HFMA briefing
June 2021

Summary of *Integrated care systems: design framework*

Introduction

The *Integrated care systems: design framework*[1] (the framework) begins to set out how the NHS will operate within a statutory integrated care system (ICS). It covers a number of areas where clarity has been requested, such as how resources will be allocated and the roles of different organisations within the ICS. It highlights where there are consistent national requirements for all ICSs and where local determination of approach can be applied. There is still a substantial amount of guidance to come as further discussions are held with stakeholders and local systems. This will support detailed local planning and is likely to follow the presentation of the proposed legislation to Parliament.

The framework is clear that local systems may make reasonable preparatory steps in advance of legislation but should not act as though the legislation is in place or inevitable. The framework goes beyond the likely minimum statutory requirements in order to set out what is needed for ICSs to be successful.

This briefing summarises the key points covered in the framework. The original document should be referred to for the full detail.

The ICS partnership

The framework states that the ICS partnership will be a committee, not a corporate body. The Government has indicated that the legislative framework for the ICS partnership will be at a high level, allowing local systems to develop the partnership arrangements that work best for them, building on existing arrangements where these are in place. These arrangements should be based on an equal partnership between the NHS and local government and be based on the principles of

[1] NHS, *Integrated care systems: design framework*, June 2021

subsidiarity (performing only those tasks which cannot be performed at a more local level), collaboration and flexibility.

Members of the partnership must include local authorities that are responsible for social care services in the area, and the local NHS, represented as a minimum by the ICS NHS body. Other members of the partnership could include the voluntary, community and social enterprise (VCSE) sector; statutory bodies with an interest in housing, justice or education; or members from health and wellbeing boards. The framework sets out the intention that there should be a broad representation of partners working to improve health and care in their communities. Public health must be included in the partnership.

The partnership will need to have a chair. This position could be carried out as a joint post with the chair of the ICS NHS body, if that supports local co-ordination. The framework sets out suggested principles to support the development of culture and behaviour within the partnership, across leadership, decision making, and transparency.

Further guidance is being developed in conjunction with the Department for Health and Social Care (DHSC), NHS England and NHS Improvement, and the Local Government Association (LGA).

The ICS NHS body

The ICS NHS body will be a statutory organisation. It is expected that all clinical commissioning group (CCG) functions and duties will transfer to the new body, along with all CCG assets and liabilities, including their commissioning responsibilities and contracts. Additional functions will also be delegated from NHS England and NHS Improvement including primary care commissioning and some specialised services.

The ICS NHS body will be responsible for:

- developing a plan to meet the health needs of their population, taking into account the broader strategy developed by the ICS partnership
- allocating resources to deliver the plan across the system
- establishing joint working arrangements with partners. This may include joint commissioning under section 75 of the 2006 Act.
- establishing governance arrangements to support collective accountability for whole system performance
- arranging for the provision of health services
- leading system implementation of the *NHS people plan*[2]
- leading systemwide work on data and digital
- driving continuous improvement through tracking delivery of plans and using data to monitor and address variation
- working with councils to invest in local community organisations and infrastructure
- driving joint work on estates, procurement and commercial strategies to maximise value for money
- planning for, responding to and leading recovery from incidents.

Governance and management arrangements

The ICS NHS body will have a unitary board. This will include, as a minimum, three non-executives who do not hold positions at other health or care organisations within the ICS footprint; executive roles for the ICS NHS body including the chief executive, director of finance, director of nursing and the medical director; and at least three members from partner organisations covering NHS trusts and foundation trusts, primary care, and local authority.

[2] NHS, *We are the NHS: people plan for 2020/21 – action for us all*, July 2020

The board is the senior decision-making body for the ICS NHS body and all partner members are expected to be full members. It is anticipated that the partner members will be the chief executives of their organisations or a relevant executive-level role.

The board will need to be of an appropriate size to be able to take into account the perspectives of all relevant partners across the system, but this may be achieved through engagement mechanisms rather than a very large board. Boards also need to provide leadership on people issues and digital transformation.

Committees and decision making

Each board will be required to establish an audit committee and a remuneration committee. It is expected that ICS NHS bodies will be able to establish joint committees with NHS trusts or foundation trusts, where appropriate. While there will be flexibility in defining local governance arrangements, each ICS NHS body will be required to maintain a 'functions and decisions map' to show its arrangements with partners.

Place-based partnerships

The framework recognises the importance of place and requires ICSs to define its place-based arrangements, however there is no definition given for what place should be as this is down to local determination. For small ICSs, place could have the same geographic footprint as the ICS. However, it is important that places reflect meaningful communities and enable joined-up decision making across the NHS, local authority and other partners.

The ICS will remain accountable for resources deployed at a place level. ICSs are required to clearly set out the role of place-based leaders which will include representing the partnership at ICS level. A number of possible governance structures for place-based partnerships are set out within the framework.

Supra-ICS arrangements

For some services that cover wide geographical areas, ICS NHS bodies will need to work together to develop shared plans. The supporting governance arrangements will be co-designed between the relevant providers, NHS ICS bodies and NHS England and NHS Improvement regional teams.

