Healthier Together

Improving health and care in Bristol, North Somerset and South Gloucestershire

Healthier Together
Level 4 South Plaza
Marlborough Street
Bristol, BS1 3NX
Tel: 0117 900 2583

8 January 2021

Simon Stevens
Chief Executive
NHSEI

Dear Simon

BNSSG Outline Draft Response to NHSEI consultation on ICS Next Steps – December 2020

Thank you for the opportunity to respond to this discussion document.

We have reviewed the document at a meeting of our ICS Executive Group in December and sought feedback from CEOs on behalf of our ICS partners. We have summarised this feedback in responding to the four questions that you have invited us to address, as set out below.

We support the four overarching aims set out in the document and the stated intention that the further development of Integrated Care Systems (ICS) will be designed to enable these aims. We particularly welcome the focus of these aims on tackling wider determinants of health, reducing inequalities and in promoting social and economic development, as statements of common purpose between the NHS and Local Authorities We also support the permissive approach that is proposed and the emphasis on primacy of 'Place' and the principle of subsidiarity. To this end we welcome the opportunity to influence the policy development process and look forward to further opportunities to engage on many important details that are yet to be determined.

One particular issue that we would like to see addressed going forwards is to recognise the broad range of partners that need to be able to participate fully in ICSs in order to achieve the stated aims. A clear example of this is in community services where in our ICS the lead provider is Sirona Care and Health: a social enterprise organisation that was established as a Community Interest Company (CIC) under the Government's *Transforming Community Services* programme. We also expect that the proposed legislation and guidance would recognise that the development of ICS should enable full participation by General Practitioners as independent contractors and should build on the development of Primary Care Networks.

We are conscious of the limited time that our partners have had to consider responses to the discussion document and would very much welcome opportunities for further and broader engagement to secure the level of buy-in that will be necessary for ICSs to succeed. This will be important in engaging staff and minimising risk of disruption and loss of talent during the process of change. This engagement must involve all ICS partners, including Local Authorities, General Practice, Social Enterprises and other key providers.

Q1. 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 support the principle of establishing ICSs on a statutory footing and other legislative changes to enable ICSs to be successful. Establishing ICSs on a statutory footing has the potential to strengthen accountability for improving health and wellbeing outcomes, reducing inequalities and in the efficient allocation of resources to these ends.

How the ICS statutory duties are defined will be a critical design question. We expect new legislation and guidance to strengthen alignment between the statutory duties of ICSs, Local Authorities, NHSE/I and other statutory bodies, and to address risks of potential conflicts of interest. One example is in the interaction of system and organisational accountabilities, including with regard to accountability for service delivery and outcomes. Another example is in the interaction between the ICS and the statutory regulators with regard to oversight and intervention functions.

There is support within our ICS for legislative change to regulations on procurement and competition to better enable collaboration in service design and delivery.

In addition we expect to see further action from Government to establish a sustainable funding position for social care to enable ICSs to achieve the stated aims. This is a longstanding issue, which was the subject of a Royal Commission in 1999 and, more recently, the independent commission established by the coalition Government in 2010. The importance of this issue has been highlighted further during the pandemic, by the critical role that additional investment in social care has played in reducing risk of acute hospitals becoming overwhelmed.

We would welcome the opportunity to engage in developing further policy details before legislative proposals are put before Parliament.

Q2. 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 feedback from our ICS partners is generally supportive of Option 2. There is a view that this would be welcome as a means of more clearly defining system leadership accountability for the ICS, in the form of an ICS Board and in the role of a full time Accountable Officer. There is also support for embedding CCG functions within the ICS as an enabler of strategic commissioning and, where appropriate, as a basis for delegating commissioning functions to placed-based partnerships and other provider collaboratives.

Establishing ICSs as corporate statutory bodies with appropriate duties and powers will not, of itself, be sufficient to provide greater incentives for collaboration than is the case within the current statutory framework. This is because greater incentives for collaboration will necessarily depend upon strengthening and deepening the commitments of our organisations and our system leaders to partnership working. We have recognised this as an overarching principle in our approach to ICS development locally. We therefore welcome strongly the permissive approach to ICS development that is advocated in the discussion document. One example of where a permissive approach will be vital is with regard to determining the appropriate geographical footprints necessary to enable meaningful collaboration with Local Authorities within ICSs.

