LEVELLING UP HEALTH

REPORT AND RECOMMENDATIONS OF THE HEALTH DEVOLUTION COMMISSION ON THE GOVERNMENT'S PROPOSED HEALTH AND CARE BILL

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PREFACE

The case for the long-overdue reform of health and social care in this country has never been stronger, but it has to be done right. This report sets out three core principles which must drive that reform if we are to create an effective integrated system fit for the future.

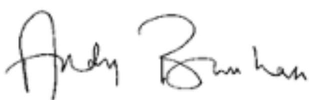
The first must be establishing a genuine partnership of equals between the NHS and local government to deliver person-centred care. The second is that real levelling up must underpin all of these reforms: levelling up between DHSC and local government, between NHS services and social care, between physical and mental health, and between treatment and prevention. All of this is crucial to redressing the stark health inequalities that still exist across the country.

The third is that there is a commitment to putting local expertise at the heart of these plans. It must be our local authorities with adult social care responsibilities, like those here in Greater Manchester, that are the building blocks of Integrated Care Systems. This is the starting point to take forward integration and delivery, and to ensure effective, place-based services for local communities.

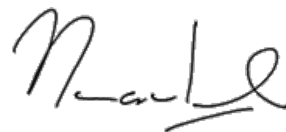
If the recommendations in this report are embraced by the Government and NHS England then there is a real opportunity to do health differently and in a way which has a genuinely positive impact on the health and prosperity of our local communities.

There is, however, a danger that unless these changes are accommodated in the imminent Health and Care Bill the Government's reforms could lead to greater centralisation not decentralisation of NHS, social care and public health services.

The White Paper offers the chance of using resources more effectively and of unleashing the power of local organisations and communities to improve health and prosperity but the proposals need strengthening in the way we have suggested in order to realise that vision through the Health and Care Bill.



Rt Hon Andy Burnham
Co-chair, Health Devolution Commission
Mayor of Greater Manchester and
Former Secretary of State for Health



Rt Hon Sir Norman Lamb
Co-chair, Health Devolution Commission and
Former Minister of State for Community and
Social Care

SUMMARY OF RECOMMENDATIONS

The Purpose of Integrated Care Systems

1 *ICSs should be mandated to ensure that their health, social care and public health providers give the right people the right personalised care and support, at the right time and in the right place.*

2 *Population health improvement and reducing health inequalities should be primary purposes of ICSs that are written on the face of the Bill and properly resourced at the ICS as well as at the place based levels for both direct delivery of services and influencing the wider determinants of health.*

3 *ICSs should promote a 'health in all policies' approach to encourage greater action by other public, voluntary and private sector organisations to improve population health and reduce health inequalities.*

4 *ICSs should adopt an 'economic wellbeing' approach in all its strategic decisions to improve the impact it has as an anchor institution in local communities.*

5 *ICSs should adopt a data-led population health management approach to planning its health, social care and public health services; assess its performance in improving public health and reducing health inequality; and address the imbalance between mental and physical health.*

The Balance of Power in Integrated Care Systems

6 *The Government should make a public commitment to parity of esteem between the NHS and Local Government, and between statutory and non-statutory partners, including community-based third sector providers of support services, to promote genuine partnership working and local service integration.*

7 *There should be a legal duty on the NHS and Local Government to mutually collaborate with each other through the Integrated Care System structure and an explicit objective to reduce health inequalities.*

8 *The Government, with local partners, should develop guidance for ICSs on supporting place-based partnerships using a 'partnership of equals at place' approach on matters such as merging health and social care budgets, and joint commissioning that can be adapted to suit local circumstances.*

9 *The Government should publicly acknowledge that 'place based partnerships', based on the principle of subsidiarity and the footprints of councils with adult social care responsibilities, are the building blocks of the Integrated Care Systems and the principal level at which integration, and delivery, of services should be taken forward.*

10 *The membership the two statutory boards of an ICS should be mandated in law but with flexibility to allow for local variation within a 'de minimus' expectation.*

11 The Government should establish a set of minimum national entitlements that the public should expect Integrated Care Systems to deliver, but leave local partners to determine how they should be delivered based on the principle of subsidiarity and setting their own additional local priorities to meet local needs.

12 The presumption should be that the ICS NHS Board should have an independent chair chosen by local partners, with vice-chairs from the NHS and Local Government respectively. Flexibility to appoint a system leader, with full transparency, should be permitted. The ICS NHS Board should also include clinical leadership, a balance of primary care and secondary care NHS providers (both physical and mental health), and patient voice through Healthwatch and other carer and service user bodies.

13 The presumption should be that the ICS Partnership is chaired by a Local Government leader - or Metro Mayor if agreed by a relevant Combined Authority - and include a range of members from the NHS, Local Government, Universities, LEP(s), the Voluntary, Community and Social Enterprise (VCSE) sector and patient representative bodies. Flexibility to appoint an independent chair, with full transparency, should be permitted.

14 The ICS Partnership should be a statutory body or committee with responsibility for producing the ICS Health and Wellbeing Plan building on, and adding value to, local authority Health and Wellbeing Boards strategies.

15 The ICS NHS Board should fulfil its mandate in ways that are compliant with the ICS Partnership's Health and Wellbeing Plan. The Government should produce detailed statutory guidance on how the ICS NHS Board will have 'due regard' to the plan of the Partnership including a 'comply or explain' approach.

16 All Mayoral Combined Authorities should be offered the option of the same statutory remit, and appropriate funding, to consider the public health implications of all its policy decisions and service delivery as the London Mayor.

17 The Secretary of State should not be involved in locally agreed health service reconfigurations or the appointment of ICS chairs; but the Secretary of State should have step-in powers if an ICS is clearly failing in its duties with regard to fulfilling the NHS Mandate, the NHS Constitution or basic patient safety.

Engaging Patients and Wider Partnerships

18 Best practice guidelines should support ICSs to draw up a community and stakeholder engagement plan that sets out how they will go about actively engaging citizens from all communities and backgrounds in their work and meeting their rights in the NHS Constitution.

19 The Bill should provide a statutory basis for Healthwatch at the ICS level and ensure a place for it on both the ICS NHS and Partnerships.

