Appendix 1

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West Yorkshire and Harrogate Health and Care Partnership/ Leeds Integrated Care Partnership

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Report of: Director of Adults & Health

Report to: Adults, Health & Active Lifestyles Scrutiny Board

Will the decision be open for call in? ☐Yes ☒No

Does the report contain confidential or exempt information? ☐Yes ☒No

What is this report about?

Including how it contributes to the city's and council's ambitions

- The purpose of this report is to set out the current context for health and social care in West Yorkshire and Leeds, and for Scrutiny Board members to consider the implications of the White Paper *Integration and Innovation: working together to improve health and social care* and the Health and Care Bill 2021-22 published on 6th July 2021.

- The report sets out proposals for a new governance structure at West Yorkshire level and at a place-based/ Leeds level.

- The report also references the national changes within the Public Health system as set out in *Transforming the public health system: reforming the public health system for the challenges of our times* DHSC 29/3/2021.

- The Health and Care Bill also includes proposals that impact on adult social care and these are summarised in the report too.

- Leeds Health and Well-being strategy sets out the ambition that Leeds will be a healthy and caring city for all ages, where people who are the poorest improve their health the fastest. The aims of integrated care support many of the strategy's priorities including "the best care, in the right place, at the right time".

- The Best Council Plan has at its heart tackling poverty and reducing inequalities. Addressing health inequalities is a key priority for integrated health and care services in Leeds.

- The Scrutiny Board (Adults, Health and Active Lifestyles) has been assigned to fulfil the council's health scrutiny function and therefore has a specific remit / responsibility in relation to reviewing and scrutinising any matter relating to the planning, provision and operation of local health services.

Recommendations

Members are asked to consider and discuss the information and guidance presented in this report.

Why is the proposal being put forward?

1. At its meeting on 15 June, Scrutiny Board members discussed the priority items it wanted to consider over the municipal year. It identified the development of integrated health and care services and the implications of the Health and Care Bill 2021-22. This report summarises the main points of the Bill and its implications for Leeds.

2. In 2015 NHS Planning guidance announced the requirement to produce Sustainability and Transformation Plans. This required NHS organisations and local authorities across England to come together to develop "place-based" plans for the future of health and care services in their area. Draft plans were produced by June 2016 and final plans were submitted in October. STPs became Sustainability and Transformation Partnerships. STPs represented a shift in the way that the NHS in England planned its services. While the Health and Social Care Act 2012 sought to strengthen the role of competition within the health system, NHS organisations were now being told to collaborate rather than compete to respond to the challenges facing their local services. This change of approach was an acknowledgement that changes such as the abolition of a range of NHS bodies, the creation of new bodies, tighter financial settlements and the outsourcing of many services had not improved outcomes and had resulted in reduced co-operation between services.

3 From 2018, some of these partnerships evolved to form even closer partnerships through **integrated care systems or ICS's**, with the West Yorkshire and Harrogate Health and Care Partnership (WY H&CP) being the ICS in which Leeds sits. In an integrated care system, NHS organisations, in partnerships with local councils and others, take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve.

4. STPs and the subsequent ICS bodies did not escape the inevitable controversy inherent in NHS change. During this period Leeds had signed off a strong Health and Wellbeing strategy rooted in integration and improving the health of the poorest the fastest. This, coupled with effective political leadership, helped guide engagement with the STP and WY H&CP. A series of 'red lines' for LCC engagement with the ICS were agreed by Executive Board in 2017/18 and these were subsequently supported by the Partnership Executive Group that also includes NHS and Third Sector colleagues. These lines included requests for greater focus on health inequality, economic development and climate change but they also included a call for greater political engagement, the development of a structure that mirrored the local Health and Wellbeing Boards and, perhaps most importantly, that resource allocation would be fair and reflect both population and deprivation where possible.

5. As a result of these conversations a Memorandum of Understanding (MoU) was drafted that set a clear direction for the ICS and its subsequent strategy. The MoU stated that local government's regulatory and statutory arrangements would remain separate from those of the NHS and whilst councils would be subject to the mutual accountability arrangements for the partnership they would not be subject to a single NHS financial control total and its associated arrangements for managing financial risk. Through this MoU Councils agreed to align planning and performance improvement with NHS partners where it made sense to do so. Democratically elected councillors would continue to hold the partner organisations accountable through their formal Scrutiny powers.

