

## BMA Member Summary – NHS England’s *Integrated Care Systems: design framework*

### Introduction

NHS England has published new guidance on the design and operation of ICSs (Integrated Care Systems), which establishes headline expectations regarding their development over 2021/22 and beyond, as well as their preparations to transition to statutory status as proposed in the Government’s Health and Care White Paper (read the [BMA briefing on the White Paper](#)). This summary provides an overview of the new design framework and the BMA’s analysis of it.

It is clearer than ever that ICSs are central to NHS England’s vision for the future of the health service. This framework is a major part of that vision and will be a key reference point in the future. It will also shape the working lives of doctors and how the services they provide are planned, funded, and organised, as well as the role clinicians take in delivering system transformation. So, it is essential that doctors are aware of and engaged in this process.

### The ICS Partnership

Should the Government’s Health and Care Bill become law, ICSs will become statutory organisations and be formed of two system-level elements – the ICS Partnership and the ICS NHS Body.

The ICS Partnership is expected to serve as a forum for the NHS, local government and others to work together on improving health and care services, addressing the wider determinants of health, and supporting broader social and economic development across their footprint. As part of this, Partnerships will also be expected to develop a collective ‘integrated care strategy’ focused on improving outcomes in health and care, reducing inequalities, and addressing the impact of the pandemic. This strategy is intended to serve as a system-wide plan, guiding the work of the entire ICS including, importantly, the work of the ICS NHS Body.

ICS Partnerships must include local authorities and the NHS but, beyond that, membership will be up to local determination. However, reflecting their broad scope, NHS England has advised that Partnerships could also include: HWBs (Health and Wellbeing Boards); other statutory organisations; the VSCE (voluntary, community and social enterprise) sector; social care providers; local employers; housing; education, and; the criminal justice system. The aim is to allow systems to largely develop them based on local circumstances – but underpinned by core principles of equal partnership, subsidiarity, collaboration, and flexibility.

Chairs of the ICS Partnership will be jointly selected by the ICS NHS Body and relevant local authorities, which will also define their role, term of office, and accountabilities. Systems may opt to have the same Chair for both the ICS NHS Body and the ICS Partnership, or have some form of consistent leadership across the two bodies such as the ICS NHS Body Chair acting as a deputy Chair on the ICS Partnership.

Importantly, NHS England are explicit that public health experts should play a significant role in ICS Partnerships, including local authority Directors of Public Health and their teams specifically, but has not specified that they should hold a board-level position.

Partnerships will also need strategies for involving the public in their work, including those with lived experience as patients, carers, and traditionally under-represented groups. They are encouraged to use citizens' panels, co-production approaches, and engagement at place and neighbourhood levels to inform their work from the bottom up. The guidance is clear that Partnerships will need to hold formal sessions in public and communicate with stakeholders in clear and inclusive language, too.

#### **BMA View:**

- the ICS Partnership could provide an important, dedicated focus on the wider determinants of health and help address health inequalities
- clarity is needed as to exactly how the ICS Partnership will interact with the ICS NHS Body in practice – including how its overarching strategy will guide the NHS
- we strongly believe that private providers of NHS services should not be involved in the leadership of ICS Partnerships, particularly if the strategies they develop help to shape the plans and activity of the ICS NHS body – the lack of reference to private sector involvement in ICS Partnerships in the framework is therefore positive, but further assurances are needed
- the explicit focus on the role of public health experts within the ICS Partnership is welcome and in line with our calls for public health doctors to have a leading role in ICSs
- wider clinical involvement is also essential – including GPs and secondary care doctors, given the potential scope of the Partnership's work
- the commitment for Partnership meetings to be held in public is positive as we have been heavily critical of the lack of transparency of ICSs to date.

#### The ICS NHS Body

The ICS NHS Body is intended to bring together all key partners in charge of the planning and provision of NHS services within their system to deliver integration and meet the needs of the local population. In so doing, they are expected to establish shared strategic priorities across the NHS and facilitate wider partnership working to tackle population health challenges and enhance services.

