INTEGRATING CARE: A UNIQUE OPPORTUNITY TO BUILD BACK BETTER HEALTH AND PROSPERITY

Response by the Health Devolution Commission to NHSE national engagement/consultation exercise: *'Integrating care - Next steps to building strong and integrated care systems across England'.*

Executive Summary

The Health Devolution Commission believes that 'Integrating Care' is a major step forward towards its vision of comprehensive health devolution and collaborative ways of working, and broadly welcomes this set of proposals. The Commission welcomes the permissive nature of the proposals that will allow local areas to shape the system to suit local circumstances.

However, the Commission believes there is a strong case for going further and giving local areas more choice about the nature of their local system in order to deliver better health and social care services, and build healthier and more prosperous communities. The Commission accordingly makes a number of observations and detailed suggestions for additional options and flexibility in the proposals.

The Commission's preferred option is that a third 'Health and Prosperity' model of Integrated Care System bodies is added to the two currently proposed. This model would extend the current options, and enable local areas through their partnerships to develop an ICS body that can address the wider determinants of ill-health, tackle health inequalities and genuinely secure an integrated approach to NHS and social care services as well as improve the health and economic prosperity of their communities.

The key elements of the Commission's proposal for an additional and optional joint 'Health and Prosperity' model of Integrated Care System bodies are that this would allow them to:

1. Embrace a wider purpose to include better social care and public health services, tackling health inequalities and improving economic prosperity
2. Embed the principles of person-centred care, active citizen engagement, and 'health in all policies' in its ways of working
3. Ensure parity of esteem between physical health, mental health, social care and public health
4. Enhance local democratic accountability through joint civic and clinical leadership in a 'partnership of equals'
5. Ensure single health and social care budgets and commissioning at the locality level
6. Enable the best alignment of new ICS body footprints with established boundaries of Local or Sub-Regional Government
7. Embrace health and social care workforce planning and management
8. Establish robust external scrutiny arrangements to ensure quality

The Commission is keen to work with NHSE and the Government to develop its suggestion of a third statutory 'health and prosperity' model as an option for local partners to adopt in the development of the Integrated Care System body for their area.

This option could be subject to Parliamentary approval through the affirmative Statutory Instrument process. The Commission also believes there is a case for dispensing with the technocratic term Integrated Care Systems and adopting the title Integrated Care Partnerships.

INTRODUCTION

This is the response of the cross-party Health Devolution Commission to the NHSE consultation paper 'Integrating care - Next steps to building strong and integrated care systems across England' (Integrating Care).

It draws directly from the Commission's final report 'Building Back Health and Prosperity' published in August 2020 and a table comparing the NHSE proposals and those of the Commission is given in appendix 1.

In this response the Commission makes a series of suggested options for improving the proposals for integrating care through enhanced ICS bodies including their values and vision of devolution, arrangements for governance and accountability, the person-centred nature of care integration, inclusion of social care in integrated workforce planning, the characteristics of place-based partnerships, the relationship between Local Government and the NHS, and funding of the system as a whole.

The Commission suggests there is value in creating a third joint 'Health and Prosperity' model for ICS bodies that local areas could choose to adopt that embraces all of its suggested proposals for going further.

The Commission is keen to contribute the experience and expertise of its members to work with NHSE and the Government in developing these proposals and options further. This could include support in:

- developing a third 'health and prosperity' model of ICS bodies as an option for local partners to adopt
- understanding the institutional relationship between local partners responsible for improving population health, promoting economic prosperity (e.g. Mayoral Combined Authorities) and delivering better care services
- identifying how national partners (government departments, NGOs and so) on could act to support local collaborative action
- understanding what joint civic and clinical leadership means in practice and how ICS bodies can be democratically accountable to both their local area and to Parliament.
- developing an ICS-level Partnership Compact as guidance for engaging a wide range of partners and stakeholders
- developing a mechanism for independent external scrutiny of ICS bodies

The next iteration of ICS bodies must avoid becoming a technocratic rearrangement of traditional 'command and control' in the NHS, predicated on a model in which ICS bodies are clinically led and primarily accountable to NHSE or central Government.

The Commission also recognises that these proposals are about structural reform but believes that successful health reform is dependent upon the sufficient, equitable and sustainable funding of health, social care and public health services. In the short term the Commission recommends that social care services (including domiciliary care and residential care) are given an immediate and very substantial funding increase.

1 DEVOLUTION

'Integrating Care' shares much of the fundamental vision of devolution and values proposed by the Commission. The proposed purpose of future Integrated Care System bodies is, for example, broad and similar to that proposed by the Commission.

