

Board of Directors – 27 January 2021 Chief Executive's Overview

Trust Strategic Goals:

- to deliver safe and high quality patient care as part of an integrated system
- to support an engaged, healthy and resilient workforce
- to ensure financial sustainability

Recommendation

For information	<input checked="" type="checkbox"/>	For approval	<input type="checkbox"/>
For discussion	<input checked="" type="checkbox"/>	A regulatory requirement	<input type="checkbox"/>
For assurance	<input type="checkbox"/>		

Purpose of the Report

To provide an update to the Board of Directors from the Chief Executive on recent events and current themes.

Executive Summary – Key Points

The report provides updates on the following key areas:

- Covid-19 update
- ICS update
- System place-based developments: City of York

Recommendation

For the Board of Directors to note the report.

Author: Simon Morritt, Chief Executive

Director Sponsor: Simon Morritt, Chief Executive

Date: January 2021

1. Covid-19 update

This is, as ever, a fast-moving situation and we will have the opportunity to talk about the up-to-date position during the Board meeting, however at the time of writing we have in excess of 200 patients with Covid-19 in hospitals, far in excess of the numbers we have seen previously.

York has felt the most impact in relation to Covid-19 admissions, which reflects the fact that case numbers are particularly high in York relative to other parts of North Yorkshire.

We have enacted further steps in our surge plan, opening additional wards for Covid patients and redeploying some staff.

We have postponed some planned operations, however our teams are working hard to continue to do as many operations as possible within the constraints we are facing. We have continued with the most urgent cases, including urgent cancer surgery.

We anticipate that the end of January will signal the end of this latest peak, and cases will begin to fall or at least level off.

An area of particular concern is the wellbeing of our staff, who have now been working in the pandemic for a year. We have asked a great deal of our staff, and they have stepped up to this without question, however it is clear that the emotional burden of this is having an impact and staff are understandably exhausted. We are doing what we can to make staff aware of the support they can access if they need to, but there is no doubt that this is a really difficult time for many.

The light at the end of the tunnel is of course the vaccine, and I am delighted with the response to the rollout of the vaccine programme within the trust. The vaccine centres are running like clockwork, and the response, both in terms of volunteers and people taking up the offer of a vaccine, has been phenomenal.

As this is my first report of 2021, I want to place on record my thanks to all of our staff for everything they've done in the past 12 months for our patients and for each other. I hope that the coming year will be one of optimism and recovery.

2. Integrated Care System Update

In November 2020 all ICSs were invited by NHS England and NHS Improvement to give their views on proposed legislative options for giving ICSs a firmer footing and to remove legislative barriers to integration across health bodies and with social care, to help deliver better care and outcomes for patients through collaboration, and to join up national leadership more formally.

These options are detailed in the document Integrating Care: Next steps to building strong and effective integrated care systems across England.

There are two proposed options:



To be a valued and trusted partner within our care system delivering safe effective care to the population we serve.

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

This option would establish a mandatory, rather than voluntary, statutory ICS Board through the mechanism of a joint committee and enable NHS commissioners, providers and local authorities to take decisions collectively. It would have a system Accountable Officer, chosen from the CEOs/AOs of the Board's mandatory members. This Accountable Officer would not replace individual organisation AOs/CEOs but would be recognised in legislation and would have duties in relation to delivery of the Board's functions. There would be a duty for the Board to agree and deliver a system plan and all members would have an explicit duty to comply with it. There would be one aligned CCG only per ICS footprint under this model, and new powers would allow that CCGs are able to delegate many of its population health functions to providers. This option retains individual organisational duties and autonomy and relies upon collective responsibility. The new Accountable Officer role would have duties to seek to agree the system plan and seek to ensure it is delivered and to some extent offer clarity of leadership. However, current accountability structures for CCG and providers would remain.