#### **Functions of the ICS NHS Body**

NHS England expect all CCG functions and duties – including commissioning – to be transferred to an ICS NHS Body, along with their contracts, assets, and liabilities. Further guidance will be published to clarify exactly how CCG statutory duties will transition to ICS NHS Bodies in practice.

As statutory organisations, ICS NHS Bodies will have a range of core responsibilities, including:

- developing a plan to meet the health needs of their population, ensure the recovery of NHS services following the pandemic and meet Long-Term Plan commitments
- allocating resources to deliver that plan across the system, including determining what resources (both revenue and capital) should be available in each place
- establishing joint working arrangements with partners to deliver their joint priorities
- establishing governance arrangements to support collective accountability between partner organisations for whole-system delivery and performance

- arranging the provision of health services in line with the resources allocated across the ICS
- leading system implementation of the People Plan, including developing and supporting a 'one workforce' approach through greater collaboration across the NHS, social care, local government, the VCSE sector, and volunteers
- leading system-wide action on data and digital, creating smart digital and data foundations to connect health and care services and deliver patient-centred care
- investing in local community organisations and infrastructure, to ensure the NHS plays a part in local social and economic development and environmental sustainability – i.e. that the NHS's role as a key employer and economic anchor in communities is emphasised and used for the wider benefit of the local area
- driving joint work on estates, procurement, supply chain and commercial strategies
- planning for, responding to and leading recovery from major incidents
- delivering functions delegated by NHS England, potentially including commissioning of primary care and certain specialised services.

#### **BMA view**

- the creation of a statutory, NHS-led body is broadly positive and in line with the BMA's call for ICSs to be led by NHS and publicly accountable bodies
- private providers should not have any role in the leadership of ICSs - ICS NHS Bodies are set to be handed a wide array of powers and functions, meaning that their transparency and accountability is pivotal, as is the need for them to be publicly led
- NHS England must be clear about the wider implications of a 'one workforce' approach and, in particular, whether this is likely to facilitate or simplify staff redeployment across the ICS footprint – something the BMA has warned against previously
- greater clarity is also needed on how ICS NHS Bodies will fulfil their many functions and what specific resources will be provided to allow them to do so.

#### People and Culture

From April 2022, ICS NHS Bodies are set to take on specific workforce responsibilities, including delivery against the People Plan, as well as the adoption of a 'one workforce' approach.

To support local and national workforce priorities across their systems, ICS NHS Bodies will be expected to work with their partner organisations to:

- establish clear and effective governance arrangements for agreeing and delivering local people priorities, as well as accountability for delivery against them
- support the delivery of standardised, high-quality HR services across the ICS, supported by digital technology
- protect the health and wellbeing of people working within the ICS footprint, delivering against the 2021/22 planning guidance and People Promise
- establish leadership structures and processes – including leadership development – in line with the leadership compact<sup>1</sup>

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<sup>1</sup> The NHS Leadership Compact will require every leader, at every level, to recognise, reflect and bring to life every day six core principles focused on: equality and diversity; continuous improvement; kindness, compassion and respect; trust; supporting people and celebrating success; and collaboration and partnership.

- undertake integrated and dynamic workforce, activity and finance planning based on population need, transformation of care models and change in skills and ways of working – reflected in the system plan and in the ICS partnership’s strategy
- plan the development and growth of the workforce to meet future need – including collaborative recruitment and retention approaches, local educational capacity and opportunities, and attracting local people into health and care
- develop new ways of working and delivering care that optimise staff skills, technology and innovation to meet population health needs and to create flexible and rewarding career pathways for staff
- contribute to wider local social and economic growth and a vibrant local labour market, through collaboration with partner organisations.

NHS England will be working with HEE to publish further guidance for ICSs on the implementation of their workforce functions.

#### **BMA view**

- NHS England must be clear about the exact responsibilities and resources ICSs will have regarding their local workforce, including long-term planning, recruitment, and retention
- clarity is needed as to how ICSs and NHS ICS Bodies will interact with HEE in fulfilling their workforce functions
- staff and trade unions must also have a central role in developing the process of transitioning workforce responsibilities to ICSs and the development of their plans, particularly where ways of working may be subject to change.