6. Perhaps most importantly, from March 2019 there has been a 'Partnership Board' in place chaired by Cllr Swift, Leader of Calderdale Council, and including Council leaders and Health and Wellbeing Board Chairs as well as Chief Executives from the range of NHS organisations, the Third Sector and patient representatives. The Partnership Board provides the formal leadership for the Partnership and is responsible for setting strategic direction. It provides oversight for all Partnership business and a forum to make decisions together as partners.

7. The current WY&H plans are rooted in ‘primacy of place’ with services delivered and strategy designed as close as possible to people themselves. Primacy of place enables Leeds (and other areas) to determine, within national guidance, its own destiny and drive change locally, preventing over-reach of the ICS. It is predicated on a subsidiarity test with three components:

   - Critical mass/scale – the size of the issue requires a regional focus, or alternatively a service is so specialist it can only be delivered at scale (e.g. bariatric surgery or particular cancers)
   - Best practice – sharing of innovation and best practice (e.g. the Bradford Healthy Hearts Programme, the Leeds Health and Wellbeing Strategy, Calderdale Cares)
   - ‘Wicked issues’ and resolving system-wide intractable problems (e.g. workforce issues and managing competition for limited staffing resources or the development of residential provision for young people with mental health issues)

8. In 2019 the NHS Long term Plan confirmed, in what it described as the biggest national move to integrated care in any major western country, that every part of England would be served by an integrated care system from April 2021. The Plan also confirmed that primary and community services would be funded to provide a greater range of services in more convenient settings.

9. The Bill now takes that a step further with proposals to bring forward into legislation from April 2022 the following:

   (a) Establishing integrated care systems in law. Clinical Commissioning groups will be dissolved and their allocative functions absorbed within the ICS NHS body
   (b) The creation of statutory ICS bodies will allow NHS England to set financial allocations and other financial objectives at a system level. There will be a duty to meet the system financial objectives and deliver financial balance. How money will flow/ be allocated to place level will be key.
   (c) NHS providers within the ICS will retain their current structures, governance and organisational financial statutory duties but there will be a new duty to compel providers to have regard to the system financial objectives
   (d) The ICS NHS body will take on the commissioning functions of the CCGs and their responsibilities in relation to oversight and scrutiny committees
   (e) The ICS partnership will bring together health, social care and public health as well as other bodies as appropriate, to develop a plan to address the wider health and care needs of the system. This plan will inform decision-making by the ICS NHS bodies and local authorities
   (f) It will create provision to allow the formation of joint committees between ICSs and NHS providers and between NHS providers separately to give a legal basis for making joint decisions. Both types of committees could include representation from other bodies such as primary care networks and local authorities.
   (g) The Bill draws attention to a forthcoming data strategy for health and care. The strategy will set out the proposals to address structural, cultural and legislative barriers to sharing data for the benefit of the individual, population and system.
   (h) It sets out plans to remove the current procurement rules which apply to the NHS and public health commissioners when arranging healthcare services. Commissioners will be able to arrange services with the most appropriate provider. Commissioners will be able to run a competitive process where it adds value, recognising their duty to act in the best interests of patients, tax-payers and the local population.

10. It described the core purpose of an ICS being to:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- help the NHS support broader social and economic development

11. The proposals represent a marked shift away from the focus on competition that underpinned the coalition government's 2012 reforms towards a new model of collaboration, partnership and integration. At the same time, removing some of the competition and procurement rules could give the NHS and its partners greater flexibility to deliver joined-up care to the increasing number of people who rely on multiple services.

12. Unlike previous reforms, the proposed legislation aims to avoid a one-size-fits-all approach and leaves many decisions to local systems and leaders. This is appropriate given the great variation across England in terms of history, demography and local health challenges.

13. It is important to recognise the limitations of what legislation can achieve. It is not possible to legislate for collaboration and co-ordination of local services – that has to come from the strength of local relationships.

14. In March 2021 *Transforming the public health system: reforming the public health system for the challenges of our times* was published which took the lessons from COVID to describe proposals to place two Public Health functions – health security and health improvement into two separate areas. The first is the UK Health Security Agency [UKHSA] whose role will be protecting against infectious diseases and external health threats; the second is a new Office for Health Promotion, within the Department of Health and Social Care, which will drive our prevention agenda across government . There will also be a new cross-government ministerial board on prevention, to drive forward and co-ordinate government action on the wider determinants of health. The policy paper notes that the changes detailed above will also impact locally on the Public Health system with statutory integrated care systems bringing local authorities and the NHS together, so they can take decisions together and strengthen the prevention agenda at a local level, as well as supporting local authorities and Directors of Public Health.