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

In this model, ICSs would be established as NHS bodies partly by "repurposing" CCGs and would – among other duties – take on the commissioning functions of CCGs. The CCG governing body and GP membership model would be replaced by a board consisting of representatives from the system partners. As a minimum it would include representatives of NHS providers, primary care and local government alongside a Chair, a Chief Executive and a Chief Financial Officer. The power of individual organisational veto would be removed. The ICS Chief Executive would be a full-time Accounting Officer role, which would help strengthen lines of accountability and be a key leadership role in ensuring the system delivers. The ICS's primary duty would be to secure the effective provision of health services to meet the needs of the system population, working in collaboration with partner organisations. It would have the flexibility to make arrangements with providers through contracts or by delegating responsibility for arranging specified services to one or more providers.

Humber, Coast and Vale Health and Care Partnership response

Following consultation with all partners, Humber Coast and Vale Health and Care Partnership (HCVHCP) submitted a letter to NHS England and NHS Improvement outlining the Partnership's collective response to the proposed options. The letter, which is attached to this report, states that the Partnership is supportive of the direction of travel set out in the document and welcomes the opportunity to build on and make the appropriate adjustments that need to be made to reflect the policy changes set out. It also states that there is broad agreement to, and preference for, option 2 amongst members of the Partnership.

The letter also includes supplementary views from the geographic partnerships within Humber, Coast and Vale.

While acknowledging that both models would drive increased system collaboration and achieve the stated vision and aims for ICSs in the immediate term, NHS England and NHS

Improvement expressed a preference for option 2 as a model that offers greater long term clarity in terms of system leadership and accountability.

Any legislative changes are likely to take effect from April 2022, subject to Parliamentary decision.

3. System place-based developments: City of York

A key part of the future functioning of Integrated Care Systems will be an emphasis on the importance of place-based working.

Health and social care organisations serving the City of York have been engaging in purposeful conversations about how a more integrated approach could be formalised for York, and a number of workshops have taken place involving all partner organisations. These discussions have focused on the potential scope of any devolved responsibility, principles and behaviours to be adopted by the collective organisations, and how the governance arrangements could work.

A final workshop is planned for mid-February, where the proposed priorities and working arrangements for the City of York Alliance model will be finalised.

I will share further updates as this important partnership develops.





January 2021

Humber, Coast and Vale Health and Care Partnership

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Dear Colleagues

RE: Integrating Care: Next Steps for Integrated Care Systems

Thank you for the opportunity to share our views on the document you published on the 24th November 2020 on Integrating Care: Next Steps for Integrated Care Systems (ICs) and the proposed legislative changes aimed at removing barriers to integration across health bodies and with social care.

The following views represent a collective response from the partner organisations of the Humber, Coast and Vale Health and Care Partnership which already holds integrated care system status.

As a partnership that has been and continues on a development journey, we are very supportive of the direction of travel set out in the document and welcome the opportunity to build on and make the appropriate adjustments that need to be made to reflect the policy changes set out.

We agree that giving ICs a statutory footing from 2022, alongside other legislative proposals, provides the right foundation for the future. There has been broad agreement and a preference through our discussions to option 2.

We believe this model will provide greater encouragement for collaboration and flexibility to establish arrangements that suit the needs of our population, alongside strengthening lines of accountability most importantly, to our patients.

We welcome the clarity of purpose rooted in creating health and care systems that will be better placed to:

- Improve population health
- Improve access and address health inequalities
- Drive better quality and value
- Directly engage the NHS with wider social and economic development.

The partners in Humber, Coast and Vale also felt we needed to ensure that other proposals in the document were drawn out as key tests for a successful integrated care system, these include:

- Operating as an equal partner with local government and the voluntary and community sectors
- Co-producing strategies, plans and outcomes with patients, citizens and their representatives.

On improving population health and health inequalities we would like to see a strengthening of strategic planning to support this and feel a longer term outlook (5-10 years) is required to make changes to population outcomes.

The emphasis on 'place' in the document is universally seen as positive and we will ensure decisions and resources are devolved as close to communities as possible. It remains a main focus for strengthening local leadership, increasing integration and developing primary care in its broadest sense as both a foundation and as an equal partner in transforming services. We see 'place' as the key enabler to continuing to improve the overall health and wellbeing of people living in our area in equal partnership with local government.

