WIRRAL

ADULT SOCIAL CARE AND HEALTH COMMITTEE

18th JANUARY 2021

REPORT TITLE:	**STRATEGIC DEVELOPMENTS IN THE NHS**
REPORT OF:	**SIMON BANKS, CHIEF OFFICER, NHS WIRRAL CLINICAL COMMISSIONING GROUP AND WIRRAL HEALTH AND CARE COMMISSIONING**

REPORT SUMMARY

On 26th November 2020 NHS England/Improvement (NHSE/I) published *Integrating Care: Next steps to building strong and effective integrated care systems across England*. This document set out proposals for legislative reform and focused on the operational direction of travel for the NHS from 2021/22 onwards. The document was intended to open up a discussion with the NHS and its partners about how Integrated Care Systems (ICSs) could be embedded in legislation or guidance. Decisions on legislation will be for Government and Parliament to make. This paper summarises the proposals set out in *Integrating Care: Next steps to building strong and effective integrated care systems across England*. This paper also sets out work in progress to respond to these proposals for Wirral as a "*place*" within the Cheshire and Merseyside ICS.

RECOMMENDATION

The Adult Social Care and Health Committee is asked to note and support the work to define what a commissioning offer at *place* should look like, setting out what commissioning functions should be delivered in *place* and what would best sit with provider partnerships. The Committee is also asked to note the work in the creation of a provider collaborative/alliance in Wirral.

SUPPORTING INFORMATION

1.0 REASON FOR RECOMMENDATION

1.1 The Adult Social Care and Health Committee should be informed of important policy changes in the NHS that impact upon Wirral and should also engaged in the development of a Wirral response such changes to maximise the benefit to the local population.

2.0 OTHER OPTIONS CONSIDERED

2.1 The options of (i) maintaining the status quo or (ii) not engaging in these national driven policy changes have been considered and dismissed as they would not benefit the population of Wirral.

3.0 BACKGROUND INFORMATION

3.1 Introduction

3.1.1 On 26th November 2020 NHS England/Improvement (NHSE/I) published *Integrating Care: Next steps to building strong and effective integrated care systems across England*, subsequently referred to as *Integrating Care: Next steps*. This document set out proposals for legislative reform and focused on the operational direction of travel for the NHS from 2021/22 onwards. The document was intended to open up a discussion with the NHS and its partners about how Integrated Care Systems (ICSs) could be embedded in legislation or guidance. Decisions on legislation will be for Government and Parliament to make.

3.1.2 *Integrating Care: Next steps* builds on the route map set out in the *NHS Long Term Plan*, for health and care joined up locally around people's needs. It signals a renewed ambition for how the NHS can support greater collaboration between partners in health and care systems to help accelerate progress in meeting our most critical health and care challenges.

3.1.3 *Integrating Care: Next steps* details how systems and their constituent organisations will accelerate collaborative ways of working in future, considering the key components of an effective ICS and reflecting on what a range of local leaders have told NHSE/I about their experiences during the past two years, including the immediate and long-term challenges presented by the COVID-19 pandemic.

3.1.4 These are significant new steps towards the ambition set out in the *NHS Long Term Plan*, building on the experience of the earliest ICSs and other areas. NHSE/I now intend now is to spread their experience to every part of England. From April 2021 this will require all parts of our health and care system to work together as ICSs, involving:

- Stronger partnerships in local places between the NHS, local government and others with a more central role for primary care in providing joined-up care;
- Provider organisations being asked to step forward in formal collaborative arrangements that allow them to operate at scale; and

- Developing strategic commissioning through systems with a focus on population health outcomes;
- The use of digital and data to drive system working, connect health and care providers, improve outcomes and put the citizen at the heart of their own care.

This means that the Cheshire and Merseyside Health and Care Partnership (HCP) is now working on an authorisation process to become an ICS by April 2021.

3.1.5 *Integrating Care: Next steps* also describes options for giving ICSs a firmer footing in legislation, likely to take affect from April 2022 (subject to Parliamentary decision). These proposals sit alongside other recommendations aimed at removing legislative barriers to integration across health bodies and with social care, to help deliver better care and outcomes for patients through collaboration, and to join up national leadership more formally.

