Response to NHSEI “Integrating Care” engagement exercise

Version 1
January 2021

Response of the Bradford District and Craven Health and Care Partnership

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?

- We agree that formally establishing Integrated Care Systems (ICS) in legislation is a logical continuation of the existing direction of travel. It embeds collaboration rather than competition as the key underpinning policy driver. Additionally, recent history has shown that collaboration across a bigger footprint is critical to tackle the major issues facing us. Furthermore, the proposals for ICS development helpfully mirror trends in local government towards combined authorities, metro mayors etc, which offer opportunities for collaboration at that level.
- It is important to note that ICSs are more than the foundation for NHS delivery. They are key partnerships for improving health and wellbeing, and reducing inequalities. To deliver on these broad goals it is critical that a sense of shared ownership is maintained. This requires behaviours and relationships more than legislation.
- Each ICS will need to carefully navigate the paradox of being both a partnership and organisation in one. Being an NHS organisation, but recognising the need for shared ownership with a wider range of partners including local government and the voluntary and community sector. We would welcome an approach which enables all partners in ICS to shape priorities in response to the needs of their population.
- We welcome that the importance of place based partnerships is emphasised in the engagement document. We should recognise the key role that CCGs currently play in enabling place based partnerships. We will need to take great care to ensure we do not inadvertently make place based working more difficult through the proposed changes. We would like to see legislation provide for a level of statutory accountability at place through an integrated care partnership, with place-based powers being clearly defined
- In line with the subsidiarity principle, we would like to see the powers of place based partnerships matched by a clearly defined flexibility for the delegation of resources from ICS to ICP, in order to maximise impact on health inequalities.
- Similarly, to reflect our commitment to meeting the needs of local communities we would also suggest that ICSs and ICPs within them should have flexibility to define the performance metrics which will drive meaningful improvements in outcome and equality for their population. These should be part of a mutual accountability framework between ICS and ICP.
- The engagement document recognises that Health and Wellbeing Boards play a crucial role in place based partnerships, in joint commissioning for health and care, and in convening action on the wider determinants of health.

However, the shift towards collaboration across the whole ICS footprint may lead to a weakening of the HWB role. We recognise that our own WY&H HCP has made strenuous efforts to mitigate this risk and we have confidence that this will continue to be the case. Nevertheless, we would welcome further detail on the intended accountability arrangements for place based partnerships, particularly in relation to Health and Wellbeing Boards. We believe that ICSs will be strengthened by focusing on ensuring the effectiveness and connectivity of place based partnerships.

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?

- True collaboration relies on partnerships establishing a clear common purpose and commitment to achieving. It cannot be effectively legislated for. Option 1 is closer to the model we have developed in West Yorkshire and Harrogate, which provides for shared ownership of common goals.
- For Local Authorities and other partners there is a risk that establishing the ICS as an NHS body (option 2), rather than as a joint committee (option 1) may actually be a barrier to collaboration; as it presupposes NHS ownership of what is a shared agenda, to improve health and wellbeing, and reduce inequality. For those partners a joint committee may be preferable.
- In terms of which option offers greatest clarity of accountability, both options improve simplicity and clarity.
- It will be important to ensure patients / citizens retain a sense of connection and visibility, which underpins accountability. Where the ICS feels more distant than their current local authority and CCG arrangements, this may be a risk, particularly if it was to lead to commissioners of health services being less present in local accountability structures such as Health and Wellbeing Boards.

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 intention to remain inclusive in both ICSs and ICPs is welcomed. It is important that the process of mandating some partners but not others, does not inadvertently create a two tier partnership or lead to the exclusion of necessary partners in the voluntary and community sector and in the care sector. Real participation and shared ownership requires common purpose. Therefore, on balance we believe that ICSs and ICPs should define their own governance arrangements.
- The mandating of participation by sovereign bodies creates an interesting regulatory dynamic which will need to be clarified. The individual accountability of sovereign organisations will need to evolve to reflect strong system working ambitions.

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?**

- We agree in principle services currently commissioned by NHSE should be capable of being transferrred to ICS bodies. In recognition of the variation in size and maturity of ICSs, this could be a matter where principles of earned autonomy may apply.
- The success of pilot schemes in relation to delegated management of tertiary mental health service commissioning have shown that the joining up of all levels of provision has potential for better outcomes for people and better use of resources. We see the leadership of this agenda by ICSs as a way that this can continue to be developed further.
- We would also wish to note that the current arrangements have highlighted some gaps in the ability of ICSs and place based partnerships to address inequalities, which could be improved by this proposal – e.g. access to dental care.