NHS
Portsmouth
Clinical Commissioning Group

Portsmouth
CITY COUNCIL

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Dear colleague

Integrated Care - next steps to building strong and effective integrated care systems across England

Thank you for the opportunity to comment on the proposals in "Integrating Care - next steps to building strong and effective integrated care systems across England."

In Portsmouth, we are supportive of many of the purposes and general principles set out in this paper, particularly the recognition of the importance of place-based care and deeper integration of agencies. Our appetite and commitment to this is a real strength in our city. Whilst we have made significant progress, we are enthusiastic about proposals to embed this approach more widely - we believe that there are significant contributions we can make to the development of these approaches based on our experiences and learning.

We understand that some decisions need to be taken at scale through Integrated Care Systems as advocated in the paper. We have concerns, however, that many of the mechanisms that will enact these principles are as yet not clearly defined. The paper also appears seriously to misunderstand the scale and significance of the system management and decision making which are required at levels of geography smaller than an ICS if good health and wellbeing are to be developed and maintained for everyone.

We believe that with an appropriately broad vision of health and wellbeing, a commitment to reducing health inequalities, and a skilled and sensitive operation of local determination in accordance with the principles of subsidiarity, it should be possible to achieve the ambitions set out in this paper. It is essential, however, to approach this task with care, avoiding superficial assumptions and by listening to the voices of those who understand needs of local populations and have experience in addressing them. If this careful approach is not taken, there is a risk that beneficial integration, across a wide range of health and care partners, is unpicked, and outcomes are jeopardised. Locally, we have

been on a journey to develop broad and deep integration in our local health and care system, under the banner of Health and Care Portsmouth and working to our locally developed Blueprint for Health and Care in Portsmouth. This encompasses the four fundamental purposes set out in the paper (1.3) and the observations reflected at 1.9. We have been clear that our ways of working are about delivering on commitments to our residents to put them at the heart of our system and focus relentlessly on their experiences and outcomes.

We have many examples of how we are integrating and designing services around our residents to better serve the population. We understand how to make community and primary care work for our population, and understand what needs to be done to make it better. We believe that there are services and needs that are appropriately organised on a wider footprint, and look forward to supporting the discussion about these as it develops. However, we also strongly believe that as a local system, we should retain the discretion to serve the population according to need and what works for residents, rather than applying superficially "consistent" templates[1].

We welcome the opportunities afforded by the proposals to strengthen this place based delegation and strengthen the integration within the City boundaries, utilising and further strengthening the budgetary delegations already in place through the Better Care Fund S5 pooled fund arrangements. We would welcome opportunities to share our learning on these areas and would be happy to meet with NHSE/I colleagues to discuss some of our examples in detail and the possibility of being considered for any 'early adopter' approaches to delivering truly delegated place based care.

In broad terms, we can provide the following feedback:

1. Devolution of function and resources

We welcome the commitment to the principle of subsidiarity (2.21). Within this, we are supportive of proposals that enable an ICS to lead on certain functions at a wider system level and have put in place measures for a strategic commissioning board at ICS level. We believe that there is great value from the wider footprint working on the development of the workforce - particularly given the known challenges for the future - and specialised commissioning. The expertise required to deliver on some of the low-volume but high-complexity health and care issues experienced by some of our residents is not replicable at a smaller place level and it makes absolute sense for this to be managed at a wider geography. The relationship between wider geography and population scale and identity is worthy of greater attention; the Paper has a tendency to over-use 'system' as a convenient catch-all where greater rigor will be needed if meaningful devolution is to be delivered. Indeed, the 'system' envisaged at ICS level for us locally is not in any way a meaningful system in real life (particularly not to the wider public) - it is instead a series of nested/related systems that local partnerships have blended to ensure there is cohesion. We are clear that much of the work that impacts on the day to day experience of residents

[1]Our experience has been that standardisation mandated from the centre tends to create sub-optimisation, as it cannot readily absorb variety. If the sub-optimisation becomes too stark, managers and staff start to devise workarounds. Even in a city as geographically small as Portsmouth, wherever there are locality models there are differing approaches that develop over time, based on staff perception of what is most appropriate locally. This is where the gulf develops between work-as-imagined (by leaders), work as prescribed (by commissioners) and work-as-done (by staff).

is organised and delivered at a much smaller footprint than ICS, whether that is within community and primary care network level, the boundary of the city or across the hospital system. This makes sense to us currently, and despite the various assertions, it is not clear how this local focus and cohesion will be maintained in terms of ensuring close contact with the locality and ensuring resources flow accordingly.