3.1.6 NHS England and NHS Improvement invited views on these proposed options from all interested individuals and organisations by Friday 8th January 2021. This paper provides an overview of the key proposals in *Integrating Care: Next steps.*

3.2 *Integrating Care: Next Steps* – Key practical changes

3.2.1 *Integrating Care: Next steps* sets out a series of practical changes that will be in place by April 2022. The preparatory work for the implementation of these changes during 2021/22 will be supported by further guidance for ICSs and by the *NHS Operational Planning Guidance for 2021/22*. These key practical changes are summarised below.

3.2.2 There will be **devolution of national and regional functions** and resources to ICSs. ICSs will be required to work together across partners to determine:

- distribution of financial resources to places and sectors that is targeted at areas of greatest need and tackling inequalities;
- improvement and transformation resource that can be used flexibly to address system priorities;
- operational delivery arrangements that are based on collective accountability between partners;
- workforce planning, commissioning and development to ensure that our people and teams are supported and able to lead fulfilling and balanced lives;
- emergency planning and response to join up action at times of greatest need; and
- the use of digital and data to drive system working and improved outcomes.

3.2.3 The **future health and care system will be built upon "*place*"**, which is defined as the local authority boundaries (at which joint strategic needs assessments and health and wellbeing strategies are made). Within each *place*, services will be joined up through primary care networks (PCNs) integrating care in neighbourhoods. The ambition is to create an offer to the local population of each *place*, to ensure that in that *place* everyone is able to:

- access clear advice on staying well;
- access a range of preventative services;

- access simple, joined-up care and treatment when they need it;
- access digital services (with non-digital alternatives) that put the citizen at the heart of their own care;
- access proactive support to keep as well as possible, where they are vulnerable or at high risk; and to
- expect the NHS, through its employment, training, procurement and volunteering activities, and as a major estate owner to play a full part in social and economic development and environmental sustainability.

3.2.4 There will be **provider collaboration at scale** for services where people will have more complex or acute needs, require specialist expertise which can only be planned and organised effectively over a larger area than *place*. Some services such as hospital, specialist mental health and ambulance will be organised through provider collaboration that operates at a whole-ICS footprint – or more widely where required. To support this there will be the need to harness the involvement, ownership and innovation of clinicians, working together to design more integrated patient pathways horizontally across providers and vertically within local place-based partnerships.

3.2.5 By April 2022 **all NHS provider trusts will be expected to be part of a provider collaborative**. These will vary in scale and scope, but all providers must be able to take on responsibility for acting in the interests of the population served by their respective system(s) by entering into one or more formal collaboratives to work with their partners on specific functions. These collaboratives will help the ICS to set system priorities and allocate resources. Joining up the provision of services will happen in two main ways:

- *within places* (for example, between primary, community, local acute, and social care, or within and between primary care networks) through place-based partnerships ('vertical integration'); and
- *between places* at scale where similar types of provider organisation share common goals such as reducing unwarranted variation, transforming services, providing mutual aid through a formal provider collaborative arrangement ('horizontal integration' – for example, through an alliance or a mental health provider collaborative).

3.2.6 There is an expectation that there will be **strong and effective *place*-based partnerships** between sectors. These will have the full involvement of all partners who contribute to the *place's* health and care; an important role for local councils (often through joint appointments or shared budgets); a leading role for clinical primary care leaders through primary care networks; and a clear, strategic relationship with health and wellbeing boards. There will be a *place* leader on behalf of the NHS, as set out above, 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.

This will be supported by ICSs who will need to 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. 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.

As ICSs are established and evolve, this will create opportunities to further strengthen partnership working between local government, the NHS, public health and social care. 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.

3.2.7 ICSs will be asked to embed **system-wide clinical and professional leadership** through their partnership board and other governance arrangements, including primary care network representation. Primary care clinical leadership will take place through critical leadership roles including:

- Clinical directors, general practitioners and other clinicians and professionals in primary care networks (PCNs), who build partnerships in neighbourhoods spanning general practice, community and mental health care, social care, pharmacy, dentistry, optometry and the voluntary sector.
- Clinical leaders representing primary care in *place*-based partnerships that bring together the primary care provider leadership role in federations and group models.
- A primary care perspective at system level.

