

NHS England / Improvement Consultation: Building a strong, integrated care system across England: Integrated Care System (ICS) legislation

08 January 2021

About the FSRH

The Faculty of Sexual and Reproductive Healthcare (FSRH) is the largest multidisciplinary professional membership organisation in the UK, representing more than 15,000 doctors, nurses, midwives and other healthcare professionals working at the frontline of sexual and reproductive healthcare (SRH). Our goal is to ensure that high standards in SRH are achieved and maintained through appropriate funding, commissioning and a highly-skilled workforce, to ensure the population can access services which realise [our Vision](#) for high-quality and holistic SRH care across the lifecourse.

Summary of recommendations

- Statutory footing for ICSs is an important means for ICSs to improve access to women's health services, embedding them in the heart of the community.
- FSRH believes option 2 seems to be more adequate to achieve the overall aims of the ICSs; however, more detail is needed. We are clear that whatever form ICSs take, they must embed partnership working and a mandate to collaborate inclusive of Local Authorities. A new statutory duty to collaborate should be introduced on all partners within systems.
- We support NHSE's proposal to develop a single system-wide approach to strategic commissioning, with a focus on improving population health outcomes. This is a welcome step in moving the healthcare system from a focus on disease to one of prevention.
- NHSE's offer for Local Authorities of closer collaboration for improved outcomes is well-intentioned. However, we strongly believe that solely relying on voluntary initiatives for collaborative commissioning will not suffice. History tells us that voluntary arrangements for commissioning governance and accountability between the NHS and Local Authorities have not worked well in the past, and the debilitating indicators in women's reproductive health (see introduction below) are a testament to that. Co-commissioning can improve the quality and availability of women's health services, increase access and reduce inequalities, but only with clear lines of accountability.
- FSRH considers that commissioning needs to go further than what is outlined in this consultation. Harnessing accountability for women's reproductive health within ICSs can be a good means to improve outcomes; however, this is not a substitute for the formal integration of women's reproductive healthcare within the NHS. We believe the fragmentation of commissioning responsibilities will likely remain until there is only one, single accountable commissioner for women's health at ICS level, and a clinical director, or similar, at national level holding accountability for commissioning and outcomes in women's health. A single accountable commissioner would ensure that services are more joined up for women, meeting their healthcare needs across the lifecourse. It would also ensure a multidisciplinary workforce is better supported and resourced.
- Whilst we acknowledge that certain features of strong system working *may* not be legislated for, we cannot risk more of the same. We urge NHSE to [consider the joint position on integrated Sexual and Reproductive Healthcare commissioning by the Academy of Medical Royal Colleges \(AoMRC\), Royal Colleges and Faculties](#), which calls for women's reproductive healthcare to be more broadly integrated into the NHS.

- As it stands, the paper also raises the question of where commissioning responsibilities currently held by Local Authorities will lie, and how they will work in practice with the commissioning responsibilities of ICSs as well as those that remain with NHSE. We call on NHSE to work effectively at ICS level to integrate the women's reproductive healthcare services currently commissioned by CCGs with the services currently commissioned by NHSE as well as by Local Authorities.
- In order to avoid letting the commissioning and delivery of women's health services fall through the cracks amongst major national restructurings, and to correct the historic neglect of this area, we believe it is crucial for every ICS to ensure that a medical Consultant in Sexual and Reproductive Healthcare is represented in ICSs governance bodies to ensure adequate leadership in women's reproductive health commissioning and accountability through systems.
- The proposals do not provide meaningful detail on workforce, the true bedrock of the health and care system. Suggestions for ICSs "*to work with partners to determine workforce planning, commissioning and development*" and to develop a "*one workforce*" strategy in line with the NHS People Plan do not provide enough assurance on any future workforce arrangements under ICSs. This is a serious omission, which we believe should be addressed through engagement with Colleges and Faculties.