### Governance and Management Arrangements

#### **ICS NHS Body**

The ICS NHS Body will have a unitary board, responsible for ensuring it achieves the core purposes of the ICS. Board members will have shared accountability for the delivery of the ICS’s functions and duties, as well as its overall performance. They must also comply with the Nolan Principles of Public Life and the Fit & Proper Persons test.<sup>2</sup> Board membership is, as a minimum, to include:

- a Chair and two other independent, non-executive directors
- a Chief Executive (who will also be the accountable officer for funding allocated to the ICS NHS Body) and a Director of Finance
- a Medical Director and a Director of Nursing; and
- three individual partner members, drawn from:
  - Trusts and Foundation Trusts within the ICS (likely a Chief Executive)
  - general practice providers within the ICS
  - local authority (or local authorities) with responsibility for social care.

Partner members are expected to be full members of the unitary board and bring a perspective and knowledge from their sectors, but not to serve as delegates of those sectors – i.e. they are there to represent the ICS, not their profession or provider. ICS NHS Bodies will also be able to make

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<sup>2</sup> [The Seven Principles of Public Life](#) outline the ethical standards those working in the public sector are expected to adhere to: selflessness; integrity; objectivity; accountability; openness; honesty; and, leadership.

additional appointments to board positions beyond the minimum membership set out in the guidance, though NHS England has indicated a preference for smaller boards.

The framework also establishes that ICS NHS Body boards and committees should take into account the perspectives of all elements of the health and care system, including physical and mental health, primary care, community and acute services, patients and carers, social care and public health. Directors of Public Health are also expected to have an official role within ICS NHS Bodies and Partnerships.

As with the ICS Partnership, the ICS NHS Body is expected to be open and transparent, to hold meetings in public and publish its papers publicly. In line with the desire for collaboration, there is also an onus on facilitating consensus in decision making and, while the Chair will be able to decide on behalf of the board in the event of disagreement, voting on decisions is seen as a last resort.

### **Committees and decision making**

ICS NHS Bodies are likely to create committees and groups to feed into their decision making and to exercise certain delegated functions. They are required to form audit and remuneration committees but could also create executive groups that support the board in its day-to-day work.

The framework is clear that these arrangements should enable the full involvement of clinical and professional leaders, as well as providers, place-based partnerships, and provider collaboratives. It may be that some committees lead on specific issues, such as patient engagement, or take the form of advisory committees to support decision making in certain areas.

To support good governance, all ICS NHS Bodies will be required to keep a ‘functions and decision map’ illustrating its structure and any arrangements with ICS partners, including any arrangements for commissioning functions delegated or transferred to the ICS by NHS England.

### **Place-based partnerships**

NHS England expect that place-based partnerships (where the NHS, local government, and other partners work together in a specific area or community) will be key to service planning and delivery and serve as a forum for partners to collectively address the wider determinants of health.

Place-based partnerships are expected to be based around meaningful geographies recognised by local people, facilitate joined up decision making and delivery, and reflect what works within their specific circumstances. Their membership and governance will be agreed with the ICS NHS Body, but, at a minimum, should involve GPs and primary care provider leadership, local authorities, Directors of Public Health, acute, community, and mental health providers, and patients.

The ICS NHS body will remain accountable for any NHS resources deployed at place level, but place-based leaders will be responsible for convening their place-based partnership, representing it within the wider ICS, and possibly taking on responsibility for any functions delegated by the ICS NHS Body.

### **Supra-ICS arrangements**

Some services, planning, and commissioning may need to take place across multiple ICSs – such as for specialised and emergency ambulance services. ICSs will also need to work collectively in planning cancer care, especially where Cancer Alliances cover more than one ICS footprint. NHS

England expect provider collaboratives – particularly those working on specialised mental health, learning disability, and autism services – to straddle multiple ICSs where relevant.

### **Quality governance**

Should the Health and Care Bill be implemented as planned, ICS NHS Bodies will take on statutory responsibilities for the quality and continuous improvement of care and be expected to address inequalities and variation. The individual responsibilities of NHS organisations regarding quality will remain unchanged, however.