Having said that, for a large geographical area such as Humber, Coast and Vale there is logic to an approach that brings a number of places together on a footprint which is smaller than the ICS, but is through the functions of the ICS. This would enable partnership working, strategic leadership and planning of integrated care to meet the needs of populations greater than a single place, to drive better value, address health inequalities and the wider determinants. In doing so, we would not envisage additional formal governance or accountability of the ICS, but instead flexible and dynamic arrangements for the practical delivery of outcomes and services across 'places'. The partnership arrangements already established in Humber, Coast and Vale are demonstrating this through the strength and depth of the managerial, clinical, professional and lay leadership. They have contributed complementary views as set out in annex one.

We feel the approach set out in the document is permissive and pragmatic enough to enable governance arrangements to be established that make sense in the context of our geography and arrangements we already have in operation but also to develop further ways of working and developing clear accountabilities with arrangements such as Health and Wellbeing Boards, we welcome this. We would encourage in any further considerations this flexibility remains so that ICSs are able to strengthen integration and reduce bureaucracy.

We are supportive of the changes proposed for provision, based on duties of collaboration at place within provider collaborations and across an ICS within provider collaboratives, where patient pathways need to rely on services of more than one trust or organisation due to the specialist nature of treatment. We acknowledge for the sector specific collaboratives the value is in designing and delivering specialist and other services at scale that meet the needs of our population, where it makes sense to do so. There are some highly specialised services where we feel it might be beneficial to still consider whether they should be delivered on a multiple ICS or even a national basis e.g. Deaf Services for CAMHS to ensure patient safety is maintained and workforce expertise is available.

We also need to continue to recognise the value of diversity in our providers particularly for areas such as Humber, Coast and Vale where we have a vibrant Voluntary, Community and Social Enterprise Sector that focus on delivering care closer to home as we increasingly shift resources into the community. They also play an important strategic role at an ICS and multi-ICS level, with many community providers working across systems and in at scale provider collaboratives. This is an important point for community providers as the landscape of provision varies greatly across the country. While some ICSs have large community providers, others such as Humber, Coast and Vale will have a more mixed collection of varying sized providers delivering a myriad of services. The proposals also only reflect community providers' relevance at place which we fully support, there is a role at an ICS level where they bring together primary and community care into a collaborative network, developing plans to deliver more care at home and in the community to improve population health outcomes. We feel it is important that the leadership role that

community providers' play at place and system level is emphasised and the changes need to ensure parity of esteem across mental and physical health, and care in the community and in hospital.

As providers, Ambulance Trusts are an important part of our provider collaboration both at place and across the ICS. We recognise that this is significantly challenging for them as they tend to span multiple ICSs. Therefore, we feel it would be beneficial for consideration to be given to ambulance collaboratives being coterminous with wider regions ensuring alignment to ICSs within that region to enable them effectively work with systems and Places.

What must not be underestimated is the balancing for all providers between place and sector and that they are supported appropriately to do both. Whilst there is some acknowledgement of their role as anchor institutions this could be strengthened to include more around their social and economic value and not just a focus on fair and equal access.

As mentioned above Primary Care is the foundation of delivering better outcomes for the population and specifically the role of Primary Care Networks within this. Whilst there is recognition through development funding that they need to be supported to grow, they are all at different levels of maturity. It would be helpful if further consideration could be given to the capacity and support needs to enable them to be an equal partner alongside the other provider organisations.

Whilst our existing arrangements are and any changes to these arrangements will be mindful of the potential reforms to local government and allow for greater alignment and integration in the future, we propose that should there be any further consideration of the model to ensure the flexibility between health, public health and social care is maintained and enables places within systems to build on existing established arrangements between the NHS and local government and create the equal partnership that can address the needs of a population. With the proposed changes to Public Health England and the impact of reduced funding to local authorities on community services and clinical aspects of health improvement / public health services, we also feel there needs to be greater consideration with local authorities of the roles of ICSs in this area.

There is clear message about the clinical and wider professional community being a powerful force for leadership and governance at every level, as well as the voluntary and community sector and citizens and this has been collectively acknowledged by partners in Humber, Coast and Vale as a positive direction. A specific response from the Clinical and Professional Group is set out in annex two.

We are also supportive of the direction in relation to our people as creating a sustainable workforce is key to the delivery of our ambitions. It is vital that there is engagement with other stakeholders, such as Health Education England, Universities, Further Education providers and schools and other public sector organisations to ensure we maximise the opportunities.