Introduction - background on women's reproductive healthcare commissioning

1. Current fragmentation in the way our healthcare services are designed and delivered mean that many women are struggling to access basic services including contraception, abortion care and cancer screening. The consequences of this are shown in debilitating indicators:
 - Almost half of British women experience poor sexual and reproductive health¹
 - Around 45% pregnancies in Britain are unplanned or ambivalent².
 - There has been a rise in abortion among women in older age groups. Rates to women over 30 have been increasing over the last 10 years³. Abortion rates in 2019 were the highest since records began, suggesting widespread unmet need for contraception.
 - GP prescription of Long-Acting Reversible Contraception (LARC), the most effective methods to prevent unplanned pregnancies, has declined by 11% in the last 3 years. More than a quarter (27%) of GPs in England responding to a RCGP survey disagreed that patients who need LARC are always able to access it⁴.
 - Late diagnosis of cervical cancer adversely impacts on survival rates. Cervical screening coverage for women aged 25 to 64 is now at 71.9%, significantly below the 80% national target⁵.
 - The CQC has found that 12% of women are not given any information about contraception after childbirth⁶.

¹ Parkes, A., Waltenberger, M., Mercer, C. et al. 2020. Latent class analysis of sexual health markers among men and women participating in a British probability sample survey. [BMC Public Health 20, 14 \(2020\)](#)

² Wellings, K. et.al 2013. The prevalence of unplanned pregnancy and associated factors in Britain: findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3). [Lancet 382\(9907\): 1807–1816.](#)

³ DHSC 2020. [Abortion Statistics, England and Wales: 2019](#)

⁴ RCGP 2017. [Time to Act](#)

⁵ NHS Digital 2020. [Cervical Screening Programme, England - 2019-20 \[NS\]](#)

⁶ CQC 2019. [2018 survey of women's experiences of maternity care.](#)

2. Put simply, the current fragmentation of governance and commissioning responsibilities in England has created confusion and barriers for women when trying to access healthcare. This is most acutely seen in sexual and reproductive healthcare (SRH) services, the commissioning of which is currently split between CCGs, Local Authorities, which fund these services via Public Health, and NHS England (NHSE). This means there is no single body invested in providing women's basic healthcare needs.
3. The 2012 Health and Social Care Act reinforced the fragmentation of the health and social care service by, for example, splitting health commissioning responsibilities amongst a range of different organisations, most of which were newly created in 2013. This meant that there were, and still are, multiple providers in competition with each another.⁷ Although subsequent policy initiatives promised local collaboration and joint working, without appropriate legislation and frameworks, only so much can be achieved.
4. Although women make up 51% of the population, the current tripartite commissioning arrangements for SRH cause significant barriers for many girls and women trying to access their basic health needs, including contraception.⁸ A review of SRH commissioning by Public Health England (PHE) and the Association of Directors of Public Health (ADPH) has found that fragmented commissioning is threatening access to contraception and other services, specifically indicating that "LARC and cervical cytology might suffer"⁹.

Other issues impacting access

5. Access is made more difficult for a number of additional reasons including stringent cuts to Public Health budgets, difficulties for women juggling work, childcare and other family commitments to get a convenient appointment, and pressures on GP surgeries. These barriers are considerable for many women, but for those who are socioeconomically disadvantaged or have difficulties accessing the health system, the barriers can become insurmountable.
6. The fact that women have to book several appointments to get their basic healthcare requirements is not only counterproductive for clinicians and women alike in terms of their time, but it is also expensive and unsustainable for the health service to continue. It also augments health inequalities and unwarranted variation in service delivery.
7. A lack of accountability and ownership in women's reproductive healthcare has also led to variations in access and quality of care. Though healthcare services still have a duty to facilitate women's access to reproductive healthcare, it is unclear in the current system who holds final responsibility for ensuring access. The All-Party Parliamentary Group on SRH ([APPG SRH](#)), in its [Parliamentary Inquiry into Access to Contraception](#), formally welcomed by DHSC, PHE, Faculty of Public Health (FPH) and others, has heard of a significant lack of local and national accountability for ensuring services are delivering full and open access to contraception. This lack of accountability has also created a system where there are few incentives to prevent health problems developing. Resultant poorer health outcomes are invariably more expensive to resolve than preventing the problem in the first place.¹⁰

⁷ E. Gadsby et al. 2017. [Commissioning for health improvement following the 2012 health and social care reforms in England: what has changed?](#); The King's Fund 2014. [A new settlement for health and social care: Final report](#); RCOG 2019. [Better for women](#)

⁸ APPG SRH 2020. [Women's Lives, Women's Rights: Strengthening Access to Contraception Beyond the Pandemic](#)

⁹ LARC stands for "long-acting reversible contraceptives", the most effective methods of contraception to avoid unplanned pregnancies (contraceptive implants, intrauterine contraception and contraceptive injections). PHE 2017. [Sexual Health, Reproductive Health and HIV. A Review of Commissioning](#)

¹⁰ RCOG 2019. [Better for women](#)

Consultation questions

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?