### **BMA view**

- we have been explicit that ICSs should embed clinical leadership, representation, and engagement at all levels, as well as be run by the NHS and publicly accountable bodies
- the inclusion of a specific ICS NHS Body board position for a representative of general practice is welcome,
- the onus on an official role for public health staff is also positive, but we believe board level representation for public health specialists is needed on both ICS Partnerships and ICS NHS Bodies
- we believe the framework falls short in respect of clinical leadership and representation, with no mention of LMCs or LNCs, or the need to involve consultants, SAS doctors, or junior doctors in the work of the ICS NHS Body, bar the presence of a Medical Director
- continued lobbying - at national and ICS level - for further representation is critical as the board membership set out in the framework is a minimum standard, with ICSs able to agree additional members if they wish
- we also note the other positions and options for representation – such as committees – where clinical voices can and should also be amplified.

## The Role of Providers

ICSs are expected to harness the expertise and insight of providers, ensuring they play a central role in establishing the priorities for transformation and improvement across the system. As part of this, NHS England expect provider contracts to evolve to have a greater focus on longer term, outcomes-based agreements, signalling a broader shift away from a pure payment by results approach.

### **Primary care**

The framework states that all primary care professionals have a fundamental role to play in ICSs being able to achieve their objectives and in the wider process of integration. It stresses that primary care should be represented and involved in planning and decision making at all levels of the ICS, including key forums at both system, place, and neighbourhood level.

The guidance also states that, in NHS England's view, there is no single voice for primary care in the health and care system – meaning that ICSs will need to explore different and flexible ways for seeking primary care and GP involvement locally.

### **PCNs (Primary Care Networks)**

PCNs are expected to play a leading role at the place level and in place-based partnerships as representatives of primary care. The framework acknowledges that this will be in addition to the existing work of PCNs and will need to be resourced by the ICS and its sub-structures. ICSs are

encouraged to review what support PCN CDs (Clinical Directors) and the wider profession will need to develop their role in leading transformation.

PCNs, in serving the patients of their constituent practices, are seen as having a major role in improving health outcomes and joining-up services within ICSs. PCN development of MDTs (multi-disciplinary teams) working across primary care, community services, secondary care, local authorities, and others is seen as key to understanding and addressing the needs of local communities – including addressing health inequalities – and keeping patients out of hospital.

### **ISPs (Independent Sector Providers)**

The framework states that ISPs working with the NHS and local authorities will need to be engaged with the work of the ICS and with other relevant partners – to ensure that care meets patient needs and is well co-ordinated. Notably, there is no indication within the framework that ISPs are expected to have formal role within ICSs, within the Partnership or the ICS NHS Body.

### **Trusts and Foundation Trusts**

Trusts and Foundation Trusts (trusts) are seen as playing a critical part in ICSs and are expected to take a leading role in improving services, outcomes, and population health as both providers of services and ‘anchor institutions’ in the local community.

As part of this, trusts will increasingly be judged against their wider contribution to the objectives of the ICS (including improving quality and outcomes, reducing variation, and meeting financial balance), alongside their existing duties. Trusts may also take on delegated functions for their local populations from the ICS NHS Body, potentially including some limited elements of commissioning previously managed by CCGs.

### **The new Provider Selection Regime and competition**

As set out in the Government’s White Paper, the Health and Care Bill is set to remove the current rules requiring the NHS to competitively tender contracts. This will be replaced by a new Provider Selection Regime, which NHS England consulted on earlier this year ([read the BMA response](#)). This seeks to give commissioners greater flexibility in how they arrange contracts and, rather than forcing them into ‘pointless tendering and competition’, giving them three options instead:

1. renew existing contracts without competitive tender
2. agree new contracts and/or new providers without competitive tender
3. hold a competitive tender where appropriate.

According to NHS England, the central requirement of the new regime is that commissioning decisions must be made transparently and in the best interest of patients, taxpayers, and the local population. It will apply to NHS bodies and local authorities commissioning healthcare services.

