West Yorkshire and Harrogate
Health and Care Partnership

Friday, 08 January 2021

Dear Colleagues

Next Steps to building strong and effective integrated care systems: West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP) response

I am writing on behalf of the leadership of West Yorkshire and Harrogate Health and Care Partnership (Integrated Care System: ICS) in response to the document 'Integrating Care - Next Steps to building strong and effective integrated care systems across England'. Many of our partner organisations and collaborative forums will also be submitting their own responses. Attached at Annex 1 are our detailed comments structured around the consultation questions and the main themes of the document.

We support the general direction of travel set out, and we also recognise that there are risks around the next steps that must be overcome if we are to succeed. Our Partnership has developed in line with the particular circumstances of West Yorkshire and Harrogate, reflecting that the partners form the Partnership, and that it belongs to them. The Partnership strongly maintains our principles of subsidiarity, distributed leadership and the primacy of our local places. This has enabled us to keep the focus in the right place on people, focusing on population health, tackling inequalities and improving outcomes. Our Partnership is broad and inclusive, bringing together the NHS, local authorities, the voluntary community and social enterprise sector (VCSE) and Healthwatch. It is important that we are able to implement legislative change in a way that strengthens these relationships, arrangements and culture which are delivering improvements for our population. We also welcome the commitment in the document to give flexibility to develop arrangements to meet local needs. Given the variation of ICSs across the country – both in size and ways of working - it is essential that we have this flexibility. We are also ambitious to do as much as possible within local control, which larger ICS' like ours and others in the North are capable of doing.

Much of what is proposed reflects the way that we already do things in West Yorkshire and Harrogate – this is our reality and not a set of concepts. We welcome the continued focus on place, provider collaboration and system working. It fits well with our collaborative style of working, which is enabling us to make progress on our 10 big ambitions within the five year plan, and to deliver significant improvements for the people who live and work here. We strongly believe that effective system working must be based on all organisations looking at changes or proposals in terms of their impact on outcomes.

Several of our big ambitions relate to population health and health inequalities so we welcome this as a core principle. Through our Improving Population Health Programme we are embedding prevention and a focus on reducing inequalities across our system. Working as a system contributes to reducing demand and improving our financial and environmental sustainability. As part of our response to the consultation, we include a section on our role on population health, health inequalities, the determinants of health and responding to climate change.

Strong provider collaboration is vital. In West Yorkshire and Harrogate it has enabled us to deliver significant service transformation successes in acute care and mental, health, learning disability and autism. Our place and system partnerships have enabled us to respond effectively to the Covid-19 pandemic and support the stabilisation and reset of health and care services. Without this partnership approach across our neighbourhoods, places, providers and the ICS, we would not be able to tackle the wider determinants of health, such as housing, and economic prosperity, which have such a significant impact on health inequalities and the wellbeing of our population.

There are some areas in the document where we suggest that further thinking will be required. The document rightly highlights the importance of strong and effective place-based partnerships. It will be important that under new arrangements for ICSs that places continue to thrive. Clear leadership and accountability in place has been central to our success, enabling us to focus on the needs of our local communities and address health inequalities. Our clinical commissioning groups (CCGs) play a critical role at place level, leading on system integration, driving our population health-based approach, supporting with others the development of clinical leadership and ensuring clear and strong local accountability. We need to ensure that we have the flexibility to ensure that accountability, leadership capacity and skills at place level are not weakened by the proposed changes to our arrangements. Partnerships between local government and CCGs in our places are strong and maturing in ways which pay real dividends. The political and clinical leadership provided by our Health and Wellbeing Boards has been an essential part of our progress to date.

A further strength of the place-based approach is that it by gives local people a strong voice, enabling co-production with our communities, and ensuring clear local accountability. Our partnership with Healthwatch and arrangements like local patient and public representative groups and lay representation on CCG governing bodies are important in ensuring this. This is further reflected in public voice at every level of decision making. We must have the flexibility to ensure that this placed-based public and patient voice is retained, co-production with our communities is supported and we continue to benefit from strong public involvement in commissioning decisions.