8. We agree with this statement. We see statutory footing for ICSs as an important means for ICSs to improve access to women's health services, embedding them in the heart of the community. This is an opportunity that should not be missed.
9. The Royal College of Obstetricians and Gynaecologists (RCOG) has recommended in its report *Better for women* (2019), for women's healthcare services to be implemented into ICSs. This will ensure a more joined-up approach to women's health, diminish unnecessarily long referral times and ensure that women receive the best possible care by providing all of their healthcare needs in one location and at one time.¹¹ The report is informing the Women's Health Strategy currently being developed by DHSC, and we urge NHSE to take stock of the Strategy when it is published.
10. We support NHSE's proposal to develop a single system-wide approach to strategic commissioning, with a focus on improving population health outcomes. This is a welcome step in moving the healthcare system from a focus on disease to one of prevention.

Workforce

11. We believe, however, that a lack of meaningful detail on workforce is a glaring omission in the proposals. Suggestions for ICSs "*to work with partners to determine workforce planning, commissioning and development*" and to develop a "*one workforce*" strategy in line with the NHS People Plan do not provide enough assurance on any future workforce arrangements under ICSs. This is a serious omission, which we believe should be addressed through engagement with Colleges and Faculties.
12. It is vital that we continue to work towards the ambitions laid out in the Long Term Plan and NHS People Plan, to ensure that the NHS has the right leadership in place and that services are underpinned by sufficient resources, staff and budget to deliver a sustainable and consistent high-quality service to England's diverse population.

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?

13. We believe option 2 seems to be more adequate to achieve the overall aims of the ICSs; however, more detail is needed. We are in agreement with paragraph 3.26 which states that "*Option 2 is a model that offers greater long term clarity in terms of system leadership and accountability*". We also agree that it has the potential to offer a *clearer* statutory vehicle for deepening integration across health and local government over time.
14. We are particularly pleased to see one of the "triple aims" focussing on population health. Scotland and Wales set good examples of integrated working in Public Health, which could hopefully inspire a new shared vision towards better health for the whole population and better quality of care at patient level supported by legislation in England, fostering effective collaboration amongst all system partners.
15. We acknowledge that some commissioners and providers of women's health, including Local Authorities, are already making progress towards effective collaborative arrangements; however, these are pockets of good practice at best, far from being the norm across the country. Therefore, we agree that the new "triple aim" enshrined in legislation could support stronger system working.

¹¹ RCOG 2019. [Better for women](#)

Mandating collaboration

16. We are clear that whatever form ICSs take, they must embed partnership working and a mandate to collaborate inclusive of Local Authorities. A new statutory duty should be introduced on all partners within systems, including Local Authorities, to deliver against shared objectives and to incentivise greater joint working across health, Public Health and social care.
17. However, we believe this is not sufficient to tackle the deep fragmentation of women's health commissioning that has led to poor outcomes. Above and beyond mandating collaborative commissioning and placing a duty on local authorities to collaborate, we believe the women's health commissioning challenge will only be tackled with the introduction of an integrated commissioning model, with one body maintaining oversight and holding accountability for commissioning of women's healthcare.
18. There is consensus across the medical and non-medical healthcare professions that the commissioning and accountability landscape is not fit-for-purpose, with calls for integrated holistic commissioning of women's reproductive healthcare. We urge NHSE to [consider the joint position on integrated Sexual and Reproductive Healthcare commissioning by the Academy of Medical Royal Colleges \(AoMRC\), Royal Colleges and Faculties](#), which calls for women's reproductive healthcare to be more broadly integrated into women's health pathways in the NHS. Similar recommendations have also been made by the [APPG SRH in its Inquiry into Access to Contraception](#).