Specialist clinical leadership across secondary and tertiary services must also be embedded in systems. Existing clinical networks at system, regional and national level have important roles advising on the most appropriate models and standards of care, in particular making decisions about clinical pathways and clinically-led service change. System-wide clinical leadership at an ICS and provider collaborative footprint through clinical networks should:

- be able to carry out clinical service strategy reviews on behalf of the
- ICS;
- develop proposals and recommendations that can be discussed and
- agreed at wider decision-making forums; and
- include colleagues from different professional backgrounds and from different settings across primary care, acute, community and mental health care.

Wider clinical and professional leadership should also ensure a strong voice for the wide range of skills and experience across systems. From nursing to social care, from allied health professionals to high street dentists, optometrists and pharmacists, and the full range of specialisms and care settings, people should receive services designed and organised to reflect the expertise of those who provide their care.

3.2.8 ICSs will be required to put in place **firmer governance and decision-making arrangements** for 2021/22. As part of this, each system should define:

- *'Place*' leadership arrangements.
- Provider collaborative leadership arrangements
- Individual organisation accountability within the system governance framework.

These governance arrangements will seek to minimise levels of decision-making and 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.

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.

ICS governance is currently based on voluntary arrangements and is therefore dependent on goodwill and mutual co-operation. There are also legal constraints on the ability of organisations in an ICS to make decisions jointly. *Integrating Care: Next steps* sets out options for changes in guidance and legislation, as described below.

During 2021/22, every ICS will be required to develop systematic arrangements to involve lay and resident voices and the voluntary sector in its governance structures, building on the collective expertise of partners and making use of pre-existing assets and forums such as Healthwatch and citizen's panels.

3.2.9 There will be a **"single pot' of NHS financial resources for each ICS**, organised at ICS level with allocative decisions being made by local leaders. ICSs will need to

- distribute resources in line with national rules, including adhering to mental health and community services investment guarantees, and locally-agreed strategies for health and care.
- deploy the resources available to them in order to protect the future sustainability of local services, and to ensure that their health and care system consumes their fair share of resources allocated to it.
- delegate significant budgets to *place* level, which might include resources for general practice, other primary care, community services, and continuing healthcare.
- move away from episodic or activity-based payment, rolling out a blended payment model for secondary care services. This is intended to greater certainty about the resources available to providers to run certain groups of services and

meet the needs of particular patient groups. Any variable payments will be funded within the ICS financial envelope, targeted to support the delivery of locally-identified priorities and increasingly linked to quality and outcomes metrics.
- agree and codify how financial risk will be managed across places and between provider collaboratives.

Through active involvement at ICS and *place* level, providers will have a greater say in how funding is deployed; particularly as new lead provider models emerge. 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.

3.2.10 **Data and digital technology** have played a vital role helping the NHS and care respond to the pandemic. *Integrating Care: Next steps* places data and digital technology at the heart of creating effective local systems. To fulfil the potential of digital and data to improve patient outcomes and drive collaborative working, ICSs will need to:

- build smart digital and data foundations – each ICS will have a Board level lead, three year digital transformation plan and will invest in workforce digital and data literacy and infrastructure to support this.
- connect health and care services – this will include developing or joining a shared care record across all health and social care settings to improve care and underpin population health and system management.
- use digital and data to transform care – this will support real time decision making by frontline teams and more effective workforce, finance, quality and performance planning.
- put the citizen at the centre of their care – this will involve improving access to personalised advice on staying well, enabling citizen's to access to their own data, and triage to appropriate health and care services. There will also be increased utilisation of remote monitoring to allow citizens to stay safe at home for longer, using digital tools to help them manage long-term conditions.

