On the day briefing: *Integrating care*, NHS England and NHS Improvement

Today NHS England and NHS Improvement (NHSE/I) has published *Integrating Care: Next steps to building strong and effective integrated care systems across England*. It sets out NHSE/I's view of the strategic direction of system working, including a consultation on two new proposals to put Integrated Care Systems (ICSs) on a statutory footing in the NHS Bill expected in late spring 2021. The paper was tabled and discussed at the NHSE/I board meeting on 26 November 2020.

This briefing summarises the key proposals for NHS trust and foundation trust boards, including the expanded role and functions of ICSs, the new emphasis on at-scale provider collaboratives and place-based partnerships, and the questions about legislative change that NHSE/I is inviting views on by Friday 8 January 2021. We will submit a consultation response based on member feedback – please contact georgia.butterworth@nhsproviders.org to share your views.

Key points

1. NHSE/I has published a paper setting out its view of the strategic and operational direction of system working, underpinned by detailed policy and legislative proposals. The paper is positioned to open up a discussion about how ICSs could be embedded in legislation or guidance.
2. It proposes a national plan to accelerate ICS development in 2021/22. NHSE/I will increasingly devolve more functions and resources from the national and regional teams to ICSs ahead of potential legislative change to be implemented from April 2022.
3. NHSE/I is seeking views on two options for putting ICSs on a fuller statutory footing than its original proposals (September 2019), both of which require legislative change. The first option involves creating a mandatory board/joint committee at ICS level with an Accountable Officer. The second option, which NHSE/I prefers, is a corporate NHS body at ICS level that essentially repurposes the CCG and brings its statutory functions into the ICS. In this scenario, the ICS leader would be a full-time accounting officer role.
4. The paper importantly recognises the leadership role played by providers at both system and place level. NHSE/I want to support at scale collaboration between acute, ambulance and mental health providers and place-based partnerships across community services, primary care and local

government (as well as other partners). This emphasis on providers and place provides a pragmatic approach to the next stage of development of system working that we welcome.

5 NHSE/I is now directing ICSs to firm up their governance and decision-making arrangements in 2021/22 to reflect their growing roles and responsibilities, including establishing place and provider collaborative leadership arrangements.

6 This document confirms that NHSE/I will increasingly organise NHS finances at ICS level, giving ICS leaders responsibility for allocating a 'single pot' of NHS funding for their patch.

7 It also reaffirms the shift to strategic commissioning at ICS level, with other commissioning activities moving to provider organisations/collaboratives/place-based partnerships. Further changes to the commissioning landscape are expected in the legislative proposals.

8 The 2021/22 NHS operational planning guidance will set out further detail on the implementation of all these changes next financial year. NHSE/I will also publish further supporting material for provider collaboratives in early 2021. We will continue engaging in this policy development process and the drafting of any legislative proposals.

Background

The proposals set out in this policy document represent a step change in NHSE/I's vision of system working, building on the ambitions in the *NHS Long Term Plan* (January 2019) and the lessons learned from successful collaboration during the COVID-19 response. While ICSs/STPs have been supported to evolve in a largely 'bottom up' way over the past few years, it is clear that NHSE/I now aims to standardise progress across England to embed ways of working ahead of potential legislative change to be implemented from April 2022.

The purpose of ICSs

In this paper, NHSE/I describes ICSs as having four core aims:

1. improving population health and healthcare outcomes;
2. tackling inequality of outcome and access;
3. enhancing productivity and value for money;
4. and helping the NHS to support broader social and economic development.

This builds on the 2020/21 NHS Operational Planning Guidance which defined two key roles for ICSs: system transformation and collective management of system performance. The list of functions has now expanded to include determining:

- Distribution of financial resources to places and sectors;
- Improvement and transformation resource;

- Operational delivery arrangements based on collective accountability between partners;
- Workforce planning, commissioning and leadership and talent development;
- Emergency planning and response; and
- The use of digital and data to drive system working and improved outcomes.

This list of functions represents a significant step change in the role of ICSs. NHSE/I will need to support systems to effectively discharge their new roles in 2021/22 and ensure their readiness for new functions if they become statutory. All ICSs/STPs will be expected to set out how they meet the phase four planning requirements by April 2021 and implementation plans for their future roles by September 2021. While some trusts and systems will welcome this shift of national/regional resources and decision-making to ICSs/STPs, others will want time to develop their ways of working further before taking on additional responsibilities. We will need to ensure that this expanded role for ICSs does not create additional bureaucracy or duplication with other organisations.

