CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny Panel

12 December 2022

Time 1.30 pm **Public Meeting?** YES **Type of meeting** Scrutiny

Venue Council Chamber- Civic Centre, St Peter's Square, Wolverhampton WV1 1SH

Membership

Chair Cllr Susan Roberts MBE (Lab)
Vice-chair Cllr Paul Singh (Con)

Labour	**Conservative**
Cllr Jaspreet Jaspal	Cllr Sohail Khan
Cllr Milkinderpal Jaspal	
Cllr Rashpal Kaur	
Cllr Asha Mattu	
Cllr Lynne Moran	
Cllr Sandra Samuels OBE	

Co-opted Member
Stacey Lewis (Healthwatch Wolverhampton)

Quorum for this meeting is three voting members.

Information for the Public

If you have any queries about this meeting, please contact the Scrutiny Team:

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Agenda

Part 1 – items open to the press and public

Item No. *Title*

MEETING BUSINESS ITEMS

1 **Apologies**
[To receive any apologies for absence].

2 **Declarations of Interest**
[To receive any declarations of interest].

3 **Minutes of previous meeting** (Pages 5 - 12)
[To approve the minutes of the previous meeting as a correct record.]

DISCUSSION ITEMS

4 **Performance, Budget Monitoring and MTFS** (Pages 13 - 38)
[To receive a presentation on Performance, Budget Monitoring and Medium Term Financial Strategy].

5 **Integrated Care System Strategy and Priorities - Question and Answer Session** (Pages 39 - 102)
[A Question and Answer Session on the Integrated Care System Strategy and Priorities including One Wolverhampton].

[Government guidance to Heath Scrutiny Panels is attached, along with four articles taken from The King's Fund website. The King's Fund is an independent charitable organisation working to improve health and care in England].

The Four King's Fund Articles are:-

1) Integrated Care Systems explained: Making sense of systems, place and neighbourhoods.
2) The first days of Statutory Care Systems: Born into a Storm
3) Placed Based Partnerships Explained
4) Social Care Providers and Integrated Care Systems: Opportunities and Challenges

6 **Date of Next Meeting and Draft Agenda Items**

[The date of the next scheduled Health Scrutiny Panel is 19 January 2023 at 1:30pm-.

The draft agenda items are :-

- Primary Care (Results of latest GP Telephone Survey from Healthwatch Wolverhampton)
- One Wolverhampton Priorities Update
- The Royal Wolverhampton NHS Trust Transport Service
- Urology Services Monitoring Report
- Supporting Communities through Ward Plans

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CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny Panel

Minutes - 22 September 2022

Agenda Item No: 3

Attendance

Members of the Health Scrutiny Panel

Cllr Jaspreet Jaspal
Cllr Milkinderpal Jaspal
Cllr Rashpal Kaur
Cllr Sohail Khan
Stacey Lewis (Healthwatch Co-opted Member)
Cllr Asha Mattu
Cllr Lynne Moran
Cllr Susan Roberts MBE (Chair)
Cllr Paul Singh (Vice-Chair)

In Attendance
Members from Staffordshire County Council Health and Care Overview Scrutiny Committee including the Chair of the Committee.

Witnesses
Professor David Loughton CBE – The Royal Wolverhampton NHS Trust (Via MS Teams)
Brian McKaig (Medical Director – The Royal Wolverhampton NHS Trust) (Via MS Teams)

Employees
Martin Stevens DL (Senior Governance Manager)
John Denley (Director of Public Health)
Becky Wilkinson (Director of Adult Services) (Via MS Teams)
Dr Ainee Khan (Consultant in Public Health)
Dr Bal Kaur (Consultant in Public Health)
Riva Eardley (Principle Public Health Specialist)
Matthew Leak (Principle Public Health Specialist)
Sophie Pagett (Principle Public Health Specialist)
Madeleine Freewood (Partnership and Governance Lead – Public Health)
Julia Cleary (Scrutiny and Systems Manager)
Kimberly Dawson (Scrutiny Officer)

Part 1 – items open to the press and public

Item No. *Title*

1 **Apologies**

An apology for absence was received from Cllr Sandra Samuels.

There were no substitutions.

The Cabinet Member for Public Health and Wellbeing sent her apologies to the Panel.

2 **Declarations of Interest**

There were no declarations of interest.

3 **Minutes of previous meeting**

The minutes of the meeting held on 30 June 2022 were confirmed as a correct record.

4 **The Royal Wolverhampton NHS Trust Quality Accounts 2021-2022**

The Medical Director, from the Royal Wolverhampton NHS Trust, gave a presentation on, The Royal Wolverhampton NHS Trust Quality Accounts. A copy of the presentation slides are attached to the signed minutes. He identified the key points as follows: -

- The objectives for 2022/23 had been set based on the priorities of the Trust, the extension of the Trust Organisational Strategy and objectives until August 2022 and considering the impact of Covid-19 for the past two years.

- The development of a new joint strategy between, The Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust. Subsequently by Autumn 2022.

- The Quality Accounts did not contain any information about the CQC National inpatient Survey results for 2021. The official CQC results were not due until October 2022.

- The Quality Accounts would be presented to the formal Annual General meeting of the Trust on the 28 September 2022.

The Chair asked about the compliance rate for mandatory training on the Mental Health Act. Compliance was only at 68.6% in March 2022. She asked for an updated figure. The Medical Director responded that the figure now sat at over 90%. It was a local offer rather than national mandatory training.

The Chair asked about the Parliamentary Health Service Ombudsman (PHSO) training which had not been delivered due to Covid. The report had stated that this intended to be reviewed and delivered within financial year. She asked if this training was on track to be delivered. The Medical Director responded that the training was back on track and was being delivered as it was pre-Covid.

The Chair posed a question regarding the development of a dashboard for deteriorating patients and sepsis. She asked for a progress update and the benefits of the dashboard. The Medical Director responded that the dashboard was developed from the electronic system that managed patient observations. It was a live dashboard used by clinical teams 24 hours a day.

The Vice-Chair commented that quality of care was very important. Patient views on the care received were important, he would have liked to have seen more on their views in the Quality Accounts. He also asked about the inequalities the Trust had identified and what were they looking to improve moving forwards. The statement referred to a drive to improve continuity of care in BAME women during their pregnancy, he asked what improvements were being made. He referred to the

Cancer Improvement Board, which had been delayed. The report had stated it was due to commence in May, he asked if this had occurred. He requested the latest position on the 62-day Cancer Performance target. Finally, he requested clarification on the statement in the Quality Accounts that said the Trust would expand their apprenticeship offer to the diverse population.

The Medical Director responded that patient involvement had been challenging. Infection prevention measures during Covid had sometimes meant patient engagement was more difficult. They did want to improve family and friends' response scores, as they were average when benchmarked. They were also looking at patient involvement with regard to developing pathways and groups. The inequalities work with maternity services was identifying high risk mothers and babies at an early stage. They were carrying out preventative work such as diabetes management, cessation of smoking and having right access to health services and support. Other inequalities identified included prostate cancer in Black Caribbean men and how the Trust engaged with them. There were also inequalities regarding waiting lists for hip and knee replacements. There were work streams ongoing on this area to ensure equity of access to services.

The Medical Director stated that the inaugural meeting of the Cancer Improvement Group had taken place at the end of May. It was looking to develop and streamline pathways to improve performance and quality. It was also linked to workstreams in the ICS (Integrated Care System). The next meeting was in the following week. An action plan was being developed. There were significant challenges around the 62-day cancer pathways.

The Medical Director commented that the Trust had a strong Mentorship scheme in the Trust. They recognised the importance of investing in staff so they could reach their potential.

The Chief Executive of the Royal Wolverhampton NHS Trust commented that there were not extensive vacancies for consultants, doctors at the Trust or GPs in the Primary Network they controlled. He had not used any agency nurses in Wolverhampton since 2005. They were also one of the best in the country for international recruitment. Nationally it was true that the biggest problem the NHS faced was workforce, but locally speaking they had done well to maintain staff figures. Waiting lists were at the highest level he had seen since the late 1980s and it would take considerable time to get them back on track. With regard to cancer services, locally they were still struggling with the effects of Covid because some people had not consulted their GP when they had early symptoms of cancer. They were seeing high levels of cancer and people presenting at a later stage in their illness.

The Chief Executive of the Royal Wolverhampton NHS Trust commented that he did have some concerns regarding the high level of international recruitment. This was because many of those staff came to work in England because of the pay. Due to inflation the amount they assumed they could send home was now less. He was doing everything he could to help them stay. The cost-of-living crisis was having a psychological impact on the 17,000 staff that worked for the Trust. They were looking at measures to try and ease the cost-of-living crisis. A hot meal could be provided to staff for £1.50 when at work.

The Chief Executive of the Royal Wolverhampton NHS Trust remarked that they were expanding the site at Cannock to include more elective surgery operating theatres. There were some unique problems with robotic surgery. The waiting list for robotic surgery with a robot was high. It was his view that the NHS had not rolled out robotic surgery fast enough. He was considering adding a third robot at Cannock to complement the two at New Cross. More staff would be required for the extra operating theatres at Cannock. The Trust were providing some mutual aid to Birmingham when they did have spare capacity to help with waiting lists. Birmingham had some of the biggest waiting lists in the country.

A Member from Staffordshire County Council's Health and Care Overview Scrutiny Committee commended the work the Trust had undertaken with the Local Universities. She also praised the volunteering work the Trust had encouraged especially with young people who could feel inspired to have a career later in life in health and care. She asked about how they balanced the overseas workforce with other staff. In addition, how the Trust was able to attract staff to work for them. It was important to ensure opportunities were made known to people and particular those in the local area.

The Chief Executive of the Trust responded that there were two groups of overseas staff. They knew from the outset some overseas staff were here for training in a partnership arrangement and would then return to their home country, the other group had plans to stay in the country long-term. People came to Wolverhampton because there were excellent training and education opportunities. There were 150 nurses on the Fellowship Programme. The Trust had been in a stable financial position in the last 14 years and so was able to invest in opportunities for staff. They had a good record in staff retention. They did everything they could to make their overseas staff welcome, this included helping them with accommodation and bank accounts.

The Medical Director added that they were very active in going to volunteer groups like the Scouts as part of their recruitment drive. Covid had led to a younger profile of volunteers working with the Trust.

The Chair of South Staffordshire's Health Scrutiny commended the Chief Executive of the Trust for investing in Cannock Hospital. She asked for information on how Doctors became Consultants. The Medical Director explained the process in detail, which included the CESR (Certificate of Eligibility for Specialist Registration) route.

The Chair of Staffordshire County Council's Health and Care Overview Scrutiny Committee thanked the Chair for inviting the Committee Members to take part in the discussion via MS Teams. He emphasised that Wolverhampton Trust was a key service provider to Staffordshire residents. He also paid tribute to the Chief Executive of the Trust and the staff for the Trust over the last two years and during the course of the Covid pandemic. He referred to the figures in the report which detailed the number of incidents which related to serious harm or death. The figures in the report showed there had been more than a doubling of the numbers year on year. He asked what processes were followed when there was an incident to ensure lessons were learnt. He also referred to the number of re-admissions for people over 16, which was at the highest level for many years. In addition, the total number of admissions was very high. He asked for some more information on these figures.

The Medical Director responded that they did recognise the figures for serious harm or death incidents. They had a formal process that was followed from moderate to serious harm and death. He described the process in detail. Encouraging there were no similar themes in serious harm or death incidents at the Trust. With reference to re-admissions for people over 16, a lot of them were related to mental health. They were trying to manage them more effectively in the community. They were also looking at using virtual wards more over the next two years. The Chief Executive of the Trust referred to problems with delayed transfer of care. Wages in domiciliary care could not compete with companies such as Amazon. He was also alarmed by the increase in the number of elderly patients with mental health problems who were being admitted. It would sometimes look like a re-admission for their original condition but was often due to a mental health problem.

The Director of Adult Services stated that they continued to work hard on moving their social care residents out of New Cross Hospital. They had also invested in extra staff for winter. They had increased their PST support and capacity.

A Staffordshire County Council Health and Care Overview Scrutiny Committee Member referred to the eye clinic in Wolverhampton, which delivered an excellent service. She asked if there were any plans to move any of the basic services to Stoke or Stafford. The Chief Executive of the Trust responded that she would have to ask UHNM (University Hospitals of North Midlands NHS Trust) as he no longer managed services in Stafford.

The Vice-Chair asked for the benefits and drawbacks of virtual wards. The Medical Director responded that they could prevent an admission to hospital and be used to monitor people being discharged from hospital. There was a virtual ward team, which could digitally monitor them via a command centre, enabling remote access to the patients medical statistics. The feedback from patients had been exceptional. He did not see any drawbacks but there was buy-in needed from the population to let them know it was safe. The Chief Executive of the Trust suggested the Panel could visit the Command Centre at the Science Park at Wolverhampton University.

The Chair congratulated the Trust on their SHMI (Summary Hospital Level Mortality Indicator) being at expected levels.

The Chair asked how the new Integrated Care Board (ICB) and One Wolverhampton were progressing as part of the new Health System. The Medical Director responded that One Wolverhampton, the place Level Group was progressing very rapidly. The governance system was now virtually agreed. There were a number of strategic working groups which were related to national initiatives or related to the local population. There was good collaboration between health partners in One Wolverhampton. The main interaction with the ICB had been through the Black Country Provider Collaborative. They were looking at how to develop effective work streams and patterns of working. There was a lot of focus on cancer pathways and discussions on other themes such as digital integration. It was a developing system.

The Chair asked about the benefits and drawbacks of a shared Chief Executive and Chairman with Walsall. He responded that the benefits were high particularly on back office work and areas such as catering. He believed it to be a positive move for both Walsall and Wolverhampton.

The Chair thanked the Members of Staffordshire County Council Health and Care Overview Scrutiny Committee for contributing to the meeting.

5 **Public Health Annual Report 2021-2022**

The Public Health Partnership and Governance lead gave a presentation summarising the main points of the Public Health Annual report, a copy of the presentation is attached to the signed minutes.

The Chair referred to the high amount of indicators marked in the report as red. There were indicators marked as red across the City from Tettenhall to Graisley. The Vice-Chair agreed with how the Public Health Partnership Lead had described the current situation as stark and challenging. On page 106 of the agenda pack / page 8 of the Annual Report document itself, every indicator with the exception of one was marked as red (worse than the national average). He asked if there was anything the seven neighbouring authorities were carrying out, which the Council were not, which could be copied to try and improve the indicators marked as red. He was particularly concerned about coronary heart disease and obesity. Obesity seemed to have got worse over the last few years, rather than better.

The Director of Public Health responded that he didn't tend to look at other neighbouring areas to look at what they did well. There was a real challenge in Wolverhampton due to intergenerational reinforcement. He believed there was a way of tackling the problems and before the Covid pandemic they were making inroads. He wanted people to live a long healthy life, free from disease as far as possible. There were too many people under the age of 75 who were dying too early, often because of Cancer and Cardiovascular disease. In the short-term one of the steps, they could take was to try and ensure that everyone eligible received a health check. The later someone was diagnosed with cancer, the worse the prognosis and the chances of a full recovery. A health check would help improve health outcomes.

The Director of Public Health referred to screening rates which were in a very poor position in Wolverhampton. How communities were engaged with was key to ensuring that screening rates improved in the City. He referred to the success there had been in Wolverhampton in reducing drug related deaths, whereas in other places in the country they had increased. Reducing infant mortality would also significantly improve the overall life expectancy figures. There had been success in reducing the number of children starting smoking. In tackling obesity, reducing barriers to places like leisure centres for families would help with the problem. He also felt this would help improve emotional wellbeing and mental health. Addressing population public health, connecting people and addressing the areas that caused people to die early was vitally important.

The Vice-Chair asked the Director of Public Health if the problem with obesity was solvable in Wolverhampton. He wanted to see improvements and asked when he would be able to see them, things had only got worse since 2015. The Director of Public Health responded that there were short term interventions that could be implemented, such as initiatives to help increase the amount of physical activity taking place. By increasing the amount of physical activity, he strove to improve the levels of obesity in the City. He hoped to turn some of the indicators to green. In 2018 they had been the eighth lowest for health checks and this had gone up to the

top quartile. He was therefore hopeful he could turn things around, but problems wouldn't rectify themselves.

