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Dear Colleague

Integrating Care: Next steps to building strong and effective integrated care systems across England

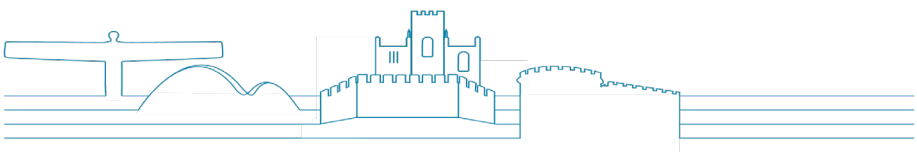
Response from the North East and North Cumbria ICS to the national engagement exercise

As system leaders in the North East and North Cumbria ICS we welcome the publication of 'Integrating care – next steps to building strong and effective ICSs across England', and see this is an excellent opportunity to build on our strong track record of system working to further improve the health of our population and the delivery of high quality, integrated services.

Although we recognise the key benefits that our scale and critical mass can bring to our shared health challenges, we are pleased to see the continued emphasis on local clinical leadership within the guidance, as well as the importance of maintaining strong place-based planning and delivery arrangements, especially with our partners in local government and the voluntary and community sectors. Such subsidiarity, and engagement with our key partners, will be crucial to ensure the effective operation of integrated health and care systems, and that the voices of our communities are represented.

We agree that current legislation, and our existing more informal arrangements, do not provide a 'sufficiently firm foundation for system working', and that addressing this will be an important step towards the further integration of health and care and meaningful action to improve health.

However, we would agree with the Secretary of State previous remarks that a big nationally-driven reorganisation would be unhelpful at this time, and that learning from previous experience we would welcome a more permissive and locally-led approach to ICS development. This flexibility will allow systems to shape their structures and membership to best suit the needs of their populations; this is especially important for us as the largest ICS area in England, with distinct sub-geographies that we need to support and work with via our emerging 'Integrated Care Partnership' (ICP) structures as the bridge from system to place. We therefore urge that the minimum is put on the face of the bill, recognising that it may be added to as any legislation progresses.



In summary, we strongly support the proposed characteristics for each ICS, especially:

- Stronger partnerships in local places between the NHS, local government, VCSE and wider partners with a central role for primary care in providing joined-up care
- Provider organisations to work through formal collaborative arrangements that allow them to operate at scale
- Developing strategic commissioning through systems with a focus on population health outcomes
- The use of digital and data to drive system working, connect health and care providers, improve outcomes and put the citizen at the heart of their own care.

We also strongly support the four fundamental purposes of an ICS, namely:

- improving population health and healthcare – based on the principle that 'decisions taken closer to the communities they affect and with their involvement are likely to lead to better outcomes'
- tackling unequal outcomes and access; because we agree that 'collaboration between partners in a place across health, care services, public health, and voluntary sector can overcome competing objectives and separate funding flows to help address health inequalities, improve outcomes, and deliver joined-up, efficient services for people'
- enhancing productivity and value for money; because 'collaboration between providers across larger geographic footprints is likely to be more effective than competition in sustaining high quality care, tackling unequal access to services, and enhancing productivity.'
- Encouraging and actively assisting helping the NHS to support broader social and economic development, which will be more important than as we look to rebuild the economy.

All these proposals strongly match the ambitions for health and social care which each of our places has been pursuing locally over many years – and which we have committed to together as an ICS since 2018. This document therefore provides a strong foundation for the next stage of our journey across the North East and North Cumbria.

On the four questions set out in the guidance, our views are as follows:

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 agree that giving ICSs a statutory footing from 2022 will provide the right foundation for the NHS to work with its Partners in Local Government, VCSE and wider partners over the next decade. This will help to create the conditions for both effective place-based and system-level working through the duty to collaborate and the proposed adjustments to the legislative framework.

ICSs rely on the strengths of their constituent organisations working together in partnership, and although we have made progress over recent years to strengthen system-working, not least in managing the pressures of COVID19, we believe that the time is now right to establish ICSs as statutory NHS bodies. Bringing CCGs' functions together into an ICS structure will deliver the clearest approach to system leadership and accountability and will minimise the complexity of our governance.

However, the establishment of the ICS on a statutory footing must, through its Partnership Board, be on the basis of respecting our place-based leadership arrangements, including Health and Wellbeing Boards, whilst providing an effective locally determined mechanism to bring them together in pursuit of shared system wide objectives. Establishing locally accountable place-based arrangements to oversee the full range of resources for the populations they serve should be a priority for every ICS, creating the conditions for the deep integration of the local NHS, Local Government, wider public services, the VCSE and local communities to improve health outcomes and the delivery of health and care services.

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?

We agree that Option 2 will provide a greater incentive for collaboration alongside clarity of accountability across systems, to both patients and parliament. Option 2 would allow for a more streamlined arrangement to progress the commissioning and delivery of system level services where it is judged that those services are best planned and delivered at the system level for our whole population of 3.1m. This will also allow us to reduce or remove the commissioner/provider separation at a system level and reduce the time, effort and costs embedded into these avoidable transactional processes.