15. In terms of the impact on social care, the Bill sets out four measures: enhanced integration through the position of social care in the ICS structure, a new standalone legal basis for the Better Care Fund and allowing "Discharge to Assess" models to follow, a legal power to make direct payments to providers and finally an enhanced assurance framework and improved data collection.

16. The Leeds Health and Wellbeing Strategy outlines an ambition to move care into the community, closer to people's homes. We have referred to this strategic objective as achieving a "left shift". The Left Shift Blueprint puts in place the metrics by which we will judge how well that strategic shift has been achieved. This is a key document with four principles:

(i) Supporting people to live, age and die well
(ii) Addressing health inequalities
(iii) More care delivered closer to home
(iv) People as equal partners in their care

City partners have signed up to the strategic indicators below as to how we will judge success in re-aligning care against the core principles:

Health Outcome Ambitions	Improve infant mortality and narrow the gap	Reduce weight in 10-11 year olds and narrow the gap	Improve Healthy Life Expectancy and narrow the gap	Reduce PYLL avoidable causes & rates of early deaths and narrow the gap	Reduce premature mortality for those with LD and SMI and narrow the gap	Reduce Suicide rate and narrow the gap	Increase the proportion of people who experience a 'good death' and narrow the gap
System Activity Metrics	**Prevention:** Reduce the proportion of adults: • With a BMI over 30 • Who smoke Increase expenditure on the 3rd Sector		**Primary/Community Services:** Increase proportion of people being cared for in P/C services Increase expenditure on the 3rd Sector		**Hospital Care:** Reduce rate of growth in non-elective bed days and A&E attendances Reduce number of face-to-face appointments in Hospital		
Quality Experience Measures	Improve the experience of Primary Care						
	Improve the experience of Community Services						
	Improve the experience of Hospital Services						

17. The key next step is to put in place the new governance structures at West Yorkshire and Leeds level. The government published the *ICS Design Framework* in June 2021. It sets out that:
    - Each ICS will have a Partnership at system level, formed by the NHS and local government as equal partners – it will be a committee, not a body. The West Yorkshire ad Harrogate Health and Care partnership already has this in place.
    - Members must include local authorities that are responsible for social care services in the ICS area. Beyond this, members may be widely drawn from all partners working to improve health, care and well-being in the area, to be agreed locally
    - The ICS partnership will have a specific responsibility to develop an "integrated care strategy" for their whole population
    - The Chair of the Partnership can also be the chair of the ICS NHS body but it does not have to be – for local determination

There will also need to be a formal ICS NHS body referred to in the Bill as the ICS Integrated Care Board. This will be the vehicle through which NHS lines of accountability will operate. Its functions will include:

- Developing a plan to meet the health needs of the population
- Allocating resources to deliver the plan across the system (both revenue and capital)
- Establishing joint working and governance arrangements between partners
- Arrange for the provision of health services including through contracts and agreements with providers and major transformation programmes across the ICS
- Have a People Plan with implementation with employers
- Leading system wide on digital and data
- Joint work on estate, procurement and community development
- Leading emergency planning and response

18. The ICS Integrated Care Board will be different from traditional NHS boards, owned by partners across the ICS. There will be a minimum requirement for Board membership set out in legislation but must include the following roles:

- An independent chair
- Two other independent non-executives (cannot be on Boards of any other NHS Body)
- A Chief Executive
- A Chief Finance Officer
- An Acute Hospital Representative
- A Mental Health Trust Representative
- A Representative of General Practice
- A Medical Director
- A Chief Nurse
- One member drawn from the local authority, or authorities, with statutory social care responsibility whose area falls wholly or partly within the area of the ICS NHS body.

This Board will be held ***accountable for delivering NHS statutory duties***: that is, duties for the use of NHS resources and for meeting NHS standards in their area. In reality, it will be very similar to the responsibilities of CCGs, but across a broader area. The guidance is permissive as to how they discharge this accountability especially in larger ICS. In West Yorkshire the intention is to seek to ***discharge these duties primarily through delegation to places***.

