CCN COUNTY COUNCILS NETWORK **Consultation Response**

Integrated Care Systems

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Introduction

What is the County Councils Network?

The County Councils Network (CCN) represents 36 English local authorities that serve counties. The 25 county and 11 county unitary authorities that make up CCN are the largest part of the local government family. They represent all four corners of England, from Cumbria to Cornwall, Durham to Kent, North Yorkshire to Suffolk, Derbyshire to Essex.

The essential services our members provide touch on the everyday lives of residents and businesses across 86% of England's landmass and 47% of its population. The areas represented by our members constitute 38% of local government expenditure; 44% of total public expenditure (£201bn); and generate just under half of all tax revenues (£255bn). The economies of our areas contribute 39% of Gross Value Added (GVA) and 42% of all employment.

County authorities and adult social care

Adult social care is of particular significance to county authorities. In 2019-20 county authorities received 915,405 requests for care representing 45% of the total number across England. They spent £7.8bn on social care. Social care is a higher proportion of county authority budgets. During the ongoing year, adult social care is projected to represent 33% of authorities' total service costs, but for CCN member councils, this figure is 39% due to the different responsibilities that county councils have.

Overall CCN is encouraged by the direction set out in this consultation document – in particular the emphasis on reconfiguring services to reflect the importance of 'place'. However, to ensure maximum effectiveness it is important the NHS definition of 'place' reflects current upper-tier local authority boundaries as far as possible. CCN recognises health geographies are complex, just as those in local government are, but best results will be achieved by seeking co-terminosity and not trying to redefine pre-existing long-term county boundaries – added complexity may disrupt delicate models for social care provision.

New report from CCN and Newton Europe on adult social care

In February CCN will be publishing a new large-scale analysis of county authorities' experience of operating the social care system conducted by Newton Europe. The report has been drawn from large scale engagement and feed-in from across CCN's 36 member authorities as well as external partners in the health and social care sectors. The aim is to help influence the Government's widely anticipated proposals for social care reform, by identifying best practice and setting out an optimised model for the delivery of social care.

The report supports the notion of ICSs playing an important role in an enhanced vision of social care reform. However the key feedback in compiling the report has been this will need equality between health and social care systems – ***"…parity of esteem, parity of funding***

models and parity of brand *will be essential for organisations to truly work in partnership within the ICS model."*

We would welcome the opportunity to talk with colleagues in NHS England and the team working on this consultation about this report in more detail.

- ***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?***

AGREE [√]

The move to putting ICSs on a statutory footing has the potential to improve the local delivery of care services – particularly by better aligning the local approaches of different organisations. But it is also important to note that any regulatory changes which lead to further divergence of the rules that health and social care must operate within would be a retrograde move. For instance – mandating a centralised contractual framework for the NHS will not lead in itself to effective joint investment and commissioning at the local level. This is because are significant regulatory differences such as differences in treatment of VAT, pension conditions, HR rules etc. which restrict alignment between health and social care.

If legislative changes are to be brought forward CCN would suggest that consideration should be given to also strengthening the legal provisions governing associated structures such as Health and Wellbeing Boards so they can be better aligned to the proposed new structure for ICSs.

County authorities strongly welcome the commitment in this proposal *"to develop effective models for joined-up working at "place"*. It is local government's view that the best models of delivery for care services are those devolved as close as possible to the communities they serve. This ensures they best meet local demand and achieve buy-in and support from the people they are built to serve – particularly important given so much social care is provided by informal carers and family which stops overburdening of the wider formal health and care system.

Local government's view of this has been strengthened during the course of the pandemic as national centralised approaches to matters such as the national distribution of PPE or Test and Trace arrangements have often struggled to respond as quickly and effectively to need on the ground as localised systems benefitting from local knowledge. Indeed the response to the COVID pandemic has in many parts of the country greatly strengthened and accelerated partnership working between health and local authorities. In particular it has necessitated the circumvention of established bureaucracy in some areas to achieve outcomes which might have taken significantly longer in other, less urgent, circumstances.