The document points towards ICSs taking on additional functions, such as leadership on workforce issues as set out in the NHS People plan and commissioning for services that are currently commissioned by NHS England / NHS Improvement (NHSE/I). We support this direction of travel, and are keen to work with you as further details are developed, building on our strong partnerships with Health Education England and the regional universities. In doing so, we will want to ensure the significant investment put into the assessment, testing and development of these functions through NHS England and supported by KPMG is exploited. It will then be important that the resources and capacity to do the work move in line with changes in responsibilities. We are also keen to explore how ICSs can be a catalyst for positive change through identification and uptake of innovation.

The document rightly emphasises the importance of close partnership working between the NHS and local authorities at neighbourhood, place and system level. This is essential to ensure a population based approach to improving outcomes and tackling inequalities. These partnerships are at the centre of how we work in West Yorkshire and Harrogate across health and social care and we see them as key to our success so far. We suggest that a similar joined up approach to policy development is followed at national level. It is essential that new arrangements place the correct emphasis on the role of local authorities (including public health, social care and housing) and their relationship with the NHS as equal partners in delivering health improvements. I recognise that this is beyond the purview of NHS England and, in part, the DHSC.

Finally, and critically, we must not to underestimate the impact on staff and organisations of legislative change – particularly at a time when the response to Covid-19 is placing exceptional strain on our people. We had planned to retain five CCGs as key partners in our place based arrangements. Either option for legislative change would therefore lead to significant disruption for people who make a significant contribution every day. It will be important that we are able to give our staff certainty about their futures as soon as possible and to support them through any transitional period. We are clear that these staff will have much to offer in the future.

I have always appreciated the collaborative approach and the support we have had from NHS England / NHS improvement as an ICS. Nearly five years into these arrangements, as sustainability and transformation partnership (STP) and as an ICS, there is much to build upon and much more to do. We look forward to working with you further as the work develops on these important proposals to embed system thinking and system working in all we do.

Yours sincerely

Rob Webster

Rob Webster
Lead Chief Executive, West Yorkshire and Harrogate Health and Care Partnership

Annex 1: Detailed comments

Question: 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?

1. Significant progress has been made since the inception of ICSs, despite the current legislative framework creating barriers to effective partnership working by slowing down decision making processes. The legislative changes proposed, including those which would place ICSs on a statutory footing, have the potential to support our direction of travel in West Yorkshire and Harrogate and further strengthen our system. However, we believe that the focus on the NHS in the question – and the document more widely – is too narrow. Our response therefore focuses on the importance of creating the right foundation for system working at neighbourhood, place and W&H level across NHS, local government, VCSE and Healthwatch partners. This wider focus enables us to take a preventative approach focussing on community assets and determinants of health, thus helping us to manage future health and care demand.

2. Given that our partnership is a genuine collaboration of sectors and partners, we recognise the added value all can bring. Our partnership is an equal partnership of key stakeholders working to address all relevant health and care priorities from the wider determinants to new models of commissioning and this should be reflected in the new legislation. The risk of maintaining an NHS specific focus is also that we might lose our diversity of perspectives and revert back into a narrower healthcare paradigm that does not allow us to genuinely address inequalities and population health. We therefore propose that ICS legislation should be strengthened in relation to addressing population health. While some of these objectives are reflected in the ICS proposals, these are currently inadequately reflected in the detail of the proposals.

3. Legislation and formal structures are not sufficient by themselves to provide the right foundation for system working. Our partnership in West Yorkshire and Harrogate is based on mature relationships, trust and a strong partnership ethos. Distributed leadership and strong local places are at the heart of this approach. Working on relationships and leadership behaviours at system, place and neighbourhood level is as important as the governance and legislative framework. This requires time and effort and in order to be successful, we believe that any ICS will need to focus specifically on these relationships and leadership behaviours. It might be necessary to provide training in these skills to the leadership teams of the whole system in order to embed the concepts of distributed leadership, shared risk taking/responsibilities and creating a shared vision. Our existing BAME fellowship is one example where we have developed this type of training for our BAME colleagues to increase the diversity of our leadership; we would be delighted to share this work with other ICSs.