NHSE/I remains focused on ensuring full ICS coverage in England by April 2021, with some of the remaining STPs becoming ICSs in November 2020 and the remainder agreeing development plans with their regional teams to meet the April 2021 deadline. NHSE/I will maintain the current footprints of the 42 systems as they currently stand through to April 2022 but recognises that smaller systems may need to join up functions (especially for provider collaboration) to carry out their 'at scale' activities effectively. NHSE/I will support the ability of ICSs to more formally combine as they take on new roles "where this is supported locally".

Renewed emphasis on the role of providers within ICSs

The document states that "all NHS provider trusts will be expected to be part of a provider collaborative" and join up services both within places (vertical integration through place-based partnerships) and through at scale provider collaborative arrangements (horizontal integration). Trusts will rightly remain the key unit of delivery for secondary care services and drive integrated care within and across systems, and some may develop further to deliver integrated care provider or lead provider contracting models. The proposals call on providers to play an "active and strong leadership role" in ICSs through their representation on ICS partnership boards and role in making decisions about system priorities and resource allocation.

At scale provider collaboratives

NHSE/I envisages collaboratives of acute, mental health and ambulance providers at ICS level – or pan-ICS level for providers working in smaller systems – to allow them to operate at scale, deliver specialist care effectively and provide equal access. NHSE/I will publish further guidance in early 2021 describing

different provider collaborative models, which will likely cover a range of formal and informal arrangements. However, there is some recognition from NHSE/I that these collaboratives will vary in scale and scope, and not necessarily be aligned to ICS boundaries. NHSE/I has therefore set out minimum standards for provider collaboratives to deliver relevant programmes, agree and implement changes developed by clinical and operational networks, challenge and hold each other to account (e.g. open book finances) and enact mutual aid arrangements.

In our view, trusts should retain the autonomy to work with their local partners to determine what type of provider collaborative arrangements work best for their local circumstances, rather than a 'one size fits all' national approach. We will explore with colleagues from NHSE/I and DHSC whether the national policy and legislative framework proposed is sufficiently enabling and has the right accountability, governance and financial structures underpinning it.

Place-based partnerships

This document positions 'place' (defined as an upper tier local authority area or other footprint that makes sense for local communities) as the building block for the ICS. NHSE/I has codified an ambition for each 'place' to offer a certain level of service provision to its local population, including but not limited to access to preventative services and support for the vulnerable. This 'offer' will be delivered through partnerships between NHS providers (community health and mental health), local government (including social care), primary care and the voluntary sector working together with delegated budgets to join up services. NHSE/I emphasises the importance of primary care clinical leadership, joint working with local authorities (often through joint appointments or shared budgets) and a clear relationship with the Health and Wellbeing Board (HWB).

The document also introduces the idea of an NHS place leader to work with the local authority and voluntary sector to support Primary Care Networks (PCNs), join up health and care, identify people at risk and coordinate contribution to social and economic development. The ICS will use the principle of subsidiarity to devolve appropriate resource, autonomy and decision-making capabilities to these place leaders.

Governance and public accountability

NHSE/I is now directing ICSs to firm up their governance and decision-making arrangements in 2021/22 to reflect their growing roles and responsibilities. These should be determined locally but consistently involve some minimum standards including:

- 'Place' leadership arrangements, which include joint decision-making arrangements with local government and representation on the ICS board.

- Provider collaborative leadership arrangements, which include joined up decision-making arrangements across providers and representation on appropriate ICS board(s). While local flexibilities are welcome the document is therefore unclear on how providers that are not referenced as being members of collaboratives – notably community providers – or individual trusts will ensure their views are heard at the ICS partnership board.
- Individual organisational accountability within the system governance framework. NHSE/I confirms that the formal and statutory responsibilities and accountability of individual providers remain unchanged in 2021/22, but the accountability relationship between providers, place-based partnerships and provider collaboratives will need to be defined by ICSs (and may change depending on whether and how ICSs are placed on a statutory footing).

During 2021/22, ICSs will need to develop systematic arrangements to involve lay and resident voices and the voluntary sector in its governance structures. ICSs should involve all system partners in the development of service change proposals to ensure decisions are not slowed down. ICSs should also seek to ensure that all the relevant bodies feel ownership and involvement in the ICS.