This has on the whole worked remarkably well and CCN's member authorities have welcomed the co-operation they have received from colleagues in health, and hope that this has been felt reciprocally. It therefore makes sense to consider how these evolutionary advances in partnership working can start to be put on a firmer footing, with ICS arrangements the obvious vehicle for attempting to make this happen particularly in bringing together different parts of the NHS to work cohesively together.

However, it is important to recognise that putting ICSs onto a statutory footing will not be without challenges. CCN is supportive of the aim *of "a progressively deepening relationship between the NHS and local authorities"*, but cautions this must be done on an equal partnership basis. ICSs also need to understand that social care is a hugely expansive term

encompassing a range of services which impact on acute health to a varying range of degrees not just directly such as e.g. transfers of care. CCN's recent report *The Other Side Of The Coin*, published ahead of the Government much anticipated plans for social care reform, states:

> *"Any consideration of the scope of ASC reform should have as its central aim facilitating effective lower-level social care in the community which minimises the need for acute health and social care as far as possible."*

This key objective focussed around prevention should be fully embedded within the wider aims of statutory ICSs, directly linked to wider social care reform proposals which are expected to emerge in the coming decade.

- ***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?***

AGREE [√]

CCN supports the trajectory towards the model in Option 2 which puts ICSs on a statutory footing as a new NHS body. However, it should also consider how it will interact and integrate with other local models for co-operation which already exist such as Health and Wellbeing Boards. This will be a vital part of strengthening partnerships and ensuring accountability.

However, it is important that if ICSs are to work more closely with local authorities, that NHS partners fully appreciate the complexity of delivery of social care and the extent to which it involves the co-ordination of many independent providers including those which are independent in the private and voluntary sector. These providers cannot be expected to operate under a command and control basis – as such and full consideration needs to made for how to incentivise these providers to act in concert with wider care strategies effectively as they cannot be mandated to.

In short this model for ICSs is likely to be helpful for NHS organisations to better co-ordinate their approaches at a local level which will in turn help to create a more joined-up approach on the ground across the entire care system. However, it is not clear whether it will also be as influential in co-ordinating social care delivery which will probably be dependent on how flexible the model can be in adapting to and reflecting the different needs and drivers inherent in social care.

- ***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?***

AGREE [√]

The following statement in the consultation is extremely encouraging.

"We will work much more closely with local government and the voluntary sector at place, to ensure local priorities for improved health and care outcomes are met by the NHS becoming a more effective partner in the planning, design and delivery of care."

The aim to devolve NHS planning and delivery of services at a more local level is admirable and would be a major step in the right direction.

However, the degree to which local authority participation within a statutory ICS will be 'mandatory' or not will be crucial to their success. Where local authorities willingly embrace working within ICSs then it is likely to be successful, but forcing this risks undermining the very trust which successful partnerships are built on.

This is a particular issue for many larger county authorities, where boundaries are not co-terminous with health authorities and the picture can be extremely complicated. For ICSs in these areas to operate effectively the NHS must also consider how it can encourage different ICSs to develop a co-ordinated approach with each other to enable seamless working across whole county areas and involving all local authorities (e.g. within Suffolk and North Essex).

This highlights the fact there will be a number of challenges which need to be considered in full to make the model work. It is also crucial that change recognises different parts of the country are at different stages of ICS development and will therefore need to move on different timescales to implementation. We know in some of our member counties – e.g. Surrey – arrangements have progressed quickly and effectively, having already developed a framework for partnership working between the NHS and LA which is hoped will enable a move towards putting the ICS on a statutory footing. This is not necessarily the case in other parts of the country where the process is either more complicated or is taking longer to put initial measures in place.

Finally public health must be an integral part of the ICS model to ensure that health services are working fully in concert with local public health approaches. To that extent Directors of Public Health should definitely be identified as a key part of the new statutory ICS in addition to wider local authority participation.

- ***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?***

AGREE [√]

Yes – this would be a major step forward in ensuring a local services are placed closer to their community and working within a wider local framework for effective health and social care.