It will be important for ambulance providers to agree their working relationships with the ICSs that they support, with a view to avoiding unnecessary variation of practice or duplication of communication.

The role of providers

Providers of NHS services will play a key role in identifying the priorities for change and delivering the solutions for better outcomes for the population. It is expected that the contracts held by the providers of healthcare services will evolve to support longer-term, outcomes-based agreements, with less transactional monitoring.

Primary care

Primary care should be included at all levels of the ICS, ensuring that the needs of their local populations at a neighbourhood level are considered in place and system-based decisions.

Primary care networks will support the delivery of care at a place level, by developing integrated multi-disciplinary teams across the NHS, local authority and VCSE sector. Where PCNs work together to drive improvement or provide representation in place-based partnerships, this should be resourced by the partnership as it is in addition to the PCN's core function.

Voluntary, community and social enterprise sector

It is expected that, by April 2022, ICS partnerships and ICS NHS bodies will develop formal agreements to engage and embed the VCSE sector in system level governance and decision-making arrangements.

NHS trusts and foundation trusts

NHS trusts and foundation trusts will play a critical role in ICSs to transform and develop services and agree how to best use resources to improve population health. Provider organisations could take on some commissioning functions, building on the provider collaborative model.

The framework states that individual trusts and foundation trusts will increasingly be judged against their contribution to the objectives of the ICS, including the delivery of their agreed contribution to system financial balance.

Provider collaboratives

Provider collaboratives are partnership arrangements involving two or more trusts working across multiple places to realise the benefits of mutual aid and working at scale. From April 2022 trusts providing acute or mental health services are expected to be part of at least one provider collaborative. Collaboratives are expected to be a key part of service transformation, enabling shared ownership of objectives and plans. Governance arrangements for the collaborative will be subject to local determination.

ICS NHS bodies may contract with a provider collaborative with a lead provider or with each individual party within the collaborative. Further guidance on provider collaboratives will be published.

Accountability and oversight

ICS NHS bodies, as statutory organisations, will be held to account by the regional teams of NHS England and NHS Improvement for ensuring the discharge of their functions. Oversight arrangements will build on the yet to be published 2021/22 system oversight framework[3]. These arrangements are likely to confirm the formal role of ICS NHS bodies in wider system oversight, through bringing parties together to identify and tackle risk, and lead oversight and support of individual organisations within their system. However, any formal regulatory action remains the responsibility of NHS England and NHS Improvement.

Executives of provider organisations will continue to be responsible to their boards for the performance of their organisations.

Where an executive of a provider organisation sits on the board of an ICS NHS body, they will also be responsible for the performance of that organisation in their capacity as a board member. When acting as a board member, they must act in the interest of the ICS NHS body and the wider system, not necessarily in the interests of their employing provider. Further guidance will be issued on managing conflicting roles.

The broader ICS partnership will be made up of many organisations, each of which retains their own statutory responsibilities. However, all parties should work to a principle of mutual accountability where they consider themselves collectively accountable to the population that they serve.

Financial allocations and funding flows

The framework sets out that NHS England and NHS Improvement will make financial allocations to ICSs, linked to population need and based on a similar approach to CCG allocations. Funding will take account of the pace-of-change work to ensure that there are no destabilising large swings in

[3] NHS, *System oversight framework 2021/22 consultation*, March 2021

funding for local health economies. Allocations will be made at ICS level. There will be no central allocation to places.

Funding will include budgets for acute, community and mental health services; primary medical care; and ICS NHS body running costs. There may also be additional allocations for other primary care budgets, specialised commissioning, transformation funding; and investment in digital and data services. Spending decisions will be devolved to ICS NHS bodies, but every ICS will still be required to meet the mental health investment standard (MHIS) and other national commitments such as the primary medical and community health services funding guarantee.

The ICS NHS body will be able to set a delegated budget for place-based partnerships, adopting the principle of equal access for equal need and the requirements to reduce health inequalities. The ICS NHS board and chief executive will remain responsible for services under delegation arrangements and should ensure that assurance can be provided on the spending of public money.

Financial and regulatory mechanisms to support collaboration

A number of enablers have already been established to support system working such as setting system financial envelopes, developing an aligned payment and incentive approach, and a change in organisational oversight to the system oversight framework.

Additional enablers for system collaboration are expected to include:

- a common duty across all NHS bodies to have regard to the wider effect of decisions in each of the three standards of the triple aim to improve population health, quality of care, and use of resources
- imposition of duties across NHS bodies to act with a view to ensuring system financial balance, supported by a review of the provider licence
- powers to ensure that organisational capital spending is in line with system capital plans.

Data and digital standards and requirements

From April 2022, ICSs are expected to have smart digital and data foundations in place. Experts in this area will have a pivotal role to enable transformation and provide a modern operating environment to support the workforce and population. The framework sets out a number of expectations on ICS NHS bodies including investment in infrastructure and the implementation of a shared care record.

A new ‘What good looks like’ framework identifies seven success measures to support this work and will be published in the first quarter of 2021/22.