Whilst we recognise there is further detail to be developed, we welcome the proposals around the financial arrangements set out in the document. This will enable us to ensure resources are more effectively linked through to our places to address health inequalities and improve outcomes for our people and communities and are also available to support delivery of national programmes and transformation change as a system.

The proposals will lead to significant change for commissioning and the document refers to absorbing Clinical Commissioning Group (CCG) functions as core ICS business. We believe to have a successful integrated care system this will only be a small part and that to deliver on the purpose described in the document we will need to ensure the functions are appropriately deployed to place, providers and the

system. As we are sure you will be aware, this causes concern for colleagues in our organisations particularly in CCGs. The document suggests 2021/22 will be a transitional year and central to this will be the redeployment of staff with guarantees of employment as we transition to new roles, ways of working are reshaped and changes are made to the current system to enable the new one to be formed and we welcome this. This will be an unsettling time and will cause significant uncertainty and anxiety for all colleagues who have been and continue to work exceptionally hard in response to COVID-19. Whilst as a collective group of leaders we will manage this change and transition, expediency in our requests for support / further national guidance, so that we can give staff the certainty they are looking for would be appreciated.

Finally, we would like to reiterate our thanks for the opportunity to share our views, we welcome the direction of travel and should you wish to follow up on any points raised then please do get in touch.

On behalf of the Partner Organisation Members of the Humber, Coast and Vale Health and Care Partnership (ICS)

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HCV Independent Chair and System Lead**

**Amanda Bloor
Accountable Officer,
Chair of North Yorkshire & York System Leaders**

**Emma Latimer
Accountable Officer,
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**Andrew Burnell
Chief Executive of City Health Care Partnership,
HCV Community Collaborative Chair**

**Chris Long
Chief Executive of Hull University Teaching Trust,
HCV Acute Collaborative Chair**

**Michele Moran
Chief Executive Humber Teaching Foundation Trust,
HCV Mental Health Collaborative Chair**

**Nigel Wells
GP, Chair of Vale of York CCG,
HCV Clinical Lead**

Annex One – Supplementary Views from the Geographic Partnerships within Humber, Coast and Vale

Humber

The Humber Partnership is a diverse health and care system comprised of 17 Primary Care Networks, four Local Authorities, four Clinical Commissioning Groups, seven NHS providers and three Community Interest Companies.

Together we work on behalf of the approximately 1 million residents of the Humber to achieve sustained improvements in the health, wellbeing and inequalities experienced by our people and communities through the four places that are aligned with each of the local authorities in the Humber.

We are supportive of the direction of travel set out in the document and agree with the approach to move ICSs to a statutory footing from 2022 (Option 2). We agree that these proposals will provide greater encouragement for collaboration to address health inequalities and improve population health. Whilst we acknowledge that option 2 will provide a longer-term solution to achieving this integration agenda compared to option 1, we have concerns that the arrangement may provide clarity of accountability for Parliament, the clarity of accountability to patients is less evident and more further consideration needs to be given to governance and public accountability.

As a partnership we recognise the potential for the proposals to really strengthen our approach to key enablers, for example:

- *System workforce planning in partnership with Further and Higher Education*

Greater system level workforce planning will enable providers to share expertise, support engagement with further and higher education, and support the development of more flexible training and career choices which encourage people to live, learn and stay local.

- *System intelligence*

True system working will require system intelligence built around individuals, communities and population groups. We recognise the need to bring all organisations and PCNs with us in order to make available linked data sets connecting primary and secondary care data with 999, NHS111, and Local Authority data, to understand and predict service utilisation, identify gaps in provision and target high risk groups.

- *Place at the heart of system health and care provision*

As a partnership we identify PCNs, neighbourhoods and place as key drivers for change. We are looking to align CCG management expertise and clinical leadership to support the rapid development of PCNs and neighbourhood service offers for populations of 30-50,000, which formalise relationships between health, social care and community assets. It is our intention to rapidly develop primary care to form a strong foundation, which is evident through every level of the ICS, and which has the capability to deploy resources at neighbourhood level differentially and disproportionately.