A Panel Member referred to the difficult national situation and the problems with people being able to afford healthy food and stay warm. People who were poor and unhappy were much more likely to face problems with their weight. She wanted enforcement action to be taken against bad landlords. She added that she wanted the roads to be safe for cyclists, as this would encourage people to use active travel which was heathier for them. There was inequality in Wolverhampton and this could be seen looking at the ward profiles in the report.

The Director of Public Health commented that in more deprived areas of the City it was harder to ascertain who was living in households. Stabilising those households and helping them, meant a high probability of ensuring a healthier life.

A Member of the Panel referred to generational poverty in some areas in Wolverhampton. He added that they needed more investment to help them out of poverty this included more education, better healthcare and the children needed better access to the higher performing schools in the City. A joined-up approach was vital. Ensuring people that were eligible for a health check were invited to do so was important. Dental health checks were also important and needed to be monitored. He asked if there were enough resources in the City to be a City of Sanctuary for people from war torn countries, due to the pressures the City were already facing in areas such as housing. They deserved to receive full support but he was unsure if the City could provide it due to the pressures it was already under.

The Director of Public Health spoke on health checks and how they could have an impact on improving population health. 900 people had recently had a heart check at the Mander Centre. Dementia and gambling problems could also feature as part of health checks. Dentistry was currently at NHS England level but he hoped the responsibility would soon be devolved to place level, which would give them more control. Pharmacy he also desired to be devolved to local level from a regional level. With asylum seekers in the City, they worked with health colleagues and the Home Office as best they could. It did at times put pressure on the system but they tried to work collectively to help manage their needs working with partners in health and the voluntary sector.

A Panel Member referred to vaping in School, which he described as an epidemic. He believed it to be a national issue and one which would continue to get worse unless action was taken. The Director of Public Health responded that vaping was better than smoking tobacco for adults. It was worrying when children were using vapes. Addressing the question of what was driving them to vape was important and addressing the harm. It was an emerging problem which didn't really exist ten years ago. National guidance would help with local plans.

A Panel Member referred to the Sure Start Programme which was providing support for families but had ceased in 2015. Youth Centres had also helped relieve pressure on the health sector. She felt direct lobbying to national government was required to secure funds to help population health. Food banks were now having to support families, particularly in deprived areas, as supermarket food was too expensive for them. Demographics were changing which meant support infrastructure needed to be appropriate for the changing demands.

The Director of Public Health responded by emphasising the importance of stability of funding which was essential to programme and risk management. Outcomes were more likely to be better when there was a long-term approach.

The Chair commented that healthy eating could cost more money and so support was needed to those that were unable to afford healthy food.

6 **Health Checks and Screening**

Public Health Officers gave a detailed presentation on health checks and screening, a copy of the presentation slides are attached to the signed minutes.

The Vice-Chair complemented Officers on the report and presentation. He would personally be encouraging eligible people to take up screening. He hoped the services would be as accessible as possible and thought would be given to people who relied on public transport.

The Chair also encouraged accessible services and making sure there was appropriate capacity. Thought should be given to the time of appointments to help people who struggled to take time off work. Encouraging people to complete tests sent out in the post, such as tests for bowel cancer was critical. Prevention was important to saving lives and helped the NHS manage their resources.

The Principle Public Health Specialist commented that they didn't want to fill standard GP Appointments with screening. Some screening was completed by nurses. The breast screening van had some success in increasing uptake, when it went to certain areas such as Bilston. They looked at weekends and evenings as well to encourage uptake. There were plans in place to look at accessibility and simplicity of wording for invitations. Being proactive would help in reducing pressure on the NHS.

The Principle Public Health Specialist commented there were planning meetings with the NHS to ensure screening initiatives didn't impact on the day-to-day GP appointments. They also held local events to help encourage uptake and were looking to build on this work. They had recently carried out health checks at the Mander Centre as part of the outreach work.

The Chair thanked Officers on behalf of the Panel for the report. She hoped to see results moving forward.

7 **Date of Next Meeting and Proposed Agenda Items**

It was reported that the date of the next Health Scrutiny Panel would be Friday, 10 November 2022 at 1:30pm.

The proposed main items were: -

Integrated Care System Strategy and Priorities
One Wolverhampton Strategy and Priorities

CITY OF WOLVERHAMPTON COUNCIL

Performance, Budget and MTFS

Health Scrutiny Panel

12 December 2022

Introduction

Budget Scrutiny for

- Background
- 2022-2023 Performance and Budget monitoring update – as at quarter 2
- 2023-2024 Draft Budget and Medium Term Financial Strategy
- Future Challenges
- Strategic Risk Register

Background

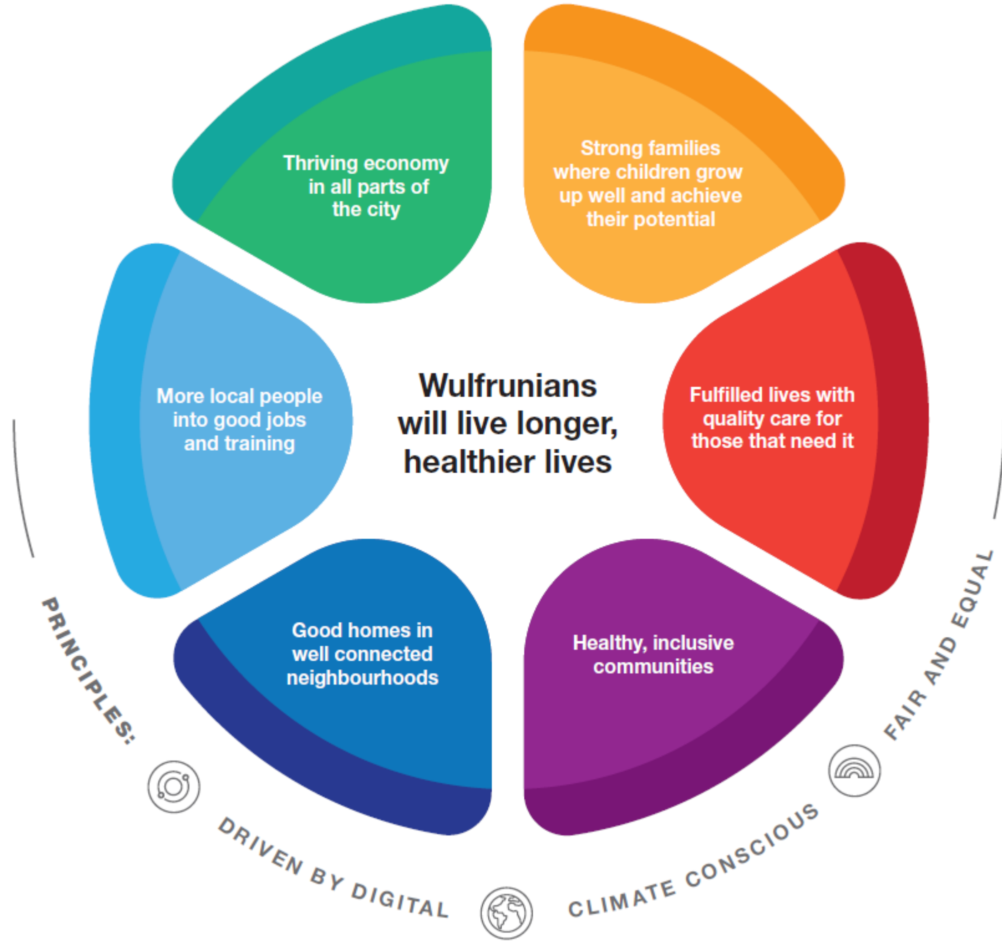
- The Council has built up a strong track record over many years of managing its finances well despite reductions in funding
- The Council's strategic approach to strategic financial planning is to align resources to Our City, Our Plan which was approved by Full Council on 2 March 2022
- Our City: Our Plan a new Council plan building on the Relighting Our City and providing a strategic framework for delivering the ambition that 'Wulfrunians will live longer, healthier lives.'

Not Protectively Marked

Background

- This presentation provides an update on the in-year performance and budget position and the draft budget for 2023-2024.
- Scrutiny are asked to:
  - consider and comment on the draft budget and how it is aligned to priorities of the Council
  - Provide feedback to Scrutiny Board for consolidation and onward response to Cabinet on the Draft Budget and Medium-Term Financial Strategy 2023-2024 to 2025-2026

Not Protectively Marked



Wulfrunians will live longer, healthier lives
Thriving economy in all parts of the city
Strong families where children grow up well and achieve their potential
Fulfilled lives with quality care for those that need it
Healthy, inclusive communities
Good homes in well connected neighbourhoods
More local people into good jobs and training
PRINCIPLES:
DRIVEN BY DIGITAL
CLIMATE CONSCIOUS
FAIR AND EQUAL

2022-2023 Performance and Budget Monitoring Quarter 2

Performance and Budget Monitoring – Quarter 2

- On a quarterly basis an integrated performance and budget monitoring report is presented to Cabinet.
- The quarter 2 position was presented to Cabinet on 16 November 2022 and to Scrutiny Board on 6 December 2022.
- Overall, a forecast overspend was reported across the Council of £1.5 million – this is in the main as a result of the 2022-2023 pay award.
- The following slides provide an overview of the services that fall under the remit of this panel.

Not Protectively Marked

Overall Our City: Our Plan Performance – Quarter 2

In total there are currently 56 KPI's in the Our City: Our Plan performance framework.

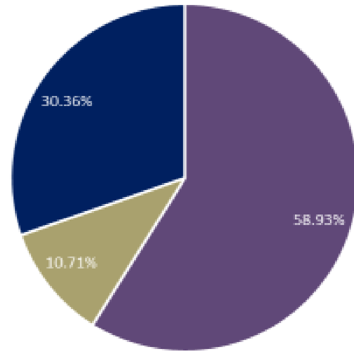
Of these;

- 33 have shown improvement or have seen similar performance
- 17 are yet to be update in the YTD (8 of these in Healthy Communities) *
- 6 saw a decrease in performance

** Those not updated are where we are awaiting the publication of national data sets and the release schedule is not in our control. An example of this is Educational Attainment, which is a yearly updated that had not been published before the end of Q2 2022/23*

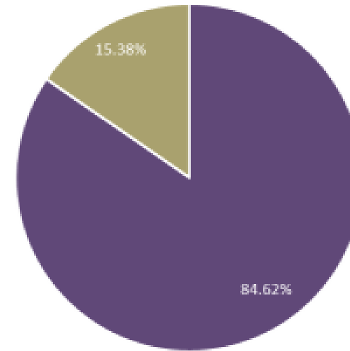
Overall Our City: Our Plan Performance – Quarter 2

% of indicators improving
(all indicators)



■ Improved or sustained ■ Decreased ■ Not reported yet

% of indicators improving
(those with avaliable updates)



■ Improved or sustained ■ Decreased

Healthy Communities Performance

- Through the pandemic, NHS postponed the release of key performance indicators. Although some performance has started to be published again, the majority of indicators within the Our City: Our Plan portfolio for health remain outstanding
- With this in mind, Data and Analytics and Public Health are currently working on a new suite of performance indicators. These include high level surveillance indicators, that help Public Health understand key trends and priorities within the city, and operational performance indicators that track the work of our internal targeted Public Health interventions
- Work continues to build a robust intelligence base using recently released data through Census 2021, Health Index and the recently commissioned Healthy Lifestyles Survey to better understand residents' needs.

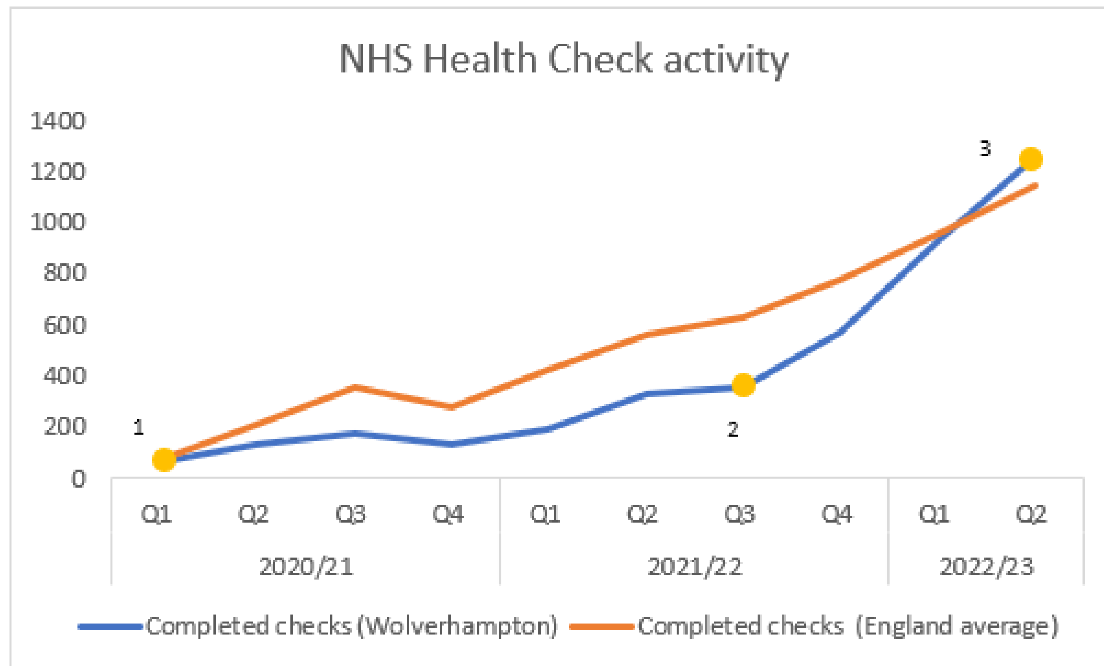
Not Protectively Marked

Healthy Communities Performance

- One of the indicators that has been published is the percentage of 40-74 years attending offered health checks.
- The recent trend shows an improvement in the Wolverhampton uptake of residents attending health checks. Data shows that for the most recent quarter the uptake of the health check offer in the city was higher than the national average.
- It is understood how important the link between the uptake of and improved outcomes across multiple health priorities. Ambitions for Wolverhampton are to continue to improve above the rate of England average and to return to pre pandemic levels of activity within the next year.

Not Protectively Marked

NHS Health Checks activity trend



1. NHS England advised GPs to pause non-urgent activity (64 completed checks)
2. GPs advised to restart locally (357 completed checks)
3. Above England average in Q2 (1,257 completed checks)

Forecast Budget Position – Summary

Service	Gross Expenditure Budget 2022-2023 £000	Gross Income Budget 2022-2023* £000	Net Controllable Forecast (Expenditure) 2022-2023 £000	Net Controllable Forecast (Income) 2022-2023* £000	Q2 Variance £000	Q2 Variance %	Reason for Quarter 2 Variance
Healthy Ageing	1,193	(1,193)	1,133	(1,133)	-	-	
Healthy Life Expectancy	5,865	(5,865)	5,829	(5,829)	-	-	
Public Health Business Management	5,229	(5,229)	5,292	(5,292)	-	-	
Starting and Developing Well	9,981	(9,981)	9,959	(9.959)	-	-	
System Leadership	214	(214)	214	(214)	-	-	
Total	**22,482**	**(22,482)**	**22,427**	**(22,427)**	**-**	**-**	

- Public Health Grant allocation for Wolverhampton for 2022-2023 is £21.7m
- Net Controllable Forecast income includes £20.7m of Public Health Grant, £1.1 million other grants and income and £660,000 use of reserves.
- A break even position is projected on these services. These services are all fully funded by either Public Health grant, other grants income or reserve.
- Public Health grant allocation totalling £1.0 million is included in services which fall under Resident, Housing and Communities and Resources and Equality Scrutiny Panel.

