Action on Smoking and Health (ASH) response to proposals set out in the document Integrated Care: next steps to build strong and effective integrated care systems across England

Closing date: Friday 8 January 2021 at midnight.

Introduction

1. Action on Smoking and Health (ASH) is a public health charity set up by the Royal College of Physicians in 1971 to advocate for policy measures to reduce the harm caused by tobacco. ASH receives funding for its full programme of work from the British Heart Foundation and Cancer Research UK. ASH has also received project funding from the Department of Health and Social Care to support delivery of the Tobacco Control Plan for England. ASH does not have any direct or indirect links to, or receive funding from, the tobacco industry.

2. Deborah Arnott, Chief Executive of ASH, is responding on behalf of the organisation.

Responses to the Questions

Q. 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?

Agree

Specific comments included in text box:

3. We agree that giving ICS a statutory footing is needed, if the proposals are to deliver the "four fundamental purposes" which we agree should be (1.3):
    - improving population health and healthcare;
    - tackling unequal outcomes and access;
    - enhancing productivity and value for money; and
    - helping the NHS to support broader social and economic development.

4. We strongly support the focus on a population health agenda, which is not limited to health and social care but includes prevention and the wider determinants of health. NHSE/I recognises only 20% of health outcomes are determined by the ability to access good quality healthcare and the wider determinants of health play a crucial role, an area where local government rather than the NHS is, and must be, the system leader. NHS England » Population Health and the Population Health Management Programme

5. We also support the need for increased system collaboration which NHSE/I states that both legislative options proposed are designed to drive (3.25 and 3.26) including:
    - local government to be an integral, key player.
    - The ICS to be responsible for planning and shaping services across healthcare, social care, prevention and the wider determinants of health.
    - To allow for the delegation of functions and money to place-based statutory committees involving NHS bodies and local government.

- To enable NHS and local government to exploit existing flexibilities to pool functions and funds.

6. However, if the NHS is to deliver on the population health agenda the legislation will need to ensure that the ICS are accountable to the local communities they serve in practice as well as in principle.

7. Furthermore as NHSE/I recognises *“ICSs need to be of sufficient size to carry out their ‘at scale’ activities effectively, while having sufficiently strong links into local communities at much more local level in places and neighbourhoods.”* (4.14) However, not all ICS footprints are currently aligned with local authority boundaries. Co-terminosity with local authorities or groups of local authorities would significantly ease collaboration and issues around democratic engagement and accountability and this needs to be encouraged rather than just supported.

Q. 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?

Agree

8. We agree that option 2 *“provides a clearer statutory vehicle for deepening integration across health and local government over time.”* (3.26) but as currently envisaged it is not sufficient.

9. If ICS are truly to deliver population health outcomes ICS democratic accountability to their local populations needs to be mandated through fully embedding local authority system leadership and accountability.

10. This could be achieved by enhancing the statutory role of Health and Wellbeing Boards (HWBs) to fulfil this role. For combined authorities with health and social care responsibilities, combined systems may be needed. For example the Greater Manchester city region has a Greater Manchester (GM) Health and Care Board and a Health Scrutiny Board equivalent to local HWBs at GM level, with the GM Board accountable to its local authorities.

11. The legislative arrangements for ICS and their role in population health must also be developed in concert with the reorganisation of public health functions following the announcement that PHE is to be abolished. It is possible that some of the regional public health functions will sit with ICS in the future and it is vital that there is proper accountability for the delivery of these. In addition, it is the ASH view that the Regional Directors of Public Health should play a key role in a future public health system. The legal structure of ICS should therefore include a consistent function for these roles.

Q. 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?

Disagree

12. We strongly 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” (2.63)

13. However, if this is to happen the voluntary sector needs to have its place in the system mandated, not merely permitted.

Q. 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?

Neutral

14. Where appropriate is an important proviso. Not all specialised commissioning services are the same and a ‘one-size fits all’ approach may not right. The examples cited in the document are a good illustration of the issues.

15. As pointed out specialised commissioning for child mental health inpatient services led to fragmented care pathways, misaligned incentives and missed opportunities for upstream investment and preventative intervention. For commissioning of services where local authorities have a key role to play delegation to ICS is appropriate.

16. However, cutting edge technologies and innovative services, or those used by a very small number of patients, are likely to continue to benefit from centralised expertise and commissioning. Although as services and circumstances change, some specialist services which should currently be commissioned centrally may benefit from transfer to ICS, and where this becomes appropriate should be allowed following consultation.