There are areas which are underrepresented in the document where further clarity would be helpful – particularly with regards to accountability (question 2 posed by the document) and governance arrangements (question three) including but not limited to:

- *Discharging quality functions and statutory responsibilities under new arrangements*

Quality (Safety, Outcomes, Patient Experience) should be a clearly defined function within the ICS. We welcome a shift in the focus of Quality Assurance, from individual provider monitoring and improvement, to cross-provider accountability for population outcomes and pathways of care. This should be reflected in a system interface with the CQC. There is opportunity to establish clarity through a Quality Framework which operates at multiple levels, from neighbourhood through to system level, with the ability to establish joint oversight with Local Authorities. We would want to harness the significant expertise of leadership for quality of care, quality assurance, quality improvement, and advocacy for patient experience which exists in CCGs to ensure that those multiple layers, especially at place, feel the benefit and the independence from providers that this brings.

CCGs have statutory responsibilities (alongside other statutory partners) for safeguarding, child death review arrangements, research and the requirement for a SEND Designated Clinical Officer. These responsibilities could be aligned through new legislation to the ICS, with strategic leadership supporting delivery of responsibilities through partnerships operating models. For safeguarding and child death review this could operate effectively through geographic partnerships, and for research through provider collaboratives and PCNs. The SEND DCO role closely aligns to place, defined by Local Authority boundaries. We welcome the opportunity to draw on our local expertise to define accountability and delivery arrangements which fulfil statutory responsibilities through the transition period and beyond.

- *There is a degree of ambiguity in systems shaping their own governance arrangements, particularly given the potential introduction of new geographically-based and sector-based collaborations, and potential implications for individual organisations in managing system performance.*

We welcome the opportunity to develop local financial rules but recognise there is a risk that financial systems will be determined by historic behaviours and practice, which traditionally 'lock-in' resource to sectors and tend not to prioritise preventive and proactive interventions which offer solutions to system problems. This approach cannot continue, particularly when set against the disproportionate impact of Covid-19 on people who are already experiencing disadvantage and discrimination, and will only contribute to rising costs of health and care in the long term.

We welcome the capability as a partnership to target our collective resources to where we have the greatest potential to address inequalities and improve outcomes for our people and communities, although disruptive financial mechanisms are required to support the shift in mindset.

However, it should be noted that in developing existing joint working structures care has been taken to work closely with local government, to establish arrangements through which decisions can be taken together (for example in East Riding, Hull, North and North East Lincolnshire through CCG/Local Authority Committees in Common / place based collaborations). This has enabled

services to be designed and commissioned in collaboration and by the most appropriate local government and / or health partner with a wide range of provider organisations in an integrated contractual form. It is not clear how integrated decision making will be facilitated within the revised arrangements. The focus of the consultation document appears to be primarily upon organisations which are formally part of the NHS. It is not apparent how private sector organisations or the voluntary sector, commissioned by local government to provide much of the integrated delivery chain for the provision of health and social care services, will be integrated into the delivery model.

While the consultation document recognises the importance of the footprint of Health and Wellbeing Boards, there is little reference to their future role. Health and Wellbeing Boards have enabled commissioners and providers to be brought together with other public and key organisations, for example the Police and Crime Commissioner, to provide the framework for development of a co-ordinated response to the wider determinants of health.

The opportunity exists to build on existing structures at place based on the knowledge developed over recent years. Decision making structures will need to respect the role of local government to allow integration with social care to continue and recognise local democratic accountability and wider social care commissioning requirements.

- *Priorities should be set by partnerships with strong clinical, lay member and elected member involvement, enabling disproportionate allocations which target those with the poorest health and support a recurrent shift in resources between sectors and geographies.*

The role of elected member, lay members and foundation trust governors has brought a wealth of experience, professional expertise and objective focus on decision making about local population health priorities. This voice will become distanced in a larger footprint and system governance arrangements will therefore need to reflect the role of place and provide the framework for democratic and community accountability, together with an understanding of people, communities and populations and how this is applied to decisions about priorities and resource allocations.