The NHS 'offer' to Local Authorities

19. NHSE's 'offer' to Local Authorities of closer collaboration for improved outcomes is well-intentioned. However, we strongly believe that solely relying on voluntary initiatives for collaborative commissioning will not suffice. Whilst we acknowledge that certain features of strong system working *may* not be legislated for (point 2.14), we cannot risk more of the same. Mandating co-commissioning to ensure effective system-working would improve the existing fragmentation of commissioning and delivery of care, which is the case with women's health.
20. The paper states that "*the greater development of working at place will in many areas provide an opportunity to align decision-making with local government, including integrated commissioning arrangements for health and social care, and local responsiveness through health and wellbeing boards. There is no one way to do this, but all systems should consider how the devolution of functions and capabilities to systems and places can be supported by robust governance arrangements*". History tells us that voluntary arrangements for commissioning governance and accountability between the NHS and local authorities have not worked well, and the debilitating indicators in women's health, outlined in the introduction, are a testament to that. To expect that merely "greater development of working at place" across health and Public Health is enough to overcome competing objectives and separate funding streams is overly optimistic.
21. We cannot afford to let the commissioning of women's health services fall through the cracks amongst major ongoing restructurings such as the implementation of ICSs and the national reorganisation of the Public Health system. We urge NHSE to consider how integrated commissioning arrangements will be more than just an opportunity at the level of "place" as well as consider a duty on local authorities to collaborate. Co-commissioning can improve the quality and availability of women's health services, increase access and reduce inequalities, but only with clear lines of accountability. Moreover, ICSs would only be able to work effectively with Local Authorities when there is adequate and sustained funding for Public Health.
22. With knowledge of their local population and know-how, Local Authorities are well-placed to commission and deliver vital Public Health interventions such as tackling social exclusion and homelessness. However, commissioning of *medical* healthcare such as women's health should be the sole responsibility of commissioners such as NHSE.

Collaboration as the new organising principle of the NHS

23. We agree with NHSE that changes to the existing legislative framework to address the challenges brought about by the Health and Social Care Act 2012 and embed collaboration instead of competition as an organising principle of the health and care system will be necessary. Historically, there has been confusion among NHS leaders, staff, patients and partner organisations regarding who is accountable for what service, with variation spreading across the country. Model 2 would hopefully deliver a clearer structure of ICSs for users of the health service, as well as for those that work within it.
24. We are in favour of a point made in paragraph 2.40: *“We will create a ‘single pot,’ which brings together current CCG commissioning budgets, primary care budgets, the majority of specialised commissioning spend”*. This should help overcome funding barriers across NHS services. We support the suggested duty for ICS leaders to ensure that resources are deployed in such a way to protect the future sustainability of local services and welcome the new freedoms these leaders would enjoy in delegating budgets to “place” level including for primary care and community services. However, it is unclear how “new powers” to form joint budgets with Local Authorities, including for Public Health functions, will work. We are concerned that commissioning and payment of women’s health services will continue to be deeply fragmented if the budget for certain Public Health functions is not pooled into joint budgets and/or the single pot. On the other hand, this must not happen at the expense of losing dedicated women’s health budget to other areas as budgets are consolidated into single pots.
25. Finally, as DHSC’s ‘Busting Bureaucracy’ report rightly notes, there are many sources of excess bureaucracy that are exacerbated by poorly integrated systems at a national, regional and local level and due to the multiple levels of hierarchy.¹² We agree that ICSs have the potential to reduce bureaucracy through increased collaboration and through streamlined structures.

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?

26. We disagree with this statement.
27. ICS governance is currently based on voluntary arrangements and is largely dependent on goodwill and mutual co-operation of those that work within it. Added to this, the organisational landscape in many ICSs is complex, especially in areas where there is more than one Health and Wellbeing Board, Primary Care Network, STP, Local Authority, and other local partners.¹³ This complex geography, current administrative boundaries and a system reliant on goodwill is unsustainable.
28. As a result, to date ICSs have varied in size and reach and whilst some have performed well in integrating services, others have struggled to align work with partner organisations.¹⁴

ICS membership and clinical leadership

29. We believe it is crucial for every ICS to ensure that a medical Consultant in Sexual and Reproductive Healthcare is represented in ICSs governance bodies to ensure adequate leadership in women’s reproductive health commissioning and accountability through systems. This would prevent the commissioning and delivery of women’s health services from falling through the cracks amongst major national restructurings as well as correct the historic neglect of this area.