20 *The Bill should place a duty on ICSs to produce a local 'Concordat' that recognises and builds on existing service provision and then describes how all VCSEs with an interest can be further engaged in the work of ICSs at every level; and describe how ICSs will invest in and support the sector to play a full part in service delivery and decision making to achieve its goals.*

21 *The Government should make clear during the passage of the Bill through Parliament that the privatisation of the NHS through the creation of large-scale private health provider collaboratives is neither its intent nor would it allow this to be an outcome of the reforms.*

Innovation and Scrutiny

22 *ICSs should actively involve universities and technological innovators from the private sector to create local partnerships for digital and other forms of health and social care innovations to improve services and reduce health inequalities.*

23 *Every ICS should have a local scrutiny body to provide challenge within the system, building on existing arrangements provided by local Health Overview and Scrutiny Committees and/or on a similar model to that of the Public Accounts Committee in Parliament. This should provide an opportunity to involve the public, patients and service users, and local MPs as well as councillors in scrutinising the leadership, service delivery and outcomes of their ICS.*

24 *The role of the independent Care Quality Commission (CQC) in monitoring and inspecting providers of health and care should be extended to include the performance of ICSs in delivering their system-level goals with a particular focus on leadership, the quality of collaborative working between the partners, and the performance and relationship between the NHS and the Partnerships.*

Funding and Social Care Reform

25 *The Government should invest in an immediate significant boost to social care funding and publish by the end of the year its long-term plan to place social care on a robust financial footing, and address the chronic challenges of low pay and uncertain working conditions of the social care workforce.*

26 *Guidelines should promote a joined up approach to the planning and management of the NHS and social care workforces. This will set out how recruitment, training and career development plans are linked to the strategic plans of the ICS; and how the NHS People Plan clearly aligns to a local Social Care and Public Health People Plan.*

27 *The Government should, as a minimum, restore Local Government public health budgets per head in real terms to the level they were in 2015/16 at a cost of £1billion*

28 *The Government should allocate resources in ways that will help to reduce health inequalities and achieve its goal of levelling up between different parts of the country.*

1 INTRODUCTION

This is a report of the Health Devolution Commission's inquiry into the Government's proposals for reform of the NHS published in the February 2021 White Paper 'Integration and Innovation'[1] that places Integrated Care Systems (ICSs) on a statutory basis to be enacted through a new Health and Care Bill. It draws upon evidence presented by witnesses and discussed by the Commissioners at two hearings held in April and May 2021. (See Appendix for commissioners and witnesses).

The Commission believes that this is a unique opportunity not just to imagine but to create a new future for the nation's health. In a post-pandemic world, we have to make a fundamental shift from the traditional 'treatment-focused' way of thinking and providing health services towards a different 'live well' approach that improves people's quality of life. In short, we have an opportunity to level up health – and opportunity that should be seized.

Now is the time not only to integrate and improve our health and social care services but also to tackle the social and economic determinants of ill-health to improve the health of the population we serve and reduce the health inequalities within our communities.

The Commission makes 28 recommendations on a range of issues including the fundamental purpose of ICSs, their partnership structure, accountability, funding, performance, and ways of working that it believes amounts to a new future for health in the country as we emerge from the impact of the Covid-19 pandemic. They seek to balance the need for both some prescription and local flexibility.

People are our starting point. The acid test is whether the way we can fund, organise and deliver our health, social care and public health services makes a real difference to the quality of the lives of the people we serve. We believe there is a risk that the current proposals for reform will not pass that test. Our proposals for change will help to ensure that a new future for health becomes a reality.

[1] https://www.gov.uk/government/publications/working-together-to-improve-health-and-social-care-for-all/integration-and-innovation-working-together-to-improve-health-and-social-care-for-all-html-version

2 THE HEALTH DEVOLUTION COMMISSION

The Health Devolution Commission (the Commission) is a cross-party, cross-sector group of commissioners (see appendix 1) co-chaired by the Rt Hon Andy Burnham, Mayor of Greater Manchester and a former Secretary of State for Health, and the Rt Hon Norman Lamb, former Minister of State for Care and Chair of the South London and Maudsley NHS Trust.

In July 2019 DevoConnect published a collection of essays on the question 'Is devolution the future of health and social care?'[2] that led to the formation of the Health Devolution Commission. In August 2020, the Commission launched its report 'Building Back Health and Prosperity'[3] that proposed a comprehensive and radical programme of devolution and integration of the NHS with social care, as part of a new 'health and prosperity' approach to improving the population's health as well as delivering better health and care services.

This was followed by the Commission's response[4] to the December 2020 NHSE consultation 'Integrating Care'[5]. The Commission proposed that the NHS should offer local partners, in addition to the two models proposed, the option of a third model for Integrated Care Systems, based on the principle of health and prosperity and that drew upon existing examples of partnerships in areas such as Greater Manchester, and West Yorkshire and Harrogate.

Most recently, the Commission published a short response 'A Glass Half Full'[6] to the Government's Integration and Innovation White Paper for NHS Reform. It welcomed the proposals for change as a positive and strong foundation to build equal partnerships between Local Government and the NHS in order to improve health and wellbeing outcomes as well as improve care and treatment.

But the Commission also expressed two major reservations: firstly, it called for more to be done to ensure the new system would have the vision, leadership and resources not only to better integrate health services, and join up health and social care services to better meet the needs of patients and service users, but also to address the systemic drivers of poor health and widening inequalities. The Commission believes that this requires 'a partnership of equals' between the NHS and Local Government in every Integrated Care System (ICS) supported by placing a legal duty on each to collaborate with the other.

Secondly the Commission believes that the absence of the Government's proposals for the long overdue reform of social care means that half of the system is being transformed before the essential changes required to transform the other half of the system have been announced, let alone implemented. This is a fundamental flaw that requires urgent action; at the least the Government must allow for sufficient flexibility in the legislation to accommodate further changes in the integrated care system at a local level when national proposals for social care reform are announced.