4. We would request greater clarity on how the legislative changes will enable good governance. These include the interface between organisation, place and system and how the primacy arrangements for these are decided, particularly when pressures increase with regard to financial matters, political differences or service challenges.

5. There needs to be greater attention given to ensuring meaningful local authority engagement, decision making and supporting governance processes. We would therefore welcome a strengthening of the relationship between governance and accountability relating to local authorities and the ICS; perhaps looking more closely at the role of the Health and Wellbeing Boards, which have a valuable role in the “place” governance and decision making processes.

6. It is critical that, within any new legislative framework, we have the flexibility to develop our detailed arrangements in a way that best meets our needs. Our Partnership has developed to meet the particular circumstances of West Yorkshire and Harrogate, reflecting our overarching principles of subsidiarity, distributed leadership and the primacy of our local places. It is important that we are able to implement legislative change in a way that strengthens and does not weaken the relationships, arrangements and partnership ethos which are delivering improvements for our population.

Question: 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?

7. Both legislative options potentially provide greater clarity of accountability at system level, but both are accompanied by risks. Option 2 creates a simpler governance and assurance structure and has the potential to strengthen WY&H-level accountability. The main risk is that it could be perceived as creating a 'top down' bureaucracy which will weaken the strong place-based leadership and accountability that the document rightly highlights as being key to effective partnership working. It will be important that the system-wide role of the ICS does not weaken our ability to work together at the most appropriate level to best serve differing populations. There are potential tensions that may arise as a result of the change in arrangements in terms of perceived power differentials between organisations. This poses risks in terms of an equitable partnership in the long term and specifically during a transition period. While not insurmountable, these risks should be addressed.

8. What is not clear to us is how the options outlined reconcile the primary duty of ICSs as securing health services alongside the stated objectives of improving population health, tackling inequality and supporting broader social and economic development. We would be keen to understand how ICSs will be accountable on these broader objectives. Particularly, a focus on commissioning or the NHS only could risk our work on the determinants of health becoming "deprioritised" by national partners.

9. Clear leadership and accountability at place level has been central to our success in West Yorkshire. Strong places enable us to focus the needs of our local communities and address health inequalities. Our CCGs play a critical role in leading system integration, driving our population health-based approach and supporting the development of clinical leadership at place and neighbourhood level and ensuring clear and strong accountability. It is critical that if option 2 is implemented, this place based accountability and presence remains strong.

10. The question rightly highlights the accountability of systems to patients, and at paras 2.36 and 2.37 the document emphasises the importance of lay people, residents and service users in governance structures. The providers within our partnership will remain directly accountable to the people they serve. From a commissioning perspective, one of the strengths of our place-based approach is that it gives local people a strong voice, for example through local patient and public representative groups, lay representation on CCG governing bodies and local Healthwatch. Our foundation trust memberships and governors are also invaluable.

11. It will be essential that placing ICSs on a statutory footing is accompanied by the flexibility to ensure that at place level there is a strong public and patient voice, including that of seldom heard groups and that we are able to retain and develop strong commissioning leadership, capacity and skills.

12. Under either option, a clear transition plan for staff affected by change will be critical. Clear communications that speak to patients and the public will also be vital. Each ICS will need to be able to tailor its communications to meet the needs of its local communities.

Question: 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?

13. Mandating participation of these organisations potentially sends a helpful signal regarding the importance of collaboration and the fact that this is a partnership within a system rather than an organisational construct in a hierarchy. It is also our view that it is not possible to mandate meaningful partnership working – this comes from leadership, relationships and trust.