Not Protectively Marked

2023-2024 Draft Budget and MTFS 2023-2024 to 2025-2026 Overview

Overview

- The 2022-2023 budget and MTFS was approved by Full Council on 2 March 2022
- Reported a forecast budget deficit of £12.6 million in 2023-2024 rising to £25.8 million over the medium term to 2025-2026
- Work has been ongoing to reduce the deficit with an update to Cabinet on 19 October 2022 reporting an updated forecast budget deficit of £7 million for 2023-2024 rising to £31.6 million by 2025-2026
- Work will continue to be undertaken to bring forward proposals to set a balanced budget for 2023-2024 and deliver a sustainable medium term financial strategy

2023-2024 Draft Budget and MTFS 2023-2024 to 2025-2026 Overview

Scrutiny Panel	2022-2023 Gross Expenditure Budget £000	2022-2023 Gross Income Budget £000	2022-2023 Net Revenue Expenditure/ (Income) Budget* £000	Pay Award Inflation** 2023-2024 £000	Growth 2023-2024 £000	Savings 2023-2024 £000	2023-2024 Draft Net Revenue Expenditure/ (Income) Budget £000
Economy and Growth Scrutiny Panel	21,129	(13,853)	7,276	85	90	(1,030)	6,421
Health Scrutiny Panel	21,886	(21,886)	-	-	-	-	-
Residents, Housing and Communities Scrutiny Panel	80,500	(46,181)	34,319	271	142	(250)	34,482
Resources and Equality Scrutiny Panel	197,087	(108,345)	88,742	14,112	3,336	(2,852)	103,338
Fulfilled Adult Lives Scrutiny Panel	119,537	(38,574)	80,963	172	4,705	-	85,840
Strong Families, Children, and Young People Scrutiny Panel	242,021	(189,715)	52,306	442	-	(1,000)	51,748
Commissioning and Transformation***	3,815	(262)	3,553	-	-	-	3,553
Net Budget Requirement	**685,975**	**(418,816)**	**267,159**	**15,082**	**8,273**	**(5,132)**	**285,382**
Corporate Resources			**(267,159)**	**-**	**(11,081)**	**-**	**(278,240)**
Budget Challenge as at October 2022							**7,142**

- *draft revised budget after reversal of one-off virements and forecast impact of 2022-2023 pay award
- ** forecast impact of increments, changes to NI, does not factor in any uplift for 2023-2024 pay award – this will be held corporately until agreed
- ***Commissioning and Transformation falls under both Fulfilled Adults Lives and Stronger Families, Children and Young People Scrutiny Panel

Overview – Uncertainties

- There continues to be significant uncertainty around
  - Future funding
  - Inflationary pressures
  - Future pay awards – currently assumes 4% in 2023-2024 and 2% for future years

Not Protectively Marked

Health
Scrutiny Panel
2023-2024 draft budget and MTFS

Changes to budget –saving / growth

- Under the remit of this panel the MTFS currently has the following no specific saving targets or growth built into the budget

Not Protectively Marked

Draft Budget

Service	2022-2023 Gross Expenditure Budget* £000	2022-2023 Gross Income Budget £000	2022-2023 Net Revenue Expenditure/ (Income) Budget £000	Pay Award Inflation** 2023-2024 £000	Growth 2023-2024 £000	Savings 2023-2024 £000	Net Revenue Expenditure/ (Income) Budget 2023-2024 £000
Healthy Ageing	1,165	(1,165)	-	-	-	-	-
Healthy Life Expectancy	5,615	(5,615)	-	-	-	-	-
Public Health Business Management	5,259	(5,259)	-	-	-	-	-
Starting and Developing Well	9,633	(9,633)	-	-	-	-	-
System Leadership	214	(214)	-	-	-	-	-
	21,886	**(21,886)**	**-**	**-**	**-**	**-**	**-**

- Current position assumes no changes in public health grant – as the 2023-2024 allocations are not yet known
- *draft revised budget after reversal of one-off virements and forecast impact of 2022-2023 pay award
- ** forecast impact of increments, changes to NI, does not factor in any uplift for 2023-2024 pay award – this will be held corporately until agreed

Draft Budget

- Budget setting process is still under way. The Draft Budget is subject to changes that are implemented to close the current deficit for 2023-2024.
- Some growth and saving targets are currently being held in Corporate Accounts and will be transferred to services.
- The Draft Budget currently does not yet reflect any virements between services in 2023-2024.
- Work is ongoing to review and challenge budget requirements.

Not Protectively Marked

Risks / Key areas to note

Covid-19

- Co-ordinated joint working continues to promote vaccination uptake to eligible groups.
- The Health Protection Forum has strategic oversight for our jointly owned ‘Local Outbreak Control Plan’ and leads on the coordination of the approach to preventing, containing and managing outbreaks.

Quality and Access of Care

- The impact of the pandemic has led to pressure on the health and social care system. Joint working with NHS colleagues through the new Integrated Care System at both a Black Country and place level is ongoing to address this, including through the promotion of local initiatives such as Health Checks.

Not Protectively Marked

Earmarked Reserves

Earmarked Reserve	Description of Reserve	Balance at 1 April 2022 £000	Forecast Balance at 31 March 2023 £000	Areas of anticipated expenditure 2022-2023	What would be the effect on services if the reserve is not utilised in this way	Approved Commitments for future years (2023-2024 onwards) £000
Public Health						
Public Health	This reserve has been established from ring fenced Public Health grant and is to fund one-off public health initiatives.	(7,936)	(6,139)*	Plans for use in 2022-2023 were approved in the Performance and Budget Monitoring Reports to Cabinet on 16 November 2022	The Draft Budget and MTFS 2023-2024 to 2025-2026 reported to Cabinet on 19 October 2022, incorporated the use of £2 million of this reserve over the period of 2023-2024 to 2024-2025	2,218*

Full list of forecast balances of all reserves reported to Reserves Working Group on 8 November 2022.

*updated to reflect use of reserves as approved Cabinet on 16 November 2022

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Strategic Risk Register

Risks last reported to the Audit and Risk Committee on 28 November 2022.

- The following strategic risk relevant to this panel:
  - Refugee and Asylum accommodation and support
- Other strategic risks which may have an impact on this panel
  - Medium Term Financial Strategy
  - Financial wellbeing and resilience
  - Charging Reform and Fair cost of care

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Department of Health & Social Care (https://www.gov.uk/government/organisations/department-of-health-and-social-care)

Guidance

Health overview and scrutiny committee principles

Published 29 July 2022

Applies to England

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This publication is available at https://www.gov.uk/government/publications/health-overview-and-scrutiny-committee-principles/health-overview-and-scrutiny-committee-principles

Purpose of this document

In advance of the statutory guidance on the Secretary of State's new powers in relation to service reconfigurations, this document sets out the expectations of the Department of Health and Social Care (DHSC), the Local Government Association (LGA) and the Centre for Governance and Scrutiny (CfGS) on how integrated care boards (ICBs), integrated care partnerships (ICPs) and local authority health overview and scrutiny committee (HOSC) arrangements will work together to ensure that new statutory system-level bodies are locally accountable to their communities.

HOSCs, local authorities, ICBs, ICPs and other NHS bodies should use this document to ensure that scrutiny and oversight are a core part of how ICBs and ICPs operate. Leaders from across health and social care should use these principles to understand the importance of oversight and scrutiny in creating better outcomes for patients and service users and ensure that they are accountable to local communities.

Further information on the role of health scrutiny can be found in the Local authority health scrutiny: guidance to support local authorities and their partners to deliver effective health scrutiny (https://www.gov.uk/government/publications/advice-to-local-authorities-on-scrutinising-health-services).

Integrated care systems

The Health and Care Act 2022 (https://www.legislation.gov.uk/ukpga/2022/31/contents/enacted) builds on the work of existing non-statutory integrated care systems (ICSs) to encourage more integrated system working, and to improve local population health outcomes through the planning and provision of services.

The act also provides for the creation of new NHS bodies, ICBs, and for each ICB and its partner local authorities to form a joint committee to be known as the ICP.

42 ICBs will be established, and the 106 existing clinical commissioning groups (CCGs) will be abolished. The ICB will take on the commissioning functions of the CCG and have a governance model that reflects the need for integration and collaboration across the system.

Each ICP will have, as a statutory minimum, a representative from the ICB and a representative from each of the partner local authorities. It may decide locally to include a broad range of representatives in its membership – including those from the independent and voluntary, community and social enterprise (VCSE) sector – concerned with improving the care, health and wellbeing of the local population. The ICP will be tasked with developing an integrated care strategy to address the health, social care and public health needs of its system. The ICB and local authorities will have to have regard to the strategy when exercising their functions.

It is important to note that ICPs, as a joint committee between the ICB and partner local authorities as well as other members agreed by the ICP locally will be within the scope of HOSCs.

There will be a continuing role for HOSCs, health and wellbeing boards (HWBs) and the local Healthwatch as their roles are protected and preserved in the new system.

HOSCs will continue to play a vital role as the body responsible for scrutinising health services for their local area. They will retain their legal duties to review and scrutinise matters relating to the planning, provision and operation of the health service in the area. As is currently the situation, some local authority areas may have separate scrutiny committees for health and for adult social care. ICBs and ICPs should develop a trusting relationship with HOSCs to enable effective scrutiny.

HWBs will continue to bring together leaders at a place level to develop joint strategic needs assessments and prepare joint local health and wellbeing strategies for their local area. HOSCs should consider these strategies when scrutinising outcomes for their local area.

Local Healthwatch organisations will retain their statutory duty to obtain the views of people about their needs and experience of local health and social care services and will need to continue working with HOSCs to make these views known.

The benefits of scrutiny

Proactive and constructive scrutiny of health, care and public health services, done effectively, can build constructive relationships that deliver better outcomes for local people and communities; the people who represent them, and the commissioners and providers of health and care services. It also has other benefits including:

• providing an opportunity for local people and their elected representatives to contribute to and comment on the local priorities for improving health and care services and outcomes

• giving a voice to local people and communities on the quality, safety, accessibility and effectiveness of local health and care services

• assuring local elected members and the public that health and care services are safe and effective, address local health priorities and reduce health inequalities

• helping health and care providers and commissioners gain insight into the health needs and concerns of particular groups

• enabling health and care providers and commissioners to develop new services and care pathways to address local health priorities more effectively

While the procedures of review and scrutiny are at the discretion of the local authority, we recommend that each individual HOSC develops a framework to help them ensure that their scrutiny work is effective, focused and adds value. While this will be informed by other partners in the system, the assessment of risks, effects and impacts should be the HOSC's own. In particular, we recommend that a framework should consider:

- risks, effects and impacts to individual populations
- risks, effects and impacts to the whole local population
- support and input from local health colleagues

Responsibilities

HOSCs, HWBs, local Healthwatch and NHS bodies collectively have a role to play in good governance and accountability across the health and care system.

The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 (https://www.legislation.gov.uk/uksi/2013/218/contents/made) will continue to apply although the formal statutory route for local authorities to report to the Secretary of State will be removed when the new reconfiguration provisions in the Health and Care Act 2022 take effect.

Local authorities

Local authorities will retain the power to:

- review and scrutinise matters relating to the planning, provision and operation of the health service in the area. This may well include scrutinising the finances of local health services
- require information to be provided by certain NHS bodies about the planning, provision and operation of health services that is reasonably needed to carry out health scrutiny
- require employees, including non-executive directors of certain NHS bodies, to attend before them to answer questions
- make reports and recommendations to certain NHS bodies and expect a response within 28 days
- set up joint health scrutiny and overview committees with other local authorities and delegate health scrutiny functions to an overview and scrutiny committee of another local authority
- have a mechanism in place to respond to consultations by relevant NHS bodies and relevant health service providers on substantial reconfiguration proposals

• have a mechanism in place to deal with referrals made by local Healthwatch organisations or local Healthwatch contractors

• report disputed reconfiguration proposals to the Secretary of State until the new reconfiguration provisions take effect

NHS bodies

NHS bodies will retain the power to:

• provide information about the planning, provision and operation of health services as reasonably required, depending on the subject by local authorities to enable them to carry out health scrutiny

• attend before local authorities to answer questions necessary for local authorities to carry out health scrutiny

• consult on any proposed substantial developments or variations in the provision of the health service

• respond to health scrutiny reports and recommendations: NHS service commissioners and providers have a duty to respond in writing to a report or recommendation where health scrutiny requests this, within 28 days of the request. This applies to requests from individual health scrutiny committees or sub-committees, local authorities and joint health scrutiny committees or sub-committees

Health and wellbeing boards

HWBs will retain the power to:

• provide assessments of the current and future health and care needs of the local population

• develop joint strategic needs assessments

• develop joint local health and wellbeing strategies at a place level

Local Healthwatch

Local Healthwatch organisations will retain the power to:

• obtain the views of people about their needs and experience of local health and social care services, and to make these views known to those involved in the commissioning and scrutiny of care services

• make reports and make recommendations about how those services could or should be improved

• promote and support the involvement of people in the monitoring, commissioning and provision of local health and social care services

The design of new models of integrated care and support that are being introduced through the Health and Care Act 2022 will inevitably lead to changes in how and where services are provided.

HOSCs will have an invaluable role to play during the initial transition and implementation of ICBs and ICPs, and beyond, in scrutinising the impact and effectiveness of integration on health services and outcomes. Under this new structure, there will be a need for scrutiny of health services and outcomes at a local place-based level, as well as more strategic scrutiny of health services and system-level outcomes. Both levels of scrutiny are important; HOSCs should maintain an appropriate balance between the 2, and establish joint health overview and scrutiny committees (JHOSCs) where appropriate and necessary. Individual local authorities hold responsibility for carrying out scrutiny tests.

Scrutiny can play a valuable role in improving the evidence base for decisions about integration and in holding local authorities, NHS bodies, and health service providers to account for the level of local ambition to improve health and integrate services in ways that benefit people who use services and in the interests of taxpayers. It can also help to ensure that the views of people in an area are fully reflected in the consideration of any proposals.

Principles and ways of working

The following 5 principles set out best practice for ways of working between HOSCs, ICBs, ICPs and other local system partners to ensure the benefits of scrutiny are realised and should form the basis of ongoing discussions between these partners about how they will work together.

The 5 principles are:

- outcome focused
- balanced
- inclusive
- collaborative
- evidence informed

1. Outcome focused

Outcome-focused scrutiny can provide a valuable and relevant platform for looking at cross-cutting issues, including:

- general health improvement

- wellbeing
- specific treatment services and care pathways
- patient safety and experience
- overall value for money

Health scrutiny also has a strategic role in taking an overview of how well integration of health, public health and social care is working and in making recommendations on how it could be improved locally.

By focusing on outcomes, ICPs, ICBs, local political leaders, professionals and communities can explore and consider the complexities of health and wellbeing and help to evaluate the planning, delivery and reconfiguration of health and care services. A strategic approach should be taken to consider how best to apply scrutiny to evaluating key strategies and outcomes of the ICB and ICP, including the integrated care strategy and the ICB joint 5-year forward plan.

Within the wider ICB area, HOSCs will have a valuable role to play in scrutinising and evaluating place-based outcomes at local authority level. HWBs will continue to develop joint strategic needs assessments and establish joint local health and wellbeing strategies; HOSCs will continue to scrutinise place-based health services in relation to these.

However, HOSCs will also play a valuable role in scrutinising the health services of the wider ICB area and should work with other local authority areas, forming JHOSCs where appropriate, to scrutinise outcomes against the joint 5-year forward plan and the integrated care strategy.

2. Balanced

Good scrutiny needs to maintain balance between being future focused and responsive. When scrutiny is future focused it can help system partners to understand how local needs are changing, as well as understand the issues that communities face and suggest and test solutions. Future-focused scrutiny can also add value to integration planning and implementation by improving the evidence base for holding local decision makers to account for the level of local ambition to integrate services and improve population health.

ICBs and ICPs should take an inclusive and future-focused approach to agreeing a clear set of arrangements for scrutiny to be built into the whole cycle of planning, commissioning, delivery and evaluation. Leaders from across health and social care should work with openness and candour to establish a clear shared set of priorities and a future work programme to improve health and social care outcomes.