'Integrating Care' also makes explicit the importance of devolving health functions and resources to regional and local levels for achieving the aims of the system. Decentralisation (as distinct from delegation) through comprehensive health devolution is also a core recommendation of the Commission and the NHSE commitment to devolution of health is welcome.

However, the Commission suggests that the purpose of Integrated Care System bodies should be broader and explicitly recognise a 'health in all policies' approach. The connection between a population's health, the role of health and social care organisations as community anchors and the economic prosperity of a locality is now well understood.

It is only by addressing the wider determinants of health – safe and affordable housing, access to training and good jobs, a safe and healthy environment, support for early years, infrastructure to support resilient communities and encouraging citizens to take an active part in their neighbourhood – that an accountable, sustainable and effective health and care system that addresses health inequalities and improves population health can be achieved.

Consequently, local partners should have the option of including within the scope of the ICS social care services, population health improvements, health in all policies, and economic prosperity. The Commission suggests that ICS bodies should also have the option of combining the responsibilities – and appropriately align their geographies - with local authorities and Mayoral Combined Authorities to secure a comprehensive approach to health creation, population health management, economic development and integrated health and social care delivery.

2 GOVERNANCE AND ACCOUNTABILITY

'Integrating Care' proposes that Integrated Care System bodies are put on a statutory footing with two models: a statutory committee or a statutory corporate NHS body. The Commission also proposed statutory changes to support the development of comprehensive health devolution and welcomes the principle of enshrining ICSs in legislation. The permissive nature of the proposals is welcome in giving local areas the flexibility to work within a legislative framework in ways that suit their circumstances.

A significant concern, however, is that without explicit and direct involvement of locally elected leaders in leadership roles in ICSs there are significant risks that the key benefits of Local Government knowledge, insight and services will have much less impact as ICS bodies become clinically led and focused. NHSE could, over time impose top down instruction by NHSE on local systems regardless of local circumstances and views. Alternatively, government could make ICS bodies politically accountable to DHSC (as distinct from NHSE) and not to their localities leading to greater centralisation and the opposite effect to what was intended.

In addition, the welcome replacement of competition - as an underlying principle of the NHS to drive of health service improvement - with collaboration between commissioners and among providers requires alternative means of ensuring quality. The Commission suggests that the new collaborative approach should be accompanied by both greater local democratic accountability and enhanced external scrutiny.

The Commission suggests that effective governance and accountability of statutory ICS bodies to achieve their purpose requires:

- joint civic and clinical leadership systems with the option of local authority leaders or Metro Mayors/regional leaders to be the chair (appropriate to local footprints and geography)
- an Annual Joint Mandate between the local area leader(s) and the Secretary of State for Health and Social Care including national health and social care entitlements to be delivered locally
- a reciprocal duty of collaboration between the NHS and Local Government to improve public health and reduce health inequalities
- a statutory public health improvement role for all Metro Mayors/regional leaders
- a new health and prosperity scrutiny committee for each ICS body (see appendix 2 for suggestions of how these could be set up)

3 INTEGRATION and the WORKFORCE

'Integrating Care' makes no specific proposal to fully integrate health and social care. There is clearly a distinction between integration *within* NHS services and *between* NHS and social care service but whilst the proposals are entitled 'Integrating Care' they do not fully embrace social care at the ICS level. The proposals also focus on the NHS workforce in isolation from the social care workforce and it is difficult to envisage how services can be truly integrated when their staff are not.

There are, however, clear references to going wider than just integration of internal NHS services at various points in the proposals with the emphasis on this at the Primary Care Network level within local authority areas

The Commission believes that structural health reform should start from the needs of the community and that integrating care should mean that citizens are actively engaged in their own health care, and that patients receive person-centred and seamless physical and mental health and social care services when and where they need them. The principles of effective integration of health and social care should include:

- collaborative leadership
- subsidiarity - decision-making as close to communities as possible
- building on existing, successful local arrangements
- a person-centred and co-productive approach
- a preventative, assets-based and population-health management approach
- achieving best value

The Commission suggests that the proposals should clearly include options for local areas to include:

- Person-centred health and social care integration at every level - primary care networks, place-level services and integrated care systems bodies.
- Integrated workforce planning and management for health and social care staff within the remit of their ICS body.
- Single budget health and social care commissioning at the locality level.

4 PLACE-BASED PARTNERSHIPS

'Integrating Care' says that an important building block for the future health and care system is at 'place'. Its ambition is to make an 'offer to the local population of each place' that embraces a wide range of health and care services). The Commission strongly welcomes this approach, and the additional reference to links to other services that contribute to better health outcomes reflects its belief in a 'health in all policies' and greater integration of services.

