NHS England/ Improvement Consultation on Next Steps for ICSs

Introduction

NHS England/ Improvement (NHSE/I) have published a consultation paper on the next steps for ICSs 'Integrating care: Next steps to building strong and effective integrated care systems across England'. This note provides a summary of the content of the consultation paper.

Place

"Place": is identified as an important building block for health and care integration. For most areas, this will mean long-established local authority boundaries (par 1.14).

There are various references to Governance at a Place Level. The document states that the place leader on behalf of the NHS will work with partners such as the local authority and voluntary sector in an inclusive, transparent and collaborative way. They will have four main roles:

- to support and develop primary care networks (PCNs) which join up primary and community services across local neighbourhoods;
- to simplify, modernise and join up health and care (including through technology and by joining up primary and secondary care where appropriate);
- to understand and identify – using population health management techniques and other intelligence – people and families at risk of being left behind and to organise proactive support for them; and
- to coordinate the local contribution to health, social and economic development to prevent future risks to ill-health within different population groups (Par 2.18).

Systems should ensure that each place has appropriate resources, autonomy and decision-making capabilities to discharge these roles effectively, within a clear but flexible accountability framework that enables collaboration around funding and financial accountability, commissioning and risk management. This could include places taking on delegated budgets (par 2.19).

The exact division of responsibilities between system and place should be based on the principle of subsidiarity – with the system taking responsibility only for things where there is a clear need to work on a larger footprint, as agreed with local places (Par 2.21).

Where partnership working is truly embedded and matured, the ability to accelerate place-based arrangements for local decision-making and use of available resources (such as delegated functions and funding), maximises the collective impact that can be achieved for the benefit of residents and communities (Par 2.23).

Later on in the document there is further reference to 'place' leadership arrangements.

Good partnership working must be underpinned by mutually-agreed governance arrangements, clear collective decision-making processes and transparent information-sharing (Par 2.28).

Place leadership arrangements should consistently involve:

i. every locally determined 'place' in the system operating a partnership with joined-up decision-making arrangements for defined functions;
ii. the partnership involving, at a minimum, primary care provider leadership, local authorities, including Director of Public Health and providers of community and mental health services and Healthwatch;
iii. agreed joint decision-making arrangements with local government; and
iv. representation on the ICS board.

They may flexibly define:

i. the configuration, size and boundaries of places which should reflect meaningful communities and scale for the responsibilities of the place partnership;
ii. additional membership of each place partnership that is likely to include acute providers, ambulance trusts, the voluntary sector and other partners;
iii. the precise governance and decision-making arrangements that exist within each place; and
iv. their voting arrangements on the ICS board. Providers of community and mental health services are "core" Place members whereas acute providers are "additional members" (Par 2.31).

The greater development of working at place will 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 (Par 2.34).

ICSs

ICS 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 (Par 2.31).

The document acknowledges that the more levels of hierarchy in a system, the more likely it is that bureaucracy will exist and grow. It states that ICSs have the potential to reduce bureaucracy through increased collaboration, leaner oversight through streamlined assurance structures and smarter data-sharing (Par 1.7).

Devolving Power

The paper states that there is a need to devolve more functions and resources from national and regional levels to local systems, to develop effective models for joined-up working at "place (Par 1.8).

There is scope to shift national or regional resources and decision making so that these are closer to the people they serve e.g. to devolve a greater share of primary care funding and improvement resource to this more local level (Par 1.11).

Provider collaboration

Some services such as hospital, specialist mental health and ambulance needs to be organised through provider collaboration that operates at a whole-ICS footprint – or more widely (Par 1.19).

Providers will join up services across systems: within places (for example, between primary, community, local acute, and social care, or within and between primary care networks) through place-based partnerships and between places at scale (Par 2.5). All NHS provider trusts will be expected to be part of a provider collaborative (Par 2.6).

In some systems, larger providers may also choose to use their scale to host functions on behalf of other system partners (Par 2.12).