### **Provider collaboratives**

Provider collaboratives are partnerships between two or more trusts collaborating across multiple areas to realise the benefits of working at scale and of mutual aid. NHS England believes that the pandemic has reinforced the need for, and potential of, these collaboratives and wants them to develop in the next year as key vehicles of recovery and transformation within ICSs.

All trusts providing acute and/or mental health services should be part of one or more provider collaboratives by April 2022. Ambulance, community trusts, and non-NHS providers (e.g. community interest companies) are also expected to participate in collaboratives where appropriate, too. There are already several mental health provider collaboratives in place.

Collaboratives will be expected to help facilitate the work of clinical networks and alliances – notably Cancer Alliances – to enable speciality-level plans and decisions to be implemented in coordination with system-wide objectives. In so doing, providers will need to determine the best model for their collaboratives, as well as work with the ICS NHS Body to define their working relationship and role.

The ICS NHS Body will need to determine how best to contract with collaboratives for services they are to provide, using the [NHS Standard Contract](#). The framework suggests two options:

- contract with and pay providers within a collaborative individually, with the collaborative agreeing how to best use their respective resources
- a lead provider model, with one provider acting on behalf of the collaborative and agreeing sub-contracts and payment arrangements with others.

#### **BMA View**

- we have consistently called for the removal of enforced competition, but have also been adamant that any new system must be transparent, have clear safeguards, and enshrine the NHS as the default option for NHS contracts – to avoid contracts being handed to ISPs without scrutiny
- the recognition of the importance of primary care and general practice is positive, as is the commitment to supporting the development of its leadership – including PCN CDs
- we are calling for formal roles for LMCs as representatives of general practice within ICSs and are concerned by their absence from the framework
- the lack of reference to secondary care doctors in respect of trusts' contributions to ICSs is concerning and must be remedied, including ensuring roles for LNCs within ICSs
- the wider focus on the role of NHS Trusts and providers as key drivers of transformation is important, but this input must be led and shaped by clinicians who are at the forefront of service provision and patient care
- the very limited focus on ISPs is welcome, as is the omission of private providers from the proposed minimum requirements of ICS NHS Body board membership – however, we want to see further assurances that they will not be involved in ICS leadership
- we have previously raised concerns regarding the possibility of Foundation Trusts' individual accountabilities undermining wider collaboration, so the fact that trust performance will be measured in part on their contribution to the ICSs and system transformation is welcome
- further clarity is needed on the role of provider collaboratives, including the services they are likely to provide and what bodies will be able to join them.

#### **Clinical and Professional Leadership**

All ICSs will be expected to develop a model of clinical and care professional leadership and a culture which actively encourages and supports such leadership to thrive. This includes ensuring professional and clinical leaders have protected time and resource to carry out system leadership



roles and are fully involved as key decision-makers with a central role in setting and implementing ICS strategy.

These arrangements should reflect the learning and experience gained from CCG clinical leadership, building on this to reflect the diversity of clinical and care professions across the wider ICS partnership, including health, social care and the VCSE sectors, embedding an inclusive model of leadership at every level of the system.

ICSs will have to determine locally specific models for clinical and care professional leadership based on their level of development. Further resources describing the features of an effective model will be provided by NHSE. These features include:

- effective structures and communication mechanisms to connect clinical leaders at each level of the system
- a culture which systematically embraces shared learning, supporting its clinical leaders to collaborate and innovate
- protected time, support and infrastructure for clinicians to carry out their system leadership roles
- clearly defined and visible support for clinical leaders, including support to develop leadership skills.
- transparent approaches to identifying and recruiting leaders, which promote equity of opportunity and a professionally and demographically diverse talent pipeline.

ICS will have to self-assess the progress and performance of their clinical and professional leadership model. Systems will be encouraged to use a peer review approach to support development in this area, buddying with other systems to undertake assessments and develop plans.

The clinical roles on the Board of the NHS ICS Body are a minimum expectation, intended to provide executive-level professional leadership of the organisation. Individuals in these roles are expected to ensure leaders from across clinical professions will be involved and invested in the purpose and work of the ICS. This could come in the form of supporting committees from specific groups of doctors, such as GPs, who feed their views into a relevant board member.