The primary statutory duty to 'secure the effective provision of health services to meet the needs
of the system population, working in collaboration with partner organisations' is very helpful in
clarifying our obligations, but must not overlook our purpose to improve health, reduce inequalities and tackle unequal access and outcomes.

We think that the ICS Partnership Board model should be constructed on the basis of place-based representation alongside members representing key sectors and functions that operate on a system-wide footprint. We believe that this model will be strengthened by being rooted in place and will help us to avoid the creation of a two-tier, or hierarchical system.

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?

We agree that alongside the mandatory participation of NHS bodies and Local Authorities, membership should be permissive enough to allow ICS to shape their own governance arrangements. We have clear ambitions for the membership and governance to be broad and open to wider public services and partners from the VCSE sector and welcome the opportunity that a permissive framework allows.

We also agree that the potential for provider collaboratives at both place and system-level is significant and will help us to strengthen the sustainability of our services and mutual aid between organisations at times of pressure. They will also help us to

maximise the social value that NHS providers can bring to local places as 'anchor institutions' over the coming decade, and will
be central to the nation's recovery from the social and economic effects of the pandemic. Nevertheless, this is potentially a radical development of the FT model and will require much greater clarity on accountabilities and responsibilities, and for our regulators to adapt how they assess both organisational performance and contributions to system-working. Similarly, we would welcome clear guidelines for ICSs and regulators on how they can ensure that change is enacted where there is local agreement to review the configuration of services and the organisational form of providers within their systems.

We also think it is important that any further guidance on ICS development stresses the importance of engaging a wider range of partners in their governance, especially the VCSE. Whilst it is not appropriate in primary legislation to set out how VCSE or others should be engaged (as VCSE support structures vary so widely), the principle of engaging them in the planning, delivery and governance of health and care services, should be clearly spelled out in the guidance.

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 that ICSs should take on NHSE's commissioning functions for primary care, public health and specialised services. Having these powers alongside CCGs' strategic commissioning responsibilities will help us tackle fragmented service pathways, by ensuring coordinated local decision-making, and that funding is used in the most effective way possible to improve outcomes for the population. Nevertheless, the delegation and transfer of these responsibilities is only the means to help us improve health outcomes and should follow the principle of bringing decisions as close to communities as possible.

The proposed legislation also affords the opportunity to consider the devolution of functions from NHS England and NHS Improvement to ensure clarity regarding their distinct roles and to provide maximum flexibility and synergy within the ICS. We would be keen to participate in a review to shape and inform how these functions work within an ICS. Given the prominence of population health, workforce transformation and capital planning within ICS plans we would further urge you to consider the delegation to ICSs of those functions currently held by NHS arm's length bodies – such as Public Health England, Health Education England and NHS Property Services – to ensure that ICSs have the local coherence, effective powers and delivery capacity to achieve their objectives. This would match the work already undertaken to establish our Integrated Covid Hub (hosted by Newcastle upon Tyne Hospitals NHS Foundation Trust), a joint initiative between all our local authorities, NHS organisations and public health teams in the North East as our central coordination and response centre. Reflecting on our experience of responding to the pandemic, and the capacity this has required to liaise with local partners, we also strongly believe that Emergency Planning, Preparedness and Response (EPRR) should become a core function of ICSs.

We have noted and welcome the emphasis upon clinical leadership for ICSs and would wish to see early delegation to ICSs of the Cancer Alliance, organisational delivery and mandated clinical network from NHSE. We have seen from Covid pressures how these networks can help coordinate and services whilst also providing independent clinical

assurance of quality and performance, functions that in the future should sit within the ICS. There is limited mention of quality control and assurance in the document . We would be keen to participate in future discussions to ensure that the quality agenda is owned and managed by the ICS and informed by the wider clinical community to ensure maximum engagement and impact.

Conclusion

Our experience of meeting the challenge of COVID-19 has reinforced our view that system-working and mutual cooperation, of the type described in this guidance – and respectful of existing place-based working arrangements with our partners – will provide a more effective mechanism for delivering a step-change in population health outcomes, as well as the sustainable delivery of improved service quality, financial balance and patient outcomes.

The North East and Yorkshire (NEY) region was the first region in England to have 100% ICS coverage, and as a result we believe the ICSs are in a very strong position to take on the statutory role and responsibilities outlined in the proposals. Building on the firm foundations, as ICSs in NEY we work closely with the regional team as part of a "four plus one" approach, with collective leadership from ICS leaders and the Regional Director. Many regional staff are already embedded within, or aligned to, the ICS. Our NHSEI Locality Director works directly to the ICS Executive Lead, playing a key role and working as a bridge between the region and the ICS.

Working in this "four plus one" way has proved highly effective in managing the response to Covid, in service planning, performance management and development of a commonly agreed framework for deploying staff. This puts the ICS and the region in a strong position to manage any transition process. Recognising that we will work together with the other ICSs in the region, through lead ICS arrangements and building on our "four plus one" approach, we feel that this would put all the ICSs in region in the strongest position to succeed.

Yours faithfully,

Alan Foster MBE
ICS Lead for the North East and North Cumbria