**The Kings Fund – The next steps towards integrated care (09 December 2020)**

*You can also read this online on the* [*Kings Fund website*](https://www.kingsfund.org.uk/publications/next-steps-towards-integrated-care)

On 26 November, NHS England and NHS Improvement published [Integrating care: next steps to building strong and effective integrated care systems across England](https://www.england.nhs.uk/integratedcare/integrated-care-systems/). The publication does two things: first, it sets out the next steps towards integrated care, continuing a journey the NHS has been on for many years and most recently articulated in the [NHS Long Term Plan](https://www.longtermplan.nhs.uk/), and second, in the light of this updated model for the health and care system, the document also sets out options for legislative change. In both cases NHS England and NHS Improvement looks to build on progress already made by the NHS and its partners in working together to integrate services in the response to Covid-19.

This explainer describes this model, sets out some of the cross-cutting themes within it and describes the associated proposals for legislative change. It concludes by identifying some of the remaining questions that will determine how this proposed package will work. Our initial assessment of these changes is set out in an [accompanying blog](https://www.kingsfund.org.uk/blog/2020/12/nhs-england-and-nhs-improvements-proposals-new-legislation).

**The model for integration and population health**

The future landscape for the NHS and its partners will be made up of four interlocking elements:

* **place,** which for most areas (but not all) will usually be based on local authority boundaries but could be other locally relevant definitions
* **provider collaboratives,** bringing together NHS trusts and foundation trusts to work more closely with each other
* **integrated care systems (ICSs),** bringing together commissioners and providers of NHS services with local authorities and other partners to plan and manage services that benefit from being considered at greater scale than can be undertaken at place
* **the national and regional bodies,**including NHS England and NHS Improvement, the Care Quality Commission (CQC) and the Department of Health and Social Care.

Although not a major focus of the document, in practice these tiers will build on, and will need to support, work at the level of local neighbourhoods, where primary care networks (PCNs) will join up primary and community services.

**Place**

For most people their day-to-day health and care services will be organised at place level, where a wide range of partners will work together to meet the health and care needs of local populations. For the NHS, at its core this will combine primary care, community health and mental health services but can include more. Critically, it is also where the partnerships with other sectors will be focused, including social care and public health, other local government services and the voluntary sector. Primary care leaders, local authorities (including the director of public health), Healthwatch, and community and mental health services must be included in the local place partnership as a minimum, and there must be agreed joint decision-making with local government. Places are free to add further members as they wish.

There will be a designated leader for place ‘on behalf of the NHS’ who will help to co-ordinate the shared work at place of bolstering primary care services, integrating health and care services and the broader agenda around promoting good health, although the details of the role remain to be clarified. These place leaders will be represented on the ICS board. The exact division of roles and responsibilities between a place and the host ICS will be based on the principle of subsidiarity so that an ICS only takes on responsibility for things where there is a local need to work at greater scale.

**Provider collaboratives**

All NHS provider trusts will be expected to be part of a provider collaborative. These can be horizontal (between providers of the same type within an ICS or multi-ICS footprint, eg, acute hospital, specialist mental health or ambulance trusts) or vertical (combining different types of providers at place level, eg, community health, mental health and acute providers). Providers may find themselves part of both horizontal collaboratives at ICS level, and vertical collaboratives at place.

The potential benefits of working at this scale include collaborating to reduce unwarranted variation, reducing inequalities of access, improving workforce planning and making efficiencies in clinical support and corporate services. Collaboratives will be expected to agree and implement clinical pathways and reconfiguration, and to challenge and hold each other to account with open-book approaches to finance.

The document makes clear that horizontal provider collaboratives will include every such provider within an ICS, eg, all acute trusts in an ICS will be part of an acute provider collaborative. In some cases, horizontal collaboratives will operate across multiple ICS footprints. Collaboratives will have mandated representation at ICS level in the systems in which they operate, alongside representatives of place and other organisations. In this way, collaboratives will help to set ICS priorities and allocate resources alongside contributing to place-based working.