14. Our successful partnership work in West Yorkshire and Harrogate has been built on a voluntary and inclusive approach to date. Our partnership has a very wide range of stakeholders including the NHS, local authorities, the voluntary and community sector, social enterprises and Healthwatch, all of whom are willing and active partners. Our Partnership would not be nearly as effective in improving population health and reducing demand for NHS services if it were not so broad in its membership. For example, our Mental Health, Learning Disability and Autism (MHLDA) collaborative 'lead provider' arrangements are founded on the principle of trying to reduce reliance on inpatient services, reduce length of stay and keep our patients within West Yorkshire. We can only do this if local authorities, VCSE groups and Primary Care Networks work in partnership to redesign services to meet people's needs. It is absolutely essential that systems have the flexibility to shape their governance arrangements to meet local needs

15. Local authorities in West Yorkshire and Harrogate are active participants in our partnership and local Health and Well Being Boards are central to our place-based approach. Their involvement is driven by a shared recognition of the need for us to work collaboratively to tackle the wider determinants of health, reduce carbon emissions, and improve outcomes, particularly for our most deprived communities. We are not clear how, in the absence of any legislative proposals, the participation of local authorities in statutory ICS arrangements can be mandatory.

Question: 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?

16. We broadly support the principle that services currently commissioned by NHSE should be either transferred or delegated to ICS bodies. We believe that there are clear benefits of developing service and pathways across an ICS footprint, with a collective understanding of resource and risk.

17. To ensure that ICSs can ensure coherence locally and that they have the capacity to deliver, we would urge the maximum devolution and/or delegation of central and regional NHSEI functions and staff. Recognising that we will work together across ICSs, including through lead ICS arrangements, building on our "four plus one" approach in NEY we think that this would put ICSs in the strongest position to succeed. If ICSs can also delegate some of their functions, e.g. to providers, this will help to reduce the transactional burden and support strong partnership workingAny change needs to be properly managed, to ensure that there is no shifting of risk, either financial or service related, without all parties being clearly sighted on the implications. Proposals to delegate functions to ICSs also need to be accompanied by a clear, shared understanding of the resourcing implications of ICS bodies taking on additional functions. It will be important that the resource and skill set is transferred from NHSE/I to enable this to happen

16. We recognise that the ICS footprint is unlikely to the right geographical footprint for planning of all services. For example some highly specialised services will need to be commissioned through groups of ICSs working together. We also recognise that commissioning of primary care services may be best delegated to place level.

Comments on the main themes

Provider collaboratives

17. We welcome the emphasis on providers playing a strong and active leadership role in systems, and joining up services within and across places and systems. We have a strong track record of collaboration involving all providers across health and social care. This approach is embedded in our working arrangements at both place and system level. The document focuses on statutory providers and perhaps underplays the important role that voluntary, community and social enterprise providers play.

18. We have developed successful models of provider collaboration at system level, including the West Yorkshire Association of Acute Trusts and the Mental Health, Learning Disability and Autism Collaborative. These collaboratives have already delivered significant service transformation successes, including stroke and vascular services, eating disorders and Child and Adolescent Mental Health services. They have also achieved significant benefits through shared approaches to procurement and a strategic approach to capital investment. We see a role for these collaboratives working together in the future as anchor institutions to play a role in addressing inequalities, embedding prevention and improving the determinants of health – one example for this is our healthy hospitals work which is in progress.

19. In addition to provider collaboration, we have also developed successful provider/commissioner collaboration models including the Cancer Alliance and Local Maternity System and have extended this approach to our Improving Planned Care programme. All of this successful collaboration has been in the context of statutory organisations working together, rather than replacing statutory organisations with new formal structures.