The board will be expected to sign off a model and improvement plan for clinical leadership that demonstrates how this will be achieved, and to ensure the five guiding principles described above are reflected in its governance and leadership arrangements.

#### **BMA view**

- the BMA has stressed that clinical leadership, representation, and engagement must be embedded at all levels of ICSs if they are to be successful
- the focus on the importance of clinical leadership within the framework is therefore welcome, as is the expectation on ICSs to provide resources and protected time to clinicians to develop their leadership abilities and roles – something we have explicitly called for
- the onus on ICSs sharing best practice on clinical leadership and involvement is also positive
- practical and tangible guidance and guidelines need to be introduced to ensure that these welcome intentions are actually put into practice

- NHS England and ICSs need to ensure genuine representation and involvement of doctors from primary and secondary as well as public health in their work, including formal roles for LMCs and LNCs in their structures.

## Working with People and Communities

All parts of the ICS will be expected to incorporate the input of local communities into their work and to be bound by a legal duty to involve patients, unpaid carers, and the public in planning and commissioning decisions. This would be alongside the existing duties on trusts.

In line with this, NHS England want ICSs to build a range of engagement approaches into their activity at every level, with a particular focus on groups impacted by inequalities and including working with Healthwatch and the VCSE sector. NHS England also stress that these arrangements should not just allow for patient and public commentary on service provision but be part of a genuine process of co-production and a means of supporting the accountability and transparency of the ICS.

### **BMA view**

- we have been clear that patient involvement within ICSs is essential, so welcome the intention set out in the framework – however, clarity is needed on how and where patients and the public will be represented within the ICS, including ICS NHS Bodies and Partnerships.

## Accountability and Oversight

The central plank of ICS accountability is set to be the statutory ICS NHS Body and its unitary board, the members of which will have shared and corporate accountability for an ICS's performance and responsibility for ensuring its functions are discharged. Each ICS will also agree its own constitution with NHS England.

While each partner organisation (i.e. NHS Trust, local authority) within the ICS will retain its existing formal accountabilities and statutory functions, they will also be expected to operate with a working principle of mutual accountability to both the communities they serve and to each other. Executives of provider organisations who also sit on an ICS NHS Body board will, when operating in their ICS capacity, be expected to act in the interests of the ICS and not of their provider. Further guidance will also be issued on the management of conflicts of interest.

### **NHS oversight within ICSs**

NHS England has set out the model for NHS oversight within ICSs in their [SOF \(System Oversight Framework\) for 2021/22](#), which was subject to consultation earlier this year ([read the BMA response](#)). This sets out that ICS NHS Bodies will increasingly take a leading role in overseeing the performance of NHS organisations within their footprint. Any formal regulatory action will be undertaken by NHS England itself but working with ICSs.

The role of CQC will be unchanged regarding assessments of the quality and safety of care at individual providers. But DHSC, NHS England, and CQC are currently developing an additional system of ICS reviews and assessments.

## **BMA view**

- the BMA has raised concerns for several years regarding ICS's lack of accountability – which their likely transition to statutory status should address at least in part
- the focus on mutual accountability is broadly positive and signals a potential shift away from a siloed focus on individual organisation's interests and toward a more collaborative model
- as set out in our response to the SOF, we believe that any measure of the performance of an ICS and its member organisations must assess how effectively it incorporates clinical input and leadership – from all sectors – into its work as well as be done in the context of the resources these organisations have available to them
- further clarity is needed regarding the extent of ICS oversight powers, particular in respect of non-NHS partners within the system, and its interaction with CQC.

## Financial Allocations and Funding Flows

The framework sets out how ICSs and ICS NHS Bodies are likely to be funded moving forward, and how they will be expected to distribute the funding allocated to their systems.

Systems are currently funded under the COVID financial regime whereby a system-wide funding envelope is allocated to each ICS. In due course, this will shift back towards a population-based funding model, in line with the [Long Term Plan funding settlement](#).