However, the proposed transfer of CCG roles to ICSs raises potential concerns about losing appropriate place-level decision-making where CCG geographical footprints are currently aligned with those of local authorities.

The Commission believes the building block of integrated care is at the local authority level as this provides the opportunity to integrate NHS and social care services, commissioning and budgets. Primary Care Networks, at a neighbourhood level, can then fit within this footprint.

The ICS footprints could then be readily aligned with those of Combined Authorities where they exist or with one or more County Councils in other areas. It is clearly unhelpful for different visions about devolved geography to be held by NHSE and different Government departments such as MHCLG, DfT and BEIS.

The Commission suggests that these differences and dilemmas can be resolved through a common sense and flexible, bottom-up approach that seeks to create the best alignment between the footprints of the new ICS bodies with the existing, established boundaries of local or sub-regional government to achieve their purpose.

Certainly, legislation should permit flexibility to allow local areas to determine how these relationships will work in practice with regard to footprints, joint budgets, and shared decision making rather than imposing a one-size-fits-all approach.

The Commission believes that local public services outside of health, social care and public health contribute to a community's health and economic prosperity and suggests that local areas have the option to make these a part of the mainstream purpose and business of the ICS body rather than regarded as just an 'important link'**.**

5 NHS AND LOCAL GOVERNMENT

'Integrating Care' proposes that each place should define its place leadership arrangements and describes some common ways of working and additional options for local areas to decide). The Commission welcomes the strong commitment to partnership between the NHS and Local Government, and the flexibility for local areas to determine how this partnership could work in practice.

This reflects the Commission's approach that also places a strong emphasis on fully recognising the contribution of wider stakeholders to the success of the NHS/LG partnership. Partnership can mean different things to different people but in this context the Commission believes it should mean genuine joint working, decision making, accountability and leadership – a 'partnership of equals'.

The Commission suggests that appropriate mechanisms within the ICS infrastructure should be created to reflect a genuine 'partnership of equals' between Local Government and the NHS. In addition, local areas should have the option of developing a broad approach to partnership with a wide range of stakeholders.

The Commission suggests that a new 'Partnership Compact' for engagement and inclusion of a wide range of key stakeholders in decision taking is developed that includes clinicians, patient voice and carers organisations, the VCSE sector, trades unions and health and social care providers.

6 FUNDING

'Integrating Care' proposes that the finances of the NHS should be increasingly organised at ICS level, and allocative decisions put in the hands of local leaders. Financial governance arrangements will need to reflect that ICS bodies should be key bodies for financial accountability. The Commission welcomes this and other proposals such as 'single pot' budgets and the flexibility to create joint locality-based NHS/LG budgets. However, the Commission has strong concerns that these positive proposals for 're-wiring' the system will not work without the funding 'electricity' to flow through it.

The Commission believes that health devolution is dependent upon sufficient, equitable and sustainable funding of health, social care and public health services to be successful. In the short term it is clear that social care services (including domiciliary care and residential care) are in urgent need of an immediate and very substantial increase to funding to ensure they are sufficient in volume and high enough in quality to provide adequate services for an ageing population.

The Commission suggests that NHSE should make clear to government that the success of its proposals for institutional reform and structural devolution rely upon sufficient funding not just for the NHS but for social care and public health services too. In particular it should make clear that its proposals for 'Integrating Care' will only be successful if there is an immediate and very significant increase in the funding of social care.

7 THE HEALTH DEVOLUTION COMMISSION RESPONSES TO THE FOUR NHSE QUESTIONS

The Commission broadly supports the NHSE proposals for Integrated Care System bodies but has identified a number of suggestions for going further to reflect its belief in the value of comprehensive health devolution and to provide additional options for local partners who wish to go further in their areas.

To that end, the Commission also suggests that the option of a third joint 'health and prosperity' model for ICS bodies is developed that has an appropriate statutory footing and which local areas could choose to adopt.

1 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?

If the statutory footing of ICS bodies includes the Commission's suggestions for creating a third joint statutory 'health and prosperity' model for an ICS body that allow local areas the option of going further on devolution, governance and accountability, care integration and place-based partnerships, then yes.

2 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?

The Commission believes that its proposal for an optional third joint 'health and prosperity' model provides the greatest incentives for local collaboration and effective accountability to patients, and local and national partners. All of the models require an element of local democratic accountability and an effective system of local external scrutiny to ensure quality.

3 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?

