East London Health & Care Partnership

8 January 2020

Via email

**North East London Integrated Care System response to the NHSE/I paper "Next steps for integrated care"**

As a newly designated ICS we have shared and discussed the paper in a number of different forums and with a range of stakeholders including provider CEOs, LA CEOs, CCG Chairs, Healthwatch representatives and staff. We have been on a journey to become an ICS over the last few years and are pleased that the paper is in line with our direction of travel and that neither of the options laid out in the legislative proposals will disrupt our intentions. The proposals need to ensure that as an ICS we can devolve decision-making and resources as far as possible to local partnerships of NHS bodies and local authorities, building on the Integrated Care Partnerships and other arrangements that have been developed already and which have strengthened during the response to the ongoing Covid-19 pandemic.

**In principle our preference is option two** which we believe will help us move to a more integrated way of working sooner. It will bring more stability for our staff and provide the accountability and leverage for the ICS to deliver its priorities. However the detail of how it will work needs further clarity as follows:

- Detail is needed on areas such as managing conflict, change and transformation and managing situations where not everyone is in agreement so that decision making is not slowed down and is as seamless as possible.
- The paper suggest that no organisation can veto a decision but how would this work in reality? There is a balance to be made between sharing ownership and responsibility and the statutory responsibility of individual bodies, so careful thought needs to be given to the governance that frames this.
- Given the above, we believe that it is not just the roles of CCGs that need to change; the statutory powers and responsibilities of Foundation Trusts will also need to change to ensure they are more firmly grounded in order to focus on delivery of ICS outcomes.
- A duty to co-operate is quite loose and we will need some stronger incentives and requirements to make delivering population health everyone's business. A clear financial and contracting framework better suited to aligning system priorities is required – enabling resources to be invested in line with population need and supporting organisations to work together to drive value rather than encourage them to act independently to drive growth. National versus local priorities and measures of performance will be critical as well as a mechanism for agreeing this across multiple partners. What are the levers to exert in order to develop system accountability for whole population planning if differences/clashes exist between partner organisations' priorities?
- One of the cornerstones of CCGs is the importance of clinical leadership – particularly that of experienced primary care leaders. We would like to see the legislation maintain and develop the voice of clinical leaders from primary care and demonstrate how the local voice continues to be heard in the new governance, ensuring we do not lose what we have in place already.
- Similarly, there needs to be more clarity about how the lay members and non-executives will be involved and able to influence at an ICS rather than just at the organisational level.

- Because of our size as an ICS, with a population of around 2 million, as well as our seven place based partnerships matching our local authority boundaries, we also have Integrated Care Partnerships covering more than one borough. We welcome the emphasis on the role of place but further clarity is needed on the relationship with other local partnerships. In addition there needs to be a stronger emphasis on joint commissioning and delivery of integrated health and care at a place level.

For north east London it is essential that any changes ensure there is a greater emphasis on the role of local authorities in addressing health inequalities and improving health outcomes as well as their role in strengthening democratic accountability in decision making. Additionally we fundamentally believe any development of integrated care needs to develop the importance of meaningful and systematic participation of residents.

**North east London response to the feedback questions:**

**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?**

In principle, we are supportive of the move to ensure ICSs have the right statutory footing and authority to make effective decisions and be held accountable to the local population. We have been working closely as providers and commissioners for some time and would welcome the opportunity to establish decision making joint committees and formally bring together providers and commissioners. It is important that the legislation should provide a foundation not just for the NHS but for a genuine partnership of the NHS with local government across health services, social care and the wider determinants of population health.

**Q.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?**

Ultimately we would welcome legislative change with minimal disruption particularly as we continue to respond to the ongoing Covid-19 pandemic, but at the same time ensures there is robust decision making and resources to strengthen partnerships of NHS and local government at a local level.

Option two makes the most practical sense and would be best particularly for our staff, noting the reassurance for CCG employees with regard to terms and conditions. We welcome the reassurance about the continued need for commissioning functions and the role this will play. However we would also welcome further clarity on ‘repurposing CCGs’, particularly clarity and reassurance around what happens to the CCG’s legal duty to involve patients and residents if CCGs are abolished.

We also welcome the emphasis on the role of local government in future plans for ICSs as they are an equal partner around the table and it is essential that any change allows us to strengthen the relationships and approach we have already developed and builds on our significant progress to date. In many ways, the proposal could go further and be more ambitious about the role of health and social care integration as it is light on details around social care. Additionally the proposal could define how ICS’s plan and provide their own services to ensure greater integration with local authorities. Further clarity is also needed on continuing health care (CHC) and the Better Care Fund where local government and NHS responsibilities and financial regimes are currently blurred.

We have made great strides in developing our provider alliances, particularly over the last 12 months and welcome the opportunity to continue to develop these as well as our place based approach which is fundamental to the way we work in NEL.

Finally, it would be helpful if the legislation could provide the necessary support to ICS's to ensure that when out of hospital services are transformed there is a focus on place based working, including primary care, community and mental health services, with an emphasis on local provision and addressing health inequalities.

**Q.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?**

Certainly across north east London we have built our integrated approach around what works best for each place, rather than applying a one size fits all arrangement. For example our three CCGs in BHR have worked collectively since 2013 and have a well-established integrated care partnership and the same approach across our City and Hackney footprint, whereas across Tower Hamlets, Newham and Waltham Forest we work much more on a borough basis. Shaping our own governance arrangements to best suit population need would be essential for us to ensure we continue to build on the progress we have already made. We would like to ensure that any change enables local partnerships to take initiatives and have discretion to use resources to respond to local need. The legislation should clarify the functions best dealt with at ICS level (and regional and national level) with a strong presumption that as much decision making as possible should be at local level.

In addition we do want a strong voice for our primary care colleagues ensuring there is good primary care representation as part of our ICS governance, so further clarity on this would be helpful and the freedom and scope to create our own approach utilising the strong clinical voice we have across NEL is essential.

**Q.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?**

In principle, yes we do agree to this. However we would want to see greater clarity on how this would work in practice, in particular clinical pathways and the operating model and population management approach. Given our close proximity to other London ICSs as well as Essex we would want to see an approach that took in to account population flow as well as footprint.

Across NEL we have already made significant progress with how we operate services such as cancer across a broader footprint and we would welcome the opportunity to build on this and reduce some of the layers of governance.

In conclusion we are broadly supportive of the proposals laid out in the paper and would welcome further clarity on the areas outlined. Our overarching priority is what is best for patients and their engagement in our new systems is critical, so we welcome any further steps to ensure this is front and centre of our ICS.



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