3.2.11 *Integrating Care: Next steps* proposes **changes to regulation and oversight** in the NHS which includes:

- subject to legislation, formally merging NHS England and NHS Improvement into a single body.
- Working with the Care Quality Commission (CQC) to embed a requirement for strong participation in ICS and provider collaborative arrangements in the Well Led assessment;
- issuing guidance under the NHS provider licence that good governance for NHS providers includes a duty to collaborate.
- ensuring foundation trust directors' and governors' duties to the public support system working.
- introducing new measures and metrics to support system- and place- level measurements, which might include reporting some performance data such as patient treatment lists at system level and an integration index for use by all systems.

- rebalancing the focus on competition between NHS organisations by reducing the Competition and Market Authority's role in the NHS and abolishing Monitor's role and functions in relation to enforcing competition. There is also a recommendation that regulations made under section 75 of the *Health and Social Care Act 2012* should be revoked and that the powers in primary legislation under which they are made should be repealed, and that NHS services be removed from the scope of the *Public Contracts Regulations 2015*.

The future System Oversight Framework will set consistent expectations of systems and their constituent organisations and match accountability for results with improvement support, as appropriate. This approach will recognise the enhanced role of systems. It will identify where ICSs and organisations may benefit from, or require, support to help them meet standards in a sustainable way and will provide an objective basis for decisions about when and how NHSEI will intervene in cases where there are serious problems or risks, potentially through a proposed future Intensive Recovery Support Programme.

3.2.12 There will be **changes in commissioning**, with a clearer focus on population-level health outcomes and a marked reduction in transactional and contractual exchanges within a system. This significant change of emphasis for commissioning functions means that the organisational form of Clinical Commissioning Groups (CCGs) will need to change, with either a single CCG being established or CCGs being abolished, subject to legislation, and their functions being delivered through an ICS. The latter is NHSE/I's preferred option.

The activities, capacity and resources for commissioning will change in three significant ways in the future:

- Ensuring a single, system-wide approach to undertake strategic commissioning. This will discharge core ICS functions, which include:
  - assessing population health needs and planning and modelling demographic, service use and workforce changes over time;
  - planning and prioritising how to address those needs, improving all residents' health and tackling inequalities; and
  - ensuring that these priorities are funded to provide good value and health outcomes.
- Service transformation and pathway redesign need to be done differently. Provider organisations and others, through partnerships at place and in provider collaboratives, become a principal engine of transformation and should agree the future service model and structure of provision jointly through ICS governance (involving transparency and public accountability). Clinical leadership will remain a crucial part of this at all levels.
- The greater focus on population health and outcomes in contracts and the collective system ownership of the financial envelope is a chance to apply capacity and skills in transactional commissioning and contracting with a new focus. Analytical skills within systems should be applied to better understanding how best to use resources to improving outcomes, rather than managing contract performance between organisations.

Commissioning functions will have to be coterminous with ICS boundaries before April 2022. However, with the spread of *place*-based partnerships backed by

devolved funding, simplified accountability, and an approach to governance appropriate to local circumstances along with further devolution of specialised commissioning activity, there will be flexibility for local areas to make full use of the local relationships and expertise currently residing in CCGs.

ICSs should also agree whether individual functions are best delivered at system or at place, balancing subsidiarity with the benefits of scale working. Commissioners may, for example, work at place to complete service and outcomes reviews, allocate resources and undertake needs assessments alongside local authorities. But larger ICSs may prefer to carry out a wider range of functions in their larger places, and smaller ones to do more across the whole system.

3.3 *Integrating Care: Next Steps* – Legislative Changes

3.3.1 In September 2019, NHS E/I made a number of recommendations for an NHS Bill. These aimed to remove current legislative barriers to integration across health and social care bodies, foster collaboration, and more formally join up national leadership. These recommendations, which remain relevant in the context of *Integrating Care: Next steps*, included:

- rebalancing the focus on competition between NHS organisations by reducing the Competition and Markets Authority's role in the NHS and abolishing Monitor's role and functions in relation to enforcing competition;
- simplifying procurement rules by scrapping section 75 of the Health and Social Care Act and remove the commissioning of NHS healthcare services from the jurisdiction of the Public Contracts Regulations 2015;
- providing increased flexibilities on tariff;
- reintroducing the ability to establish new NHS trusts to support the creation of integrated care providers;
- ensuring a more coordinated approach to planning capital investment, through the possibility of introducing FT capital spend limits;
- the ability to establish decision-making joint committees of commissioners and NHS providers and between NHS providers;
- enabling collaborative commissioning between NHS bodies – it is currently easier in legislative terms for NHS bodies and local authorities to work together than NHS bodies;
- a new "triple aim" duty for all NHS organisations of 'better health for the whole population, better quality care for all patients and financially sustainable services for the taxpayer; and
- merging NHS England and NHS Improvement - formalising the work already done to bring the organisations together.