20. We strongly support the proposal that ICSs take on a greater leadership role in relation to workforce, as set out in the NHS People Plan. We were one of the key systems testing the operational reality of this and have done substantial work, supported by NHS England and KPMG, to test this out. We see this as one of the biggest opportunities of the ICS developments. Through our Health and Care Academy we facilitate the shared training of 57,000 health and care staff. Through our People Board we are creating broad partnerships including NHS, Local Authorities, Universities, the VCSE and unpaid carers. This is allowing us to work on issues such as one health and care workforce andthe relationship to wider economic recovery and economic growth. Specifically, the workforce gap within health and care could provide a route to employment for people who are unemployed as a result of COVID-19; we are working closely with our economic recovery board to support people to transition into the sector. We are also building closer collaboration with the university sector, including the development of a workforce observatory; and how we better support unpaid carers and the VCSE. Our commitment to address inequalities for our Black, Asian and Minority Ethnic staff is demonstrated in the recent independent review and action plan. We would be really keen to engage on these issues as you further develop the thinking on these important issues

Place-based partnerships

21. We welcome the focus on strong and effective place-based partnerships. In particular, we welcome the commitment that the division of responsibility between system and place should be based on the principle of subsidiarity.

22. It is at place and neighbourhood level that the vast majority of work is done to support people and communities and to take forward our population-health based approach to tackling health inequalities. Primacy of place is embedded in how we work in WY&H and our subsidiarity principle means that work takes place as near to local as possible. Our local partnerships include commissioners, providers, local authorities, the voluntary and community sector and primary care networks.

23. Health and Wellbeing Boards are the cornerstone of our place-based Partnership arrangements. They set the strategy for our Integrated Care Partnerships (ICPs) to deliver. We want to be able to lead on behalf of each other at place, both across our local systems but also at WY&H level. Our ambition is to align leadership capacity and work together as a single leadership team, bringing together NHS, social care and public health skills and capacity. We have already made good progress on establishing joint appointments across health and local government. We have highlighted above some possible tensions between cultures across NHS and wider sectors.

24. Each of our places is developing their ICP in a way that best meets the needs of their local community. As our ICS model is built on the primacy of place, our arrangements at ICS level are designed to support, and dovetail with these place-based arrangements. For example, our Leadership and Development programme is driving ICP maturity work which will set out clearly 'what good looks like' for our ICPs.

25. Strong and mature places are key to our further development as a partnership. CCGs play a central role in our place-based arrangements and there is a risk that organisational change resulting from placing ICSs on a statutory footing will weaken leadership, accountability and capacity in our places. We also work closely regional partners such as the Combined Authority as many activities can only be taken forward at this level; this is vital to the wider ambitions of the ICS proposals around addressing the wider determinants and contributing to wider social and economic development.

26. The document highlights the important role of Primary Care Networks (PCNs) in building partnerships in neighbourhoods and joining up primary and community services. PCNs are still at a relatively early stage of their evolution and not all yet have the leadership and capacity needed for them to thrive. It will be important to ensure that they are given the right level of support to enable them to develop successfully to support their local communities.

Clinical and professional leadership

27. We welcome the emphasis on system-wide clinical governance and professional leadership. The West Yorkshire and Harrogate system is built on strong clinical engagement at neighbourhood, place and system level.

28. At system level, our multi-disciplinary West Yorkshire and Harrogate Clinical Forum brings together medical, nursing and allied health professionals and has played a critical role in shaping our priorities and how we work as a partnership. This has made a significant contribution to service transformation, for example in stroke and vascular services and the roll out of the West Yorkshire and Harrogate Healthy Hearts project. It has also been instrumental in ensuring a successful collective response to Covid-19 by leading on the stabilisation and reset of services and developing an ICS level ethical framework to support clinical decision making. Its work is augmented by a combination of strong and newly created networks in cancer, vascular and other services, alongside profession specific groupings.

29. Our clinical leaders work together at all levels across the partnership – within our neighbourhoods and places and in the WY&H programmes where we come together to tackle specific priorities. Our CCGs have played an important role in providing; supporting and developing leadership at all three levels and we need to keep these leaders engaged as we shape the future. CCGs have established the support structures and resources needed to develop clinical leaders and it will be important that any change in organisational arrangements does not weaken this. Primary care clinical staff, in particular GPs, have taken on a wider system leadership role and there is a danger that this could be lost. Much effort has gone into developing leadership capacity and capability and supporting the development of PCNs and it is important that we retain and develop this capacity.

