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

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

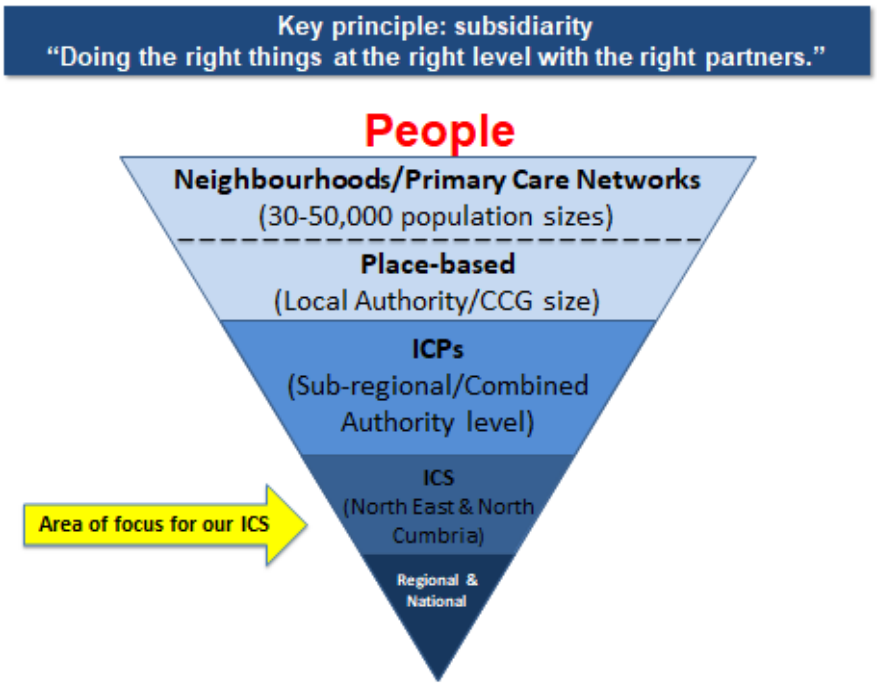
Timing of the Consultation

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.