3.3.2 *Integrating Care: Next steps* proposes that ICSs should become statutory bodies. The document sets outs two possible options for enshrining ICSs in legislation, without triggering a distracting top-down re-organisation:

- Option 1: a statutory committee model with an Accountable Officer that binds together current statutory organisations.
- Option 2: a statutory corporate NHS body model that additionally brings CCG statutory functions into the ICS.

3.3.3 Both models share a number of features – broad membership and joint decision-making (including, as a minimum, representatives from commissioners; acute, community and primary care providers; and local authorities); responsibility for owning and driving forward the system plan; operating within and in accordance with the triple aim duty; and a lead role in relating to the centre.

3.3.4 Either model would be sufficiently permissive in legislation to allow different systems to shape how they operate and how best and most appropriately deliver patient care and outcomes support at place.

3.3.5 Under either model local government will be an integral, key player in the ICS. 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.

3.3.6 While both models would drive increased system collaboration and achieve the vision and aims of NHS E/I for ICSs in the immediate term, NHS E/I believe Option 2 is a model that offers greater long term clarity in terms of system leadership and accountability. They suggest that it also provides a clearer statutory vehicle for deepening integration across health and local government over time. Additionally NHS E/I also believe that this provides enhanced flexibility for systems to decide who and how best to deliver services by both taking on additional commissioning functions from NHS England (NHS E)[1] but also deciding with system colleagues (providers and local councils) where and how best service provision should take place.

3.4 *Integrating Care: Next Steps* - Implications and Next Steps

3.4.1 Appendix 2 sets out the detail of the implications for the NHS following the proposals in *Integrating Care: Next steps*.

3.4.2 NHS E/I expect that every system will be ready to operate as an ICS from April 2021, in line with the timetable set out in the *NHS Long Term Plan*. To prepare for this, they expect that each system will, by this time, agree with its region the functions or activities it must prioritise (such as in service transformation or population health management) to effectively discharge its core roles in 2021/22 as set out *Integrating Care: Next steps*.

3.4.3 All ICSs should also agree a sustainable model for resourcing these collective functions or activities in the long term across their constituent organisations.

3.4.4 To support all of the above, all systems should agree development plans with their NHS E/I Regional Director that clearly set out:

[1] NHS England and NHS Improvement have a shared management structure but are legally distinct organisations under the Health and Social Care Act 2012. Commissioning functions and regulation legally reside with NHS England, provider development and regulation with NHS Improvement.

- By April 2021: how they continue to meet the current consistent operating arrangements for ICSs and further planning requirements for the next phase of the COVID-19 response.
- By September 2021: implementation plans for their future roles as outlined above, that will need to adapt to take into account legislative developments.

3.4.5 Throughout the rest of 2020, the Department of Health and Social Care and NHS E/I will continue to lead conversations with different types of health and care organisations, local councils, people who use and work in services, and those who represent them, to understand their priorities for further policy and legislative change.

3.4.6 The legislative proposals set out in *Integrating Care: Next steps* go beyond NHS E/I's original legislative recommendations to the Government. This is why NHS E/I published the document with the intention of seeking views on the proposed options from all interested individuals and organisations. These views will help inform future system design work and that of Government should they take forward the recommendations for legislative change in a future Bill. The closing date for the submission of views was set as Friday 8th January 2020.

3.4.7 In *Integrating Care: Next steps* NHS E/I sought views on four specific 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?
- 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?
- 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?
- 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?

3.5 *Integrating Care: Next Steps* – A response by Wirral as a *Place*

3.5.1 Whilst the direction of travel for the NHS is to create an ICS across Cheshire and Merseyside the future health and care system needs to be built on *place*, which is defined as the local authority boundary as set out in 3.2.3 above. Clearly this is, for us, the population served by Wirral Council.