30. We welcome the commitment set out in the document to give us the flexibility to further develop the multi-disciplinary leadership structures and support that meet WY&H needs.

Governance and accountability

31. We welcome the focus on mutually agreed governance arrangements, clear collective decision making and transparent information-sharing. We also welcome the emphasis on strong place leadership arrangements, and critically, the commitment to give systems the flexibility to decide the detail of the precise governance and decision-making arrangements in each place.

32. We have a very well–established model of distributed leadership in WY&H and our Memorandum of Understanding sets out clear governance and accountability arrangements at system level. The arrangements minimise levels of decision-making and set out defined responsibilities of organisations, places, collaborative forums and the ICS.

33. In each of our places, clear governance arrangements support collaborative decision making. These arrangements are supported by our place-based mutual accountability and peer review frameworks, which provide system-level support and ensure a single, consistent approach to assurance and accountability.

34. The leaders of health and care providers understand their accountability to their organisation and the wider system. Providers are fully engaged in all Partnership-level governance forums, with sector-specific arrangements enabling effective provider collaboration. These include the West Yorkshire Association of Acute Trusts (WYAAT) and Mental health, learning disability and autism (MHLD&A) collaborative. Committees in common (CiC) enable them to transact business quickly and effectively.

35. We already have systematic arrangements in place to involve non-executive, lay and resident voices. Chairs of Trust Boards and CCGs sit on the Partnership Board which also includes independent co-opted members. The Joint Committee of CCGs has an independent lay Chair and lay member representation and sector collaborative forums have lay and non- executive representation. We use a wide range of ways to involve the public, including public and patient reference groups and engagement events. We seek assurance about the effectiveness of public and patient involvement through Healthwatch, the co-opted members on our Partnership Board and mechanisms such as the Joint Committee of CCG's Patient and Public Involvement Assurance Group.

36. We will need to ensure that under any new arrangements we retain our strong place-based public and patient involvement and assurance arrangements.

Financial framework

37. We support the direction of travel set out in the document. The financial working arrangements which we have developed across West Yorkshire and Harrogate are a clear move in this direction and are designed to strengthen system working and mutual accountability.

They include:

- Moving away from purely activity based contracts, to provide more certainty for commissioners and providers on income levels for a given period and reduce transactional costs where possible
- A stronger emphasis on open-book, place based planning, recognising that financial success of different organisations within a system are inextricably connected.
- The operation of a 'single control total' arrangement across West Yorkshire – which emphasises the importance of strong organisational and place financial performance- but creates collective oversight for system performance overall.

38. These arrangements have supported much stronger financial performance across WY&H in the past 2 years.

39. The changes signalled in the document have significant implications for our ways of working. We are keen to work closely with you as the thinking on this evolves. We are particularly interested in:

    - The way the money flows in to WY&H and how it is distributed in line with our principle of subsidiarity. We are keen to ensure that these mechanisms are fair, transparent, and supportive of our strategic objectives as a partnership. We are keen to work with you on the approach taken for NHSE commissioned services to ensure that we have an allocation that reflects population need. There are also complex issues around inequalities, rurality and PFI costs that need to be addressed.
    - The approach to accountability, including at ICS level and for statutory bodies (particularly Foundation Trusts) within the system.
    - The national support offer to ICSs around evidence-based resource distribution (health inequalities and place population need, efficiency benchmarking
    - How the financial framework incentivises integration of services in place, given the differing regimes between NHS and Local Authorities and the increased focus on population outcomes. Linked to this is the need for a sustainable financial solution to properly resource social care, and greater certainty and national support for public health grant funding.
    - The timelines and phasing of implementation given the complexity of these changes.
    - The extent to which there will be flexibility over the delegation of resources to place to ensure that we maintain the principles of subsidiarity and distributed leadership.

Data and digital

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

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

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

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

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

45. On an ICS and wider footprint, the Digital Programme is working to support effective date flow and connectivity, and we have a small team which provides analytical support to our transformation programmes. Our innovation and improvement and system leadership and development programmes support our work towards becoming 'learning health systems'.