### **ICS allocations**

NHS England will make financial allocations to each ICS NHS Body, which will then be responsible for spending decisions at the system level as well the distribution of this money across the ICS. These allocations will include the budgets for acute, community and mental health services, primary medical care (general practice) services (currently delegated to CCGs) and running cost allowances for the ICS NHS body.

Allocations will be linked to population need and based on the principles of supporting equal opportunity of access for equal needs and the reduction of health inequalities. Allocations will also be set in a way that avoids large swings in funding that could risk destabilising local health economies. Full capital allocations will also be made to the ICS NHS body.

### **Distribution of funds by the ICS NHS body**

The ICS NHS Body will agree how the allocation will be used to perform its functions, in line with health and care priorities set at a local level. Money will flow from the ICS NHS body to providers largely through contracts for services/outcomes, which may be managed by place-based partnerships or provider collaboratives. The ICS NHS Body will be able to commission jointly with local authorities under a section 75 joint commissioning arrangement, as CCGs can currently.

All spending by the ICS NHS Body will be part of a wider plan to deliver financial balance within a system's financial envelope, which will be set by NHS England. This envelope covers expenditure across the whole system, including spending by NHS trusts/foundation trusts for services delivered for commissioners outside the system.

Each ICS will be expected to have an agreed framework for collectively managing and distributing financial resources to address the greatest need and tackle inequalities in line with the NHS system plan, having regard to the strategies of the Partnership and the Health and Wellbeing board.

Based on these local priorities and national rules (including the National Tariff Payment System), ICS NHS Bodies will agree:

- how the priorities and outcomes established in their plans will be delivered within the NHS budget (while also paying regard to the wider ICS Partnership strategy)
- the distribution of the NHS revenue allocation to:
  - each place-based partnership as appropriate
  - each NHS provider (individually contracted or via a lead provider contract)
  - contracts with other service providers
  - other collaborative partnerships
- A capital plan, including how capital spend should be prioritised locally.

The ICS NHS Body board and Chief Executive will be ultimately responsible for services under delegation arrangements with place-based partnerships or through lead provider contracts. They will need to put in place proportionate mechanisms to provide assurance on the spending of public money.

### **Setting budgets for places**

ICS NHS Bodies will have the freedom to set a delegated budget for place-based partnerships, allowing for financial decisions to be made at a local level. This process should also involve local authority partners and, where appropriate, allow for shared planning and pooling of NHS and local authority budgets.

Budgets allocated to and managed at place level may include:

- primary medical care
- dental, pharmaceutical, and ophthalmology services
- community services
- community mental health, including IAPT
- community diagnostics
- intermediate care
- services subject to a Section 75 agreement with a local authority
- any acute or secondary care services where it has been agreed they should be commissioned at place level.

### **Financial and regulatory mechanisms to support collaboration**

In the framework, NHS England sets out a range of existing and expected enablers of collaboration that it wants to proliferate as part of its system-by-default approach. These include:

- setting system financial envelopes – i.e. the funding available to each ICS
- proposals to establish API (aligned payment and incentive) approaches with fixed payments set for an agreed level of planned activity, providing greater certainty over income
- including a System Collaboration and Financial Management Agreement in the NHS standard contract – aimed at ensuring system partners work together to meet financial objectives
- the System Oversight Framework and its focus on tackling problems as a system
- future guidance for providers supporting them to work collaboratively as part of ICSs, including a requirement for NHS providers to collaborate in the NHS Provider Licence.

Beyond these, NHS England also outlines a number of other enablers of collaboration that are likely to be introduced within the coming Health and Care Bill, including:

- a common duty for ICS NHS Bodies and NHS trusts to pursue the triple aim – to improve quality of care, population health, and the use of resources
- the imposition of duties on the ICS NHS Body and NHS trusts to act to ensure system financial balance – giving all a shared investment in collaboration
- powers for the ICS NHS Body to ensure organisational capital spending is in line with the system-wide capital plans

### **Services currently commissioned by NHS England**

The Health and Care Bill is expected to enable NHS England's direct commissioning functions to be jointly commissioned, delegated, or transferred to ICS NHS Bodies, when appropriate. NHS England's stated intention is to enable ICSs to take on this responsibility as soon as they are ready to, depending on the passage of the legislation.