3.5.2 The Cheshire and Merseyside Health and Care Partnership, the emergent ICS, recognises the lead role of local authorities in system design and in the integration of care. Over the past four years in Wirral the NHS, through NHS Wirral CCG, and Wirral Council has built a strong, strategic and integrated commissioning partnership – Wirral Health and Care Commissioning. Whilst it is proposed that some commissioning functions will move from CCGs to ICSs in April 2022, both NHS Wirral CCG and Wirral Council are clear that *place* is the primary building block for integration between health and care and other sectors of the service system. The commissioning and delivery of health and care services will only be on a wider foot print where absolutely necessary.

3.5.3 Following a meeting on 3rd December 2020 between Wirral Council (represented by the Chair of the Adult Social Care and Health Committee, Chief Executive and Director of Adult's Care and Health) and NHS Wirral CCG (represented by the Chair and Chief Officer) it was agreed that we want to build on our successful local commissioning partnership and retain skills, experience and knowledge of the health and care of our population in our *place*.

3.5.4 As this meeting it was agreed to undertake some work through the Joint Health and Care Commissioning Group (JHCCEG) to, by the end of January 2021, define what a commissioning offer at *place* should look like, setting out what commissioning functions should be delivered in *place* and what would best sit with provider partnerships. This would be shared with the Cheshire and Merseyside Health and Care Partnership and NHS England/Improvement to influence the development of the arrangements for commissioning from April 2022.

3.5.5 It was also agreed that the two organisations wished to take a strong role in influencing governance at *place*, supporting the development of new provider collaborations and creating a new partnership with providers and commissioners based on emerging guidance and legislation. This would need to link into the governance of the ICS and, importantly, Wirral Council. Democratic leadership and stewardship is key to the legitimacy of *place* based development. Strategic leadership for Wirral will come via the Health and Wellbeing Board, Adult Social Care and Health Committee and Children's, Young People and Education Committee.

3.5.6 At the meeting of the *Healthy Wirral* Partners Board on 10th December 2020, provider organisations serving the borough accepted that there was a strong case for Wirral as a *place* and that the current commissioning arrangements reflected many of the changes that the revised policy expected. There was an expectation that 80% of commissioning would take place locally and that as such local commissioning would hold primacy. There was a debate about how providers would fit into the new arrangements but Partners Board members were generally supportive of the current direction of travel.

3.5.7 At the same *Healthy Wirral* meeting it was agreed that work needed to commence to create a provider collaborative/alliance in Wirral, which would require a strong primary care and third sector involvement. It was agreed that the Chair of Wirral University Teaching Hospitals NHS Foundation Trust, would lead on the creation of a scope for work to develop a provider collaborative/alliance that would be agreed amongst the Chairs of the constituent organisations in *Healthy Wirral*. The work to create the provider collaborative/alliance would be delegated to the *Healthy Wirral* Project Delivery Unit (PDU).

3.5.8 The Adult Social Care and Health Committee is asked to note and support the work to define what a commissioning offer at *place* should look like, setting out what commissioning functions should be delivered in *place* and what would best sit with provider partnerships. The Committee is also asked to note the work in the creation of a provider collaborative/alliance in Wirral.

4.0 FINANCIAL IMPLICATIONS

4.1 This report is principally for information only and as such, there are no financial implications.

5.0 LEGAL IMPLICATIONS

5.1 It is likely that, in 2021, primary legislation will be introduced by Her Majesty's Government to further support the implementation of the NHS Long Term plan and to give ICSs statutory roles.

6.0 RESOURCE IMPLICATIONS: STAFFING, ICT AND ASSETS

6.1 There is a direct impact of these changes on staff employed by NHS Wirral CCG. It is anticipated that there will be a human resources framework within which these proposed changes will be managed.