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[2] https://devoconnect.co.uk/2019/07/02/devoconnect-launches-new-collection-of-essays-on-health-devolution/

[3] https://healthdevolution.org.uk/wp-content/uploads/2020/08/DEVO-Report-of-the-Health-Devolution-Commission-Final.pdf

[4] https://healthdevolution.org.uk/wp-content/uploads/2021/01/Integrated-care-A-unique-opportunity-to-build-back-better-health-and-prosperity-Final.pdf

[5] https://www.england.nhs.uk/publication/integrating-care-next-steps-to-building-strong-and-effective-integrated-care-systems-across-england/

[6] https://healthdevolution.org.uk/wp-content/uploads/2021/03/II-White-Paper-HDC-response-A-Glass-Half-Full3.pdf

3 THE GOVERNMENT'S PROPOSALS FOR NHS REFORM

The Government's intentions for NHS reform were further spelled out in the accompanying documentation[7] to the May 2021 Queen's Speech to Parliament that announced a new Health and Care Bill. This is reproduced below in full as this clearly shows an aspiration to undertake a major reform of the purpose and structure of health and social care landscape:

"The purpose of the Bill is to:

- *Lay the foundations for a more integrated, efficient and accountable health and care system - one which allows staff to get on with their jobs and provide the best possible treatment and care for their patients.*
- *Give the NHS and local authorities the tools they need to level up health and care outcomes across the country, enabling healthier, longer and more independent lives.*

The main benefits of the Bill would be:

- *Delivering on the proposals put forward by the NHS in its own Long-Term Plan, while building on the lessons learned from the successful vaccine rollout.*
- *Making it easier for different parts of the health and care system, including doctors and nurses, carers, local government officials and the voluntary sector to work together to provide joined-up services.*
- *Removing bureaucratic and transactional processes that do not add value, thus freeing up the NHS to focus on what really matters to patients.*
- *Enabling the system to most effectively prevent illness, support our ageing population, tackle health inequalities, tailor support to the needs of local populations, and enhance patient safety and quality in the provision of healthcare services.*
- *Ensuring the NHS and the wider system can respond swiftly to emerging issues while being fully accountable to the public."*

What is missing from this document is a reference to children – who often miss out in the current system, for example in respect of mental health and learning disability services – and specific proposals to reform social care itself (see section 8 later).

However, if the purposes and benefits outlined above are fully reflected in the legislation to go before Parliament, and implemented in practice through genuine local partnerships of the NHS, Local Government and other key stakeholders, the Health and Care Bill would deliver a step-change towards the vision the Commission has been calling for.

The Bill has the potential to transform the NHS from a single body of organisations focused primarily on clinical care and treatment, to a broad partnership of the NHS and Local Government with other non-statutory partners that delivers both better health and social care services based on population health planning, and delivers improvements to the population's health and reduces health inequalities.

[7] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/986770/Queen_s_Speech_2021_-_Background_Briefing_Notes..pdf

Inevitably there is a dilemma in any proposed devolved system of governance and delivery between the extent to which legislation should prescribe arrangements and how far these should be allowed to be determined at the local level by the partners who understand their own circumstances and have built between them the all-important relationships upon which success is based.

There is therefore a need to find the right balance between laying out core design principles (e.g. subsidiarity, equal partnership between NHS and local government, etc) and statutory 'de minimus' requirements (e.g. clinical leadership on the ICS NHS board) AND a permissive, locally determined approach which allows flexibility through 'light touch' legal requirements and non-binding guidance.

The Commission also considers some level of prescription about structures and processes are – somewhat paradoxically - required to avoid the risk of the reforms leading to greater centralisation of the NHS and social care with ICSs becoming entirely NHS-led outposts of the DHSC/NHSEI. Prescription in this context is advocated to ensure local flexibility.

Based on the evidence the Commission heard and the input of our Advisory Commissioners[8], this report analyses the Government's proposals in detail and makes a series of balanced recommendations to ensure that the legislation delivers the shared aspiration of a better, more joined up NHS and care service driven by a focus on population health.

[8] See appendix

4 THE PURPOSE OF INTEGRATED CARE SYSTEMS

4.1 **Improving population health and reducing health Inequalities**

National action on health inequalities

Most of the determinants of peoples' health lie outside the delivery of health and social care services. Whilst ensuring good quality services is essential to meet an individual's health and social care needs, these can have only a marginal impact on inequalities of health within a local population.

Evidence in the Marmot Review[9] shows that annual improvements to life expectancy in the UK have stopped, that for those on low incomes it has reduced and that health inequalities have widened over the last decade. This is shocking and unparalleled in peace time, but is not a failure of the health and social care system. Many of these wider determinants of ill-health and health inequality such as the impact of low incomes as determined by the minimum wage and/or benefit levels may only be addressed at a national level.

Local and regional action on health inequalities

Some determinants of ill-health, however, can be addressed at a regional or local level, and if ICSs are to have as part of their purpose the goal of improving the population's health, then they must have the ability – working in collaboration with local authorities and mayors - to address issues such as educational underachievement, poor housing, pollution, diet, smoking, unemployment, transport to access services, poverty, mental health inequalities, loneliness and isolation, health literacy and so on upon which local action can be taken. This was described by the Health Devolution Commission as a 'health in all policies' approach and should be the approach taken by all ICSs.

Their efforts will have most impact if supported by appropriate decisions taken nationally by the government policy for example regarding tax, benefits and housing. Local government should be funded in a way that reflects a 'proportionate universalism' approach: this is the allocation of resources, both within national Government and to local government, in proportion to the need to reverse health inequalities.

It is also important to understand BAME health inequalities which the pandemic exposed. For example, the challenge in mental health – where young black men and women are less likely to access early help services and young black men in particular are far more likely to be detained under the Mental Health Act - must be confronted. There should be a clear and explicit focus on ensuring that all communities get fair treatment and equal access and benefit from improved population health.

Build back fairer

The purpose of ICSs and their role in improving population health and reducing health inequalities is rooted in decisions about the kind of society we wish to create as we emerge from the pandemic.

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[9] https://www.instituteofhealthequity.org/resources-reports/marmot-review-10-years-on/the-marmot-review-10-years-on-full-report.pdf

To that end, the Commission would like to see ICSs given a general duty to improve population health and reduce health inequalities. However, the Commission believes that the Government should not impose a new duty of this kind on the NHS and Local Government without providing the means to deliver it; and would expect to see additional resources provided at the ICS as well as at the place based levels for both direct delivery of specific public health programmes such as smoking cessation and influencing the wider determinants of health for example early years, housing and regeneration.