19. An ICS Integrated Care Board could establish any of the following place-based governance arrangements with local authorities and other partners:

- **Consultative Forum,** informing decisions by the ICS Integrated Care Board, local authorities and other partners
- **Committee of the ICS Integrated Care Board** with delegated authority to take decisions about the use of the ICS BHS body resources
- **Joint Committee of the ICS Integrated Care Board** and one or more statutory providers, where the relevant statutory bodies delegate decision-making on specific functions/ services/ population to the joint committee
- **Individual Directors of the ICS Integrated Care Board** having delegated authority, which they may choose to exercise through a committee
- **Lead Provider** managing resources and delivery at place level under a contract with the ICS Integrated Care Board

20. In Leeds we believe we have been working as an integrated care partnership for some time with numerous pieces of working spanning re-modelled care pathways, a population health approach, workforce and data and digital integration. The establishment of a formal body is a logical next step.The current thinking in Leeds for our own Board is to establish it as a Joint Committee of the ICS Integrated Care Board. This would allow for the full devolution of the NHS budget to Leeds plus the ability to add non-NHS resources such as the Better Care Fund and pooled budgets with the Council under this governance.

21. The Leeds Board will be:
    - Accountable to the ICS with wider partners for achieving the best possible improvements in the health and wellbeing of all the people of Leeds and ensuring for them the provision of high-quality services within a delegated NHS Budget.
    - Delivering these on behalf of, and in line with, the strategies of the West Yorkshire ICS and the Leeds Health and Wellbeing Board.

- Responsible for the delivery of the Leeds ambitions around Population Health Management, The Left Shift and addressing Health Inequalities.
- Responsible for ensuring the integration of services in Leeds driven-by data informed, personalised and preventative care based around citizen's needs.
- Responsible for establishing the necessary infrastructure and capabilities in Leeds to facilitate allocation of resources, effective risk sharing mechanisms, and statutory duties across Leeds for NHS services.

22. The most important issue is that Leeds adopts a governance structure that allows the maximum possible autonomy and to do so in a way that does not inhibit other places in the wider West Yorkshire Partnership.

What impact will this proposal have?

Wards Affected:		
Have ward members been consulted?	☐Yes	☒No

23. When the Bill passes into law, we will see the dissolution of Leeds NHS CCG and its role and responsibilities transfer to the West Yorkshire and Harrogate Health and Care Partnership. Depending on what model of governance is adopted at place (i.e. local authority level) this will affect how much control and autonomy the Leeds system has over its NHS resources.

24. In the future, there will not be a formal commissioner/ provider split but rather collective decision-making on the use of resources for the whole system.

What consultation and engagement has taken place?

25. The government ran a formal consultation process on its proposals before publishing the White paper and Bill.

What are the resource implications?

26. To a certain extent these are unknown as we do not know how precisely money will flow into the Leeds NHS system.

What are the legal implications?

27. The proposals in the Bill are intended to pass into law by April 2022.

What are the key risks and how are they being managed?

28. The key risk in the Bill is the loss of control of Leeds NHS resources which can be mitigated by adopting a model of governance that supports the devolution of resources to a Leeds Integrated Care Board. This is a working title and we may need to change it to make a clearer distinction between the West Yorkshire Board and the Leeds Board.

Does this proposal support the council's 3 Key Pillars?

☐Inclusive Growth ☒Health and Wellbeing ☐Climate Emergency

29. Leeds Health and Well-being strategy sets out the ambition that Leeds will be a healthy and caring city for all ages, where people who are the poorest improve their health the fastest. The aims of integrated care support many of the strategy's priorities including "the best care, in the right place, at the right time".

Options, timescales and measuring success

a) What other options were considered?

30. The options for different types of local governance will be determined by national legislation as set out earlier in this report. The other option Leeds could choose that would ensure a devolved budget is to be a sub-committee of the ICS.

b) How will success be measured?

31. Leeds partners have agreed that the "left shift blueprint" as set out in paragraph 16 as our measures of success.

c) What is the timetable for implementation?

32. The Health and Care Bill 2021-22 is expected to pass into legislation by April 2022. The Leeds Board is expected to be established in shadow form by October 2021 in preparation for the new arrangements.

Appendices

33. None

Background papers

34. *Integration and Innovation: working together to improve health and social care* – government White Paper, Department of Health and Social Care, February 2021

Integration and innovation: working together to improve health and social care for all (HTML version) - GOV.UK (www.gov.uk)

35. The Health and Care Bill 2021-22, House of Commons library, July 2021
CBP-9232.pdf (parliament.uk)

36. *Integrated care systems: Design Framework,* Department of Health and Social Care, June 2021
Report template - NHSI website (england.nhs.uk)