People and culture

From April 2022, it is expected that ICS NHS bodies will have specific responsibilities for delivering against the *NHS people plan*. While the *NHS people plan* sets out actions for individual organisations, ICS NHS bodies are expected develop shared principles and ambitions for people and culture across the ICS, including local authorities, VCSE sector and other partner organisations. The framework states that the ICS should take a ‘one workforce’ approach.

This approach should be supported by a number of actions including clear governance arrangements for agreeing and delivering local people priorities, and establishing leadership structures to drive the culture and behaviours needed to support people working within the ICS. It is also expected that standardised, high-quality transactional human resources services such as payroll, will be delivered across the ICS to reduce duplication.

Additional guidance will be published with Health Education England to support ICSs in developing their people strategies.

The framework also sets out the importance of clinical and professional leadership, highlighting that protected time is needed to allow these leaders to carry out system roles and to be fully involved as key decision-makers.

Managing the transition to statutory ICSs

Additional guidance has been provided on the employment commitment[4] to support the transition to statutory ICSs. It is designed to minimise uncertainty and provide employment stability throughout the transition period for those working in affected organisations. The commitment applies to those working below board level and organisations are asked not to undertake significant internal organisational change or displace people during the transition period.

Support is also being offered to those working at board level who will be impacted by the changes and are likely to experience disruption to their roles as statutory ICSs are established and board level appointments made.

The expected timetable for transition included in the framework, is set out below.

By end Q1 Preparation	• Update system development plans (SDPs) against the key implementation requirements (functions, leadership, capabilities and governance) and identify key support requirements. • Develop plans in preparation for managing organisational and people transition, taking into account the anticipated process and timetable, and any potential changes to ICS boundaries and the need to transform functions to support recovery and delivery across the ICS.
By end Q2 Implementation	• Ensure people currently in ICS chair, ICS lead or accountable officer roles are well supported and consulted with appropriately. • Carry out the agreed national recruitment and selection processes for the ICS NHS body chair and chief executive, in accordance with guidance on competencies and job descriptions issued by NHS England and NHS Improvement. This will reflect the expected new accountabilities and responsibilities of ICS NHS bodies. • Confirm appointments to ICS chair and chief executive. Subject to the progress of the Bill and after the second reading these roles will be confirmed as designate roles. • Draft proposed new ICS NHS body MoU arrangements for 2022/23, including ICS operating model and governance arrangements, in line with the NHS England and NHS Improvement model constitution and guidance. • Plan for CCG teams to only operate at sub-ICS level where the SDP confirms that the ICS plans to establish a significant place-based function at that footprint. • Begin due diligence planning.
By end Q3 Implementation	• Ensure people in impacted roles are well supported and consulted with appropriately. • Carry out the recruitment and selection processes for designate finance director, medical director, director of nursing and other board level role in the NHS ICS body, using local filling of posts processes.

[4] NHS, *Guidance on the employment commitment: supporting the development and transition towards statutory integrated care systems*, June 2021

	• Confirm designate appointments to ICS NHS body finance director, medical director and director of nursing roles and other board and senior level roles. • ICS NHS bodies and ICS partnerships to be ready to operate in shadow form. • Engagement on local ICS constitution and governance arrangements for ICS NHS body and ICS partnership.
By end Q4 Transition	• Ensure people in affected roles are consulted and supported. • Continue the recruitment and selection processes for all other designate ICS NHS body senior roles, including place-level leaders and non-executive roles, using local filling of posts processes. • Confirm designate appointments to any remaining senior ICS roles (in line with our relevant guidance) so that as much of the ICS NHS executive board and other senior leadership is ready (subject to formal decisions on appointments after the legislation is in place/in force). • Complete due diligence and preparations for staff and property (assets and liabilities, including contracts) transfers from CCGs and other NHS staff transfers to new ICS NHS body in line with our guidance. • Commence engagement and consultation on the transfer with trade unions. • Complete preparations to shift our direct commissioning functions to ICS NHS body, where this is agreed from 1 April 2022. • Ensure that revised digital, data and financial systems are in place ready for 'go live'. • Submit the ICS NHS body constitution for approval and agree the 2022/23 ICS MoU with NHS England and NHS Improvement, setting out key elements of how the new ICS NHS body and ICS partnership will operate in the future, in accordance with guidance to be issued by NHS England and NHS Improvement.

About the HFMA

The Healthcare Financial Management Association (HFMA) is the professional body for finance staff in healthcare. For over 70 years, it has provided independent and objective advice to its members and the wider healthcare community. It is a charitable organisation that promotes best practice and innovation in financial management and governance across the UK health economy through its local and national networks.

The association also analyses and responds to national policy and aims to exert influence in shaping the wider healthcare agenda. It has particular interest in promoting the highest professional standards in financial management and governance and is keen to work with other organisations to promote approaches that really are 'fit for purpose' and effective.

The HFMA offers a range of qualifications in healthcare business and finance at undergraduate and postgraduate level and can provide a route to an MBA in healthcare finance. The qualifications are delivered through HFMA's Academy which was launched in 2017 and has already established strong learner and alumni networks.

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