The legislation should be clear on the purpose of ICSs but allow flexibility on how they organise themselves – their form - to deliver that purpose. Specifically, the population health improvement and reduction of health inequalities functions of ICSs should be a mandatory responsibility with clear mechanisms for accountability locally and nationally for their performance in achieving them.

4.2 Economic wellbeing

Economic wellbeing in all health policy

ICSs have an important role to play beyond improving public health to actively contributing to the broader economic and social wellbeing of communities in their area. The NHS (in all its forms) and social care should be seen, and regard themselves when appropriate, as 'anchor institutions' with the potential to support the wellbeing of the community in all its decisions including, for example, in their choice of local suppliers, local employment policies, investment in local premises and buildings, and support for local facilities such as community green spaces and healthy town centres.

This approach has been described as an 'economic wellbeing in all health policies' approach to complement the 'health in all policies' approach and has been very clearly described by the NHS Confederation in a variety of studies and reports. This should be explicitly recognised during the passage of the Bill.

ICS engagement with the private sector in their areas will be an important aspect of this work. Local corporations and large employers can be supported to explore what they can do to reduce health inequalities in the way they work. This could bring benefits to themselves as companies through for example reducing sickness rates and improving productivity as well as benefits to the community's health as a whole.

4.3 A data-led population health management approach

Planning health and care services

ICSs should adopt a population management approach to planning local health and social care services. Health and social care services should be planned on a population's needs not on 'who turns up' to use services. Given the nature of health inequalities within the population, ICSs should ensure that health and social care providers give the right people**,** the right personalised care, at the right time, and in the right place. Providers will need to take into account the full range of people's circumstances, identities and preferences, to avoid their services working well for some but not for others.

ICSs should be judged by their success in preventing ill-health with clarity about the balance of spend on prevention and acute care services, and the balance between spend on physical and mental health. Use of measures such as the ONS health Index to assess and compare performance of ICSs could help to focus on population health improvement. ICSs should also contribute to a new cross-Government strategy to reduce health inequalities and the levelling up agenda.

Vulnerable groups

ICSs can identify and join up services to priority groups of vulnerable people such as people who are sleeping rough or homeless, ex-prisoners, travellers and refugees where a cross-sector and culturally sensitive approach is needed to meet their physical and mental health and social care needs, prevent ill-health and empower them to adopt better self-care practices. Within this there must be additional support provided for those whose past experiences of mainstream services has been negative. This approach had proven success with rough sleepers in Greater Manchester. ICSs could be mandated to adopt this approach in their areas as a means of identifying and reducing inequality of access to health and care services for those in most need.

Workforce planning

An ICS plan for the health, social care and public health workforce should be rooted in the population health analysis that identifies local needs. A joint approach to workforce planning and management is needed that clearly shows how the recruitment, training and career development plans for all three are directly linked to the strategic plans of the ICS; and how the NHS People Plan clearly aligns to a local Social Care and Public Health People Plan.

RECOMMENDATIONS

1 *ICSs should be mandated to ensure that their health, social care and public health providers give the right people the right personalised care and support, at the right time and in the right place.*

2 *Population health improvement and reducing health inequalities should be primary purposes of ICSs that are written on the face of the Bill and properly resourced at the ICS as well as at the place based levels for both direct delivery of services and influencing the wider determinants of health.*

3 *ICSs should promote a 'health in all policies' approach to encourage greater action by other public, voluntary and private sector organisations to improve population health and reduce health inequalities.*

4 *ICSs should adopt an 'economic wellbeing' approach in all its strategic decisions to improve the impact it has as an anchor institution in local communities.*

5 *ICSs should adopt a data-led population health management approach to planning its health, social care and public health services; assess its performance in improving public health and reducing health inequality; and address the imbalance between mental and physical health.*

5 THE BALANCE OF POWER IN INTEGRATED CARE SYSTEMS

5.1 People power

The Commission believes that improving people's health and reducing health inequalities requires ICSs to actively engage with local people of all backgrounds and identities in all its services and decision making at every level. This is not a 'nice-to-have' feature of ICSs but is a fundamental approach that should be visible throughout their work. The Government White paper makes little mention of meaningful engagement by ICSs directly with local people but the NHS constitution[10] is clear about the right that patients have to be involved:

> ***"Your rights***
> *You have the right to be involved in planning and making decisions about your health and care with your care provider or providers, including your end of life care, and to be given information and support to enable you to do this. Where appropriate, this right includes your family and carers. This includes being given the chance to manage your own care and treatment, if appropriate.*
>
> *You have the right to an open and transparent relationship with the organisation providing your care. You must be told about any safety incident relating to your care which, in the opinion of a healthcare professional, has caused, or could still cause, significant harm or death. You must be given the facts, an apology, and any reasonable support you need.*
>
> *You have the right to be involved, directly or through representatives, in the planning of healthcare services commissioned by NHS bodies, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services."*

ICSs must demonstrate they understand the needs of individuals and communities, show how they have engaged with local people in the development of their plans and services, and provide evidence of the impact of this way of working on improving people's health and wellbeing.

To that end, the legislation should include a duty on ICSs to produce a plan for how they will go about actively engaging citizens in their work and meeting their rights as spelled out in the NHS Constitution. This plan should be informed by guidance that draws on best practice already in place among ICSs and includes a wide range of methods and innovative approaches such as citizen's juries, targeted focus groups, systematic collection of feedback from the public, and involving citizens directly or through representatives in decision-making parts of the structure.

Crucially, active citizens engagement is not just about having 'a seat on the board' for a patient or service user representative. This approach risks being both tokenistic and unsuccessful in ensuring that ICSs are accountable to the public and different local communities in their area. A comprehensive system of active involvement of patients and service users' representative bodies including Healthwatch at every level will help to ensure that both strategic and operational decisions are both informed by the views of service users and accountable in some way to them.

[10] https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england

5.2 Ministerial power

A concern with the current proposals is that, where there is clarity about where power lies in the system, the direction of travel appears to be in the wrong direction. The purpose and nature of the new powers proposed for the Secretary of State for Health and Social Care (SoS) will together result in greater accountability of the NHS upwards to government rather than outwards to local government, partners and communities on key areas such as how an ICS organises itself, local service reconfigurations and the appointment of system leaders. Over time there is a concern about 'mission creep' in which greater centralised control and accountability for the NHS becomes the norm, rather than greater decentralisation and local accountability to local communities.