These provider collaboratives are mostly at an early stage of development, and NHS England and NHS Improvement will provide further guidance in early 2021 describing a number of potential models based on some already established.

**Integrated care systems**

The NHS Long Term Plan has already stated that [all of England will be part of an ICS by April 2021](https://www.kingsfund.org.uk/publications/integrated-care-systems-explained). ICSs combine the places within their footprints, provider collaboratives and partnership working with other bodies.

Increasingly the NHS will organise its finances on an ICS footprint, such that resources and prioritisation decisions are taken at ICS level (except where there is a pre-existing national commitment, eg, on mental health, that they must implement). This will bring together funding for primary care, clinical commissioning group (CCG) budgets and much of specialised commissioning (though these will still be based on nationally determined standards) into one pot, with the intention to move to a more strategic outcomes-based approach. There is an expectation that ICSs then delegate some spending and functions to place level. Continuing recent trends in the financial arrangements between ICSs and providers, the NHS will continue to move away from activity-based payments (the tariff). ICSs will also be given increased control over capital spending.

However, the proposals on legislation set out alternative paths for the future of ICSs and we return to this in later sections.

**National and regional bodies**

The primary interaction between ICSs and NHS England and NHS Improvement will be through a thinner regional tier (as some functions, eg, specialised commissioning, switch to ICSs). In addition, NHS England and NHS Improvement will create a new System Oversight Framework that will set out the expectations of ICSs and the organisations within them alongside a new Intensive Recovery Support Programme for the most challenged systems, whether on finance or quality. In 2021 NHS England and NHS Improvement will launch a new ‘integration index’ to support measurement of performance at system level. Working with CQC, NHS England and NHS Improvement will also look to include assessments of system participation (both in the ICS and provider collaboratives) in the CQC ‘well-led’ assessment.

All legislative proposals include the full merger of NHS England and NHS Improvement, who have already started working together.

In addition, the document refers to the need for parliament to define in legislation the mechanisms by which the formally merged NHS England and NHS Improvement will be held to account, both by the Secretary of State for Health and Social Care and by parliament itself. NHS England and NHS Improvement suggests this should be done in a way that protects its clinical and operational independence.

**Cross-cutting themes in the changes**

Aside from the largely organisational changes set out above, there are a number of common themes running through the changes.

**More local determination**

Many believe that previous attempts at NHS reform have suffered from a top-down, one-size-fits-all approach. In this new approach, NHS England and NHS Improvement is seeking to leave room for local discretion and flexibility, for example:

* allowing local flexibility to define the size and boundaries of places
* flexibility over the exact division of roles and responsibilities between place and ICS level
* flexibility over the scale and scope of provider collaboratives and their precise membership
* flexibility over how ICSs may work together when organising specialised services.

However, one area where there is no flexibility is that CCGs (irrespective of any legislation) will be required to merge and become co-terminous with ICS footprints ‘before April 2022’.

**Clinical and professional leadership**

Primary care clinical leadership will be expressed at neighborhood (PCN) level, at place, and there will be a primary care perspective at ICS level. Specialist clinical leadership will be present in both ICSs and horizontal provider collaboratives and, where appropriate, at regional and national level as well. At ICS and collaborative level, clinical networks should be able, for example, to undertake clinical service reviews and develop recommendations for the ICS and collaborative.

**Data and digital**

Building on existing commitments and the experience of Covid-19, there will be a continued major push to enhance data and digital capability. This includes building the digital infrastructure; connecting health and care, eg, through a shared care record; using data and digital to transform care; and developing a roadmap for citizen-centred digital channels and services.

