Appendix 1

LCR response to proposals set out in" Next Steps to building strong and effective integrated care systems across England" December 2020

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 general, we support the direction of travel of the proposals towards joining up health and care support around the individual, based on collaboration between organisations, and where decision-making is at the most local level. However, the proposals are in danger of reducing or replacing established place based leadership, best placed to achieve greater investment in prevention and community-based health and wellbeing services by addressing the wider determinants of health: safe and affordable housing, access to training and good jobs, a safe and healthy environment, support for early years, and infrastructure to support resilient communities. Place must be recognised and understood by local communities and for local communities 'place' is the Local Authority in which they live.

We support the move away from a centralised arrangement towards one which places resources and decision making with local communities. However, we are concerned that the proposals set out in the NHS consultation document will just result in new NHS led regional and local command and control governance and systems that bypass or replace Health and Wellbeing Boards which are established, locally accountable place based partnerships, best placed to lead on population health. The aim to devolve power and resources at a local level would best be achieved by ICSs joining existing locally accountable Health and Wellbeing Boards as a partner within this established wider system partnership.

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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 support option 2 and would welcome CCG functions being transferred into the ICS and also NHSE commissioning functions as this would be the most streamlined model for the system (we believe option 1 would leave too many potentially competing layers at a system level and be too complex and may not facilitate the level of whole system working that is required).

We welcome the recognition in the paper of the importance of Place and neighbourhoods and of the principle of subsidiarity but some of this needs to be made clearer over the next 12 months regarding how budgets will be delegated to Place by the ICS and for CCG staff affected by these changes (we welcome the employment promise) and who will they be employed by at Place when their CCG is dissolved.

We would also recommend that some of the other functions of CCGs e.g. safeguarding, CHC, Primary Care delegated functions are all left in the remit of Place based integrated commissioning teams and that the traditional performance and assurance functions of CCGs are simplified.

In addition, whilst both options set out in the consultation document recognise the need for local government representation, neither option proposes local government as an equal partner. The aim is to accelerate integration of health and care through statutory reform, which should legislate local authorities as equal partners. We would suggest that ICSs to be a statutory joint committee acting as strategic partnership bodies for the whole system, with a parity of esteem and representation between local government and the NHS, within which there should be a reciprocal duty of cooperation to address health inequalities on the NHS and local government. The accountability of the statutory ICS joint committee should be established within existing democratic structures and Directors of Adult Social Care (DASS) should be included as mandatory members of 'place' integrated care partnerships; and DASS representation on the ICS joint committee should be mandated. We would suggest that partners within the statutory joint committee should take on current clinical commissioning group (CCG) functions, as determined at a local level, recognising the maturity of local systems.

The statutory joint committee should delegate commissioning to place unless there is an exceptional business case to commission at a scale greater than place. To ensure the success of place-based commissioning resources will be devolved at a local level.

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The integration of health and care will be best delivered through the development of place-based partnerships. Different performance and legislative frameworks are barriers to true integration. If local government remain subject to the Public Contracts Regulations this proposal will introduce new barriers to joint commissioning and risks commissioning activity being inappropriately channelled through the NHS. If the aim of legislative change is to progress integration, the whole of the public sector, but social care, should operate within the same legal framework. The local system needs to be incentivised with clear duty on HWB's to hold providers to account- we would want to see the role of HWBB strengthened in the option 2. If this option is progressed, we would want to see a duty of collaboration built in with reciprocal focus on the importance of addressing health inequalities and wider determinants of health. Collaboration can be a great lever for change and to improve outcomes, however there needs to be an acknowledgement that there are significant variations both in terms of service delivery and in funding gaps across the region – the paper does not sufficiently address how funding gaps and inequalities will be prioritised and rectified and how resources will be distributed.	
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 agree it is important at a Place level that there is the flexibility / freedom to form partnerships that are best suited to a local Place, however we would welcome some guiding principles to support this as not all systems are as mature as others and may need support / guidance to establish effective local and larger system boards / partnerships. We welcome the mandatory participation of Local Authorities as well as the NHS as this recognises the vital and pivotal role local government play in their communities and acknowledges that social care, health, community safety and economic regeneration are interlinked and all key factors in terms of improving health & wellbeing and reducing inequalities. It will be important that the relevant government departments are supportive of this to ensure the NHS and all aspects of local government come together on this agenda.	

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	As the proposed legislative change progresses, we would welcome clarity regarding Place Boards that are outlined in the paper – would these replace Health & Wellbeing Boards? Will they be afforded any statutory footing as a criticism of Health & Wellbeing Boards has been that they have no real decision-making powers? Will the potential governance relationships between the ICSs and integrated commissioning functions at Place be specified or will each system be allowed to work these out? We agree with the premise that statutory direction should be sufficiently permissive as to allow systems to shape their own governance but would argue that the statutory role and leadership of DASSs must be recognised as mandatory within ICSs and ICPs. New governance should include local accountability through existing local systems including health and wellbeing boards and scrutiny committees. We recognise that some integrated partnerships at place and integrated systems are more developed than others. Therefore, if ICSs are created in all parts of England by April 2021, statutory partners at place, including health and local authorities should be provided with the necessary support and resources to ensure some places are not disadvantaged and that all places are in a position to take on delegate powers as an Integrated Care Partnership. Local authorities / HWBB need to be represented at ICS level - there is a strong reference to place leaders and the role of provider collaboratives, but we would want to see democratic decision making enshrined in legislation, policy and process.
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?
	Yes, we agree that services commissioned by NHSE should transferred (not delegated) to ICSs. This relates back to question 2 in that by transferring these services to ICSs the system will be simpler to understand by the public and accountability will be in one place. We would also recommend that the legislative change allow the commissioning of Primary Care to remain at Place as it does now through delegated commissioning from NHSE to CCGs.

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We strongly support delegation of NHSEI commissioning to ICSs, where appropriate. Furthermore, we would like to see an equal emphasis on delegating commissioning to place level, ensuring the application of the principle of subsidiarity. We would suggest that a new statutory reciprocal duty of collaboration to improve population health and address health inequalities is required of all NHS organisations and local authorities and that a legal requirement on ICSs to involve Health and Wellbeing Boards in the development of plans is implemented and the development of place or locality plans be devolved to HWBs. A new power for HWBs to 'sign off' on all ICS plans should be introduced, together with arrangements for commissioning to continue to have a strong place-based focus, with a strong and proactive role in HWBs in approving commissioning plans. There should be a statutory duty on ICSs to be accountable to their local communities through existing democratic processes. Greater control at a local level of specialised services and inclusion in the overarching wider pathway of services would be welcomed.