We are broadly supportive of an approach whereby services currently commissioned by NHSE transfer to ICS bodies. We welcome the opportunity to bring all available resources together to deliver population health care from cradle to grave, across whole cycles of care. We also recognise that there needs to be a multi-layered approach to ensure that value in terms of outcomes and resources is maximised.

There is benefit in moving elements of primary care commissioning to work more locally with PCNs, whilst other primary care services such as performer action lists should continue at scale.

The same is true of specialised services which require a larger population footprint beyond ICSs to maintain service quality and sustainability. Mechanisms will be needed whereby ICSs work through collaborative or hosting arrangements to preserve capacity and capability.

More broadly there are services and strategies which require a regional coordinated approach, for example Yorkshire and Humber Integrated Urgent and Emergency Care Strategic Commissioning and the Yorkshire and Humber Care Record.

As a Humber Partnership we have strength and depth by virtue of our partners and active involvement of managerial, clinical, professional, lay and elected members. The pace of change required to get us to April 2022 presents a significant challenge, recognising the scale and scope of proposed change and the level of ambiguity that remains.

In order to respond to the challenge we are mobilising our local leaders and subject matter experts; to develop and test new arrangements through 2021, learn from and share with other ICSs across the region, and support our members of staff – particularly those in CCGs and NHS EI – to play active roles in our system as it emerges.

North Yorkshire and York

North Yorkshire and York (NY&Y) Partnership has a diverse population of approximately 775,000 residents. It comprises of 76 GP Practices in 19 Primary Care Networks, two Local Authorities (North Yorkshire County Council and City of York Council), two Clinical Commissioning Groups and five NHS providers.

The NY&Y Partnership leaders are supportive of the direction of travel set out in the consultation document and support the approach to move Integrated Care Systems to a statutory footing from 2022 (Option 2). We agree that these proposals will provide greater encouragement for collaboration and will maximise the contribution the NHS makes to the social, economic and environmental conditions that shape good health.

As a partnership we recognise the potential for the proposals to really strengthen our approach to key enablers, and have the following key points to make:

A Strategic and Collaborative Approach to Economic and Social Recovery

We welcome the opportunity to come together as experts to greater influence economic and social recovery, particularly due to the impact of COVID-19 pandemic. We believe that a single, more powerful, voice to represent our regions working closely with other geographic partners will create a sustainable future for our population and our significant workforce. In short, we will work together more effectively so that the people of North Yorkshire and York get the health and social care system they deserve.

System workforce planning in partnership with Further and Higher Education

As detailed within the People's Plan and already embedded within our organisational development plans, we understand the importance of workforce planning, talent management and succession planning through further and higher education and are committed to greater system level workforce development. A flexible approach to workforce planning across wider sectors and geographies will enable a greater level of shared expertise and will encourage talented individuals to come into and remain in the area.

System Intelligence

We support the importance of a strong collaborative approach to system intelligence and for the system to understand how it can aggregate collective effort together at differing levels in the system to make sense of, and deliver on, the specific issue we are addressing. A strong intelligence function

is crucial for the ICS to deliver improved population health and needs to be flexible enough to support local 'place' requirements.

Primary Care at the Heart of System Health and Care Provision

We recognise that PCNs form a key building block of the NHS long-term plan. Bringing general practices together to work at scale is already a priority. We agree that the local voice of our clinicians is paramount in the successful development of PCNs and their sustainability. We agree with our clinicians that we must continue to develop PCNs at pace and for their voice to be heard in order to: improve the ability of practices to recruit and retain staff; to manage financial and estates pressures; to provide a wider range of services to patients and to more easily integrate with the wider health and care system.

Improving Health Outcomes and Reducing Health Inequalities across a Wide Geographical Footprint

We understand the challenges of working across a wide geographical footprint and recognise that the size, scale and reach of the NY&Y Partnership means it can influence the health and wellbeing of the population by aligning core functions to improve health outcomes of local communities. We strongly believe that the notion of place needs to be a flexible concept working closely with communities in order to enable an agile response to improving health and care outcomes and reducing health inequalities.

Governance Arrangements

As a system that has worked even more closely together over the previous months in response to the pandemic, we have a greater understanding of how our governance models can flex and adapt in light of statutory changes. We have taken the opportunity to embed strong links and working arrangements with our local authorities and would want to see this continue to be strengthened.