We will need to explore the potential implications of 'collective accountability' for system operational and financial performance, and how that interplays with trusts' accountabilities to ensure there are clear governance arrangements in place, and avoid duplication.

Financial framework

This document seeks to establish ICSs as key bodies for financial accountability and embeds recent changes to contracting arrangements and ICS-led revenue allocations and capital spending limits and controls. It confirms that NHSE/I will increasingly organise NHS finances at ICS level, giving allocation decisions and duties to ICS leaders (working with provider collaboratives to distribute in line with national rules for mental health/community and primary care, as well as local priorities) and rolling out the blended payment model for secondary care services. NHSE/I want to foster collective system ownership of the financial envelope and support ICSs to codify how financial risk will be managed across places and between provider collaboratives. New powers will make it easier to form joint budgets with the local authority, including for public health functions.

ICSs will manage a 'single pot' including CCG commissioning budgets, primary care budgets, the majority of specialised commissioning spend, some other directly commissioned services, sustainability and transformation funding. ICSs will divide this into place funding, block contracts to providers and a small ICS central budget, and develop incentive arrangements and outcome measures. While NHSE/I

indicates that providers will be able to influence allocations via the ICS partnership board, there is concern from some trusts that the bigger players in a system are able to advocate for more funding than others and it is challenging to engage in this process if you are a provider working across several systems.

NHSE/I will set out in the 2021/22 NHS operational planning guidance how they will support ICSs to begin operating more collective financial governance in 2021/22 and prepare for the powers/duties outlined above.

As members will be aware, we are closely engaged with NHSE/I colleagues on the development of the financial architecture for 2021/22 (and the implications of the current arrangements) and will be working with trusts and national policy makers as this approach evolves.

Regulation and oversight

This policy document proposes a greater role for ICSs in regulation and oversight, in exchange for greater autonomy assuring delivery within a system. The proposals raise some questions about the interplay of roles and between the NHSE/I regional teams and the ICS, and what peer support between providers will look like in practice.

NHSE/I is taking practical steps to adapt its regulatory functions to support systems, including focusing on how local arrangements are improving pathways, maximising use of resources and acting in partnership to achieve joint financial and performance standards. We expect the system oversight framework (out for consultation in early 2021) will set consistent expectations of systems and their constituent organisations. The proposed future Intensive Recovery Support Programme will give support to systems facing the greatest quality and/or financial challenges. In 2021, NHSE/I will introduce an 'integration index' to support greater adoption of system- and place-level performance data/outcomes measures to be developed by each ICS (presumably agreed with their NHSE/I region).

NHSE/I will issue guidance under the NHS provider licence that good governance for NHS providers includes a duty to collaborate and ensures NHS Foundation Trust directors' and governors' duties to the public support system working. NHSE/I maintains there is an important role for patient choice, including choice between qualified providers.

How commissioning will change

The policy document sets out how commissioning activities and resources will change in three significant ways, which will be broadly welcomed by trusts:

1. Strategic commissioning will take place at ICS level, including assessing population health needs and prioritising how to address them, modelling capacity and demand, and tackling health inequalities. NHSE/I states it is the commissioning activities that must be coterminous with ICS boundaries before April 2022 (rather than CCGs themselves). Under option 2 in the legislative proposals, current CCG functions would subsequently be transferred to core ICS business.
2. Other commissioning activities will move to provider organisations/collaboratives/place-based partnerships, including service transformation and pathway redesign. Systems should agree which functions are delivered at place and system level depending on what makes sense for their size.
3. The current focus on transactional commissioning and contracting will shift to population health analytics and outcomes measurements. The proposals intend to make full use of expertise residing in CCGs and provide continuous employment until March 2022.

Changes to the national commissioning arrangements for specialised services

The policy document explicitly references moving strategic commissioning, decision making and accountability for specialised services to either ICS, multi-ICS or national level (depending on what is most appropriate). Clinical networks and provider collaboratives will drive quality improvement, service change and transformation. NHSE/I is considering allocating budgets on a population basis at regional level (rather than provider-based allocations) for specialised services from April 2021 and will provide further information in due course. Adjustments will be made in the first year to ensure stability. NHSE/I will publish a needs-based allocation formula before using it to inform allocations against an agreed pace of change in future years. This phased approach is welcome as getting the geographies for specialised commissioning right is a complex task and the resources must follow the responsibilities.