It is also the case that many of the issues that impact on health sit outside the formal health system (the wider determinants) and are organised and addressed on local place footprints - for example, housing or community support. Again, it not clear from the proposals how the local place-based arrangements will be empowered to take full advantage of what integration at that level can bring. Community and primary healthcare are interdependent on a whole range of wider community resources, including social care, schools, housing, leisure provision and the local network of voluntary and community provision. In Portsmouth city, there is a complex set of relationships and local understanding of these relationships has been built up over decades. There needs to be local flexibility to continue to develop and nurture the system that is right for the place, recognition that all places are different, and that different models are at different points in their maturity.

There is also a linked issue around local accountability which is fundamentally important to the effective coalescence of the NHS and local authorities. The resource directed by the ICS should be linked explicitly to those issues that are best planned and delivered at that ICS level. Within the spirit of subsidiarity, perhaps this should be devolved to the ICS from local places, not the other way around as the paper infers? This means recognising the strong part that local authorities play, as service commissioners and providers and democratically accountable advocates for their communities. One of the values of local commissioning is to fully understand the ways that services are experienced, and also where they are not meeting a need. A system that dilutes this locally-based intelligence and advocacy for those with poorer experiences will be poorer overall, and already failing in the purpose of improvement. For example, the interface between social care services and early help and prevention is critical, and needs to be worked through locally.
This brings challenges around mandate. Decision-makers in local authorities have a direct democratic mandate from their local electorate, and tensions within the system that this may bring are best resolved in the local system. Local health systems have already started to think through how this works in the development of health and wellbeing boards, and these boards have understandably developed differently to reflect different local circumstances and dynamics. In all cases, HWBs have had regard to the line of decision-making and resource allocation back to local governance bodies.

In Portsmouth, this is recognised in an explicit acknowledgement of the important interplay between the clinical, political and executive strands of leadership and decision making necessary for a local system to function effectively and collaboratively. Clarity about this triumvirate interplay in decision-making is essential; the proposals in the paper discuss governance, but have not clearly reconciled this, particularly at the ICS level. This leaves unanswered important questions including, for example, the future role for Health and Wellbeing Boards - will these be the local, place-based governance? Or will there be an additional body? How will health overview and scrutiny functions work? How will the political, clinical and executive voices be heard and be reflected in decision-making at the ICS tier? It is not only the local "place-based" governance proposals that must be developed on a footprint that makes sense when viewed through the lens of local

democracy and accountability. It will be important to demonstrate how the duty placed on ICS leaders (2.42) '*to deploy resources to protect the future sustainability of local services and to ensure that their health and care system consumes their fair share of resources allocated to it*' will be guided by clearly evidenced equity models and be held to democratic account. Hopefully, the expectation on ICS leaders to delegate significant budgets to place level (2.42) will assist this; protecting the sustainability of local services is a laudable aim if those services address the prioritised needs – if not it could be a recipe for status quo.

2. Place: an important building block for health and care integration

We strongly believe in 'the place' as a building block – if not the keystone. We consider that for Portsmouth, a key 'place' that works as the core of most health and care planning is the city level. The hospital footprint is, of course, another level of place which is important and the basis of our current Integrated Care Partnership.

At city level, through our shared working, we have gained an understanding of the challenges faced by our population, and how these manifest themselves. We have developed responses to address this and collaboratively have allocated resources accordingly. This means that in some areas (for example, mental health services for young people) we are now doing things differently to better address local need. We understand the intentions around wanting to ensure that there is equality of access and outcome, but we are concerned that this can suggest a homogeneity of response across a system. What is actually needed is equity in how communities are understood, advocated on behalf of and responded to by decision-makers. This is achieved by allowing resources to be directed as flexibly as possible at the lowest possible level of geography, not necessarily by aggregating and 'levelling'.

The issues of equality/equity are also about measurement - how will performance be measured and understood in future? There doesn't appear to be anything in the document about requiring ICSs to consider outcomes at a local (city) level, nor any obligation then to address areas where outcomes and priorities are different.

In maintaining a sense of place, the GP representation currently on CCG Boards provides a vital local voice expressing the experience of the patients in the place that the GP's work in. GP representation on CCG Boards is structured to ensure direct representation between patient experience and healthcare commissioning and provision. GP colleagues are often best placed in their communities to implement digital tools that work well for patients. In Portsmouth, the 'responsible clinician for care home' role has enabled a local focus on the needs of vulnerable patients and support to reduce unnecessary conveyance. These tailored responses to local needs could be diluted by local arrangements being removed to a larger geographical level.

We have seen care pathways constructed in response to out of hospital care during the pandemic that have worked successfully because they are recognised to meet locally observed need (and demonstrate the clear value of shared recording systems that enable better informed clinical decisions and avoidable conveyance).