7.0 RELEVANT RISKS

7.1 The system changes outlined in this report will have risk management frameworks as part of their implementation.

8.0 ENGAGEMENT/CONSULTATION

8.1 Engagement will need to take place in regard to the system changes outlined in this report.

9.0 EQUALITY IMPLICATIONS

9.1 Wirral Council has a legal requirement to make sure its policies, and the way it carries out its work, do not discriminate against anyone. An Equality Impact Assessment is a tool to help council services identify steps they can take to ensure equality for anyone who might be affected by a particular policy, decision or activity.

This report is for information and no EIA is required.

10.0 ENVIRONMENT AND CLIMATE IMPLICATIONS

10.1 None as a result of this report.

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APPENDICES

Appendix 1 Legislative Options for Integrated Care Systems
Appendix 2 Implications of *Integrating Care: Next Steps*

BACKGROUND PAPERS

- NHS Five Year Forward View, https://www.england.nhs.uk/five-year-forward-view/
- NHS Long Term Plan, https://www.longtermplan.nhs.uk/
- NHS Planning Guidance, https://www.england.nhs.uk/publication/delivering-the-forward-view-nhs-planning-guidance-201617-202021/
- NHS England/Improvement, Designing Integrated Care Systems (ICSs) in England, https://www.england.nhs.uk/wp-content/uploads/2019/06/designing-integrated-care-systems-in-england.pdf
- Integrating Care: Next steps to building strong and effective integrated care systems across England, https://www.england.nhs.uk/wp-content/uploads/2020/11/261120-item-5-integrating-care-next-steps-for-integrated-care-systems.pdf

SUBJECT HISTORY (last 3 years)

Council Meeting	Date
Partnerships Committee	**9th November 2020** **13th January 2021**

APPENDIX 1 LEGISLATIVE OPTIONS FOR INTEGRATED CARE SYSTEMS

Option 1 – a statutory ICS Board/Joint Committee with an Accountable Officer

This option 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.

It would have a system Accountable Officer, chosen from the CEOs/AOs of the Board's mandatory members. This Accountable Officer would not replace individual organisation AOs/CEOs but would be recognised in legislation and would have duties in relation to delivery of the Board's functions. There would be a duty for the Board to agree and deliver a system plan and all members would have an explicit duty to comply with it.

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.

This option retains individual organisational duties and autonomy and relies upon collective responsibility. Intervention against individual NHS organisations (not working in the best interests of the system) would continue to be enhanced through the new triple aim duty and a new duty to comply with the ICS plan.

The new Accountable Officer role would have duties to seek to agree the system plan and seek to ensure it is delivered and to some extent offer clarity of leadership. However, current accountability structures for CCG and providers would remain.

Option 2 – a statutory ICS body

In this option, ICSs would be established as NHS bodies partly by "repurposing"CCGs and would – among other duties – take on the commissioning functions of CCGs. Additional functions would be conferred and existing functions modified to produce a new framework of duties and powers.

The CCG governing body and GP membership model would be replaced by a board consisting of representatives from the system partners. As a minimum it would include representatives of NHS providers, primary care and local government alongside a Chair, a Chief Executive and a Chief Financial Officer. The ICS body should be able to appoint such other members as it deems appropriate allowing for maximum flexibility for systems to shape their membership to suit the needs of their populations.

The power of individual organisational veto would be removed. The ICS Chief Executive would be a full-time Accounting Officer role, which would help strengthen lines of accountability and be a key leadership role in ensuring the system delivers.

The ICS's primary duty would be to secure the effective provision of health services to meet the needs of the system population, working in collaboration with partner organisations. It would have the flexibility to make arrangements with providers through contracts or by delegating responsibility for arranging specified services to one or more providers.

Although there would be a representative for primary care on the Board, there would no longer be a conflict of interests with the current GP-led CCG model (created by the 2012 Act) and it could be possible to allocate combined population-level primary care, community health services and specialised services population budgets to ICS.

Many commissioning functions for which NHSE is currently responsible could, for the most part, be transferred or delegated to the ICS body, but with the ability to form joint committees as proposed through our original recommendations, with NHSE, if and where appropriate.

Through greater provider involvement, it could also reduce some of the transactional burdens of the current contracting processes. There would be powers for the ICS to delegate responsibility for arranging some services to providers, to create much greater scope for provider collaboration to use whole-population budgets to drive care pathway transformation.