Minimum standards and 'step-in' powers

The Commission believes that ICSs should work within a minimum set of national standards but in ways that that allows maximum local flexibility for partners to develop their boards and working practices to suit local circumstances. The Government should establish a set of minimum national entitlements that the public should expect Integrated Care Systems to deliver, but leave local partners to determine how they should be delivered and to set their own additional local priorities to meet local needs.

The SoS should have step-in powers if a local system is clearly failing in its duties. The approach should be that local partners decide, through the ICS, their strategies and priorities; and that, if the SoS intervenes to set aside their decisions, he or she should do so explicitly, transparently and with accountability to Parliament.

Central intervention through the Government's step-in power in local structures, policies and decision should be limited in number and scope and restricted to areas of failure relating to delivering the NHS Mandate[11], the NHS Constitution[12] and basic patient safety.

Service reconfigurations

The existing process for improving the configuration of NHS services in an area is regarded as working well and includes a clear statutory role for Local Government to make a referral to Independent Reconfiguration Panels. The vast majority of them are dealt with at local level by Health Overview and Scrutiny Committees and are only referred to the Independent Reconfiguration Panel if the NHS has not followed due process or if the proposal has substantial opposition. Very few proposals have been referred, due to success of local scrutiny.

The existing mechanisms provide a clear and successful mechanism for resolving disputes. Removing this function from Local Government and giving the Secretary of State the power to intervene in local reconfiguration proposals will lead to a loss of local insight, is clinically unnecessary, practically very challenging and politically unwise.

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[11] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/972947/The_government_s_2021_to_2022_mandate_to_NHS_England_and_NHS_Improvement.pdf
[12] Op cit

Such powers will undermine the very intentions of the Bill to support local flexibility and leadership, as the priorities and powers of the statutory Integrated Care Systems will be undermined by unnecessary central intervention. Complete transparency in the reasons for the SoS to intervene and the rationale for any decisions made will be essential if this new centralised approach is to be implemented.

Appointments

It is not clear what problem the new power for the Secretary of State to make local appointments to chair ICS Boards is designed to solve. There is a very transparent and open system currently in place among local NHS organisations for the appointment of senior leaders, supported by good governance and, of course, the Nolan principles. This change raises the suspicion that these will be political appointments by the Government that will inevitably compromise the clinical independence of the NHS and undermine public confidence in the system.

5.3 Local power

Parity of esteem

The Commission is convinced that parity of esteem between the NHS and Local Government, and between statutory and non-statutory partners within ICSs is essential if genuine partnership working and integration is to be achieved. This parity of esteem should be reflected in parity of involvement in local decision-making, the allocation of funding and resources, and mechanisms for scrutiny and accountability. Parity of esteem should also be reflected between investment in physical and mental health to address the mental health inequalities which have been exacerbated during the pandemic.

Place-based partnerships

The Commission believes maximising the subsidiarity of ICS resources and powers to place-based partnerships that are based on a 'partnership of equals at place' approach is also central to the successful delivery of integration and innovation in health and social care services for local communities.

Government should make clear its expectation that there will be close alignment between NHS and Local Government systems and boundaries; and that the structures of an ICS will remove duplication and create new partnerships for joint working and decision making. Transparency of the structures created and the process for arriving at them will be important for gaining local ownership and confidence in them.

There are many examples of these partnerships working well, and the Government with local partners should develop guidance on supporting place-based partnerships for ICSs that can be adapted to suit local circumstances. This should be seen as a process of evolution that builds on what works rather than 'revolution' that risks overturning many years of patient relationship-building work.

The ICS NHS Board

The ICS NHS Board is expected to be a statutory body responsible for the commissioning and quality of ICS NHS services. Its membership should reflect the principle of a 'partnership of equals' between the NHS and Local Government. The presumption should be that the ICS NHS Board should have an independent chair chosen by local partners, with vice-chairs from the NHS and Local Government respectively. Flexibility to appoint a system leader as chair should be permitted as long as this is done with full transparency and accountability to local leaders and the public.

The NHS Board should also include clinical leadership, a balance of primary care and secondary care NHS providers (both physical and mental health), and patient voice through Healthwatch and other and other carer and service user bodies.

The ICS Partnership

The Partnership should also be a statutory body with responsibility for producing a broad Health and Wellbeing Plan for the health geography of the ICS. The presumption should be that it is chaired by a Local Government leader - or Metro Mayor - as agreed by local partners, and include a range of members from the NHS, Local Government, Universities, LEP(s), the Voluntary, Community and Social Enterprise (VCSE) sector and patient representative bodies. Flexibility to appoint an independent chair should be permitted as long as this is done with full transparency and accountability to local leaders and the public.

It will be important that the ICS Partnership recognise that local authority Health and Wellbeing Boards currently deliver strategies including 'health in all policies' and health inequalities. ICSs must ensure that they add value, rather than duplicating, bypassing or replacing existing place based arrangements.

The Relationship between the ICS NHS Board and the ICS Partnership

The Commission believes that much greater clarity is needed on the statutory roles of, and the relationship between, the proposed ICS NHS Board and the ICS Health and Social Care Partnership.

The NHS Board is expected to have 'due regard' to a health and wellbeing plan produced by the Partnership. However, this wording is too vague and there must not be a fudge of what 'due regard' means. Detailed statutory guidance including a 'comply or explain' approach that reflects existing good practice will be needed on how this duty will be realised in practice, and what action will be taken if that statutory guidance is not adhered to.

It should be clear in law that it is the statutory duty of the Partnership to set the ICS health and wellbeing strategy within which the operational NHS Board works in fulfilling its mandate to commission the delivery of efficient and effective health services.

This dual structure and these arrangements are not about the NHS or Local Government giving or receiving instructions from the other. They are about the statutory underpinning to support genuine partnership working in which both organisations work collaboratively in both Boards to arrive at what is best for their local communities to fulfil their respective statutory roles.

A separate legal duty on the NHS and Local Government to co-operate with each would give added support to the policy intention to improve the alignment and integration of health, social care and public health services.