Ensuring that local areas retain autonomy to decide on appropriate provider collaboratives and leadership and respond to local challenges can ensure public involvement and insight to inform decision-making, using tools such as citizens' panels, local health champions,

and co-production with people with lived experience. Systems should make particular efforts to understand and talk to people who have historically been excluded. Again, we would argue this is often best achieved at the smallest local level, where local community voices can represent their communities.

The delivery of Continuing Health Care; rapid response; reablement and rehabilitation; out of hospital pathways; care and support to people with severe mental illness; commissioning and delivery to people with a Learning Disability are all currently delivered in Portsmouth through a truly integrated, one team approach, based on advanced partnership relationships between NHS commissioners, NHS providers, local support providers and the Local Authority. To recreate an eco-system such as this at a regional level that is accountable to local patients would be overly complex and challenging and likely to lose the richness of local design and response.

A sense of place is also embodied in VCS providers. The heart of many communities are voluntary organisations and many of the city's Better Care Fund Contracts depend on local, grassroots VCS organisations that would not gain representation at a regional/ICS level. There is a need for both autonomy and, of course, accountability, for place based commissioning and provision to ensure that these relationships continue to be available, are able to flourish and they are part of the feedback into health and care.

3. Developing provider collaboration at scale

In Portsmouth, we have a strong provider partnership in the 'P3' arrangement (Portsmouth Provider Partnership), and our commentary here reflects these arrangements.
The Portsmouth Provider Partnership welcomes and unreservedly supports a move towards cooperation and collaboration, with responsibilities devolved to place based partnerships. Within Portsmouth we have been working within a virtual Multi-speciality Community Provider (MCP) framework, which is now a Provider Partnership that spans primary, community, secondary, voluntary and social care. We believe that a focus on collaboration over competition, allowing providers to work together to transform services in a way that minimises the need for resource intensive competitive procurements, is the right approach for our city. As with the wider proposals, we would of course want to clearly understand the mechanisms that will enable and support the delegation of budgets, assurance processes and contractual obligations and would appreciate early sight of the detail behind those.

Our provider partnership is comprised of clinical and managerial leadership spanning health and care in the way described within the consultation paper (representation is detailed below), all with a strong insight into what is needed within Portsmouth. Functioning networks that ensure broader system leadership at ICP level, surrounding our acute Trust, are also well embedded, providing the right level of challenge and support to the planning and provision of care across Portsmouth and South East Hampshire. Strong local leadership is enabling the voice of patients to be heard throughout, from the voluntary sector and patient representative bodies (such as Healthwatch) through Primary Care with PCN and CCG Clinical Leads and through to our Primary Care Alliance, Community Trust and Acute sector. The focus, driven by local leaders, on making tangible improvements to what we already have and from the perspective of person-centred care provision is already enabling inspiring and efficacious innovations to take shape.

Whilst we welcome reform and progress around the mechanisms that will support greater collaboration, particularly in removing bureaucracy and organisational barriers, the most important element is the establishment of effective and trusted relationships. We do not believe this can be effectively achieved at a scale as broad as Hampshire and Isle of Wight and would therefore strongly urge that a significant proportion of what is currently managed at CCG level continues to be managed at 'place' - for us, the city. The Portsmouth Provider Partnership arose from our virtual MCP, within which significant progress has still been made around many of the Long-Term Plan commitments (outside of any formal statutory change). It is vital that these relationships can continue to flourish and that the programme isn't destabilised as part of the reforms. It is also important that the role of non-statutory NHS bodies is recognised and can be included as an equal partner in the proposals for provider collaboratives.

There are a number of unanswered questions in the consultation regarding Governance arrangements and these are important issues, for example on the process for making financial allocations, the rules under which they are governed (for example management of risk and the extent of budgets) and to whom they are delegated to (or from) at a place based level.

In respect of the specific questions in the paper:

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?

As the paper states, there are things best done at an ICS level and a statutory footing (Option 1 or 2) may be the best way to achieve these objectives; but this should take care to safeguard the primary principles, including subsidiarity and the delegation of funding to place.
The wider vision and system within which such legislation operates is absolutely crucial, however. As we have set out, it is essential to understand how place based health and care systems connect health and care providers, improve outcomes and put the citizen at the heart of their own care. A deep understanding and promotion of place based arrangements within the accompanying guidance would conform to the route map set out in the NHS Long Term Plan and support the aspiration for health and care (and the wider determinants of health) to be joined up locally around people's needs.

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?