46. Since the ICS is a partnership rather than an organisation it does not sit naturally within the NHS data architecture. The Partnership analytics team has access to a variety of CCG level data sets via Data Services for Commissioners Regional Offices, but we rely significantly on NHSE/I for data at a WY&H level. Establishing the ICS on a statutory footing may help us to increase our strategic capacity to bring together key data sets across West Yorkshire and Harrogate.

47. As well as enabling the use of data for system planning to improve health outcomes we will also be able to improve the use of data for research across the system. We know that organisations that are more research active have better health outcomes for their service users and the secondary use of data for research across the whole system will allow us to discover and develop products and services to improve health over the long term and increase economic growth for the region

Regulation and oversight

48. We welcome the shift in emphasis towards regulation and oversight at system level, which supports systems to improve and make change happen. This approach fits well with our established place-based mutual accountability and peer review frameworks (based on the Local Government Association model of sector led improvement), and our constructive and collaborative relationship with our NHSE locality team. We also welcome the commitment in the document for the CQC to engage at system level and we would welcome more detail on how this will work.

49. ICSs in NEY work closely with the regional team as part of a "four plus one" approach, with collective leadership from ICS leaders and the Regional Director. Many regional staff are already embedded within, or aligned to, an ICS. NHSEI Locality Directors work directly to ICS leaders, playing a key role and working as a bridge between the region and the ICS. Working in this "four plus one" way has proved highly effective, e.g. in managing the response to Covid and in service planning and performance management. ICSs are strong partnerships, building on the best from their constituent organisations and sharing this across the region. Working together in this way has produced many benefits, including the development of a commonly agreed framework for deploying staff and this puts the ICSs and the region in a strong position to manage any transition process.

50. Our approach in West Yorkshire and Harrogate is based on understanding performance at a place and system-level. Our MoU sets out a consistent approach to mutual assurance and accountability between partners on West Yorkshire and Harrogate system-wide matters. This well established approach is operationalised by monitoring progress against our big ambitions in each place and across programmes. The arrangements for ensuring this include our System Oversight and Assurance Group, peer review and check and confirm process. Our place-based approach means that we are able as a system to support each place in developing their local partnership arrangements.

How commissioning will change

51. We welcome the emphasis on commissioning becoming more strategic, having a clearer focus on population-level health outcomes, including net zero carbon targets, and working collaboratively with providers. We also welcome the commitment in the document that systems should decide which functions are best delivered at place or system level. We have already moved significantly in this direction and our 'commissioning futures' programme is setting out the route map for further developing our approach.

52. Commissioning in WY&H has already become more strategic. We have delegated strategic commissioning decisions on key services like stroke and urgent and emergency care to our Joint Committee of CCGs. We have made significant progress in making our CCGs coterminous with our places, reducing from 11 to 6 and shortly to 5. We have transferred commissioning responsibilities to providers and are leading system integration in our places with local authorities and providers.

53. Building on our subsidiarity model - doing what is right for our places and our populations - our commissioning futures work focuses on only commissioning at ICS level where we cannot do it at place, only commissioning in place where we cannot do it in communities and only commissioning in communities where individuals can't do things for themselves. This approach to commissioning is built on the uniqueness of each of our places. Our vision is that commissioning is everyone's role and that reducing health inequalities is embedded at the heart of all commissioning.

54. In this model, place-based integrated care partnerships will work as commissioners and providers together, taking a population-health based approach to deliver the strategy set by the Health and Wellbeing Board. All of this requires strong commissioning leadership and significant commissioning and public health capacity in our places. There is a risk that by placing ICSs on a statutory footing a hierarchical structure will be established which drains capacity and skills from our places. It is therefore essential that systems are able to decide which functions are best delivered at place and which at system level and to establish commissioning leadership, functions and structures which support that balance of responsibilities.