Scrutiny also needs to be reactive and responsive to issues of concern to local communities, including service performance and proposed NHS reconfigurations, local authorities, and other system partners, should ensure that HOSCs have the capacity to respond reactively to public concerns and reconfigurations. ICBs can

assist with this by working with HOSCs to shape their forward plans. ICBs should take a proactive approach to sharing at an early stage any proposals on reconfigurations, drawing a distinction between informal discussions and formal consultations. ICBs should also take a proactive approach to involving relevant bodies on any other matters which system partners expect to be contentious, to help navigate complex or politically challenging changes to local services.

With regard to concerns about service performance, ICBs should be open and transparent with HOSCs, bearing in mind that in some cases there may be legal or assurance proceedings. Equally, HOSCs must appreciate the need for regulatory and legal processes to run their course, but ICBs should update HOSCs on the progress of these processes.

3. Inclusive

The primary aims of health scrutiny are to strengthen the voice of local people and provide local accountability. They should ensure that local people's needs and experiences are considered as an integral part of the commissioning and delivery of health services, and that those services are effective and safe. Effective scrutiny allows for more inclusive public conversation than might be delivered as part of a formal consultation exercise. As such, it is important for scrutiny to engage the community, involving the right people at the right time in the right place.

HOSCs are a fundamental way for democratically elected local councillors to voice the views of their constituents, hold the whole system and relevant NHS bodies and relevant health service providers to account and ensure that NHS priorities are focused on the greatest local health concerns and challenges. Flexible and accessible arrangements to scrutinise integration issues provide the best opportunities for councillors to hear from people and groups with whom they may not have previously had much contact, for example primary care practitioners or people who use services. HOSCs, subject to time and resource constraints, may be well placed to engage with members of the public directly.

Systems and NHS bodies should form trusting working relationships with HOSCs, and work together to ensure that this important community intelligence is fed directly into system-wide decision making. Engaging with scrutiny is a way for ICBs and ICPs to add richness to their understanding of local need, and a way to connect strategic planning at system level to the nuances of local pressures and requirements.

4. Collaborative

Work plans that detail the future decisions and issues to be scrutinised by HOSCs should be informed by communities, providers and planners of health and care services to ensure that scrutiny is focused on achieving the most value for its population. Effective health scrutiny requires clarity at a local level about respective roles between the health overview and scrutiny committees, ICBs, ICPs, the NHS, local authorities, HWBs and local Healthwatch.

Service change and integration are typically not challenges that are confined to one local authority's area; these are issues that can straddle one or more local authority population. Under the new system-level structures, health scrutiny may increasingly need to cover issues that cut across local authority boundaries. Therefore, local authorities on ICB boundaries, and neighbouring councils within an ICB area should take a collaborative approach in order to identify any strategic issues that would benefit from joint scrutiny. Under Regulation 30 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013, local authorities must appoint a joint health overview and scrutiny committee where a relevant NHS body or health service provider consults more than one local authority health scrutiny function about substantial reconfiguration proposals; however local authorities also have the discretion to set up joint committees in other circumstances.

The role of JHOSCs is particularly important in assessing strategic issues that cover 2 or more local authority areas, and will be even more important under the new arrangements as ICB areas will span more than one local authority area in most cases. In particular, JHOSCs will have a strategic role to play in scrutinising the delivery and outcomes of the integrated care strategy.

It is important for ICBs, councils and scrutiny committees to develop joint protocols in advance of the need for any joint scrutiny arrangements, whether these arise under legislation or are optional arrangements. This includes having a clear view about how councils should work together, the structure of joint arrangements, and the time needed to establish these arrangements. JHOSCs will also need to recognise and take into account the potential difficulties of working together, particularly around the political balance between different local areas, as well as resourcing. Developing this shared understanding helps build the foundations for effective joint working. ICBs should have an active role in providing support in these situations and should recognise the complexity and time involved in establishing formal JHOSCs.

5. Evidence informed

Scrutiny informed by evidence can help make the case for better integration of services, better joint working around service improvements and better approaches to major service reconfigurations. Scrutiny adds value to decision making by ensuring that evidence is sound and based on the right insight, so that no voice is unheard or evidence overlooked. The types of evidence that aid effective scrutiny include evidence on quality and safety of services and evidence on population health needs. Qualitative evidence from those with lived experience – including patients, the public and those who are most likely to be excluded from services – are particularly valuable forms of evidence for aiding scrutiny.

Health scrutiny has a role in proactively seeking information about the performance of local health services and institutions; in challenging the information provided to it by commissioners and providers of services for the health service locally and in testing this information by drawing on different sources of intelligence. Local

Healthwatch are an important source of evidence and should work with HOSCs to pass on the views of people about their needs and experience of local health and social care services.

HOSCs can request evidence from systems and NHS bodies, and should ensure that their requests for evidence are reasonable, proportionate and relevant.

The health system has a responsibility to provide information needed for health scrutiny. Health and care providers and commissioners should respond positively and constructively to the requests for information from HOSCs. Where an NHS body cannot provide a response to a request for information, it should work with the HOSC to attempt to provide information and support where possible. ICBs should have plans and protocols in place for sharing information for the purpose of scrutiny, as this will avoid the need for continual ad-hoc decision-making when information is requested.

Next steps

The Health and Care Act 2022 introduces a power for the Secretary of State to call in and take decisions on or connected to reconfiguration proposals at any stage in the proposal's process. This does not change local authorities' scrutiny responsibilities for service change. To support this intervention power, the local authority referral power, which is set out in regulations, will be amended to reflect the new process.

DHSC will also issue statutory guidance on the new powers outlining how the Secretary of State proposes to exercise their functions during this new process, including the new Secretary of State call in power. This guidance will also include information for NHS commissioning bodies, NHS trusts and NHS foundation trusts about how they should be exercising their functions under the new reconfigurations process. We expect that these principles will complement the new guidance to help ensure that scrutiny is embedded across the new statutory system-level bodies.

Exact timelines are still to be determined; however, any changes to the reconfiguration process introduced through the Health and Care Act 2022 will not be implemented immediately following Royal Assent. We will work with the system to help prepare for any proposed changes and to develop the new statutory guidance.

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The King's Fund

Integrated care systems explained: making sense of systems, places and neighbourhoods

19 August 2022
12 comments

Authors

Anna Charles

This explainer was originally published on 9 April 2020. It was updated on 19 August 2022.

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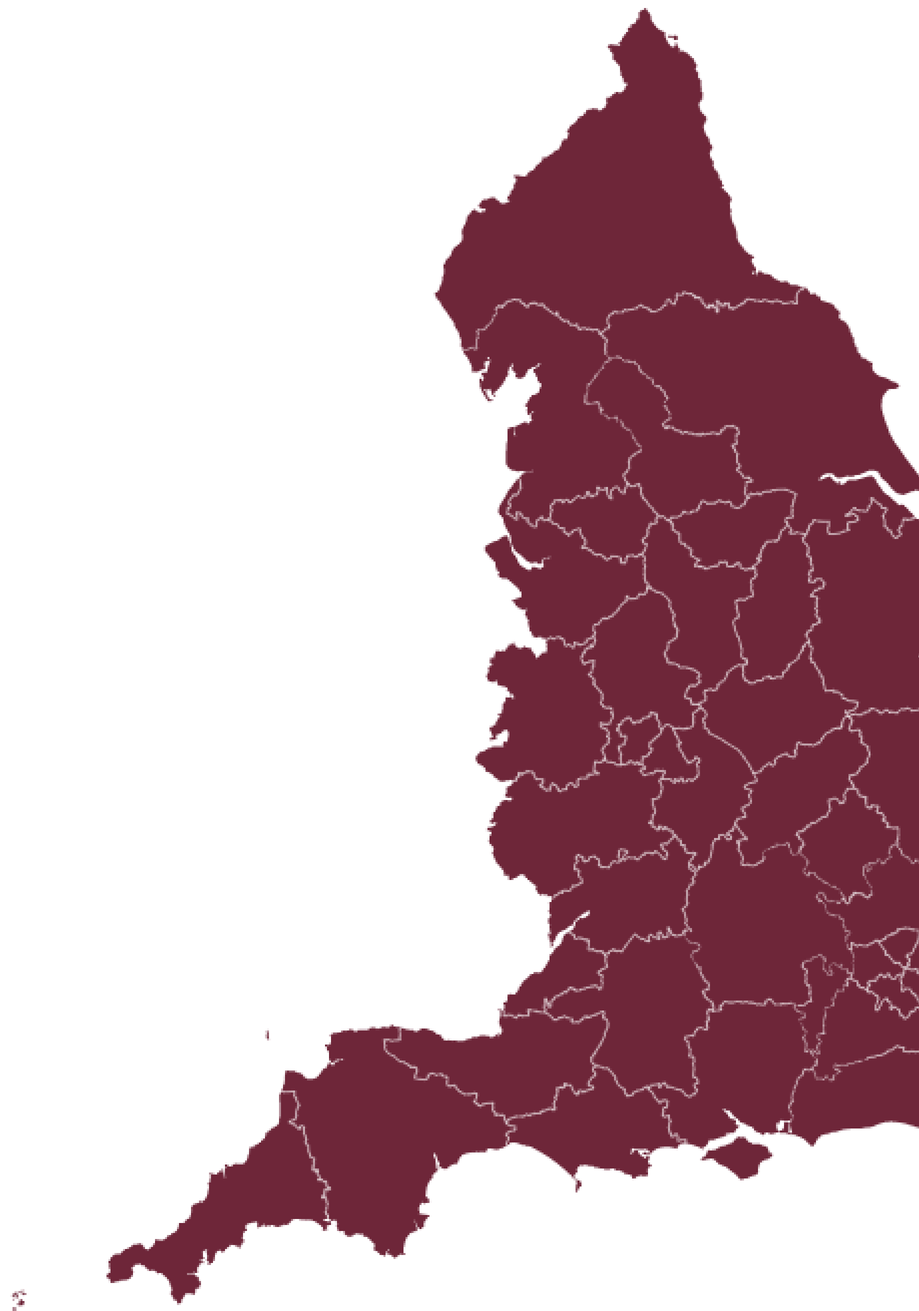
What are integrated care systems?

Integrated care systems (ICSs) are partnerships that bring together NHS organisations, local authorities and others to take collective responsibility for planning services, improving health and reducing inequalities across geographical areas.

There are 42 ICSs across England, covering populations of around 500,000 to 3 million people.

Map 1: The 42 integrated care systems in England

This map shows the location and boundaries of the 42 integrated care systems (ICSs) in Engla



Source: © Crown copyright and database right 2020 • Created with Datawrapper

ICSs have existed in one form or another since 2016, but for most of this time have operated as informal partnerships using soft power and influence to achieve their objectives. Following the passage of the 2022 Health and Care Act, ICSs were formalised as legal entities with statutory powers and responsibilities. Statutory ICSs comprise two key components:

- **integrated care boards (ICBs):** statutory bodies that are responsible for planning and funding most NHS services in the area
- **integrated care partnerships (ICPs):** statutory committees that bring together a broad set of system partners (including local government, the voluntary, community and social enterprise sector (VCSE), NHS organisations and others) to develop a health and care strategy for the area.

Working through their ICB and ICP, ICSs have four key aims (https://www.england.nhs.uk/publication/integrating-care-next-steps-to-building-strong-and-effective-integrated-care-systems-across-england/) :

- improving outcomes in population health and health care
- tackling inequalities in outcomes, experience and access
- enhancing productivity and value for money
- helping the NHS to support broader social and economic development.

ICSs are the centrepiece of the reforms introduced through the 2022 Health and Care Act and are part of a fundamental shift in the way the English health and care system is organised. Following several decades during which the emphasis was on organisational autonomy, competition and the separation of commissioners and providers, ICSs depend instead on collaboration and a focus on places and local populations as the driving forces for improvement.

Why are ICSs needed?

When the NHS was set up it was primarily focused on treating single conditions or illnesses, but since then the health and care needs of the population have changed. People are living longer with multiple, complex, long-term conditions and increasingly require long-term support from many different services and professionals. As a consequence, people too often receive fragmented care from services that are not effectively co-ordinated around their needs. This can negatively impact (https://www.gov.uk/government/publications/integrated-care) their experiences, lead to poorer outcomes and create duplication and inefficiency. To deliver joined-up support that better meets the needs of the population, different parts of the NHS (including hospitals, primary care and community and mental health services) and health and social care need to work in a much more joined-up way. ICSs are the latest in a long line of initiatives (https://www.nao.org.uk/report/health-and-social-care-integration/) aiming to integrate care.

As argued in The King's Fund's vision for population health (/publications/vision-population-health) , an integrated health and care system is just one of the four pillars of a population health system (https://www.kingsfund.org.uk/publications/vision-

population-health#what-is-population-health) . Evidence (https://www.instituteofhealthequity.org/resources-reports/marmot-review-10-years-on) consistently shows that it is the wider conditions of people's lives – their homes, financial resources, opportunities for education and employment, access to public services and the environments in which they live – that have the greatest impact on health and wellbeing. Health inequalities (/publications/what-are-health-inequalities) are wide and growing but they are not inevitable, as evidence shows (/blog/2017/08/reducing-inequalities-health-towards-brave-old-world) that a concerted approach, combining the NHS and wider policies to address the social and economic causes of poor health, can make a difference. ICSs therefore also have a critical role to play in driving forward efforts to improve population health and tackle inequalities in their local areas. These goals are clearly set out in the four functions of ICSs (see above), and the new Triple Aim for NHS bodies (which was amended to specifically include consideration of inequalities).

The triple aim is a legal duty on NHS bodies which requires them to consider the effects of their decisions on:

- the health and wellbeing of the people of England (including inequalities in that health and wellbeing)
- the quality of services provided or arranged by both themselves and other relevant bodies (including inequalities in benefits from those services)
- the sustainable and efficient use of resources by both themselves and other relevant bodies.

To meet these objectives, ICSs need to reach beyond the NHS to bring together local authorities, VCSE organisations and other local partners.

These are complex reforms, and it is vital that they are underpinned by a clear narrative describing how they will benefit patients, service users and communities. Working alongside National Voices, Age UK and the Richmond Group of charities, The King's Fund has developed a joint vision (https://www.nationalvoices.org.uk/sites/default/files/public/publications/reform_for_people_-_a_joint_vision_for_integrating_care_0.pdf) that sets out what integrated care and partnership working could mean for people and communities. It will be important for ICSs to not lose sight of these core objectives, and to find ways to hear from local communities (/publications/understanding-integration-listen-people-communities) and involve them (/projects/lessons-wigan-deal) directly in their work.

Where did ICSs come from?

ICSs have been developing for several years. They evolved from sustainability and transformation plans/partnerships (STPs) (/topics/integrated-care/sustainability-transformation-plans-explained) – geographical groupings of health and care organisations formed in 2016 to develop 'place-based plans' for the future of health and care services in their areas. Since then, local systems have been strengthening these partnerships (/publications/year-integrated-care-systems) and working through them to plan and improve health and care.

Over recent years, the work of ICSs (and before them STPs) has focused on a number of areas, including:

- reaching a shared view between system partners of local needs and the resources available for health and care
- agreeing a strategic direction for local services based on those needs and resources
- driving service changes that are needed to deliver agreed priorities
- taking a strategic approach to key system enablers, for example by developing strategies around digital technologies, workforce and estates
- establishing infrastructure and ways of working to support collaborative working, for example by putting in place new governance arrangements to enable joint decision-making and agreeing system-wide leadership arrangements
- strengthening collaborative relationships and trust between partner organisations and their leaders.

Until July 2022, there was no statutory basis for these arrangements. STPs and ICSs were voluntary partnerships that rested on the willingness and commitment of organisations and leaders to work collaboratively. This meant that progress sometimes had to be made through workarounds to the legislative framework, creating complex and protracted decision-making processes and leading to concerns around transparency and accountability. This has all changed with the 2022 Health and Care Act and the establishment of ICSs as legal entities. However, it is also important to recognise the limitations of what this legislation can realistically achieve. It is not possible to legislate for collaboration and co-ordination of local services; this requires changes to behaviours, attitudes and relationships among staff and leaders right across the system.