Commissioning of primary medical services, currently delegated to CCGs from NHS England, is expected to transition to ICS NHS Bodies immediately upon their creation as statutory bodies. This will mean that existing arrangements between GP practices and CCGs will transfer to the ICS NHS Bodies, along with any relevant contracts. ICS NHS bodies might also take on primary dental services, general ophthalmic and pharmaceutical services commissioning.

### **BMA view**

- it is essential that any changes to existing funding arrangements are fully communicated to those impacted by them
- GP practices in particular must be supported through any transition, with any agreements between them and CCGs outside of their core contracts retained as funding flows move from CCGs to ICS NHS Bodies
- wider GP funding has to be protected too, in order to ensure their financial security in the short, medium, and long-term
- delegating management of funds to local – i.e. place – level could be welcome too, with a greater focus on the needs of local areas, however, it is essential that there is strong clinical leadership helping to shape its use at that level
- safeguards are also needed to ensure that NHS funding is not used to plug gaps elsewhere in the system, including social care
- NHS England and ICSs must also commit to ensuring transparency as different funding streams are rearranged – to avoid confusion and ensure clarity regarding GP funding in particular.

Data and Digital Standards and Requirements

NHS England expects that digital and data experts will have a pivotal role in ICSs, supporting system transformation and modernising services. This will be underpinned by the requirement for all ICSs to have “smart digital and data foundations” in place from April 2022 – specifically, these will include:

- a renewed digital and data transformation plan
- clear lines of accountability for digital and data, with a named and experienced SRO
- investment in the levelling-up of the relevant infrastructure, including facilitating a cloud-first approach allowing for ‘frictionless’ cross-site working
- the implementation of a shared care record
- ICS-wide interoperability
- a single, co-ordinated offer of digital support for patients across the ICS, including remote technology to allow care to be managed at home and by patients themselves
- a cross-system intelligence function, allowing ICSs to share relevant data with each other in support of work on issues impacting multiple systems
- an agreed plan for embedding population health management capabilities, supported by the necessary data and digital infrastructure.

#### **BMA view**

- while we recognise the role and potential digital and data can have within ICSs and for collaborative working across health and care services, this cannot be fulfilled without proper, long-term investment in IT infrastructure
- efforts are also needed to ensure that ICSs gain patient trust in the use of data as well as transparency about what data is collected and shared, with whom, and for what purpose
- a nationally-led mandate on IT suppliers to ensure all software made available to the NHS is built to be interoperable is also essential.

#### Managing the Transition into Statutory ICSs

NHS England has stated that it hopes to make the transition to statutory ICSs as smooth as possible, with minimum uncertainty for the bodies and staff impacted by the changes involved – most notably the absorption of CCGs into ICS NHS Bodies.

To do so, NHS England are working with systems, affected organisations, trade unions (including the BMA), central and local government, and others on its ICS Transition Partnership Group in developing its approach to the transition. This includes its Employment Commitment – guaranteeing that staff below board level at all affected organisations will have new roles and continuity in their terms and conditions elsewhere within the system. Organisations are also asked not to undertake significant internal reorganisations during the transition period, to reduce uncertainty for staff.

Accountability for managing the process of change sits with current ICS and CCG leaders, as well as any new leaders appointed ahead of ICSs becoming statutory bodies. This includes a responsibility to ensure that ICSs have sufficient capacity in place to implement their statutory duties by April 2022. However, NHS England has also stressed that ICSs cannot pre-empt the successful passage of the Bill through Parliament, or how it is likely to be amended, in their planning.

**BMA view**

- we have been clear that one of the most positive and vital elements of CCGs has been their clinical/medical staff and local knowledge, which we have stressed must be retained within ICSs – we therefore welcome NHS England’s Employment Commitment
- continued and meaningful involvement of the BMA and other trade unions in NHS England plans for the CCG-ICS transition is essential.