The intention should be that NHS, Local Government and their VCSE partners are clear about the contribution they will each be making to putting the Health and Wellbeing Plan into practice through either leading or following key priorities within the plan. If they are not leading or following the plan then they could help by keeping out of the way of those who are.

These structures of an ICS should be mandatory but with flexibility to allow for local variation within a 'de minimus' requirement of which local NHS (physical and mental health), Local Government, and voluntary and private sectors are legally entitled to be involved in the different boards and committees at the level of the ICS and at level of 'place'.

This flexible or permissive approach to the legislation is not intended to be a 'free-for-all' but a rational recognition of the differences between localities to allow ICSs to arrange themselves based on local circumstances to achieve the outcomes prescribed by the legislation.

The fundamental nature of the shift from a treatment-focused approach to population health improvement will require strong leadership by the chairs of both the Health and the Partnership and the CEO to reduce health inequalities given the competing demands for attention and resources by those providing health and social care services.

The health prevention role of Metro Mayors

Metro Mayors have an important role in public health improvement. Local Government should retain and enhance its public health functions and responsibilities in its contribution to the ICS Health and Wellbeing Plan. However, as the experience in Greater Manchester and London shows, metro mayors can provide leadership across a much wider policy agenda and geography to support the health improvement goals of ICSs. The Mayor of London for example, has a duty to have regard to public health when producing his or her other six statutory documents – transport, economic development, housing, spatial development, environment and culture, and to produce a health inequality strategy.

All Metro Mayors should adopt a 'health in all policies' approach to their economic development leadership role within their geographic area of responsibility. To that end, all Mayoral Combined Authorities should be offered the option of the same statutory public health improvement role as the London Mayor. ICSs should, where appropriate – for example where the ICS has the same footprint as the Combined Authority - have the option of directly involving the Metro Mayor as chair of their Partnership if that is what the local authority leaders in the combined authority decide.

Provider collaboratives

New provider collaboratives that involve all Foundation Trusts should aim to break down the existing silos between different health and social care providers within a particular care pathway or across a location and create a more patient centred service. Care will be needed to ensure that the process of creating provider collaboratives provides rather than prevents opportunities for the involvement of the VCSE sector in delivering local services.

RECOMMENDATIONS

6 The Government should make a public commitment to parity of esteem between the NHS and Local Government, and between statutory and non-statutory partners, including community-based third sector providers of support services, to promote genuine partnership working and local service integration.

7 There should be a legal duty on the NHS and Local Government to mutually collaborate with each other through the Integrated Care System structure and an explicit objective to reduce health inequalities.

8 The Government, with local partners, should develop guidance for ICSs on supporting place-based partnerships using a 'partnership of equals at place' approach on matters such as merging health and social care budgets, and joint commissioning that can be adapted to suit local circumstances.

9 The Government should publicly acknowledge that 'place based partnerships', based on the principle of subsidiarity and the footprints of councils with adult social care responsibilities, are the building blocks of the Integrated Care Systems and the principal level at which integration, and delivery, of services should be taken forward.

10 The membership the two statutory boards of an ICS should be mandated in law but with flexibility to allow for local variation within a 'de minimus' expectation.

11 The Government should establish a set of minimum national entitlements that the public should expect Integrated Care Systems to deliver, but leave local partners to determine how they should be delivered based on the principle of subsidiarity and setting their own additional local priorities to meet local needs.

12 The presumption should be that the ICS NHS Board should have an independent chair chosen by local partners, with vice-chairs from the NHS and Local Government respectively. Flexibility to appoint a system leader, with full transparency, should be permitted. The ICS NHS Board should also include clinical leadership, a balance of primary care and secondary care NHS providers (both physical and mental health), and patient voice through Healthwatch and other carer and service user bodies.

13 The presumption should be that the ICS Partnership is chaired by a Local Government leader - or Metro Mayor if agreed by a relevant Combined Authority - and include a range of members from the NHS, Local Government, Universities, LEP(s), the Voluntary, Community and Social Enterprise (VCSE) sector and patient representative bodies. Flexibility to appoint an independent chair, with full transparency, should be permitted.

14 The ICS Partnership should be a statutory body with responsibility for producing the ICS Health and Wellbeing Plan building on, and adding value to, local authority Health and Wellbeing Boards strategies.

15 *The ICS NHS Board should fulfil its mandate in ways that are compliant with the ICS Partnership's Health and Wellbeing Plan. The Government should produce detailed statutory guidance on how the ICS NHS Board will have 'due regard' to the plan of the Partnership including a 'comply or explain' approach.*

16 *All Mayoral Combined Authorities should be offered the option of the same statutory remit, and appropriate funding, to consider the public health implications of all its policy decisions and service delivery as the London Mayor.*

17 *The Secretary of State should not be involved in locally agreed health service reconfigurations or the appointment of ICS chairs; but the Secretary of State should have step-in powers if an ICS is clearly failing in its duties with regard to fulfilling the NHS Mandate, the NHS Constitution or basic patient safety.*

6 ENGAGING PATIENTS AND WIDER PARTNERSHIPS

6.1 Patient voice

The White Paper says relatively little about the voice of the patient in ICSs but emphasises the role of Healthwatch:

> "…working with organisations such as Healthwatch there is a real chance to strengthen and assess patient voice at place and system levels, not just as a commentary on services but as a source of genuine co-production."[13]

The role of Healthwatch in ICSs is welcome and necessary but is not sufficient to ensure that the voice of patients is heard in a variety of ways and by different parts of the system.

This gap should be addressed through national guidance on best practice relating to engaging with local communities and providing a voice for patient and service users in the health and social care system including the infrastructure needed to support patient voice and a means of monitoring and acting upon its effectiveness.

Imagination will also be required to gain insights from the voice of marginalised or vulnerable groups for whom attending a meeting in the lecture room of the local hospital is unlikely to be an effective form of engagement.

6.2 Partnerships with voluntary, community and social enterprises

The Commission believes that strong partnership working by ICSs with the Voluntary, Community and Social Enterprise (VCSE) sector is central to their success in achieving their health improvement and health equality goals.