In contrast to previous attempts at NHS reform, national NHS bodies have adopted a relatively permissive approach allowing the design and implementation of ICSs to be locally led within a broad national framework. As a result, there are significant differences (https://www.health.org.uk/publications/long-reads/integrated-

care-systems-what-do-they-look-like) in the size of systems and the arrangements they have put in place, as well as wide variation in the maturity of partnership working. The statutory requirements for ICSs have created greater consistency in their governance arrangements and responsibilities, but still leave significant flexibility for systems to determine their own arrangements. This means that much remains to be seen in terms of how the reforms are implemented locally.

Variation in how ICSs have developed means they can be complex and difficult to understand. But systems of care and the health needs of local populations are themselves complex in ways that don't lend themselves to simplicity and standardisation. The flexibility ICSs have been given has the advantage of enabling them to develop arrangements to suit their local contexts, respond to population needs and build on their existing strengths, and could help to engender a greater sense of local ownership of and commitment to the changes than in previous NHS restructures.

What do ICSs look like?

How ICSs are structured

As set out above, statutory ICSs include two key parts: an ICB and an ICP. This section sets out further detail on each of these structures and the interface between them.

Integrated care boards (ICBs)

The role of the ICB is to allocate the NHS budget and commission services for the population, taking over the functions previously held by clinical commissioning groups (CCGs) and some of the direct commissioning functions of NHS England. The ICB is directly accountable (/publications/understanding-accountabilities-structures-health-care) to NHS England for NHS spend and performance within the system. ICBs may choose to exercise their functions through delegating them to place-based committees (see below) but the ICB remains formally accountable.

Each ICB must prepare a five-year system plan setting out how they will meet the health needs of their population. In developing this plan and carrying out their work, the ICB must have regard to their partner ICP's integrated care strategy and be informed by the joint health and wellbeing strategies published by the health and wellbeing boards in their area (https://www.gov.uk/government/publications/joint-strategic-needs-assessment-and-joint-health-and-wellbeing-strategies-explained). In addition, the ICB and its partner NHS trusts and foundation trusts must develop a joint plan for capital spending

(spending on buildings, infrastructure and equipment) for providers within the geography.

The ICB operates as a unitary board, with membership including (at a minimum); a chair, chief executive officer, and at least three other members drawn from NHS trusts and foundation trusts, general practice and local authorities in the area. In addition, at least one member must have knowledge and expertise in mental health services. ICBs have discretion to decide on additional members locally. Each ICB must also ensure that patients and communities are involved in the planning and commissioning of services.

ICBs must not appoint any individuals to their board whose membership could reasonably be regarded as undermining the independence of the health service. This requirement is intended to ensure that private sector organisations do not exert undue influence and that their participation is to the benefit of the system, reflecting sensitivities around private sector involvement in the NHS.

Integrated care partnerships (ICPs)

The ICP is a statutory joint committee of the ICB and local authorities in the area. It brings together a broad set of system partners to support partnership working and develop an 'integrated care strategy', a plan to address the wider health care, public health and social care needs of the population. This strategy must build on local joint strategic needs assessments and health and wellbeing strategies and must be developed with the involvement of local communities and Healthwatch. The ICB is required to have regard to this plan when making decisions.

There is significant flexibility for ICPs to determine their own arrangements, including their membership and ways of working. Membership must include one member appointed by the ICB, one member appointed by each of the relevant local authorities, and others to be determined locally. This may include social care providers, public health, Healthwatch, VCSE organisations and others such as local housing or education providers.

> Take a look at our diagram (/node/94444) illustrating the structure of integrated care systems and other key local planning and partnership bodies.

This dual structure was designed to support ICSs to act both as bodies responsible for NHS money and performance at the same time as acting as a wider system partnership. It remains to be seen how this will work in practice,

including how the two bodies will relate to one another and what dynamic will emerge between them. For example, it may be difficult for ICPs to have real clout in the system and drive the agenda of their ICS when much of the resource and formal accountabilities sit with the ICB.

Some systems are further ahead (https://www.wypartnership.co.uk/application/files/9916/5729/3814/West_Yorkshire_functions_ar in embedding these arrangements than others, and in many cases the formation of the ICP lagged behind (https://www.hsj.co.uk/policy-and-regulation/boards-responsible-for-integration-strategy-unlikely-to-be-fully-operational-before-autumn-2022/7030956.article) the initial establishment of the ICB (which was held to tighter deadlines due to the legislative timetable).

Systems, places, neighbourhoods

A key premise of ICS policy, and a core feature of many of the systems that have been working as ICSs the longest, is that much of the activity to integrate care, improve population health and tackle inequalities will be driven by commissioners and providers collaborating over smaller geographies within ICSs (often referred to as 'places') and through teams delivering services working together on even smaller footprints (usually referred to as 'neighbourhoods'). This is important as ICSs tend to cover large geographical areas (typically a population of more than 1 million people) so aren't well suited to designing or delivering changes in services to meet the distinctive needs and characteristics of local populations.

This three-tiered model of neighbourhoods, places and systems is an over-simplification of the diverse set of arrangements seen in reality, but the terminology is now in widespread use within the health and care system. National policy (https://www.gov.uk/government/publications/health-and-social-care-integration-joining-up-care-for-people-places-and-populations) and guidance (https://www.england.nhs.uk/publication/integrating-care-next-steps-to-building-strong-and-effective-integrated-care-systems-across-england/) has made it clear that ICSs will be expected to work through these smaller geographies within their footprints.

An overview of neighbourhoods, places and systems

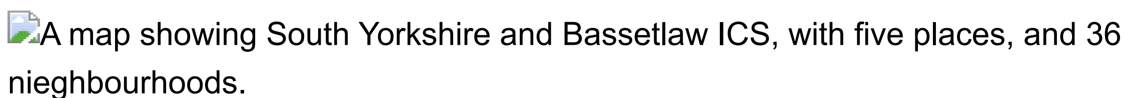
Neighbourhoods (covering populations of around 30,000 to 50,000 people*): where groups of GP practices work with NHS community services, social care and other providers to deliver more co-ordinated and proactive care, including through the formation of primary care networks (/node/93397) (PCNs) and multi-agency neighbourhood teams.

Places (covering populations of around 250,000 to 500,000 people*): where partnerships of health and care organisations in a town or district – including local government, NHS providers, VCSE organisations, social care providers and others – come together to join up the planning and delivery of services, redesign care pathways, engage with local communities and address health inequalities and the social and economic determinants of health. In many (but not all) cases, place footprints are based on local authority boundaries.

Systems (covering populations of around 500,000 to 3 million people*): where health and care partners come together at scale to set overall system strategy, manage resources and performance, plan specialist services, and drive strategic improvements in areas such as workforce planning, digital infrastructure and estates.

* Population sizes are variable – numbers vary from area to area and may be larger or smaller than those presented here. Systems are adapting this model to suit their local contexts, for example some larger systems have an additional intermediate tier between place and system.

Map 2 An example of the places and neighbourhoods within an ICS


A map showing South Yorkshire and Bassetlaw ICS, with five places, and 36 nieghbourhoods.

There is no simple answer for which activities should sit at which level due to wide variation in the scale and characteristics of local areas. As a consequence, the exact division of roles and responsibilities between ICSs and their constituent places and neighbourhoods has not been laid out in legislation or guidance. Instead, there is freedom for this to be determined locally with an expectation that decisions should be based on the principle of subsidiarity , meaning ICSs will take responsibility only for things where there is a need to work at scale. Local systems are taking different approaches to applying this principle, for example West Yorkshire ICS has agreed three 'subsidiarity tests (https://www.wypartnership.co.uk/application/files/6716/5703/3676/NHS_West_Yorkshire_ICB_C ' to determine whether something should be led by the wider system or by the local places within it.

ICSs will be expected to delegate significant responsibilities and budgets to place-based partnerships, as stressed by the government's integration White Paper (https://www.gov.uk/government/publications/health-and-social-care-integration-joining-up-care-for-people-places-and-populations) and the guidance document *Thriving places* (https://www.england.nhs.uk/wp-content/uploads/2021/06/B0660-ics-implementation-guidance-on-thriving-places.pdf) . The 2022 Health and Care Act

made provision for the formation of place-based committees (which can be established as subcommittees of the ICB) but left flexibility for local areas to determine how these should be formed and how they will operate. Outside of the legislation, the recent integration White Paper set out a greater degree of formality and national oversight of these arrangements, and outlined plans to introduce minimum expectations around place-level governance, leadership arrangements and a new shared outcomes framework from April 2023.

For more detail on the formation of place-based partnerships, and the relationship between place and system, see our report, *Developing place-based partnerships (/publications/place-based-partnerships-integrated-care-systems)*.

What does this mean for commissioning?

The 2022 Health and Care Act entailed significant structural change for NHS commissioning. CCGs were abolished, with their functions and many of their staff transferred into ICBs. ICBs have also taken on some commissioning responsibilities from NHS England (https://www.england.nhs.uk/wp-content/uploads/2022/05/PAR1440-letter-roadmap-for-all-direct-commissioning-functions-may-2022.pdf), including the commissioning of primary care and some specialised services (with a plan (https://www.england.nhs.uk/publication/nhs-england-commissioning-functions-for-delegation-to-integrated-care-systems/) for further delegation over time), giving local systems a greater say in how budgets for these services are spent in their area.

These shifts build on changes to commissioning (/publications/what-commissioning-and-how-it-changing) that have been underway for several years. Before their abolition, many CCGs had been working more closely together at a system level through joint management structures or formal mergers and the number of CCGs had fallen significantly. At the same time, many CCGs were working more closely with local councils at 'place' level to align and integrate commissioning for NHS and local authority services, and some larger CCGs were organising some of their functions across a system-wide footprint and other functions around place footprints.

The legislation has also changed procurement and competition requirements, removing the requirement for mandatory competitive retendering (supported by a new provider selection regime, due to be implemented by December 2022).

This is all part of a shift towards strategic commissioning (/publications/thinking-differently-commissioning) and a more collaborative approach to planning and improving services. This means that, instead of focusing on procurement and

contract management, the role of commissioners is to work closely with key partners across the system (including with providers) to understand population needs, determine key priorities and design, plan and resource services to meet those needs.

What does this mean for NHS providers?

NHS providers are increasingly being expected to look beyond their organisational priorities to focus on system-wide objectives and improving outcomes and reducing inequalities for the communities they serve. While the legal functions and duties of NHS trusts and foundation trusts remain largely unchanged under the recent reforms, they are also expected to participate in multiple collaborative forums, including membership of the ICB and forming collaboratives with other providers (/publications/provider-collaboratives) . NHS trusts and foundation trusts are also now bound by a new duty to collaborate with local partners and a shared duty to promote the triple aim (see above).

NHS providers are already playing a critical role in the changes underway in many systems, contributing to and/or leading work at ICS level to plan and transform services and improve system performance, and collaborating with other local providers (including those from outside the NHS) at place and neighbourhood levels to redesign care pathways and deliver more integrated services for local people.

The policy intention is that commissioners and providers should increasingly be working hand in hand to plan care for their populations. While distinct commissioning and provision responsibilities still formally sit in separate organisations, in practice the division is becoming increasingly blurred (for example, as providers are represented on the ICB). Fundamentally, a key principle in the reforms is that providers are part of the ICS – just as much as the ICB and ICP are – and as such they are being asked to take on wider responsibilities for the performance of the whole system.

What does this mean for local government?

Since ICSs first began developing in 2016, the involvement of local government has varied widely (/publications/articles/health-wellbeing-boards-integrated-care-systems) . The King's Fund has argued (/publications/year-integrated-care-systems) that, for ICSs to succeed, they will need to function as equal partnerships with local government not just involved but jointly driving the agenda alongside the NHS and other key partners. Importantly, partnerships between local government

and NHS organisations are also developing at the level of 'place', which is usually coterminous with local authority boundaries.

The involvement of local government in ICSs and place-based partnerships can bring three key benefits. The first is the opportunity to join up health and social care at all levels in the system, creating better outcomes and a less fragmented experience for patients and users. The second is the potential to improve population health and wellbeing and tackle inequalities through the leadership of public health teams as well as NHS and local government acting together to address wider determinants of health such as housing, local planning and education. Finally, the involvement of local government can enhance transparency and accountability through supporting engagement with local communities and providing local democratic oversight.

Within the new statutory ICS structures, the involvement of local government has been formalised through the ICP and through the direct representation of local authorities on the ICB. In addition, ICSs must draw on the joint health and wellbeing strategies of their local health and wellbeing boards in producing their integrated care strategies and five-year system plans.

However, now that ICBs have significant NHS budgets and responsibilities, there is a risk of their focus on NHS resources and performance crowding out wider system priorities and undermining the sense of equal partnership many systems have worked hard to nurture. This is already causing tensions between the NHS and local government (https://www.hsj.co.uk/integrated-care/icss-are-an-nhs-steamroller-says-disrespected-council-leader/7032734.article) in some areas.

What does this mean for VCSE organisations?

VCSE organisations play a critical role within local health and care systems both as service providers and as vehicles for community engagement and voice. They are therefore important strategic partners for ICSs in terms of delivering improvements in health and wellbeing and reducing inequalities – which often involves working more closely with communities.

The involvement of VCSE organisations within formal ICS structures is open to local determination, but national guidance (https://www.england.nhs.uk/wp-content/uploads/2021/06/B0905-vcse-and-ics-partnerships.pdf) has set clear expectations that they should be involved both within the governance structures (for example, through membership of the ICP) and in delivering key workstreams.

Resource constraints and the diversity of the sector can both act as barriers to the participation of VCSE organisations, and their involvement in shaping priorities, plans and decisions at system level remains limited in many cases. In some systems, VCSE alliances or infrastructure organisations are playing an important role in bridging this gap, while other ICSs have identified funding for a dedicated post or function. Importantly, VCSE organisations also have an important role at place and neighbourhood levels.

What does this mean for oversight and regulation?

Despite the focus on collaboration and system-working in recent years, the primary focus of NHS regulators has continued to be on managing the performance of individual organisations. The interventions and behaviours of the regulators have sometimes made it more difficult for organisations to collaborate. Over time, national and regional NHS bodies will be expected to shift their focus to regulating and overseeing systems of care (alongside their existing responsibilities in relation to individual organisations), increasingly working alongside local systems to support them to change and improve services.

In line with this ambition, NHS England is developing a new operating model. This will build on changes that have already been made to the work of its national and regional teams (including bringing together the regulation of commissioners and providers through the merger of NHS England and NHS Improvement). A new integration index (/blog/2019/07/meaningful-measures-integration) is also under development to better measure the success of efforts to integrate care from the perspective of patients, carers and the public.

At the same time, the CQC is adapting its approach to monitoring and inspection to better reflect system working. The 2022 Health and Care Act introduced a duty on the CQC to review health care and adult social care in each ICB, including looking at how partners in the ICS are working together.

How will we know if ICSs are working?

ICSs will be accountable nationally to NHS England, via their ICB, for NHS spending and performance. They will be expected to achieve financial balance and to meet national requirements and performance targets.

In addition to these national accountabilities, ICSs also have the potential to nurture different forms of oversight to drive local improvements in care. This is

because ICSs are partnerships in which local organisations exercise collective leadership and work towards developing a sense of mutual accountability for resource use and outcomes. This may take the form of peer challenge and support from partners within an ICS, drawing on local data on performance and outcomes.

Importantly, to really understand whether their work is making a difference, ICSs will need to use insights from local people including patients, service users and families. As we have argued in previous work (/publications/understanding-integration-listen-people-communities) , the best way to understand whether integration is delivering results is through the eyes of people using services.

Where next?

The coming months will be a critical period for the development of ICSs as they begin operating as statutory bodies. Ultimately, whether or not these reforms succeed will come down to how they are implemented locally, and whether the right national conditions can be created to support their work.