Other key policy developments

The policy document emphasises the **importance of ICSs embedding clinical and professional leadership**, including PCN representation at place and system level. It also sets out how **data and digital technology will be at the heart of system working**, with ICSs having a named SRO with clear accountability for data and digital on the ICS partnership board and developing a system-wide digital transformation plan.

NHSE/I describes all the policy developments in this document as aiding the NHS in becoming a better **partner for local authorities and the voluntary sector in meeting local population needs**, which seems an evolution of the previous narrative of ICSs being jointly owned by the NHS and local government.

While the ambition for "progressively deepening relationships" between the NHS and local authorities remains, there is little detail on what this would look like beyond the suggestion of "delegated functions and funding". There is a suggestion that HWBs could be a way to align decision making with local government but we are aware that relationships with HWBs vary across the country. Some ICSs are developing more innovative ways of getting this horizontal accountability right, but it is still a challenge.

NHSE/I is advocating for the NHS Bill to **formalise the merger of NHSE/I** and expects Parliament to use the legislative opportunity to **specify the Secretary of State's powers of direction over NHSE**. In the meantime, NHSE/I will further develop its operating model, including supporting systems through thinner regional teams, delivering fewer national programmes and increasing ICSs' autonomy in terms of assurance. NHSE/I describes the primary interaction between the regions and collective ICS leadership, with limited cause for national functions to intervene with individual providers.

Legislative proposals for ICSs

Discussions are underway within government about the possible content of the NHS Bill, which is likely to be introduced in late spring 2021; this will probably be the only chance this parliament for NHS legislation so we expect the Bill to cover a wide range of topics, including the original NHSE/I legislative proposals (September 2019). However, it is clear that the government and national NHS bodies have developed their thinking on the legislative change required to embed system working since these proposals. NHSE/I now sees a supporting policy framework as insufficient to deliver its vision of system working, and are looking to strengthen their original recommendation to put ICSs on a statutory footing by establishing voluntary joint committees at ICS level. NHSE/I now believes any statutory ICS model should be mandatory to provide long-term clarity in terms of accountability and future-proof ICSs.

NHSE/I is proposing two options for putting ICSs on a fuller statutory basis:

- **Option 1: a statutory, mandatory ICS board/joint committee** model with an Accountable Officer (AO) (chosen from the chief executives/AOs of the ICS board's mandatory members) that binds together current statutory organisations and enables collective decisions across/between providers, commissioners and local authorities. The AO role would be recognised in legislation and have duties in relation to the board's function. There would be a duty on all members to comply with the system plan and new powers for CCGs to delegate population health functions to providers. Current accountability structures would be unchanged.
- **Option 2: a statutory ICS body** that repurposes the CCG and brings CCG statutory functions into the ICS (and potentially some NHSE commissioning functions). This will create a new framework of duties and powers, replacing the CCG governing body and GP membership model with the ICS board, which would have as a minimum representatives from NHS providers, primary care and local

government, alongside an ICS chair, chief executive and chief financial officer. The power of individual organisational veto would be removed. The ICS leader would be a full-time accounting officer role with a primary duty to secure effective service provision that meets population needs.

NHSE/I is seeking views on the following questions, which will help inform their recommendations to government. We will of course engage with our members and respond in full.

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?

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?

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?

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?

These proposals represent a significant evolution in NHSE/I's thinking about how to embed system working arrangements. We will need to consult widely with trust leaders on their views about how these arrangements could improve outcomes for patients and support a fuller collective focus on population management and a reduction in health inequalities. We will work with colleagues in NHSE/I and trusts to consider the impacts of these proposals on their existing accountabilities and powers and ensure any new legislative framework is sufficiently enabling and allows for appropriate local determination.

NHS Providers view

The proposals set out in this policy document represent a step change in the evolution of system working. They offer greater clarity on NHSE/I's view of the strategic direction of system working, underpinned by detailed policy and legislative proposals ahead of an NHS Bill expected next year.

Overall, the document sets out a welcome translation of what a 'system by default' operating model could look like. There is now a clear national plan to accelerate ICS development in 2021/22. This anticipates legislative change aimed at underpinning those developments from April 2022.