Effective public health measures require the active participation of the VCSE sector that have social value 'baked in' to their structures and have a key role to play in delivering services to hard-to-reach communities that may be distrustful of statutory bodies; in providing person-centred services that give people support across a range of circumstances and needs; in mobilising and supporting volunteers across physical and mental health, social care and public health; in delivering flexible social prescriptions and 'Living Well' services for people in the community; and in providing challenge to statutory providers and a voice for citizens to articulate and address the needs of particular groups already known to be experiencing severe challenges.

The existing role of social enterprises in delivering NHS services – particularly but not exclusively community health services – should be acknowledged by ICSs. Most have a good track record in terms of quality, financial stability and employment practices and form the foundation for further involvement.

[13] Op cit

The Health and Care Bill 2021 provides a unique opportunity for the NHS to 're-set' its relationship with the VCSE sector and through a new 'partnership of equals' approach. However, the Commission recognises that the VCSE embraces a very wide range of types and sizes of organisation, and that their presence and strength vary between different parts of the country with few operating at the ICS system level.

ICSs must have a clear vision of the future for their VCSE sector, and build good relationships with and actively give it support and resources. They cannot assume that the wide range and variety of services and community groups provided and supported by the VCSE (the lunch clubs, activity groups, counselling and therapy sessions, community centres and so on) will always be there for the NHS and social care to draw on without support for their work.

To make the most of the potential benefits that VCSEs can bring to an area, ICSs should take active steps to engage and build the sector, and to formalise its partnership relationship to the VCSE sector to always have a presence 'in the room' as part of its wider health and wellbeing strategy. The VCSE should be visible throughout an ICS 'like letters through a stick of rock'.

ICSs should be asked to report on the health of the VCSE sector within their footprint; take steps to remove barriers for small VCSE organisations to participate through a co-production approach; value the types of evidence and expertise, and the different relationships with communities that the VCSE sector brings; and invest funding and support for people in the VCSE sector. This approach may require a culture shift among some parts of the NHS unfamiliar with the benefits and methods of working in this way.

The Bill should place a duty on ICSs to produce a local 'Concordat' describing how VCSEs will be engaged in the work of ICSs at every level; produce a description of the 'state of the VCSE sector' in their area; and describe how ICSs will invest in and support the sector to play a full part in service delivery and decision making to achieve its goals.

6.3 The for-profit health sector

Whilst there is consensus on the key role that the VCSE sector should play within ICSs there are uncertainties and consequently concerns about the role of 'for-profit' independent health providers in the new system.

The contribution of the independent health sector being funded by the NHS to deliver its goals when the system is under pressure is recognised and understood. This relatively small but significant role is expected to continue in helping to reduce the large backlog of cases created by the focus on responding to the pandemic.

There are also examples of private sector providers such as Kooth who collaborate with the NHS in providing digital mental health support to complement traditional services. That sort of partnership can offer innovation and improved experience for patients and doesn't fragment services. In addition it is the case that, since the formation of the NHS in 1948, many local community health services are provided by General Practices that themselves are small 'for-profit' organisations governed and financially supported through contractual arrangements with the Government that would continue within the new system of Primary Care Networks.

However, there are wider concerns that the new system of provider collaboratives in which services are delivered through a merger of organisations or a lead-provider model of collaboration could allow large-scale private health organisations in the USA to run all the health services within a locality or across a care pathway including community and acute care services.

Concerns have also been raised about the potential for some private providers embedding outdated models of care in the NHS and social care system. In learning disability services for example, their involvement in provider collaborative of large institutional providers could make it harder to transform care.

These are not outcomes of the reforms that the Commission would support and contradicts the public's long-held support for the tradition of the NHS as publicly provided service funded through general taxation and free at the point of need.

The Commission believes that the Government should make clear during the passage of the Bill through Parliament that the privatisation of the NHS through large-scale private health provider collaboratives is neither its intent nor would it allow to be an outcome of the reforms.

RECOMMENDATIONS

17 *Best practice guidelines should support ICSs to draw up a community and stakeholder engagement plan that sets out how they will go about actively engaging citizens from all communities and backgrounds in their work and meeting their rights in the NHS Constitution.*

19 *The Bill should provide a statutory basis for Healthwatch at the ICS level and ensure a place for it on both the ICS NHS and Partnerships.*

20 *The Bill should place a duty on ICSs to produce a local 'Concordat' that recognises and builds on existing service provision and then describes how all VCSEs with an interest can be further engaged in the work of ICSs at every level; and describe how ICSs will invest in and support the sector to play a full part in service delivery and decision making to achieve its goals.*

21 *The Government should make clear during the passage of the Bill through Parliament that the privatisation of the NHS through the creation of large-scale private health provider collaboratives is neither its intent nor would it allow this to be an outcome of the reforms.*

7 INNOVATION AND SCRUTINY

7.1 Innovation

Digital health and social care offers opportunities for innovation and improvement across a number of the core outcomes to be achieved by ICSs including:

- **Better population health**: The use of population data and Artificial Intelligence (AI) systems and analytics at scale to identify patterns and trends to inform health, social care and public health diagnosis, planning and decision making.
- **Effective person-centred services**: The sharing of client information in digital form by practitioners from different health and social care settings to create single electronic patient records of all a patient's clinical and social care episodes and treatment to make it easier to do the right thing for that individual; to enable staff to work better together across different clinical and care disciplines; and to improve the patient's experience of care
- **Efficient delivery of health and social care**: The use of digital ways of delivering health care (e.g., remote monitoring of patients) rather than only building-based services.
- **Better self-care**: The use of apps and devices by individuals to support better care of themselves and prevent ill-health

It will be important to ensure that the shift from 'analogue' to 'digital' ways of working is carried out in ways that do not create further health inequalities for those who cannot afford digital devices or the cost of accessing the internet; or who may need support to build their digital literacy and confidence.

Relationships with the Academic Health Science Network and other research collaborations should continue. ICSs have a critical role in leading research, and we wouldn't want to lose the dynamism and the value that is created when hospitals partner with innovators in university and industry.

For example, ICSs should actively involve universities and technological innovators from the private sector to create local partnerships for digital and other forms of health and social care innovations to improve services and reduce health inequalities.

7.2 Scrutiny

ICSs depend upon a culture of strong working relationships between the partners to be effective. Experience shows that spending time together to build a shared vision, with shared values, a focus on outcomes and having common goals will both build better relationships and help to ensure success. If local partners are given the freedom to act locally then these relationships can flourish, positive and innovative changes to ways of working will follow, and progress will be both illuminated and accelerated.