It won't be easy to find the bandwidth to do the hard work of changing ways of working (/blog/2022/03/integrated-care-systems-need-to-be-different) at a time when health and care services are under such pressure, and there is a risk (/blog/2022/07/are-ics-getting-right-start) that established ways of working will be recreated within the new structures. To avoid this, ICSs will need to keep sight of their core objectives and the ethos of system working behind their development.

Evidence from previous attempts to integrate care indicates that these changes will take time to deliver results. This means that local and national leaders need to make a long-term commitment to the development of ICSs and avoid the past mistake of moving swiftly to the next reorganisation if desired outcomes are not rapidly achieved.

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The first days of statutory integrated care systems: born into a storm

01 December 2022

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On 1 July 2022, integrated care systems (ICSs) finally arrived in statutory form, some five years after their initial conception through the first of the sustainability and transformation plans.

ICSs are partnerships that bring together NHS organisations, local authorities and others (/publications/integrated-care-systems-explained) to take collective responsibility for planning services, improving health and reducing inequalities across geographical areas. There are 42 of them in England. They stem from a recognition (https://www.england.nhs.uk/five-year-forward-view/) that the traditional barriers between GPs, hospitals and community services, between physical and mental health, and between health and social care need to be broken down to provide care that is much better integrated. So that people with multiple health conditions, not just single diseases, are better supported. Integral to the concept is that a much stronger emphasis needs to be placed on prevention, on population health and on tackling socio-economic inequalities and the health consequences that flow from them – things that neither local authorities, nor the NHS can achieve on their own, even when working with the voluntary, community and social enterprise (VCSE) sector.

Following the 2022 Health and Care Act (/publications/health-and-care-act-key-questions) , what in most places was a single non-statutory partnership board for an ICS has been replaced by two statutory parts: an integrated care board (ICB), responsible for NHS services but with much wider duties, and a statutory integrated care partnership (ICP), convened by local government and the NHS, which brings together local authorities, the VCSE sector and others concerned with health and wellbeing to develop a health and care strategy for the ICS. ICPs have until December to produce a draft of these strategies, which the ICB will be

required by law to take into account when commissioning and delivering NHS services. And the near alliteration between an ICB and an ICP operating as part of an ICS does not making explaining any of this to non-specialists easy, especially verbally.

The King's Fund has been following the development of integrated care systems since 2017. Over this time, we have conducted several pieces of research including interviews with senior system leaders (/publications/leading-integrated-care) as the concept has developed. To continue this work, over the summer and early autumn of 2022, we spoke to 25 chairs and chief executives of ICBs and chairs of ICPs, asking them to reflect on the creation of the new bodies, and their very earliest days as statutory entities.

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Context

It is only fair to open by noting that ICSs have been born into the mother of all storms.

- There has been huge political instability, with three prime ministers and three secretaries of state for health and social care, over the period these interviews took place.1 (#footnote1_tfq5ard)
- There has been massive economic instability.
- Record numbers are waiting for treatment and many, though not all, waiting times are getting worse.
- Inflation is hitting local government finances and eroding the real-terms spending increases that the NHS was meant to be receiving. There is talk of the entire public sector needing to produce more 'efficiencies', which threatens budgets further.
- There are big staff shortages in both social care and health.
- Ballots are being held, or being considered, for industrial action over NHS pay.
- NHS Digital and Health Education England are being merged into NHS England with up to 40 per cent of their workforce expected to go (https://www.hsj.co.uk/workforce/6000-plus-jobs-to-be-cut-at-new-nhs-england/7032760.article) . That inevitably leaves NHS England's regional staff, among others, worried about their jobs.
- Over the summer, ministers have been introducing new rather than fewer targets.
- ICSs now have statutory duties to reduce health inequalities, and to improve population health. The cost-of-living crisis, however, looks certain to send those numbers in the wrong direction, at least in the short term.

For some, this is the burning platform that will force change. For all, it is deeply challenging. And so fast have circumstances changed that it already feels as though the world has moved on since some of the earliest of these interviews were conducted.

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1 (#footnote1_tfq5ard) Arguably four health and social care secretaries if you count Steve Barclay's return after an initial two-month stint in the summer.

Balancing competing priorities

The NHS and local government always face competing priorities. But the context outlined above, set against the new statutory duties to take greater account of population health and health inequalities, means that balancing 'the next five

minutes against the next five years', as one ICB chief executive puts it, feels particularly tough.

One effect of that, in the eyes of many of those we spoke to, is that the chairs of ICBs have a particularly crucial role to play.

All the ICB chief executives we spoke to are committed to, indeed excited by, the broader integration and population health goals that are at the heart of the ICS concept. But they are under huge operational and financial pressure over the day-out, day-in business of the NHS. They – and, very much, the chairs themselves – see a key role for the chair being to ensure the ICB keeps its eyes trained on the further horizon: the end goal of all of this.

This is explained most eloquently by one ICB chief executive, who says:

> *All my interview questions were about health inequalities, population health, social and economic wellbeing, and about how I was going to lead. A completely values-based interview. Which was brilliant. I want that. But that is not what the government wants us to be focused on at the moment. What I am going to be measured on is not those things. [I am] going to be [measured on] a safe winter, the money being delivered, waiting times, and basically getting performance there or thereabouts. So I completely agree that a core part of the chair's job is to make sure we retain the focus on our broader statutory duties.*

There must be a danger that the intense short-term pressures will undermine the longer-term agenda for which ICSs have been created. In some places, the fact that the chair of the ICB and the ICP is the same person, is seen as a guard against that – a point to which we return below.

Developing new forms of accountability

Accountability within the NHS

One of the bigger shifts that the legislation brings, at least in theory, is changes to accountability. Before exploring that, it is important to say that there is a lot of variation in terms of how developed ICSs are, precisely how they are operating, their relations with local government and their bigger providers, and in their relations with NHS regions and NHS England (again, a point to which we will return).

But the key point here is that up to now ICSs have essentially been coalitions of the willing. ICBs are now statutory organisations, with much NHS revenue flowing

through them, and with some influence over capital (or however much capital survives the coming spending squeeze). That, in theory, provides an authority over the constituent NHS organisations which, in systems where co-operation and joint ownership are already strong, has not really been needed. In others it puts a clear duty on NHS providers to work with the ICS – although, it must be said, several of our interviewees saw the continued relative independence of foundation trusts as a problem, and one ICB chair fears that the big provider collaboratives, particularly those centred on teaching hospitals, will be 'the cuckoo in the nest. They will eject the ICS'.

More positively, one ICP chair from local government says:

> *In my patch, I think the acute trusts have woken up to the fact that the ICB is actually where things are going to happen. And it's quite interesting sitting on the ICB board because – how shall I put it? – there is a bit of manoeuvring going on as you see the acute trusts trying to ensure that they still have the sort of influence that they're used to having.*

Or as one ICB chair puts it:

> *Quite simply, under the Act, the integrated care board is collectively accountable for the performance and the finances of the NHS in our system. So we're accountable for not just the money in the way that the clinical commissioning groups were as commissioners. We're accountable for the total system. But we don't own and run the providers.*
>
> *So establishing an understanding and a framework of mutual accountability and holding each other accountable inside the system is absolutely key. And that does include mutual accountability between the NHS and social care, with the performance of those two totally interdependent.*

It remains to be seen how far the legislation will, in practice, give the ICB teeth in those parts of the country where collaboration and integration within the NHS are weakest.

Accountability with local government

ICBs, are of course accountable to NHS England. But, under the legislation, they are also accountable to local government and the VCSE sector through ICPs and the strategic plans that are due in draft in December.

One ICB chief executive puts it this way: ‘I am accountable to both the ICB and the ICP – definitely.’ One ICB chair says: ‘If we and enough of the 42 systems do not have a lot of support locally, which we will only get by showing progress and involving people, then we’ll be swept away, and this huge opportunity will have been lost.’

It is far too early to be sure how, in the longer run, the new statutory arrangements will affect the relations with local government. Some ICPs did not have a chair when this round of interviews started, and many have had only one or at most two meetings.

One ICP chair says: ‘The big test will come when the ICP strategies are in draft form, as to what degree the ICBs will be ready to take mandates from the ICPs. And how far there are local priorities.’ Critical to that, he says, ‘will be the ICS view of subsidiarity’. This chair says he knows of one ICS ‘that is totally committed to subsidiarity and will delegate funds into each of the alliances that sit below. So that you have really locally based solutions. Another one is fairly committed, another is much more centrist.’

But while it is early days, some say that the move from coalitions of the willing to a statutory basis has seen greater engagement from some of the less-engaged local authorities. Indeed, the size of some ICB boards reflects a desire by some local authorities to ensure they have a seat where at least some of the real action may be.

One ICP chair says the fact that all this is now in statute ‘is definitely starting to change the conversation’. And given the population health duties of both ICPs and ICBs, this chair sees directors of public health, who are located in local government, as key to progress.

> *Public health is almost like a sort of honest broker between the NHS and local government. It should have various programmes to do with obesity and mental health et cetera, and to actually get the NHS to think beyond the acute, to actually think about health prevention. Getting to people before they become ill.*

The acid test, according to one ICB chair with a background in both local government and health, will be: ‘How much is the ICP going to be the ornamental part of the new arrangements and how much is it going to be an engine for change?’

One difference across systems is that in some, the same person chairs both the ICB and the ICP while in others, there are separate chairs. This is an area where the flexibility that characterised the way ICSs were originally set up has survived.

The debate is intriguing. Those areas that have gone for a joint chair argue that doing so helps demonstrate the NHS commitment – the ICB's commitment – to the work of the ICP. By contrast, where there are separate chairs, both the ICB chair and people from the local authority side argue that having a single chair would only fuel fears that the NHS will dominate the ICP. As one local government person puts it:

> *The NHS has all these targets and this top–down approach. And when you turn the old partnerships into statutory NHS bodies, with accountability through to the head of the NHS, that cannot be the vehicle for partnership. So it has to be done differently, with the ICP as a genuine partner.*

Time may tell which of these two approaches works best, although it may prove immensely difficult to assess that. And it may be that 'what works best locally' is indeed the answer.

Accountability for poor performance

Many of those interviewed believe that an absolutely key part of their accountability is to use the joint resources of the ICS to sort out troubled or failing institutions within it – at least in the first instance. This view was not universal. More than one feels that responsibility for that should lie with regional and national teams within NHS England.

Many, however, including some of the ICP chairs from local government to whom we spoke, believe this to be an essential role for the ICS – perhaps drawing on regional resources, but with those being the partner in the process, not the imposer.

One ICB chair says:

> *In the old system that didn't work. You'd have a troubled trust getting different requirements from different parts of the system. There would be the CQC* [Care Quality Commission] *report, the national improvement team bit, the regional bit and the CCG* [clinical commissioning group] *bit, with differing messages about what needed to be done, and none of it coherent. We have to bring coherence to that.*
>
> *We* [the ICB] *have to fill that gap, with a clear unambiguous plan for improvement and where people have to get to by when. We have to equip ourselves to be able to do it, and we have to be accountable for*

it. If ICBs are either incapable or unwilling to grab that space, they're not going to be around for very long. They will just have become another post box for the money.

According to this chair, that is already happening with one trust in their patch that has a long-troubled history, with the region and the national improvement team working closely with the ICB to produce a single view of what is needed for recovery. But that collaborative approach is not seen universally, which brings us on to relations with national bodies and regional teams.

Recasting the relationship with NHS England and its regional teams

Both before and after the recent operating framework, ICB chief executives and chairs report continued direct intervention from NHS England with individual trusts, from both the centre and regions.

One says:

There has to be a different interface with the region and what they do and what they don't do, and the same applies nationally. But it is fair to say national can't help themselves from going straight to chief execs of individual trusts to beat them up about elective care or ambulance waits and generally forget to involve me or the ICB.

I think in our region, they are trying their best to not to do that, but sometimes region doesn't know what NHSE is doing nationally. We do need to be clearer about what the role of region is going to be. I am certainly keen to step into the space of taking on a number of regional responsibilities.

There was much support for Chris Ham's recent paper for the NHS Confederation (https://www.nhsconfed.org/publications/governing-health-and-care-system-england), which argues that if ICSs are to be a success much more decision-making has to be devolved to them, and by them to neighbourhoods and places, with a much less command-and-control approach – with the number of staff working at the centre and in regions reduced substantially to enable ICSs to fulfil their potential as system leaders. Or as one ICB chair puts it: 'We need a peer-to-peer relationship with the region, not an adult–child one.'

In the time available it has not been possible to return to earlier interviewees to get their view of more recent developments. But the impression is that central intervention has risen since the earliest interviews, not least since Therese Coffey

enunciated her 'ABCD' priorities of 'ambulances, backlogs, care, doctors and dentists'. And that despite earlier [NHS England guidance](https://www.england.nhs.uk/nhs-oversight-framework/) (https://www.england.nhs.uk/nhs-oversight-framework/) , and the operating framework, stressing a more devolved approach. Quite what Steve Barclay's stance will be remains to be seen.

One ICP chair says:

> *The NHS is very command and control. In our area, regionally and nationally, the NHS and the Department of Health and Social Care are carrying on as before. And the NHS does like to control the narrative to the letter. I'm co-chair of the integrated care partnership and I'm really quite amazed at what the comms in the NHS put in front of me, as if they know exactly what I am going to say. And I'm not used to that as an elected member – at all!*

Relationships between ICSs, the regions and the centre, clearly do vary. One highly experienced ICB chief executive says:

> *We've got good senior people in the region and the regional director understands subsidiarity. So we just get on with it. We do things together. We decide which challenges we want to work on collectively. And the region often shields us from some of the stuff that rains down on them. And we'll call it out when, nationally, they intervene directly with organisations, or whatever. So, we tend to have a really good relationship with the region. But I appreciate it's different in other places, where they might have 11 ICSs to deal with and they take a more straightforward historical approach to performance management.*
>
> *I do think Amanda* [Pritchard, Chief Executive of NHS England] *and the team have tried to get into this ethos of 'It's system by default, let's try and do things in the right way.' I think they have been trying to put a stop to direct intervention without involving the ICS or ICB.*

Or, as others put it, it is the layers in between where the issue lies. One ICP chair says: 'It is in middle management where I think we have the problem,' while an ICB chief executive says: 'It is not the top bods. It's those thousands of people in NHSE where that's their job. And either it is because there isn't faith in the ICB team, and/or because the NHS regional team are threatened by not having an existence.' Another ICB chair makes this point even more forcefully: 'I personally have found really quite egregious the extent to which relatively junior people at a regional level have acted and used the authority of their regional position to completely undermine more senior people working within their systems.'

The role of national politicians and regulators

These are interviews only from the field, so to speak. Alternative views from NHS England, the Department, the minister, and others have not been sought. Nonetheless there were some clear asks from system leaders directed at ministers and the Department of Health and Social Care.

The local government chair of one ICP says:

> *One thing I would really encourage you to say is that government came forward with integrated care systems as a principle, and it is all now in law. But when you talk to some of the civil servants in the Department on the social care side, they are just a tiny little bit within the Department, and they have to really battle to be even heard by the health side of it. Within their own Department that transformation* [of better integration] *hasn't taken place. And in many ways it is holding back integration on the ground. Because if the NHS is still being given guidance, and having the big stick waved at individual organisations, not looking at it across the system like we need to, then that's not helping them to do what we want to do locally.*

Complaints about excessive targets and too many central initiatives are longstanding. But they remain, sometimes put most strongly by ICB chairs who might feel most at liberty to deliver them. As one chair put it most colourfully:

> *The way the centre and politicians think that they can have an impact is to set targets and launch initiatives. So there is a new discharge programme someone has discovered, or a great way of getting people through A&E and into hospital, or some other great new programme we want you to report on and a little sliver of money comes with it. And then the initiative and the money runs out. But they still want us to report on it and then some other numb-nut idea comes down from the centre. Politicians need to stop tinkering...* [they] *need to tackle the big issues of workforce, of adult health and social care, of integration and in my view solve the foundation trust problem. Stop promising the population short-term improvements. Stop saying 'A, B, C and D' – it just does not come down to something as simple as that.*

One emerging issue that is not yet at the top of most people's agenda, but is a worry, is how ICSs will be inspected and rated. Several ICSs have been working with the Care Quality Commission (CQC) on how to develop an inspection regime for systems – with most acknowledging that measuring how well integration is going will not be easy. There are questions, for example, about whether one

failing organisation in an ICS will produce a severe down marking. One ICB chief says:

> *It seems to me that you can't be an outstanding trust in a deficit system, or you can't be an outstanding trust if another organisation in your place is not. That is where the CQC could be really helpful in terms of driving collaborative behaviour. What better incentive would you want, as an ICS leader, to have everybody actually coming together to work on your weakest link? So if anything is inadequate in any bit of your place, nobody gets outstanding. Something like that would be incredibly powerful.*

Others take a very different view. That it would not be fair if one struggling organisation saw an entire system severely marked down when it was otherwise performing well.