APPENDIX 2 IMPLICATIONS OF *INTEGRATING CARE: NEXT STEPS*

1. Changes in NHS England and NHS Improvement's operating model

NHS E/I will support systems to adopt improvement and learning methodologies and approaches which will enable them to improve services for patients, tackle unwarranted variation and develop cultures of continuous improvement.

This will be underpinned by a comprehensive support offer which includes:

- access to our national transformation programmes for outpatients and diagnostics;
- support to tackle unwarranted variation and increase productivity (in partnership with the Getting it Right First Time programme);
- the data they need to drive improvement, accessed through the 'model health system';
- the resources and guidance that they need to build improvement capability; and
- assistance from our emergency and electivity intensive support teams (dependent on need).

Much of this support offer will be made available to systems through regional improvement hubs, which will ensure that improvement resource supports local capacity- and capability-building. Systems will then able to flexibly and rapidly deploy the support into place partnerships and provider collaboratives.

NHS E/I developed a joint operating model during 2019, with input from senior NHS leaders including those in systems and regions, as well as frontline staff and other stakeholders. This resulted in a description of the different ways NHSEI will operate in future, underpinned by a set of principles including subsidiarity, and a set of 'levers of value' that NHS E/I can use at national and regional level to support systems.

NHS E/I will continue to develop this operating model to support the vision set out above, and any legislative changes. This will include further evolving how we interact with systems nationally and regionally; and ensuring that its functions are arranged in a way that support and embed system working to deliver our priorities.

The new operating environment will mean:

- increased freedoms and responsibilities for ICSs, including greater responsibility for system development and performance, as well as greater autonomy regarding assurance.
- the primary interaction between NHSEI and systems will be between regions and the collective ICS leadership, with limited cause for national functions to directly intervene with individual providers within systems.
- as systems take on whole population budgets they will increasingly determine how resource is to be used to 'move the dial' on outcomes, inequalities, productivity and

wider social and economic development against their specific health challenges and population health priorities.
- NHS E/I regional teams will become ‘thinner’ as we move direct commissioning responsibility out to systems (individually and collectively). They will increasingly continue to enable systems to take on greater autonomy, working with them to identify their individual development priorities and support needs.

2. Transition

NHS E/I are supporting ICSs through to April 2022 at their current size and scale, but recognise that smaller systems will need to join up functions, particularly for provider collaboration. They will support the ability for ICSs to more formally combine as they take on new roles where this is supported locally.

NHS E/I will work with systems to ensure that they have arrangements in place to take on enhanced roles from April 2022. They will set out a roadmap for this transition that gives assurance over system readiness for new functions as these become statutory.

NHS E/I recognise that under either legislative proposal they need to ensure that they support staff during organisational change by minimising uncertainty and limiting employment changes. They are therefore seeking to provide stability of employment while enabling a rapid development of role functions and purpose for all our teams, particularly in CCGs directly impacted by legislative Option 2.

NHS E/I have stated that they want to take a different approach to this transition; one that is characterised by care for our people and that there is no distraction from the’ day job’: the critical challenges of recovery and tackling population health.

Stable employment: As CCG functions move into new bodies NHS E/I state that they will make a ‘continued employment promise’ for staff carrying out commissioning functions. We will preserve terms and conditions to the new organisations (even if not required by law) to help provide stability and to remove uncertainty.

New roles and functions: For many commissioning functions the work will move to a new organisation and will then evolve over time to focus on system priorities and ways of working. The priority will be the continuation of the good work being carried out by the current group of staff and NHS E/I have stated that they will promote best practice in engaging, consulting and supporting the workforce during a carefully planned transition, minimising disruption to staff.

Other functions will be more directly impacted, principally the most senior leaders in CCGs (chief officers and other governing body / board members). ICSs need to have the right talent in roles leading in systems. The stated commitment by NHS E/I is:

- not to make significant changes to roles below the most senior leadership roles;

- to minimise impact of organisational change on current staff by focusing on continuation of existing good work through the transition and not amending terms and conditions; and
- offer opportunities for continued employment up to March 2022 for all those who wish to play a part in the future.