Specialised commissioning

55. We believe that there are clear benefits of developing service and pathways across an ICS footprint, with a collective understanding of resource and risk. For example, our MHLDA provider collaborative is already commissioning Adult Eating Disorders across our footprint that were, until recently, commissioned by NHSE/I, with plans to go live in 2021 for the same with CAMHS Tier 4 and Adult Secure. Through our new care models pilots, we have seen the benefit that system responsibility for services can deliver so would agree with the transfer of other appropriate services; linking local and system pathways of care. Through our aligned incentive contract on acute specialist care, we have collectively managed the single biggest national contract from specialised services between Leeds Teaching Hospital and NHS England.

56. Any change needs to be properly managed, to ensure that there is no shifting of risk, either financial or service related, without all parties being clearly sighted on the implications. Proposals to delegate functions to ICSs also need to be accompanied by a clear, shared understanding of the resourcing implications of ICS bodies taking on additional functions. It will be important that the resource and skill set is transferred from NHSE/I to enable this to happen.

57. We also recognise that the ICS footprint is unlikely to the right geographical footprint for planning of all services. For example some highly specialised services will need to be commissioned through groups of ICSs working together or even at a national level. We also recognise that commissioning of primary care services may be best delegated to place level.

Improving Population Health

58. We believe that operating at the level of ICSs to address health inequalities and climate change will allow strategic direction setting which is nuanced enough to allow for variation in place but also high level enough to allow for a system wide, co-ordinated approach which can manage functions (such as collaborative procurement and large capital projects), that otherwise would be lost at place level. Many actions required also cut across types of organisation. For example – action on inhalers which are a key driver of climate change and respiratory health cuts across primary and secondary care – so the ICS level is core to addressing these issues.

59. We provide here a short outline of the way in which our Improving Population Health Programme has been working. The Programme is overseen by a Programme Board and two Senior Responsible Officers from our system. The Programme has delivered numerous successes in the past year, detailed in our annual report by;

60. Influence: We work with other WY&H HCP priority programmes to influence the inclusion of population health principles within their priorities. The programme provides constructive challenge within WY&H HCP to embed approaches that promote prevention and seek opportunities to reduce health inequalities throughout the work that we do

61. Partnerships: The programme brings together the stakeholders required for cross-sector teams that tackle complex issues related to population health. Coming together around common aims as the WY&H HCP enables the programme to use the power of a collective voice. This helps to ensure that population health themes are featured throughout all our priority programmes, such as cancer, maternity care and mental health and to influence approaches with partner organisations to improve everyone's health and wellbeing.

62. Increasing population health capacity: The programme operates in a way that has the autonomy and agility to respond to emerging needs within the population and the requirements of health and care partnerships. This approach has allowed us to be flexible and to respond to programme asks during the pandemic, including around developing a better understanding of the direct and indirect impact of the pandemic and how this may disproportionately affect specific population groups.

63. Increasing partnership capability: We have developed and nurtured an environment for learning and continuous improvement, both for members of the team and for those across the partnership involved in our networks, steering groups and projects. Our programme has a network for each objective. These provide leadership, opportunity to share expertise and best practice, and support learning across WY&H HCP. We have appointed subject matter experts to lead our work on climate change and health and housing, helping to embed subject-specific expertise relating to population health providing additional capacity to move forward with change at pace. Within the team we have provided opportunities for work experience and are a training location for public health registrars.

64. Insight and intelligence: The programme supports WY&H HCP with increasing use of data and insight to understand population health priorities for the partnership, whilst identifying interventions.

65. We would particularly welcome the inclusion of wider determinants, health inequalities and supporting wider social and economic development as core ICS objectives but are concerned at the lack of detail about how these objectives will be delivered under the new proposal which remains largely NHS healthcare commissioning focused. We strongly feel we have a successful model for achieving these objectives working closely with other key stakeholders – our work on housing, climate change and economic recovery are just three examples of this. We would strongly recommend that NHSE/I focus more on how the ICS proposals will deliver on these core objectives and any associated tensions regarding the focus on commissioning of health services.