Incentivisation by statute is a sad place to start. People will be incentivised through the knowledge and belief that their choices in designing and deploying the systems and resources will meet the evident needs of the communities they work for and feel part of. The statutory duty to develop, comply with and deliver an ICS plan signed up to by the mandatory members (Option1) would appear to offer a similar surety for collaboration and accountability via the ICS AO as Option 2. This option would also appear to enable collaborative commissioning and provision between NHS bodies. Neither should be confused with incentive.

The delivery of some NHS services at scale will always be the most effective and efficient

option for public investment. However there is a necessity for a 'feedback loop' into commissioning and provision of services, bridging the current divide between commissioning and providers proposed by both Options 1 and Option 2. This ‘loop’ or a re-casting of the relationship into one which better reflects the need for feedback from patients/clients and constant tuning of the system and the services, will strengthen the relevance of both processes, but without a place based operation, input and outcomes can be more complex to demonstrate.

There is no detail in the proposals set out in the paper about the acute provider footprint that currently operates at an ICP level. If ICP footprints are considered important, and we believe they are, it would be helpful to give them a clear mandate in guidance including their relationship to the other ‘provider partnerships’ mentioned. In Portsmouth, we have developed a place-based provider partnership (‘P3’) which includes the hospital trust, the community trust, the GPs and the local authority. This will co-exist and collaborate with relevant emerging provider partnerships on other footprints.

The proposals indicate that population health management should inform decision making at all levels. This is welcomed. Recognising that skills and infrastructure to support this work may appropriately sit across a larger area is important, but utilising this approach in a tailored way at place level is key. To deliver a system fit for the future, prominence should be given to this programme. More detailed understanding of the governance arrangements that will support such an approach is needed, as well as the need to understand potential conflict of interests and to ensure that providers are able to reach decisions in the ‘common good’ rather than those based on individual organisational preferences.

The role of public health at ICS level is not articulated. A strong public health link to healthcare decision making is crucial at all levels in order to integrate a population approach. If strategic commissioning is a role of the ICS, it makes sense that public health is embedded within these arrangements as well as at place level. This is also important for quality assurance, for example around screening and immunisation programmes.

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?

Whether Option 1 or 2 or some hybrid, the level of representation of Local Authorities and provider bodies needs careful consideration. Whilst the Lower Tier Local Authorities (LTLA) have significant responsibilities pertinent to health and well-being, including housing, leisure and environmental health, Upper Tier Local Authorities (UTLA) have many more resources and responsibilities with which to serve the health and wellbeing needs of their local population. The character and nature of places differs in terms of the health and wellbeing needs of its population. Any Board constituted under either Option 1 or Option 2 needs to reflect the nature of local places as well as the region of the ICS. The leadership role of the UTLA Health &
Wellbeing Board and the scrutiny function of the Health Overview and Scrutiny Panel, is key to holding health and care systems to account on behalf of the local population. Political engagement from every UTLA (and appropriate relationships with the autonomous LTLAs) is therefore essential on any ICS Board, though it may be a better option to continue current arrangements which would most effectively be facilitated by Option 1.

There is also a question about how the breadth of local authority functions needs to be recognised. Local authority functions including housing, transport and regeneration have important roles to play in improving the wider determinants of health, for instance, recognising the impact of physical place on physical activity. It's this link which we would encourage the ICS to consider as a primary prevention measure with downstream impacts on healthcare activity. As a particular local example, Portsmouth has excellent partnerships with businesses and wider institutions across the city whose input into the work of Health and Care Portsmouth is significant.

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?

The range of services currently commissioned by NHSE cover a significant variety and scale of service provision including primary care commissioning (general practice, optometry and dentistry), through to specialist tertiary service provision. It is therefore unlikely that a one size fits all solution as suggested by transferring and delegating these services to the ICS will provide the most optimal solution. There needs to be consideration of the commissioning of these service in line with the overall aims of the paper - including the principle subsidiarity expressed at 2.21. So for primary care commissioning, for example, all three elements may best fit within an overall place-based budgetary delegation, recognising that the ability to respond and align these responsibilities is better served closer to local needs and decision making. However, for some of the more specialist services, it may absolutely make sense for these to be delegated up to ICS level. Some of the most specialist tertiary services may continue to benefit from a regional or national approach to commissioning.

In conclusion, would welcome early sight of the additional guidance and for a consultative approach to that as well. As previously set out, we believe that those working in Portsmouth can add value in developing a place-based approach and articulating some of the opportunities, and just as we continue to learn from the work and experience of other cities across the country, we would welcome a wider engagement. We also note that there is an ambitious timetable for change, and that this may be a challenge given the significant issues that are currently being addressed, and the scale of work that will be required around recovery. It is important that these changes do not detract from or destabilise operational delivery.

Yours sincerely

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On behalf of Health and Care Portsmouth