Appendix 2 - Nottinghamshire County Council response to NHSE/I consultation paper

Comments on Purpose (Section 1)

- The Council supports the objectives and supports the ICS Board moving to a statutory body. However, it does not support the creation of two statutory bodies in the County of Nottinghamshire and would therefore expect to see one Statutory ICS Board for the County and its residents.
- The Council fully agrees with the principles of a place-based approach and strongly supports the principle of a greater focus on population health needs and health inequalities in NHS commissioning and planning. It is not clear what this means in practice and how the statutory powers of the new body will be exercised to enable place worked partnership working.
- The Council would want to see further detail about how NHSE/I nationally and regionally will devolve decision-making to the ICS and powers, or budget of the CCG and newly formed ICS would be devolved. This detail would enable the Local Authority to have a view as to how Integration of Health and Care would be developed within the new Statutory Body.
- The paper refers to 'system' when what it actually means is the NHS providers and commissioners in a particular area. This is a different set of relationships in what the Local Authority would consider the Nottinghamshire system. It would be helpful to describe this as the health system.

Comments on Putting this into Practice (Section 2)

In paragraph 2.18, the paper described the NHS identifying a place leader who would:

- *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.*

- This function would sit well as a practical vehicle for the NHS to take forward the Nottinghamshire Health and Wellbeing Strategy and to translate the Joint Strategic Need Assessment (JSNA) into practical action in local areas. This is welcomed.
- The population health profiles are a key tool and the work undertaken with interoperability and the successful DAIT strategy in the ICS are key enablers here.
- A focus on commissioning for improved health outcomes and addressing health inequalities is fully supportive and a positive step. Clearly, this is a huge shift in patterns of planning and commissioning, and further detail is required to understand how this would happen in practice and how the ICS Board would shape that approach.

In paragraph 2.22, the Paper sets out the NHS's offer to local government:

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

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

- The role of the Health and Wellbeing Board needs to be strengthened in this thinking and the governance formalised to ensure the ICS delivers to local health priorities.
- Services, whether commissioned or provided, are best placed to link at neighbourhood level to deliver personalised care and support based around families and communities. It is not clear how system working at a strategic level will enable integration at place to support more effective personalised care.
- The role of the person in planning their own care and coproduction in strategic planning is evidenced as effective. Greater emphasis on how this will be supported and developed would be welcome.
- Partnership with wider partners that have a role in health, housing or care for adults, children and families are central to system thinking and approach. This

is a large and complicated set of relationships and partners to manage. This takes time, a culture of partnership and agile ways of working. There is huge variation in the success of this work. The intention is welcome but will take clear commitment and objectives to deliver this ambition.

The paper sets out:

As part of this, each system should define: 'place' leadership arrangements. These should consistently involve:

i. every locally determined 'place' in the system operating a partnership with joined-up decision-making arrangements for defined functions;
ii. 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; i
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.

- There is clearly an opportunity here to shape places as it makes sense to residents and be clear as to what activity takes place in what partnership or ICS level. For the County, the work must tackle planning at population level that incorporates Bassetlaw, and a focus on neighbourhood and PCNs that reflect local people and their lives, rather than boundaries of services
- It is not clear how this will enable a focus on population and place-shaping, and Health and Wellbeing Board will be an important component of ensuring that happens.
- The County Council would be looking for the ICS to add value in terms of supporting the shift in commissioning away from service consumption and transaction to relational commissioning for health outcomes.

Comments on Legislative Proposals (Section 3)

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

Yes. This is important if the NHS wants to move to a systems approach.

It is not clear how the Local Authority would relate its democratic decision-making to the body in practice. Clarity about the level of delegation with the NHS and expected accountability would be needed for the LA to determine the possibility of the relationship in driving integration and/or place based approaches.

The Local Government Association has made a response to the consultation (https://www.local.gov.uk/parliament/briefings-and-responses/lga-response-nhs-england-and-nhs-improvement-consultation) and has called on the government to introduce a number of duties and powers in support of greater integration, place based working and local accountability, and to deliver the principles identified by the LGA, the NHS Confederation, NHS Clinical Commissioners, NHS Providers, the Association of Directors of Adult Social Services (ADASS) and the Association of Directors of Public Health (ADPH) that must underpin effective integrated care. They are:

- collaborative leadership
- subsidiarity - decision-making as close to communities as possible
- building on existing, successful local arrangements
- a person-centred and co-productive approach
- a preventative, assets-based and population-health management approach
- achieving best value.

The Council supports the LGA response.

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

- No, not necessarily. There is still a great deal of work to address the different working styles, culture and practice that enables integration to happen in places.
- Option 2 does give greater accountability for strategic commissioning and NHS budgets/governance and is more consistent with a top down approach of the NHS, but not of collaboration.
- The consultation document is not clear on delivery and how the objectives will be realised through the two options proposed. The Local Authority has a role in both options, but without the detail of what this looks like it is difficult to assess the implications for it.
- The role and boundaries of the CCGs (there are two in Nottinghamshire) are not explicit in the paper. It is not clear if Bassetlaw CCG would become an ICS in Option 2 for example, or what the role of the CCGs are in option 1.

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

- Yes. The right people need to be in the room to make decisions and there is local variation due to different commissioning approaches on who the key providers and partners are. Patient groups, user led organisations, local politicians, councils and VCSE need to engage in the right parts of the ICS to make a meaningful contribution.
- Due to ICS boundaries not matching council boundaries, this needs to be locally determined rather than centrally defined.
- For example, in Nottingham and Nottinghamshire the ICP for Nottingham is a relevant planning footprint for the City Council and City partners. The ICPs in Nottinghamshire are less relevant, as are the two ICSs, as they do not match. However, the PCNs make sense on an operational planning footprint for integration around the person's life.

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

- Yes. The underlying principles cannot be achieved without this. We welcome the lead Accountable Officer role with similar duties for system leadership with local authority statutory roles.
- The ICS has the potential to offer a place for wider partnership, especially in public health, health, housing and care.
- The Health and Wellbeing Board remains the key statutory body for integration and county-wide population health planning through the JSNA and associated work programme. The BCF is a key element of the work.
- The JSNA and Health and Wellbeing strategy should drive ICS priorities and strategic commissioning
- PCNs are a place to build neighbourhood approaches with partners to meet need and new ways of working. There is a huge opportunity in mental health. Bassetlaw ICP is a useful planning footprint as it makes sense to people and partners. Further work is needed to understand activity at place level and what value an ICP can add.