¹² DHSC 2020. [Busting bureaucracy: empowering frontline staff by reducing excess bureaucracy in the health and care system in England](#)

¹³ The King’s Fund 2019. [Health and wellbeing boards and integrated care systems](#)

¹⁴ The King’s Fund 2018. [A year of integrated care systems: Reviewing the journey so far](#)

30. We agree with point 2.24 which states that: *“Clinical and other frontline staff have led the way in working across professional and institutional boundaries, and they need to be supported to continue to play a significant leadership role through systems. ICSs should embed system-wide clinical and professional leadership through their partnership board and other governance arrangements, including primary care network representation.”* It is important that this is embedded and mandated within the minimum requirements, including clinical leadership from community services and Public Health.
31. While some leeway on membership is necessary, as there is not one ICS area that has exactly the same number and spread of partners, it is important for a blueprint for membership to be developed so that leaders are aware of minimum expectations and can more effectively work together to tackle the current issues summarised above. Differences in membership, and thereby engagement with partners, could cause tension, and unwillingness to cooperate, which may lead to differences in success rates with the ultimate goal of integration.

ICS governance

32. We are in agreement with point 2.28 which states: *“Systems have told us from recent experience that good partnership working must be underpinned by mutually-agreed governance arrangements, clear collective decision-making processes and transparent information-sharing.”*
33. Paragraph 2.32 also importantly notes that *“Integrated care systems draw their strength from the effectiveness of their constituent parts. Their governance should seek to minimise levels of decision-making and should set out defined responsibilities of organisations, partnerships at place, provider collaboratives and the core ICS role. Each ICS should seek to ensure that all the relevant bodies feel ownership and involvement in the ICS.”*
34. To achieve these two aims, it is important that all relevant parties form part of the membership, even when levels of decision-making are diminished. Therefore, although some lenience is required, the absolute minimum requirements should be set centrally by NHSE/I.
35. Furthermore, we consider that it is important for leaders to communicate effectively how ICSs will run, how they plan to work with Local Authorities, who will form part of their membership and their overarching powers and responsibilities. It is arguable that to date, the public, NHS staff and other partners have been confused by what responsibilities ICSs have, what the ambitions are, and for patients, how access to their healthcare may change. This is an opportunity to make ICSs visible and transparent that should not be missed.

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?

36. Yes. The ideas laid out in paragraph 3.22 suggest that there would be a more joined up approach to commissioning. However, it remains unclear and confusing as to what commissioning responsibilities would remain the responsibility of NHSE, which would be passed onto ICSs and whether there would be a consistent approach across the country.
37. We consider that commissioning needs to go further than what is outlined in this consultation. Harnessing accountability for women’s reproductive health within ICSs can be a good means to improve outcomes; however, this is not a substitute for the formal integration of women’s reproductive healthcare within the NHS. We consider that fragmentation of commissioning responsibilities will likely remain until there is only one, single accountable commissioner for women’s health at ICS level, and a clinical director, or similar, at national level holding accountability for the commissioning and outcomes in women’s health. A single accountable commissioner would ensure that services are more joined up for women, meeting their healthcare needs across the lifecourse. It would also ensure a multidisciplinary workforce is better supported and resourced.

Ending the fragmentation of women's health services

38. As it stands, the paper also raises the question of where commissioning responsibilities currently held by Local Authorities will lie, and how they will work in practice with the commissioning responsibilities of ICSs as well as those that remain with NHSE. We call on NHSE to work effectively at ICS level to integrate the women's reproductive healthcare services currently commissioned by CCGs (contraception for gynaecological care; abortion care; contraception in the abortion pathway, to name a few) with the services currently commissioned by NHSE (contraception under the GP contract; cervical screening; sexual assault referral centres (SARCs), amongst others) as well as by Local Authorities (contraception in sexual health/SRH clinics, intrauterine contraception and injections in general practice for contraceptive purposes, amongst others) .
39. Whether contraception is for gynaecological purposes or to avoid unplanned pregnancies or both at the same time, and where commissioning responsibility falls according to "purpose", ultimately does not matter to women. The system needs care pathways designed around the needs of the patient, not existing institutional structures. In the case of contraception and women's reproductive health more broadly, this means focusing on where women prefer to access contraception. Data shows that 80% of contraception is delivered in GP practices, a strong indicator that this is women's preferred setting, not Local Authority-commissioned integrated GUM/sexual health clinics.
40. Clarification is urgently required to end the fragmentation of service delivery and access to healthcare, and to achieve a fully joined-up system that we have all been working towards. Above all, we believe that commissioning responsibility for all women's health services should sit with NHSE.

For further information please contact

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