Partnership working in local places

These interviews did not get into the detail of what is happening at a more local level through place-based partnerships (/publications/place-based-partnerships-explained) . The impression from these interviews, however, is that some quiet progress has continued there, even as the superstructure of ICSs has been changing. The picture is, however, enormously variable.

By way of example, one ICP chair says some local GP practices are very good at engaging the wider health community and council services:

> *...and that actually supports them, and takes some of the pressure off. Other GP surgeries just really want people to come in the door and go away again. They're not interested in what's going on beyond. And I think that's one of the prime targets for the ICP.*
>
> *We haven't, as an ICP, got any real power. But an ICP has soft power, and where we can see areas in the system that aren't working properly, we can start to have discussions about why not?*
>
> *We have one local partnership that is very good, all-singing, all-dancing. We've got one that's only really woken up to the fact that it exists. And over the next 12 months we want a real push to try and even them up a bit. Because that is where all the different aspects of health, with the community, the voluntary sector, the NHS and local government come together. The real integration.*

But many of the acute hospitals don't like it because it means that the focus will end up being taken away from them, including some resources. To put more resource at place. And to try to reduce the number of people that actually need an acute service.

Managing the change

Creating statutory ICSs has been, for many, a bigger change than originally billed. Initially canvassed as mainly putting a statutory framework around what was already happening, it has, in many systems, produced significant (and very time-consuming) governance changes. Before the legislation, the 'top' of an ICS, so to speak, was in most places a single board that was a coalition of more or less willing partners from the NHS, local government and the VCSE sector. That has now been divided into two statutory boards – an ICB and an ICP, with the ICB required by law, when commissioning and delivering NHS services, to take into account the ICP's strategy (the first draft of which is due in December).

For the more advanced and mature ICSs, and despite the time spent on governance changes, this change to statutory status has been a relatively smooth evolution. As one ICB chief executive says:

Our ICB has been running since January, our ICP has been running since March, my exec team have been stable, and I've done a year's development with them. So in terms of the way we run our business, it's been exactly the same, and in terms of how I spend my day, it has been exactly the same.

For others, the change has felt, and has been, much bigger.

Some ICSs have come through this with few changes of key personnel, whether as chairs, chief executives, non-executive directors or other senior personnel in the ICB. In others there has been large-scale change, both for ICBs and in creating the ICP's membership.

For some, this has been a deliberate refresh. For others, it has been a knock-on effect from the new arrangements. It is worth noting however that David Flory, a former deputy NHS chief executive and now chair of one of the northern ICSs, once remarked that (/publications/worlds-biggest-quango-nhs-england) , on looking back at multiple NHS reorganisations over 30 years, their relative success or failure depended much less on the structures than 'the personalities, the relationships, the behaviours and the degree of trust between individuals, or lack of it'. As true today, he says, as ever, 'if not more so'. Building new trust between individuals where there has been a significant change of personnel will take time.

Making the new structures work

The division into ICBs and ICPs, with the need for cross-representation from local government in particular, has for some produced some very large, and potentially unwieldy, ICB boards. In at least one system the ICB has become huge because the local authorities did not feel they could represent their views collectively and therefore all wanted to be represented individually.

For some, these large boards do not matter, so long as the committee structures beneath the board and the local place-based partnerships, where much of the real integration needs to take place, work. The hope among some others seems to be that the size of the ICB board will be slimmed down in time as trust is built that the NHS is genuinely pursuing better integration with local government and the VCSE sector, and is acting on the goals of reducing inequalities and improving population health.

However, there is a worry, that is not shared by all, that the landscape now looks decidedly crowded. In a very different way, the 1974 re-organisation (which itself sought to integrate NHS care better) became a case of 'tears about tiers (https://www.health.org.uk/publications/reports/glaziers-and-window-breakers) ': too many tiers. The issue here is not just the number of tiers but the number of players that need to be involved, and it isn't simple.

Currently there is the Department of Health and Social Care, NHS England, the regions, an ICS consisting of an ICB and an ICP, and their constituent partner organisations, which include councils, the VCSE sector and some private providers. Then there are place-based partnerships that will need to interact with primary care networks (/publications/primary-care-networks-explained) and neighbourhood teams, and the continued role of health and wellbeing boards. Some do worry that there is risk of more talk than action. One ICP chair says: 'A lot of my colleagues politically say that to me, "Well, this will end up just being another talking shop." And my answer to them is, "You might be right, but if we don't engage, we'll never find out".'

Conclusion

ICSs, in their statutory form, have been born into deeply challenging times – politically, economically and in terms of performance. Workforce shortages abound in both health and social care and there are problems over pay.

No one has set ICSs up to fail. But there is a significant risk (https://www.nao.org.uk/press-releases/introducing-integrated-care-systems-joining-up-local-services-to-improve-health-outcomes/) that the context into which they have

been born makes it harder for the original vision of much better-integrated care to be fulfilled. The challenge is to continue to make progress to the destination even as the storms are weathered.

Given their history, there is a lot of variation in terms of how developed ICSs are, precisely how they are operating, and their relations with NHS regions and NHS England, which is itself undergoing a significant reorganisation. Not to mention differences in internal relations between local government, the VCSE sector and the NHS. There is much unfinished business.

If ICSs are to succeed, there needs to be a new and more consistent relationship with regional and national teams, and a willingness to allow forms of local and mutual accountability to take their place alongside the inevitable remaining vertical accountability to NHS England and national government. A willingness to let ICSs do the job for which they are envisaged. This new relationship appears to be developing in some places, but not all, and is under pressure from the context.

Now that ICSs are statutory, there are undoubtedly reports that, for some, the relationships with acute trusts are improving, that care is continuing to be better integrated, and that some parts of local government that were most sceptical have become more engaged. Compared to the early days of the sustainability and transformation plans, relations between local authorities and the NHS are, broadly speaking, much improved – even if it is, by definition, too early to tell how the interaction between the ICPs and the ICBs will play out in the long run.

Those we interviewed were, by definition, committed to the concept of ICSs. But their enthusiasm, and their belief that progress will be made was striking. 'This is the only one of the many reorganisations of the NHS that makes sense,' as one ICB chair puts it. Or in the words of a ICP chair from local government: 'Do I think the ICS is a force for good and it's something we should be doing? Absolutely.' Or in the words of another ICB chair, 'We have to make this work. If we do not, it will be a huge lost opportunity.'

To succeed, ICSs need both space and oxygen. Space is tight, given the wider context and current performance pressures. Oxygen includes of course the money, but also the freedom of action to deliver what they have been set up to do. Both must be provided.

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Place-based partnerships explained

03 November 2022
14-minute read
1 comment

Authors

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Place-based partnerships are collaborative arrangements between organisations responsible for arranging and delivering health and care services and others with a role in improving health and wellbeing. They are a key building block of the integrated care systems (https://www.kingsfund.org.uk/publications/integrated-care-systems-explained) (ICSs) recently established across England and play an important role in co-ordinating local services and driving improvements in population health.

Contents

- What are place-based partnerships? (https://www.kingsfund.org.uk/publications/place-based-partnerships-explained#what-are-they)
- What is the purpose of place-based partnerships? (https://www.kingsfund.org.uk/publications/place-based-partnerships-explained#what-is-their-purpose)
- What is a 'place'? (https://www.kingsfund.org.uk/publications/place-based-partnerships-explained#what-is-a-place)
- What are the expectations and requirements in national policy and guidance? (https://www.kingsfund.org.uk/publications/place-based-partnerships-explained#national-policy-and-guidance)
- How are place-based partnerships governed and led? (https://www.kingsfund.org.uk/publications/place-based-partnerships-explained#governance)
- What resources do place-based partnerships have at their disposal? (https://www.kingsfund.org.uk/publications/place-based-partnerships-explained#resources)
- How do place-based partnerships relate to health and wellbeing boards? (https://www.kingsfund.org.uk/publications/place-based-partnerships-explained#health-and-wellbeing-boards)
- What next? (https://www.kingsfund.org.uk/publications/place-based-partnerships-explained#what-next)

What are place-based partnerships?

There are currently around 175 place-based partnerships in England, typically covering populations of around 250–500,000 people (although this varies widely) – significantly smaller than the populations covered by ICSs. While ICSs can bring the benefits of working at scale to tackling some of the major strategic issues in health and care, smaller place-based partnerships within ICSs are better suited to designing and delivering changes in services to meet the distinctive needs and characteristics of local populations.

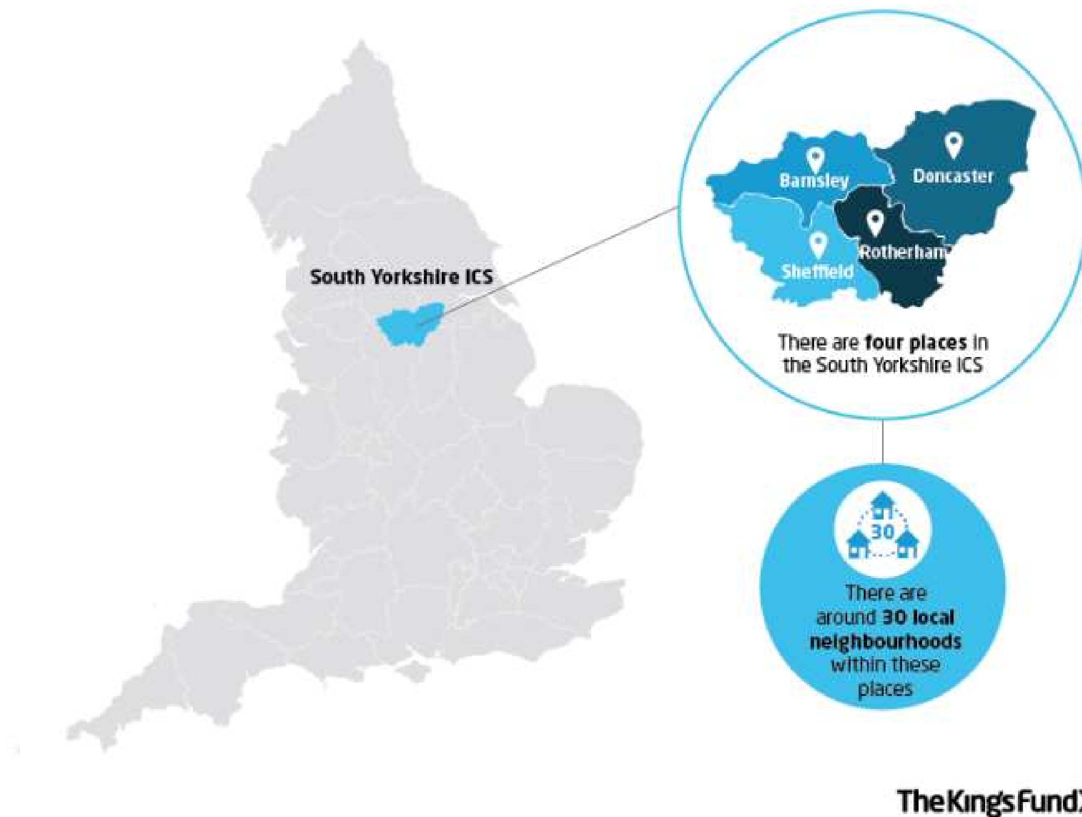
Place-based partnerships often (although not always) match the area covered by an upper-tier or unitary local authority (https://www.newlocal.org.uk/articles/local-government-explained-types/) . This means that in many areas, place is the level at which most of the work to join up budgets, planning and pathways for health and social care services will need to happen.

Place-based partnerships typically involve the NHS, local government and other local organisations with responsibilities for planning and delivering services, such as voluntary, community and social enterprise (VCSE) sector organisations and social care providers. They may also include or work alongside other community partners with an influence on health and wellbeing, such as schools, emergency services and housing associations, and work with people who use services, their carers and local residents.

Unlike ICSs, place-based partnerships are not statutory bodies. The 2022 Health and Care Act (https://www.kingsfund.org.uk/publications/health-and-care-act-key-questions) (which formalised ICSs as legal entities with statutory powers and responsibilities) did not create any legal requirements for place-based partnerships, leaving flexibility for local areas to determine their form and functions. This flexibility is welcome and necessary given that the characteristics and capabilities of place-based partnerships vary widely across the country.

Within places, even more-localised arrangements are being established around 'neighbourhoods' (https://www.england.nhs.uk/publication/next-steps-for-integrating-primary-care-fuller-stocktake-report/), where multi-agency teams can come together to deliver better joined-up, proactive and personalised care, building on the work of primary care networks (https://www.kingsfund.org.uk/publications/primary-care-networks-explained).

Figure 1 An example of the places and neighbourhoods within an ICS



What is the purpose of place-based partnerships?

Place-based partnerships exist to make more effective use of the combined resources available within a local area. The specific priorities of each place-based partnership will vary depending on the vision and goals agreed locally by partners. There are a number of common functions (as described in our report, Developing place-based partnerships (https://www.kingsfund.org.uk/publications/place-based-partnerships-integrated-care-systems)), including understanding and working with communities, joining up and co-ordinating services, addressing the social and economic factors that influence health and wellbeing, and supporting the quality and sustainability of local services (see Figure 2). These functions reflect the ways in which place-based partnerships have the greatest potential to add value over and above the contributions of individual organisations or entire systems.

Figure 2 Key functions of place-based partnerships

Understanding and working with communities	1. Developing an in-depth understanding of local needs 2. Connecting with communities

	Joining up and coordinating services around people's needs	3. Jointly planning and coordinating services 4. Driving service transformation
	Addressing social and economic factors that influence health and wellbeing	5. Collectively focusing on the wider determinants of health 6. Mobilising local communities and building community leadership 7. Harnessing the local economic influence of health and care organisations
	Supporting quality and sustainability of local services	8. Making best use of financial resources 9. Supporting local workforce development and deployment 10. Driving improvement through local oversight of quality and performance

Place-based partnerships need to focus on activities that complement the work of their ICS and vice versa. In principle, the 'system' tier focuses on strategic planning, overseeing overall resources and performance, planning specialist services and driving strategic improvements in areas such as workforce planning, digital infrastructure and estates. In contrast, place-based partnerships tend to be more focused on delivering tangible service change and engaging directly with communities – particularly in relation to community services, social care and primary care, and to tackle the wider factors that influence health and drive inequalities (*see* box below).

The exact balance of functions across system, place and neighbourhood levels will vary depending on local circumstances, meaning there is no simple answer to exactly which activities will sit at which level (and on many issues, complementary activity will be needed across all levels).

Examples of work led by place-based partnerships

- The Bradford District and Craven Health and Care Partnership (https://bdcpartnership.co.uk/transformation-programmes-our-year-in-review-2021-2022/) is delivering eight transformation programmes from 'Better Births' to 'Ageing Well'. One of these, the 'Healthy Hearts' programme, has seen VCSE sector organisations working closely with GPs to deliver health checks in community settings, enabling better uptake among people who have historically faced barriers in accessing preventive services.
- Nottingham City Place-Based Partnership (https://healthandcarenotts.co.uk/care-in-my-area/nottingham-city-pbp/priorities-programmes/) 's work includes a programme focused on 'severe multiple disadvantage' (living with a combination of homelessness, substance use, mental ill health, contact with the criminal justice system and domestic abuse). Central to this is a focus on sharing local intelligence – both to better identify people who may benefit from a more coordinated package of support and to encourage the delivery of preventive services to reduce the likelihood of needs escalating.
- The Healthier Wigan Partnership (https://healthierwigan.nhs.uk/) , established in 2018, aims to prevent illness by joining together health and social care services and giving local people the best opportunity to look after their own wellbeing. It has a particular focus on working more closely with communities by spreading the asset-based approaches developed through the Wigan Deal (https://www.kingsfund.org.uk/projects/lessons-wigan-deal) .

