future and what input local areas will have in these arrangements to ensure that they are consistent with local priorities and meet the needs of their communities.

If option 2 is progressed, there is a good case for some form of statutory oversight arrangement that would include health and care representatives (including primary care) to which ICSs would be accountable. This oversight body/committee could also advise the ICS Board on integrated commissioning and the application of the subsidiarity principle. As part of these arrangements, there would also be a need to address the democratic deficit that would otherwise exist at ICS level, through appropriate political representation, supported at Place level by existing statutory Health & Wellbeing Boards.

Given the comments outlined above, it would also be important that commissioning talent and experience of Place currently held by CCG staff is retained.

Qn3. Do you agree that, other than mandatory participation of NHS bodies and Local Authorities, membership should be sufficiently permissive to allow systems to shape their own governance arrangements to best suit their populations needs?

In an ICS that covers such a large area as the North East and North Cumbria, permissive governance arrangements that work locally and have support of local partners will be essential to a strong functioning system.

It is very important, therefore, that health and care systems have the necessary freedoms and flexibility to determine their own membership, beyond any statutory minimum set. To this end, there should be stronger emphasis on enabling system governance arrangements to build upon and enhance existing place and neighbourhood arrangements. It follows that they should not bypass, undermine or duplicate existing governance arrangements at Place. HWBs should continue to be the key place based statutory decision-making body but with an enhanced role in representing Place, in addressing local health inequalities and shaping broader ICS arrangements.

Q4. Do you agree, subject to appropriate safeguards and where appropriate, that services currently commissioned by NHSE should be either transferred or delegated to ICS bodies?

If ICSs were to become statutory bodies, this would clearly impact upon the role of NHSE so it would be important that there is absolute clarity on their respective roles going forward. It would also be important that arrangements for the future commissioning of services currently undertaken by NHSE embraces a holistic view of health and care and that there is appropriate accountability built in as part of those arrangements from the very outset. In particular, it is felt that there should be emphasis on and a commitment to delegating any commissioning that can best be done at place level, ensuring the application of the principle of subsidiarity previously mentioned.

Please note that the following pharmacy will change its hours as indicated below:

L Rowland & Company (Retail) Limited
t/a Rowlands Pharmacy
Former Five Star Batteries, Meresyde, Leam Lane, Gateshead NE10 8PE

Existing hours

Days	Contracted Hours	Supplementary hours (if any)	Total hours
Monday	09:00-13:00; 14:00-17:30	08:45-09:00; 13:20-14:00; 17:30-18:00	08:45-13:00; 13:20-18:00
Tuesday	09:00-13:00; 14:00-17:30	08:45-09:00; 13:20-14:00; 17:30-18:00	08:45-13:00; 13:20-18:00
Wednesday	09:00-13:00; 14:00-17:30	08:45-09:00; 13:20-14:00; 17:30-18:00	08:45-13:00; 13:20-18:00
Thursday	09:00-13:00; 14:00-17:30	08:45-09:00; 13:20-14:00; 17:30-18:00	08:45-13:00; 13:20-18:00
Friday	09:00-13:00; 14:00-17:30	08:45-09:00; 13:20-14:00; 17:30-18:00	08:45-13:00; 13:20-18:00
Saturday	09:00-11:30	11:30-12:30	09:00-12:30
Sunday			
Total Hours per week	40hr	7hr 5min	47hr 5min

Revised hours with effect from 1st February 2021

Days	Contracted Hours	Supplementary hours (if any)	Total hours
Monday	09:00-13:00; 14:00-17:30	13:20-14:00	09:00-13:00; 13:20-17:30
Tuesday	09:00-13:00; 14:00-17:30	13:20-14:00	09:00-13:00; 13:20-17:30
Wednesday	09:00-13:00; 14:00-17:30	13:20-14:00	09:00-13:00; 13:20-17:30
Thursday	09:00-13:00; 14:00-17:30	13:20-14:00	09:00-13:00; 13:20-17:30
Friday	09:00-13:00; 14:00-17:30	13:20-14:00	09:00-13:00; 13:20-17:30
Saturday	09:00-11:30	11:30-12:00	09:00-12:00
Sunday	None	None	Closed
Total Hours per week	40hr	3hr 50min	43hr 50min

Please note that the total hours column represents the times that a pharmacist will be available to the public.

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Please note that the following pharmacy will change its hours as indicated below:

L Rowland & Company (Retail) Limited
t/a Rowlands Pharmacy
76-78 Saltwell Road
Gateshead
NE8 4XE

Existing hours

Days	Contracted Hours	Supplementary hours (if any)	Total hours
Monday Tuesday Wednesday Thursday Friday Saturday Sunday	09:00-13:00; 14:00-17:30 09:00-13:00; 14:00-17:30 09:00-13:00; 14:00-17:30 09:00-13:00; 14:00-17:30 09:00-13:00; 14:00-17:30 09:00-11:30 None	13:20-14:00 13:20-14:00 13:20-14:00 13:20-14:00 13:20-14:00 11:30-12:00	09:00-13:00; 13:20-17:30 09:00-13:00; 13:20-17:30 09:00-13:00; 13:20-17:30 09:00-13:00; 13:20-17:30 09:00-13:00; 13:20-17:30 09:00 – 12:30
Total Hours per week	40hr	3hr 50min	44hr 20min

Revised hours with effect from 1st February 2021

Days	Contracted Hours	Supplementary hours (if any)	Total hours
Monday Tuesday Wednesday Thursday Friday Saturday Sunday	09:00-13:00; 14:00-17:30 09:00-13:00; 14:00-17:30 09:00-13:00; 14:00-17:30 09:00-13:00; 14:00-17:30 09:00-13:00; 14:00-17:30 09:00-11:30 None	13:20-14:00 13:20-14:00 13:20-14:00 13:20-14:00 13:20-14:00 11:30-12:00	09:00-13:00; 13:20-17:30 09:00-13:00; 13:20-17:30 09:00-13:00; 13:20-17:30 09:00-13:00; 13:20-17:30 09:00-13:00; 13:20-17:30 09:00 – 12:00
Total Hours per week	40hr	3hr 50min	43hr 50min

Please note that the total hours column represents the times that a pharmacist will be available to the public.

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Item 9.3

NHS E/I Notification of Temporary Change to Opening Hours
Boots Pharmacy, Cameron Walk, Metrocentre, Gateshead

Please be advised that the pharmacy above is currently operating reduced hours due to COVID 19.

It is expected that the pharmacy will revert to usual opening on 20th February 2021. Should there be any change to these plans NHS E/I will advice you at the earliest opportunity.

Existing Hours	**Revised Hours**
Monday: 09:00-21:00 Tuesday: 09:00-21:00 Wednesday: 09:00-21:00 Thursday: 09:00-21:00 Friday: 09:00-21:00 Saturday: 09:00-19:00 Sunday: 11:00-17:00	Monday: 09:00-18:00 Tuesday: 09:00-18:00 Wednesday: 09:00-18:00 Thursday: 09:00-18:00 Friday: 09:00-18:00 Saturday: 09:00-18:00 Sunday: 11:00-17:00

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