NHSE/I will set out further guidance in early 2021, describing a number of potential models for provider collaboratives (Par 2.13).

Primary care networks in neighbourhoods and thriving community networks are also provider collaboratives, and for integration to be successful there will be a need for primary care to work with community, mental health, the voluntary sector and social care as close to where people live as possible (Par 2.20).

Financial Framework

The finances of the NHS will increasingly be organised at ICS level and allocative decisions put in the hands of local leaders. ICSs are to be key bodies for financial accountability and financial governance arrangements will need to reflect that (Par 2.39). A single pot will be created that brings together different budgets (Par 2.40).

ICS leaders will be expected to delegate significant budgets to 'place' level, which might include resources for general practice, other primary care, community services, and continuing healthcare.

Decisions about the use of all of these budgets will usually be made at the lowest possible level, closest to those communities they serve and in partnership with their local authority. New powers will make it easier to form joint budgets with the local authority, including for public health functions (Par 2.43).

Workforce

From April 2022, this will include:

- developing and supporting a 'one workforce' strategy;
- enabling employees to have rewarding career pathways that span the entire system, by creating employment models, workforce sharing arrangements and passporting or accreditation systems that enable their workforce to be deployed at different sites and organisations across (and beyond) the system, and sharing practical tools to support agile and flexible working (par 2.16).

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 (Par 2.24).

Data

Systems will need:

- A system-wide digital transformation plan that outlines the journey to digitally-driven, citizen-centred care, and the benefits that digital and data will realise for the system and its citizens.
- To develop or join a shared care record joining data safely across all health and social care settings.
- To build the tools to allow collaborative working and frictionless movement of staff across organisational boundaries (Par 2.51).

The document also states that NHHE/I would support legislative change that clarifies that sharing data for the benefit of the whole health and care system is a key duty and responsibility of all health and adult social care organisations (Par 2.51).

Legislative Proposals

The document sets out options for giving ICSs a firmer footing in legislation likely to take affect from April 2022. Two possible options are set out for enshrining ICSs in legislation, without triggering a distracting top-down re-organisation (Par 3.9):

Option 1: a statutory committee model with an Accountable Officer that binds together current statutory organisations:

- It would establish a mandatory, rather than voluntary, statutory ICS Board through the mechanism of a joint committee and enable NHS commissioners, providers and local authorities to take decisions collectively (Par 3.11).
- There would be one aligned CCG only per ICS footprint under this model, and new powers would allow that CCGs are able to delegate many of its population health functions to providers (Par 3.13).
- This option retains individual organisational duties and autonomy and relies upon collective responsibility (Par 3.14).
- However, current accountability structures for CCG and providers would remain (Par 3.15).

Option 2: a statutory corporate NHS body model that additionally brings CCG statutory functions into the ICS.

- ICSs would be established as NHS bodies partly by “repurposing” CCGs and would take on the commissioning functions of CCGs (Par 3.18).

- The CCG governing body and GP membership model would be replaced by a board consisting of representatives from the system partners (Par 3.19).

Both models offer a basis for planning and shaping services across healthcare, social care, prevention and the wider determinants of health. Both would allow for the delegation of functions and money to place-based statutory committees involving NHS bodies and local government. Both would enable NHS and local government to exploit existing flexibilities to pool functions and funds (Par 3.25).

NHSE/I believe that Option 2 is a model that offers greater long-term clarity in terms of system leadership and accountability. It states that it provides:

- A clearer statutory vehicle for deepening integration across health and local government over time.
- Enhanced flexibility for systems to decide who and how best to deliver services by both taking on additional commissioning functions from NHS England but also deciding with system colleagues (providers and local councils) where and how best service provision should take place (Par 3.26).

The consultation document can be accessed at https://www.england.nhs.uk/wp-content/uploads/2020/11/261120-item-5-integrating-care-next-steps-for-integrated-care-systems.pdf