Integrating Care – Next Steps to building strong and effective integrated care systems across England

London Association of Directors of Public Health response, January 2021

About this response

This response is from the Association of Directors of Public Health for London, which represents Directors of Public Health (DsPH) in London's 33 local authorities, and supports them to improve and protect the health of their local populations. ADPH London brings together DsPH and their teams to work together to address issues which can either only be successfully tackled on a pan-London basis and/or which enhance the ability of boroughs to meet their responsibilities locally, for example through delivering efficiencies, sharing of best practice, reducing duplication, and improving coordination of related work.

Further information on ADPH London, including current priorities, is available online here: http://adph.org.uk/networks/london/

This response represents the professional collective response of Directors of Public Health in London local government. At a local level, individual boroughs will submit their own responses to the consultation.

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Our response to the Consultation questions

Question 1: 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 welcome the ambitions outlined in the recently published NHS 'Integrating Care' document to improve population health and healthcare, tackle unequal outcomes and access, enhance productivity and value for money and to help the NHS to support broader social and economic development. We understand that this is just a start of the process and would welcome full engagement in 'designing' the new system to ensure Directors of Public Health (DPHs) and Health and Wellbeing Boards are crucial leaders at the 'place' level.

We would suggest that DPHs get a statutory place at the ICS Board or equivalent emerging structure, as well as ensuring that the role of the Health and Wellbeing Board is strengthened to include local oversight of the commissioning for public health outcomes, reducing inequalities based on the local needs as well as an active role in ensuring adequate allocation of NHS funding to drive improvements in prevention. Transformation of the NHS commissioning and provider landscape does need to be firmly embedded in the population needs based on the local evidence and articulated by those for whom care is provided.

There have been some good examples across the country where various parts of the system worked effectively in partnership to achieve better outcomes for population health however real delivery and implementation has often been hindered by varying cultures of the organisations, conflicting priorities and outcomes, unequal financial allocations and different degrees of scrutiny on co-production, residents engagements and the overall spend.

The COVID-19 Pandemic has taught us that we can work effectively and at pace when we are striving to achieve the same outcome and when financial barriers are removed, at some degree.

We welcome a suggestion to further strengthen good practice across the country by introducing legislation where ICSs will be given statutory footing however there is an imperative to ensure sufficient flexibility is given to commission and provide integrated health and social care that is person-centred and which includes interventions aimed at tackling wider determinants of health. We recommend an explicit role for the NHS in tackling wider determinants of health including a clear path for the development of NHS trusts as anchor institutions of their communities and their contribution to tackling climate change and creating co-benefits for health.

ICSs should therefore include vertical and horizontal integration not only of the NHS but also should, at its core, have an equal place for local authorities including Directors of Public Health, the voluntary and community sectors, Healthwatch, academic institutions, local businesses and residents. Residents' involvement can be further strengthened by potentially mandating independent local voice via existing structures at the place level such as Healthwatch.

Question 2: Do you agree that option 2 (statutory corporate body) offers a model that provides greater incentive for collaboration alongside clarity of accountability across systems, to Parliament and most importantly, to patients?

Both proposals have their pros and cons however statutory alignment of commissioning and provision that is funded and delivered at place level would bring benefits to the local population health and can enhance a mandate for reducing local health inequalities. This can however only be achieved effectively if it is recognised that this model needs to focus on local partners relationships across the whole system, including the public as well as decisions driven and embedded in the population health management approach. In order to implement this statutory function effectively, local accountability and scrutiny for delivery of the outcomes linked back to funding allocations at place, would be essential. Further development of the local role of primary care groups working closely with LAs, the voluntary sector and the community they service is a great opportunity for truly place based services. This requires explicit delegation of decision making and funding and clear accountability for the local £.

ICS should ensure that, within their new structure, there is a strong focus on prevention and we would welcome further engagement on how can this be best achieved by utilising skills and expertise of local public health teams.

Voices of local residents will be a paramount to successful reduction of inequalities and that could be potentially achieved via stronger Healthwatch or voluntary and community sector engagement as well as appropriate scrutiny and constructive challenge via local and meaningful engagements at, for example, the Health and Wellbeing Boards or/and Health and Overview Scrutiny Committees.

Question 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?

Our view is that, to succeed, legislation must give local leaders flexibility to develop partnership arrangements appropriate to the needs of their areas. However, it may be useful that the centre describes a set of minimum standards, a set of mandated population health outcomes and expectations that would drive integration, tackle wider determinants of health and improve population health outcomes across the

country. These standards and outcomes can all be further refined in discussion with local areas and co-produced with residents.

Question 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 understand that this process is just a start of an engagement that will take place over several months and would like to be fully involved in designing the commissioning and delivery architecture of the Public Health Functions (section 7A) agreement, especially in line with the Public Health England and wider public health system reorganisation currently taking place.

Timing of these transformational changes are somehow unfortunate as we are in the midst of another peak of the COVID-19 pandemic and therefore could not fully review all of the lessons learnt and consider how do we collectively improve performance of screening and immunisation programmes. We are however really keen to ensure London ADPH have full oversight and scrutiny over how section 7A functions are delivered and performance managed in the future in order to achieve maximum benefits for the local populations.

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London Association of Directors of Public Health
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