We welcome the proposed shift to strategic commissioning and away from transactional contracting, as well as the clear emphasis on the pivotal role of trusts, and other providers, as leaders and co-leaders

of collaborative arrangements at neighbourhood, place and system level. It makes sense to collaborate and deliver different services at different levels of scale, but all of these partnerships will need appropriate resourcing and cannot necessarily continue operating from within the existing staff base. Trust leaders tell us that 80% of care is delivered locally where people live, so it is right to position 'place' as the key building block for integrated care in partnership with local government and others. This emphasis on providers and place, and avoiding creating ICSs as new style, all powerful, Strategic Health Authorities, provides a sensible and pragmatic approach to the next stage of development of system working that we welcome.

As ever, the detail of the document – and the two options to place ICSs on a statutory footing – raises a host of complex and important questions about the detailed operation of the proposals in practice. The existence of providers, provider collaboratives, neighbourhoods, places, ICSs and NHSE/I regions, will require clear, effective, non-duplicative "plumbing and wiring" in areas such as governance, accountabilities, financial flows and statutory responsibilities. The document sets out approaches in these areas where we, inevitably, have questions and possible concerns. We therefore welcome the period of engagement on these issues that the paper triggers. We will want to talk to members about them as we know there is a spectrum of views on many of these issues across the provider sector.

What we do know is that trust leaders – and partners from across the health and care system – are cautious about any top-down, inflexible reorganisation of the NHS, particularly in the middle of a pandemic. While NHSE/I is rightly seeking to avoid such disruption, we will work with them, the Department of Health and Social Care (DHSC), and others, to seek an enabling national policy and legislative framework. With that in mind, NHSE/I and DHSC must facilitate a robust debate with the health and care sector about the scale and implications of both these proposals and the proposed legislative reform, which we are ready and eager to contribute to.

What we do know is that trust leaders – and partners from across the health and care system – agree with NHSE/I about the need to avoid any top-down, inflexible reorganisation of the NHS, particularly in the middle of a pandemic. While NHSE/I is rightly seeking to avoid such disruption, we will work with them, the Department of Health and Social Care (DHSC), and others, to seek an enabling national policy and legislative framework. With that in mind, NHSE/I and DHSC must facilitate a robust debate with the health and care sector about the scale and implications of both these latest proposals and the proposed legislative reform, which build on the prior proposals we have already supported. We are ready and eager to contribute.

How is NHS Providers responding?

Over the last few months NHS Providers has already been extensively involved in commenting on drafts of this document as it developed and the broadly policy development process that underpinned it. We will make an extensive written response to this consultation document on behalf of the provider sector, informed by trusts views, including those of the member reference group we have established to underpin this work in detail. Individual trusts and ICSs/STPs may also wish to respond to the consultation in their own right, and we would welcome trusts sharing these responses with us to help us form a representative view.

We welcome the government's commitment to engage on its legislative proposals ahead of a further period of significant legislative change for the NHS, and expect a formal engagement process to begin shortly. It seems likely that this will be the single chance for NHS legislation this parliament and we are therefore expecting an omnibus Bill covering a range of different areas. We understand that the original NHSE/I legislative proposals will be included, with the proposals on ICS statutory underpinning amended following this consultation. Initial engagement has deliberately been concentrated on ICSs in law, hence the document issued today. Chris Hopson, our Chief Executive has already contributed to an initial stakeholder meeting chaired by the Secretary of State for Health and Social Care.

We will continue to work closely with the senior leadership at NHSE/I and DHSC, and their officials, to feed in the views of trust leaders, influence their thinking and test the detail of both the proposals in today's document and the wider emerging Bill. This will include, but is not limited to additional policy documents we expect to be forthcoming including: the guidance around provider collaboratives that NHSE/I plans to publish in early 2021, the NHS Operational Planning Guidance 2021/22 and the detailed drafting of the NHS Bill over the next six months.

We have also fed into the COVID-19 phase four planning process, including convening a roundtable series with senior NHSE/I representatives to help shape the NHS Operational Planning Guidance 2021/22. These conversations focused on the financial framework, system governance and operational challenges. We will continue to influence the ask of the provider sector for 2021/22.

Finally, we will undertake extensive engagement in anticipation of the NHS Bill, which we expect to be announced in the forthcoming Queen's Speech and introduced in late spring 2021 following a period of public engagement. We do not expect a draft Bill, but expect some form of extensive pre-legislative engagement. We will continue to raise the profile of trust leaders' views and concerns with ministers, NHSE/I senior team and our staff level contacts.

Contact: Georgia Butterworth, Policy Advisor (systems)
georgia.butterworth@nhsproviders.org