The Commission supports the permissive nature of the proposals and suggests that this should be extended to include the option for local areas to adopt a joint 'health and prosperity' model that it proposes. Non-statutory guidance should be developed on best practice in all models regarding key elements such as the scope of the system; joint civic and clinical leadership at every level; parity of esteem between health, social care and public health; person-centred care; external scrutiny; and a Partnership Compact for engaging stakeholders.

4 Do you agree, subject to appropriate safeguards and where appropriate, that services currently commissioned by NHSE should be either transferred or delegated to ICS bodies?

The Commission supports the principle of devolution of services currently commissioned by NHSE national commissioning to local ICS bodies subject to appropriate safeguards.

Appendix 1:

Summary comparison of 'Integrating Care' and 'Building Back Better health and Prosperity'

NHSE	Health Devolution Commission
Purpose of the system	
• improving population health and healthcare • tackling unequal outcomes and access • enhancing productivity and value for money • helping the NHS to support broader social and economic development A new triple aim: better health for the whole population, better quality care for all patients and financially sustainable services for the taxpayer.	• delivering better health and social care outcomes • improving public health and reducing health inequalities • integrating health, social care and public health services • helping to build local economic prosperity Integrating local social care and public health services with NHS (physical, mental and acute care health) services, and delivering a 'health in all policies' approach to other services such as housing, employment, transport, education, the environment and economic development.
Devolution	
To deliver the core aims and purposes we will need to devolve more functions and resources from national and regional levels to local systems, to develop effective models for joined-up working at "place", ensure we are taking advantage of the transformative potential of digital and data, and to embed a central role for providers collaborating across bigger footprints for better and more efficient outcomes. The aim is a progressively deepening relationship between the NHS and local authorities, including on health improvement and wellbeing.	There is now a fundamental choice to be made between greater centralisation of NHS and social care services or a comprehensive health devolution approach which incorporates national entitlements and targets but embeds the delivery of an integrated NHS, social care and public health service within broader, powerful, democratically led local partnerships.
Statutory options	
Option 1: Statutory Committee model with an Accountable Officer that binds together current statutory organisations. Option 2: statutory corporate NHS body that additionally brings CCG statutory functions into the ICS.	An Annual Joint Mandate (AJM) between the Secretary of State for Health and Social Care and each devolved health area leader (Metro Mayors, leaders of Combined Authorities with no Metro Mayor and designated leaders in non- Combined Authority areas).

Both models share a number of features – broad membership and joint decision-making (including, as a minimum, representatives from commissioners; acute, community and primary care providers; and local authorities); responsibility for owning and driving forward the system plan; operating within and in accordance with the triple aim duty; and a lead role in relating to the centre. Local Government to be an integral, key player in the ICS under either model both of which offer a basis for planning and shaping services across healthcare, social care, prevention and the wider determinants of health. Both would allow for the delegation of functions and money to place-based statutory committees involving NHS bodies and Local Government. Both would enable NHS and Local Government to exploit existing flexibilities to pool functions and funds.	A formal public health improvement role should be given to Metro Mayors, leaders of Combined Authorities with no Metro Mayor and designated leaders in non-Combined Authority areas (as is given to London Mayor) New city region health and prosperity scrutiny committees and to give a statutory role for Healthwatch in every devolved health area ….for a more visible and higher profile method of democratic accountability for health devolution, which draws upon the democratic political and professional expertise and experience within the relevant MCA.
Integration	
Integrating care makes a number of key references to health and social care integration: • recognising 'place' as an important building block for health and care integration • joining up the provision of services both within and between places • primary care working with community, mental health, the voluntary sector and social care as close to where people live as possible for integration to be successful • integrating digital and data • removing legislative barriers to integration • new statutory committees that provide a clearer statutory vehicle	The Commission believes that comprehensive health devolution is the most viable route to integrate local NHS, social care and public health services in a single place-based service, and makes specific proposals including: • integrating health and social care workforce planning and management • joint leadership of the three services • a single health, social care and public health budget • joint commissioning of all local health, social care and public health services including mental health and acute hospital care