However, to underpin this approach there needs to be a set of minimum regulations and standards about the qualities of leadership and outcomes that ICSs should be expected to achieve as a system.

Every ICS should have a local scrutiny body to provide challenge within the system, particularly as competition is being replaced by collaboration as the organising principle for service commissioning and delivery.

Given the scope of ICSs to improve health and care services, and improve population health and wellbeing there is a case for creating ICS scrutiny committees on a similar model to that of the Public Accounts Committee in parliament. This would provide an opportunity to involve the public, patients and service users, councillors and local MPs in scrutinising the leadership, service delivery and outcomes of their ICS. Existing Local Government health scrutiny committees and Health and Wellbeing Boards would continue to operate at a place-based level.

The role of the independent Care Quality Commission (CQC) in monitoring and inspecting providers of health and care should be extended to include the performance of ICSs in delivering their system-level goals with a particular focus on leadership, the quality of collaborative working between the partners, and the performance and relationship between the NHS and the Partnerships.

The distinction between a system failure and single organisation failure is an important one to be clear on, with an important role for the CQC in assessing in a transparent way when there are system failures.

RECOMMENDATIONS

22 *ICSs should actively involve universities and technological innovators from the private sector to create local partnerships for digital and other forms of health and social care innovations to improve services and reduce health inequalities.*

23 *Every ICS should have a local scrutiny body to provide challenge within the system, building on existing arrangements provided by local Health Overview and Scrutiny Committees and/or on a similar model to that of the Public Accounts Committee in Parliament. This should provide an opportunity to involve the public, patients and service users, and local MPs as well as councillors in scrutinising the leadership, service delivery and outcomes of their ICS.*

24 *The role of the independent Care Quality Commission (CQC) in monitoring and inspecting providers of health and care should be extended to include the performance of ICSs in delivering their system-level goals with a particular focus on leadership, the quality of collaborative working between the partners, and the performance and relationship between the NHS and the Partnerships.*

8 FUNDING AND SOCIAL CARE REFORM

ICSs will fail if they do not have the resources to do the job they are being expected and mandated to do. And this must go wider than providing sufficient resources for the NHS or acute care providers. It must include resources for a range of community physical and mental health services, resources for social care services, and resources for local public health activities to address the social determinants of ill-health.

An immediate significant boost to social care funding is needed now alongside a long-term plan to place social care on a robust financial footing, and address the chronic challenges of low pay and uncertain working conditions of the social care workforce.

Funding of public health activities is key to delivering health improvement and according to the King's Fund £1bn is needed just to restore Public Health spending per head of population to where they were in 2015/16.[14] If ICSs are to fulfil their purpose of improving population health and reducing health inequalities they must be properly funded to do so.

As well as health inequalities within an ICS population, there are health inequalities between the populations of different ICSs. This reality should be acknowledged and reflected in NHS and local government funding decisions by the Government to allocate resources in ways that will help to reduce health inequalities and achieve its goal of levelling up between different parts of the country.

RECOMMENDATIONS

25 The Government should invest in an immediate significant boost to social care funding and publish by the end of the year its long-term plan to place social care on a robust financial footing, and address the chronic challenges of low pay and uncertain working conditions of the social care workforce.

26 Guidelines should promote a joined up approach to the planning and management of the NHS and social care workforces. This will set out how recruitment, training and career development plans are linked to the strategic plans of the ICS; and how the NHS People Plan clearly aligns to a local Social Care and Public Health People Plan.

27 The Government should, as a minimum, restore Local Government public health budgets per head in real terms to the level they were in 2015/16 at a cost of £1billion

28 The Government should allocate resources in ways that will help to reduce health inequalities and achieve its goal of levelling up between different parts of the country.

[14] https://www.kingsfund.org.uk/projects/positions/public-health

APPENDIX 1: HEALTH DEVOLUTION COMMISSIONERS AND WITNESSES AT EVIDENCE SESSIONS

Commissioners

- Rt Hon Andy Burnham, former Secretary of State for Health and Mayor of Greater Manchester (Co-chair)
- Rt Hon Sir Norman Lamb, former Minister for Care and Support (Co-chair)
- Rt Hon Alistair Burt, former Minister for Care and Support
- Rt Hon Stephen Dorrell, former Secretary of State for Health
- Phil Hope, former Minister of State for Care Services
- Dr Linda Patterson OBE FRCP, former Medical Director of CHI and Vice President of RCP
- Peter Hay, former President ADASS

Advisory Commissioners

- Cllr Paulette Hamilton, Vice Chair, LGA Community Wellbeing Committee
- Dick Sorabji, Deputy Chief Executive, London Councils
- Sarah Walter, ICS Network, NHS Confederation
- Michael Wood, Head of Health Economic Partnerships, NHS Confederation
- Professor Jo Pritchard, Social Enterprise UK
- Dr Andrew Catto, Social Enterprise UK
- Dr Seamus O'Neill, Chair, the Northern Health Science Alliance
- Hannah Davies, Head of External Affairs, NHSA
- David Weaver, President, BACP
- Steve Mulligan, Four Nations Lead, BACP
- Sarah Price, Chief Officer, Greater Manchester Health & Social Care Partnership
- Warren Heppolette, Executive Lead, Strategy & System Development, Greater Manchester Health & Social Care Partnership
- Rob Webster, Lead Chief Executive, West Yorkshire and Harrogate Health and Care Partnership
- Jo Webster, Chief Officer, Wakefield CCG and Member WY&H H&CP

Witnesses

At evidence session on 26th April regarding the purpose of ICSs

- Professor Michael Marmot, Health Equity in England: The Marmot Review 10 Years On
- Jo Bibby, Director of Health, the Health Foundation
- Imelda Redmond, Chief Executive, HealthWatch
- James Bullion, President, ADASS
- Bill McCarthy, Regional Director NW, NHS England/Improvement

At evidence session on 21st May regarding balance of power in ICSs

- Lord Victor Adebowale, Chair, NHS Confed and Chair, Social Enterprise UK
- Cllr David Fothergill, Chair, LGA Community Wellbeing Board
- Jacqui McKinlay, Chief Executive, Centre for Governance and Scrutiny