**Further reading**

* Blog:[A recipe for baking in collaboration? NHS England and NHS Improvement’s proposals for new legislation](https://www.kingsfund.org.uk/blog/2020/12/nhs-england-and-nhs-improvements-proposals-new-legislation)
* Explainer:[Integrated care systems explained](https://www.kingsfund.org.uk/node/93892)
* Explainer:[Primary care networks explained](https://www.kingsfund.org.uk/node/93397)
* Explainer:[The NHS long-term plan explained](https://www.kingsfund.org.uk/node/93350)
* Infographic:[How funding flows in the NHS](https://www.kingsfund.org.uk/node/3899)

**Legislation**

NHS England and NHS Improvement had proposed a [set of legislative changes](https://www.longtermplan.nhs.uk/nhs-publishes-response-and-recommendations-on-long-term-plan-legislative-proposals/) in 2019 which it believes ‘still stand’. These changes included the merger of NHS England and NHS Improvement; reducing the role of competition and procurement in the NHS; a new ‘triple aim’ for all NHS organisations to improve population health, quality of care and financial sustainability; and enabling easier co-operation between NHS bodies. However, the previous proposals did not include putting ICSs on a statutory footing, instead proposing a new statutory underpinning to establish ICS boards through voluntary joint committees.

NHS England and NHS Improvement believes that, since those earlier proposals, the need and appetite for enshrining ICSs in legislation has increased, in part due to the greater partnership working between NHS bodies and their partners observed during their response to Covid-19.

NHS England and NHS Improvement has now put forward two further options.

**Option one:**to create a statutory ICS board, with an accountable officer. This would create a mandatory board and would allow the partners to make decisions collectively. However, all NHS bodies – whether providers or commissioners – would remain, and all would also retain their existing accountable officers/chief executives. CCGs that have not already done so would have to merge to be on the same footprint as the ICS.

**Option two:**to create ICSs as new statutory bodies to secure health services for its population. This would be a formal NHS organisation and would replace CCGs. As a minimum, its board would include representatives of NHS providers, primary care and local government as well as a chair, chief executive and chief financial officer. Alongside subsuming CCGs, many NHS England commissioning functions would be delegated to the ICS.

While all options imply changes for commissioners, CCG staff ‘who wish to play a part in the future’ will be offered opportunities for continued employment ‘up to March 2022’ as part of a package to minimise the disruption these changes would cause. However, this commitment will not apply to CCG chief officers or members of CCG governing bodies and boards under option two, whose roles will be ‘more directly impacted’.

Though NHS England and NHS Improvement believes both options would support integration, it makes clear that it prefers option two. NHS England and NHS Improvement is now [engaging on these proposals with a closing date of 8 January 2021](https://www.engage.england.nhs.uk/survey/building-a-strong-integrated-care-system/) with recommendations to the Department of Health and Social Care to follow.

**Remaining questions**

While NHS England and NHS Improvement has set out a roadmap for the future direction of the NHS and its co-operation with partners, there are questions about how this will work, though many of these pre-date these new legislative proposals. These include the following.

* Exactly what powers will an ICS have over its constituent NHS organisations, particularly over foundation trusts?
* What will the role for local government and other non-NHS partners in the ICS be, particularly in the scenario set out in option two (above), where it becomes a statutory NHS body accountable for NHS finances?
* What will be the models for new provider collaboratives and how will they be structured to enable mutual support between provider organisations and effective co-operation within sectors at the level of place?
* In light of the recent announcement to abolish Public Health England, how will these proposals align with the operating model for public health, which is being developed separately?
* How will delegation of functions (and budgets, in some cases) to the level of place be supported in practice?
* How will the cultural change that underpins better integration be supported? How will staff at all levels be supported to genuinely collaborate across organisational and professional boundaries?
* How will the voices and priorities of residents, service users and patients be captured and meaningfully reflected in the governance and decision-making of ICSs?

Until further detail is made available, it is difficult to assess the legislative proposals fully. Our initial view is set out in our [accompanying blog](https://www.kingsfund.org.uk/node/94123). We will continue to review additional information as it becomes available.