for deepening integration across health and Local Government over time	
Place-based approach	
Place for most areas will mean long-established local authority boundaries (at which joint strategic needs assessments and health and wellbeing strategies are made). However, the right size may vary for different areas, and that within each place, services will be joined up through primary care networks (PCNs) integrating care in neighbourhoods. An 'offer to the local population of each place' will be met through providers of primary care, community health and mental health services, social care and support, community diagnostics and urgent and emergency care working together with meaningful delegated budgets to join up services. Delivery will be through NHS providers, Local Government, primary care and the voluntary sector working together in each place in ICSs, built around primary care networks (PCNs) in neighbourhoods. The NHSE says its offer will also allow important links to be made to other public or voluntary services that have a big impact on residents' day-to- day health, such as by improving local skills and employment or by ensuring high-quality housing.	Place' is the central feature in the definition of comprehensive health devolution: 'Healthy, resilient and prosperous communities through 'health in all policies', place-based, democratically led, local partnerships'. A place-based approach to planning all public services should be based on an understanding of all the local factors that drive ill-health or contribute to successful local economies. Full integration of health, social care and public health services in local areas is required as well as place-based ways of working that embrace key services such as transport, education, housing and economic development. The geographical footprints of devolved health areas are best determined locally and agreed nationally, and reflect relevant Local Government and NHS boundaries.
Place leadership	
Each ICS should define 'place' leadership arrangements that should consistently involve: • every locally determined 'place' in the system operating a partnership with joined-up decision-making arrangements for defined functions; • the partnership involving, at a minimum, primary care provider	A health devolution approach which incorporates national entitlements and targets but embeds the delivery of an integrated NHS, social care and public health service within broader, powerful, democratically led local partnerships.

leadership, local authorities, including Director of Public Health and providers of community and mental health services and Healthwatch; • agreed joint decision-making arrangements with Local Government; and • representation on the ICS board. They may also flexibly define: • the configuration, size and boundaries of places which should reflect meaningful communities and scale for the responsibilities of the place partnership; • additional membership of each place partnership that is likely to include acute providers, ambulance trusts, the voluntary sector and other partners; • the precise governance and decision-making arrangements that exist within each place; and • their voting arrangements on the ICS board.	A critical success factor for successful comprehensive health devolution is shared civic/clinical leadership. The geographical footprints of devolved health areas are best determined locally and agreed nationally, and reflect relevant Local Government and NHS boundaries. Comprehensive health devolution should have at its core genuine and deep-rooted partnerships with key stakeholders and community-based networks including patient voice and carers organisations, clinicians, voluntary, community and social enterprises, and local employers and trades unions. Key stakeholders outside of statutory bodies should be 'at the table' at all stages planning, delivery and scrutiny in devolved health areas and this includes the voluntary sector. A new Partnership Compact should be developed in devolved health areas for working with key stakeholders such as clinicians, patient voice and carers organisations, the VCSE sector, trades unions and health and social care providers in devolved areas
Funding and Finance	
Finances of the NHS to be increasingly organised at ICS level and allocative decisions put in the hands of local leaders. ICSs to be key bodies for financial accountability and financial governance arrangements will need to reflect that. Creation of a 'single pot,' which brings together current CCG commissioning budgets, primary care budgets, the majority of specialised commissioning spend, the budgets for certain other directly commissioned services, central support or sustainability funding and nationally-held	Parity of esteem between health (including physical and mental health), social care and public health funding is essential. Health devolution is dependent upon sufficient, equitable and sustainable funding of health, social care and public health services to be successful. Social care services (including domiciliary care and residential care) are in urgent need of an immediate and very substantial increase to funding to ensure they are sufficient in volume and high enough in quality to

transformation funding that is allocated to systems. Bring together at ICS level responsibility for allocating capital envelopes with responsibility for allocating the revenue budgets which fund day-to-day services. New powers will make it easier to form joint budgets with the local authority, including for public health functions As systems take on whole population budgets they will increasingly determine how resource is to be used to 'move the dial' on outcomes, inequalities, productivity and wider social and economic development against their specific health challenges and population health priorities.	provide adequate services for an ageing population. Integration of health, social care and public health budgets in a single budget is essential in devolved areas with a duty to spend on services and in places that ensures greatest health benefits. There should be single accountable officers (ACOs) for joint commissioning and integrated budgets.

Appendix 2: Options for an ICS Scrutiny Committee

If ICS Scrutiny Committees are established, some indication of how these would operate and what the membership might look like is helpful. For example, such a body would need to be properly resourced to meet monthly and empowered to conduct inquiries as well as hold accountability sessions in public. Membership would need to the subject of further consideration and consultation but, for example, could include:

- 5 MPs (in proportion to the number of MPs from each party in the respective area)
- Local Government nominee
- Healthwatch nominee
- Health and Wellbeing board nominee
- Business sector nominee (a nominee from LEP Chairs)
- Social enterprise/charity nominee
- Workforce nominee (arranged through the TUC)
- Regional Public Health Director

Much of the detail regards these arrangements for enhanced scrutiny - such as which of the members had voting rights, where the ICSSC would meet and how each nominee would be selected - would need to be considered further. It will be important however to ensure that these proposals at the ICS level do not cut across other scrutiny arrangements that operate at the local authority level through local authority Health and Wellbeing Boards and oversight committees and, of course, local Healthwatch.