Engagement within our ICS has also highlighted questions that will need to be addressed as further detailed policy is developed with regard to the democratic accountability of ICSs under Option 2. This in turn raises questions about how the role of the ICS Board will relate to the roles of Elected Councillors and to the roles of Non-Executive members of provider Boards; and on the role of the Placed Based Leader and the strategic relationship to Health and Wellbeing Boards. We would like to see further details on these issues as part of the narrative on how ICSs will strengthen public accountability.

Q3. **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?**

We support a permissive approach to defining ICS membership and governance. There is also strong support within our ICS for the stated intention that Local Authorities will be equal partners in ICSs. In a system such as ours this means that all three Local Authorities within our ICS should be represented as equal partners.

We think that the proposals should be strengthened to achieve the policy ambitions on inclusive membership. In particular, we expect that further proposals will give greater emphasis to the important roles of other partners within an ICS. For example, Sirona Care and Health is a social enterprise organisation and the lead provider of community services within our ICS. We are aware of similar arrangements within other ICSs and we think that such a significant feature of community services provision in England should be acknowledged and addressed specifically. Given the critical importance of community services within our system it is vital that Sirona is enabled to participate fully in our ICS, and in our place based partnerships. This will depend on access to equivalent resources and other support from NHSE/I as is provided to NHS Trusts/Foundation Trusts performing equivalent roles in other ICSs. We expect this to be addressed as the policy and legislative proposals are developed further.

We would like to see further details on proposals for how General Practice as independent contractors, Primary Care Networks and other providers will be enabled to participate in ICSs and placed based partnerships.

We therefore expect that new legislation and guidance will address the challenges of partnership governance between organisations that have different legal forms, organisational governance and accountabilities.

We note the emphasis in the discussion document on the role of place based partnerships and other provider collaboratives, which in practice may carry out important functions of ICSs in line with the principle of subsidiarity. These different strands of policy need to be fully aligned so as to avoid creating new and unintended barriers to integration. We expect that new legislation and guidance will provide a coherent framework within which all these structures are enabled to work effectively together within an ICS. This is important for enabling service integration across traditional sectoral boundaries and also to avoid creating excessive burdens for organisations that need to participate in multiple levels of governance.

We recognise that some of these issues are not straightforward and need to be balanced within an overall permissive approach and with appropriate safeguards/oversight. We would therefore welcome opportunities to engage in further detailed policy design prior to proposals being introduced into Parliament.

Q4. 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?

There is support within our ICS for transferring or delegating commissioning functions from NHSEI to ICS bodies to help ensure that these services are aligned to the needs of our local populations and to enable integration.

There is also recognition that the opportunities and risks will vary for different services. We would welcome opportunities for further engagement as the detail of these proposals are developed so that we may better understand the opportunities and risks in relation to different services.

The principle of integrated commissioning is broadly welcomed and will need to take account of Local Authority footprints diversity of need. For example our ICS footprint covers the cities of Bristol and Weston Super Mare, as well as large swathes of rural areas.

With regard to primary care commissioning, our discussions have acknowledged the challenges of incorporating within a local ICS structure those services currently commissioned nationally from General Practice and other primary care providers. These challenges are deeply political as much as they are practical and commercial. We request that policy intentions on this issue be clarified at the earliest opportunity to help secure buy-in from primary care colleagues and to avoid uncertainty becoming a barrier to partnership working within ICSs.

For specialised services there is support for commissioning functions to be transferred or delegated from NHSE/I to ICSs where this is appropriate to the level of population that is being served and it increases opportunities for integration. This is important for maximising quality of care and economies of scale, as well for maintaining an appropriate level of coherence in specialised services pathways between ICSs and Places, and for avoiding unwarranted variation.

Where services need to be planned and managed at pan ICS population levels then the commissioning structures will need to reflect this. This is the case for some of the specialised services provided by our two Acute Trusts, our Mental Health Trust and for the services provided by our Ambulance Trust.

Lead commissioning arrangements may be appropriate in some cases where one ICS commissions services on behalf of others, or where commissioning responsibilities may be delegated to a provider collaborative. Where commissioning responsibilities have already been devolved to provider collaboratives spanning multiple ICSs then these should be allowed to continue (e.g. as is the case now for some specialist mental health services).

We would welcome the opportunity for further engagement in the development of proposals for how various commissioned elements could work across different levels and on the design of appropriate safeguards relating to financial and other risks.

Yours sincerely,

Julia Ross
Joint STP Lead Executive and Chief Executive of Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

Robert Woolley
Joint STP Lead Executive and Chief Executive of University Hospitals Bristol and Weston NHS Foundation Trust