As a recently merged CCG, North Yorkshire CCG understands the complexities of joint governance arrangements of multiple statutory organisations. We would therefore welcome decisive authority to act to bring organisations together to act on behalf of consolidated populations and lay aside organisation sovereignty through the transition period towards a single ICS.

We support our ICS formation of two strategic geographical partnerships each with common issues, population needs and aims as a cornerstone of collaborative working both locally and strategically.

We recognise the important principle of subsidiarity and would want to promote the important decisions about health and care being made as close to our local communities as possible.

System Financial Management

We welcome the opportunity to develop local financial rules but recognise there is a risk that financial systems will be determined by historic behaviours and practice. The COVID-19 financial regime has allowed our geographical partnership to have constructive conversations about how to use growth funding which has been refreshing and enabled constructive collaboration across sectors. A return to the previous financial regime could see us return to the requirement of very high levels of efficiency requirements of 3% per annum due to historic recurrent deficit positions of partner organisations. We would like to see recognition of the need for longer term financial recovery period of up to 5 years (setting trajectories locally) to allow challenged financial systems to

make real progress in meeting the financial challenge while also being able to invest in collaborative transformation.

A recognition of the real cost of smaller remote hospitals would also be welcome through national allocations, in particular the hospitals recognised by ACRA.

We would also welcome the continuation and scaling of system performance management and financial performance measures which aid collaboration rather than organisational sovereignty

Annex Two – Humber, Coast and Vale Clinical and Professional Group Response

The following views represent a response from the clinical & professional group of the Humber, Coast and Vale Health and Care Partnership. The clinical and professional group was set up in the response to Covid 19 in April 2020 but has developed over the last 9 months into a wide inclusive group that looks at all areas of health strategy and response.

As a group, we are very supportive of the direction of travel set out in the document and welcome the opportunity to build on the areas we have highlighted over the past months. We have secured agreement across the partnership for a set of principles that establish a focus on shared ownership of care, transparency in communication, shared health demand lists, health access equity, integrated health and care pathways, the prevention agenda and allocation of resources to community solutions.

We agree that giving ICSs a statutory footing from 2022, alongside other legislative proposals, provides the right foundation for the future and will allow us to build on the principles outlined above. We believe option 2 in the document will provide greater encouragement for collaboration and flexibility to establish arrangements that suit the needs of our population, alongside strengthening lines of accountability most importantly, to our residents.

The group welcomes the clarity of purpose rooted in creating health and care systems that will be better placed to:

- Improve population health
- Improve access and address health inequalities
- Drive better quality and value
- Directly engage the NHS with wider social and economic development.

There is clear message about the clinical and wider professional community being a powerful force for leadership and governance at every level, as well as the voluntary and community sector and citizens and we welcome this. We feel that this approach needs to be underpinned by a commitment to a longer term strategy around improving population health and reducing health inequalities. We would like to see a population health management approach embedded in every work stream and strategy going forward.

Primary care networks within our places will be key drivers of integration and collaboration; resource and capacity needs to be liberated for them. We feel option 2 could allow significant resources to flow to place and neighbourhood and drive positive impacts. As key partners within anchor networks and settings we all need to encourage employment in the health and care sector with emphasis on wellbeing and prevention. It is clear that we need to mobilise social justice to build a wellbeing movement and economy.

We are supportive of the changes proposed for provision, based on duties of collaboration at place within provider collaborations and across an ICS within a sector provider collaboratives (acute and mental health). We acknowledge for the sector specific collaboratives the value is in designing and delivering specialist and other services at scale that meet the needs of our population, where it

makes sense to do so. This needs however to be truly cross sector collaboration and we need to recognise and encourage the contribution of the primary care and the VCSE sectors to these forums. All networks and collaboratives within the emerging ICS will need to acquire or grow expertise and provide the people with the skills for 'whole pathway' commissioning and whole pathway quality improvement. This will require some organisational development to be built in across all areas.

We truly agree with and encourage reduction in bureaucracy and hierarchy and understand the need for high trust partnerships and relationships across all sectors; we would not want additional layers of governance and assurance built in via this change for Integrated Care Systems.