What is a 'place'?

In most cases, places are based on local authority boundaries. This is particularly common where unitary authorities exist.

South East London ICS

South East London ICS (which covers a population of around 1.9 million people) is made up of six places, co-terminous with the six borough councils.

A map of South East London ICS

Dorset ICS

Dorset ICS (covering a population of around 800,000) has two constituent places, each co-terminous with a unitary authority.

A map of the Dorset ICS

In other systems, the relationship between place and local authority boundaries is less straightforward. Place footprints might instead be established around clusters of district councils, the area served by a hospital or established groupings already being used for joint working across the NHS and local government.

Nottingham and Nottinghamshire ICS

Nottingham and Nottinghamshire ICS (which covers a population of around 1.2 million people) consists of four places, and spans two upper-tier local authorities – the unitary city council and the two-tier county council. One place is co-terminous with the city council, one is co-terminous with a district council and the other two each cover several of the six remaining district councils (roughly aligning to patient flows into the two acute providers).

A map of the Nottingham ICS

Suffolk and North East Essex ICS

Suffolk and North East Essex ICS (which covers a population of around 1 million people) consists of three places and spans two upper-tier local authorities – most of Suffolk County Council and part of Essex County Council. The places are based around established organisational footprints (reflecting the previous boundaries of clinical commissioning groups (CCGs) and patient flows around acute hospital providers). Each place covers more than one lower-tier local authority.

A map of Suffolk and North East Essex ICS

Even within a single ICS, places can vary widely in their size, population and complexity (although they cannot span ICS boundaries). This variation has implications for the capabilities and challenges across different place-based partnerships.

What are the expectations and requirements in national policy and guidance?

Place-based partnerships have existed in various forms for many years, supported by a range of national and local initiatives (https://lankellychase.org.uk/publication/historical-review-of-place-based-approaches/) designed to enable cross-sector working at place (many of which have been led by local government). There is now a renewed push to strengthen place-based partnership working as part of the integration reforms associated with the 2022 Health and Care Act.

While the Act itself includes no legal requirement to create place-based partnerships, it does allow for integrated care boards (ICBs) to establish place-based sub-committees and to delegate some of their functions and budgets to these committees. Thirty-nine of the 42 ICSs established across England have chosen to operate through a place sub-structure, and there is an expectation that they will delegate some of their functions to this level. ICBs will remain formally accountable for any functions and resources they delegate in this way.

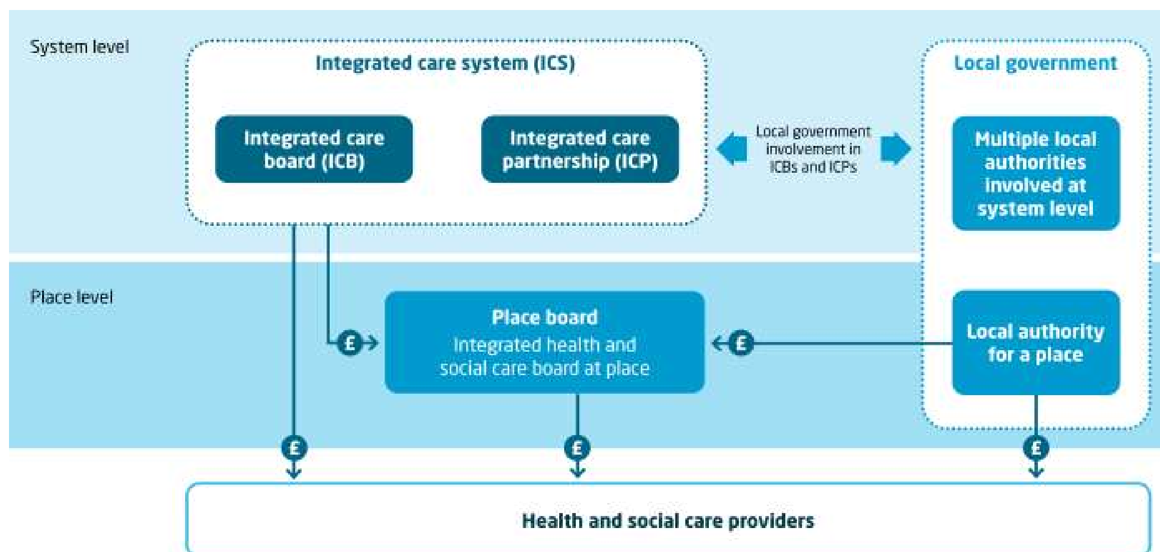
Further guidance on the expectations for place-based partnerships has been set out in national policy and guidance, in particular in *Thriving places* (https://www.england.nhs.uk/publication/integrated-care-systems-guidance/) (joint guidance from NHS England and the Local Government Association) and the government's integration White Paper (https://www.gov.uk/government/publications/health-and-social-care-integration-joining-up-care-for-people-places-and-populations) . These set clear expectations that ICSs should delegate significant responsibilities and budgets to place-based partnerships. Neither document attempts to prescribe the allocation of functions between system and place, acknowledging that this will depend on local circumstances, but recommend that this is guided by the principle of subsidiarity (meaning decisions should be taken as close to local communities as possible, with ICSs only taking on functions that benefit from working at scale).

The integration White Paper published in February 2022 aimed to strengthen governance and accountability arrangements at place level, including through an expectation that all places should develop a clear and transparent governance model meeting a core set of requirements (*see* below). The change of government means it is now uncertain which of the proposals in the White Paper will be taken forward.

How are place-based partnerships governed and led?

All place-based partnerships are required to have robust governance arrangements in place for their work. A common arrangement is to have a board or committee to which local authorities and ICBs can delegate some of their functions and budgets – referred to in the integration White Paper as a 'place board' (see below). Partnerships have freedom to develop alternative governance models that fit local circumstances provided these meet a set of minimum expectations, including clear decision-making processes and arrangements for resolving disagreements.

Figure 3 The place board model, adapted from the integration White Paper



Many places have developed governance structures close to the 'place board' model, often building on pre-existing local arrangements. For example, in North Central London, each place-based partnership has an executive group providing strategic leadership (comprising senior executives of local partner organisations) and a delivery board reporting to it, building on established structures developed locally over several years.

Many places have appointed a single place lead accountable to both the ICB and the local authority (or authorities) – in line with one of the proposed requirements in the integration White Paper. The role of the place lead includes representing the place in system-level conversations, and they often sit as board members of the ICB. Place leads usually also hold other leadership roles in one or more of the local partner organisations, including chief executives of local authorities (eg, Calderdale), directors of public health (eg, Bromley), directors of adult social care, or senior leaders from mental health trusts (eg, Southwark) or acute trusts (eg, Croydon and Bolton).

The role of the wider senior leadership team around the place lead is critical. For example, in Leeds there is a nominated place lead (the local authority chief executive) but there is also an agreement that leadership of the partnership work should be a collective endeavour involving chief executives from across the local health and care system rather than being the sole responsibility of the place lead.

Place leads are also usually supported by a team responsible for delivering the partnership's objectives. The size and nature of these teams varies considerably and is likely to change over time. In some places there is a substantial team accountable to the place lead, employed by the ICB. Elsewhere, there is only a very minimal core team underpinning the place-based partnership, with partner organisations expected to make additional staff time available to support delivery of agreed objectives.

What resources do place-based partnerships have at their disposal?

Place-based partnerships vary in terms of the resources they control directly, and those they are able to influence.

National guidance encourages ICBs to delegate some of their resources and responsibilities to place-based partnerships – recognising the fact that much of the work needed to integrate services, improve population health and tackle inequalities needs to happen at a more local scale. The extent to which this is happening at present is very variable, in part reflecting the different levels of maturity of partnerships across the country and the varying arrangements that ICBs inherited from the CCGs that came before them.

West Yorkshire ICS has adopted a maximum delegation approach, in which almost all the ICB's £5 billion budget is being put under the control of its five place committees (covering the same footprints as the CCGs that were responsible for local NHS budgets before July 2022). Commensurate with this high level of responsibility at place level, most of the ICB's staff are part of place-based teams, although many also have responsibilities straddling more than one place.

Some ICSs are pursuing a more targeted approach to resource delegation, and in others there are ambitions to delegate ICB budgets in future but currently no concrete arrangements for doing so.

The approach taken in some ICSs is to work in partnership with providers to bring together resources at place level. For example, in Greater Manchester, the bulk of NHS budgets will flow directly from the ICB to providers and those providers will then come together with local authorities, voluntary sector organisations and

wider public service partners in place-based 'locality boards'. The locality boards operate with the principle of joint stewardship of the total resource for the population.

Place-based partnerships also aim to shape how a broader set of resources are used to improve health and wellbeing. A key function is to look across the range of resources available in the NHS, local authorities and elsewhere – including budgets, staff, data and estates – in order to improve how these are used to meet local needs. The ethos of 'one place, one budget' is more advanced in some areas than others but has become a key aspiration in many places, and the government has indicated that it would like to support local partnerships to go further in terms of pooling local authority and NHS budgets through 'section 75' arrangements and the Better Care Fund (https://www.kingsfund.org.uk/topics/better-care-fund) .

How do place-based partnerships relate to health and wellbeing boards?

Since 2012, all upper-tier local authorities in England have hosted a health and wellbeing board (https://www.kingsfund.org.uk/publications/health-wellbeing-boards-explained) (HWB) – statutory committees responsible for assessing local health and care needs and agreeing a health and wellbeing strategy. How these relate to place-based partnerships depends to a large extent on whether 'places' align with local government boundaries.

In areas where each place-based partnership covers the same population as a single HWB, there can be a close relationship between the two and complementary roles. For example, in Nottingham partners have agreed that the role of the HWB is to set the strategic priorities and the place-based partnership is then responsible for overseeing the delivery of this strategy, reporting to the HWB on a regular basis.

In other areas there are multiple place-based partnerships operating within a single HWB area. For example, in Essex the intention is that the joint health and wellbeing strategy for the county provides a strategic framework for places to work within, allowing for some flexibility to tailor the priorities to the specific needs of each place – informing rather than determining their work. The HWB also sees itself as having a role in sharing ideas and learning across places within Essex.

Whatever the arrangements agreed locally, the 2022 Health and Care Act is clear that that all ICBs – and by extension, place-based partnerships – have a responsibility to pay regard to local health and wellbeing strategies in developing

their plans. A key challenge is ensuring HWBs and place-based partnerships are complementary and avoid duplicating functions.

What next?

The development of place-based partnerships is a work in progress – they are evolving, and some are much more advanced than others. The ambition in most areas is for these partnerships to take on greater responsibilities over time.

It remains to be seen how the relationship between place-based work and system work led by ICSs will play out. If successful, place-based partnerships and ICSs are an opportunity to make a reality of the 'systems within systems' (https://www.kingsfund.org.uk/publications/place-based-systems-care) approach The King's Fund has argued for, combining the benefits of localism with the benefits of scale.

There are still important questions about how place-based partnerships will function in practice when formal, legal accountability sits elsewhere with ICB leaders and councils: how they will have the influence they need; whether they will be able to encourage and support service providers to work in a place-based way; and how they will be held to account for delivery.

The real test for place-based partnerships will be whether they can help to deliver the improvements needed locally – in particular, whether they can support the development of new models of service provision that give people a better experience of care, improve the health of the population and reduce inequalities. To do this they will need to work closely both with providers of health and social care services and with the communities they serve (https://www.kingsfund.org.uk/publications/communities-and-health) .

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Social care providers and integrated care systems: opportunities and challenges

31 October 2022
5-minute read

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For people unfamiliar with adult social care it sometimes comes as a shock to realise the sector's size and diversity. It employs around 1.5m people in around 17,700 organisations, most of which are in the private sector but with a decent number of voluntary sector organisations as well.

The sector's reach is wide – there are, for example, more beds in care homes than there are in acute hospitals and the sector employs nearly 800,000 frontline care workers who work not just in residential care but in community and home-based settings. It's a sector, then, that has huge importance and potential within the wider health and care landscape.

An opportunity but also a challenge for newly created integrated care systems (ICSs) is how to best engage with adult social care to deliver on ambitions to support the health, wellbeing and independence of their populations, addressing workforce challenges and designing integrated, person-centred services. It was for this reason that NHS England asked The King's Fund to explore with adult social care providers their hopes and expectations for integrated care systems, their current level of engagement in ICSs and what could be done to improve involvement.

We spoke to nearly 40 providers from across adult social care, some individually and some as part of focus groups. We also spoke to the bodies representing social care providers, such as Care England, the Homecare Association and the National Care Forum. In total around 14 hours of interviews and focus groups took place during April 2022.

What we heard demonstrated both the potential of the social care sector and the challenges that will need to be overcome to fully involve it in integrated care

systems.

We heard that adult social care providers are clear they bring values, knowledge and skills that are essential to the vision of ICSs. Providers spoke about their passion for the principles of person-centred care and the importance of their reach into communities and homes, often – thinking of home care in particular – into people's living rooms. They also talked about the knowledge and data that this experience provided, and its potential for service planning and prevention.

Providers saw real potential in ICSs to improve the outcomes for individuals and their families, and to shift the health and care system towards a more person-centred approach. They also saw opportunities for efficiency and collaboration on issues of joint concern, such as staffing.

> **Providers saw real potential in ICSs to improve the outcomes for individuals and their families, and to shift the health and care system towards a more person-centred approach.**

However, there were real barriers to their involvement and providers were not shy in telling us about them. They spoke with passion and often frustration about the cultural differences between health and care, and what they saw as a lack of trust between the two sides. They spoke about basic misunderstandings of what the ASC provider sector is and does, and a lack of trust in the expertise of their staff. All this led, they said, to a paternalistic, transactional relationship in which ASC providers did not feel valued or appreciated. This needed to be overcome for providers to be fully engaged in ICSs, they said.

Providers recognised that the scale, capacity and particularly the diversity of the sector was a further barrier to involvement. This was partly a question of available time for smaller organisations but also, for larger ASC providers, to engage with multiple ICSs. There was also a clear recognition among providers that the scale and diversity of the sector meant it struggled to represent itself, and that it might therefore need to adapt to engage with ICSs.

We felt that many of these issues had their roots in the deep and complex cultural and historical divisions between health and care, including the division between a 'free' NHS and a means-tested social care system, an NHS that is largely staffed and delivered by public sector workers and a social care system in which most providers are in the independent sector, and a clinically focused NHS and a social care system that increasingly focuses on individuals' wider wellbeing.

> **We felt that many of these issues had their roots in the deep and complex cultural and historical divisions between health and care...**

But we didn't feel the challenges were insurmountable. We suggested three immediate actions. In the short term, there is a need to improve communication and engagement by ICSs with adult social care providers, most obviously as integrated care strategies are developed. More generally, there is a need to improve the basic understanding between the health and care sectors, to tackle some of the divisions that currently exist. Finally, there is a need to develop structural options for adult social care providers to be involved in ICSs.

With integrated care partnerships due to develop their integrated care strategies over the coming months there is an opportunity for partners from across health and social care to come together and identify the work they want to do together in areas like prevention, workforce, digital transformation and new models of care. DHSC has new guidance (https://www.gov.uk/government/publications/adult-social-care-principles-for-integrated-care-partnerships) on how integrated care partnerships and adult social care providers are expected to work together.

No one should imagine that the full involvement of adult social care providers in ICSs will be achieved simply and quickly but it is essential and a 'litmus test' of ICS's ambitions: a marker of the extent to which ICSs genuinely set out to transform local health and care systems.

If you would like to find out more about this work, please email england.systempartnerships@nhs.net (mailto:england.systempartnerships@nhs.net) for further information.

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