CIPFA

Integrating care: policy, principles and practice for places

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Foreword

Health and care integration is not a new phenomenon, but it has been a constant and dominant policy theme for many years. Over time, integration has moved from specific pilots and programmes through voluntary partnerships of health and care organisations with no formal powers or accountabilities.

The Health and Care Act 2022 (the 2022 Act) changes this, putting integrated care systems (ICSs) on a statutory footing and providing a legislative framework that moves away from competition in the NHS and aims to better support collaboration and partnership working.

Rather than being an end point, the passage of the 2022 Act marks a new chapter in the integration journey – a new opportunity. Even before it had passed, the government published a further White Paper, aiming to go "further and faster" with integration.

Central to the success of this ambition will be a 'whole systems' approach to public financial management. That is an understanding that outcomes can be significantly improved by working across organisational boundaries, recognising the interconnectedness of partners involved and the greater impact they can have through closer collaboration.

The 2022 White Paper poses many questions, reflecting the challenges remaining at 'place' level. Many of these questions relate to outcomes, accountability and finance arrangements, all of which are key components of good public financial management. They are also critical elements in enabling effective collaboration across organisations with such different systems and cultures.

Here we seek to provide an overview of the changes as a result of the 2022 Act, what integration is seeking to achieve, the wider landscape in the current climate and where we are now, as well as addressing some of the remaining challenges at place level.

We hope that this publication, and the recommendations it contains, will be helpful in both informing the development of further guidance by the government and NHS England and providing support for practitioners at a local level.

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Executive summary

A new architecture for integration

The Health and Care Act 2022 provides a legislative framework to support closer integration of health and care. It has put integrated care systems (consisting of a board and partnership) on a statutory basis, marking a new chapter in the integration journey.

A further White Paper has set out expectations for place-based arrangements and has raised further questions fundamental to public financial management on outcomes, accountability and finance.

Integrating care: what and why?

The renewed focus on integration presents a new opportunity for partners across the health and care sector to work differently. A more strategic, long-term focus on the social determinants of health and wellbeing, reducing inequalities and prevention should improve population health, but also help ensure that health and care services remain sustainable for future generations.

Taking a truly place-based and preventative approach could make a huge contribution to achieving the core purposes of ICSs and the triple aim duty set out in the 2022 Act.

Local government, at all levels, hold many of the levers that are key to influencing population health and wellbeing. Councils also have a deep knowledge of and engagement with the places and neighbourhoods they serve. As partnership and place-level arrangements evolve, all councils – at all levels – have vital roles to play in closer integration.

Where are we now?

There is huge variation between systems and places due to local factors and the way they have developed over time, and to date, there has been little consistent or comprehensive evaluation.

It is crucial that national policy and mechanisms for evaluation recognise the significant variation among systems and places and are realistic about what can be achieved, both within reasonable timescales and with the resources available.

Integration in the context of the wider landscape

Both the NHS and local government are facing enormous and growing challenges – existing pressures, recovery from the pandemic and the cost of living crisis sit among wider policy reforms and political and economic pressures. Such competing priorities can distract from and add tensions to the integration agenda.

There is a clear disconnect between immediate pressures and the longer-term investment required to focus on prevention and population health. Good financial management depends on consideration of the entire breadth of responsibilities over a long-term horizon to ensure outcomes and value for money are achieved. This requires certainty of funding and coherence of policy priorities.

Some areas of government policy remain misaligned with national integration policy. Developing complex workarounds drains resources and distracts from the goal of closer integration. The ideal solution would be to improve policy alignment within and across government departments. However, sharing experiences and improving understanding of potential workarounds would be a welcome first step.

Central government departments should lead by example and demonstrate an integrated approach to co-ordinating and clarifying policy priorities for the health and care sector overall. Otherwise, it is difficult to envisage how integration can progress "further and faster" as expected.

Within this crowded landscape, a shared understanding among partners is essential. Openness and transparency about the priorities and pressures they face is key for cultivating relationships and trust, which partnerships are built on.

Shared outcomes

A focus on outcomes can highlight interdependencies between services and organisations and so help foster a shared vision and understanding in partnership working.

Good public financial management requires making evidence-based decisions on the allocation of public funds to outcomes and the ability to track and evaluate progress.

Government departments should work together to clarify priorities across national policy and develop a national outcomes framework that provides a single, coherent set of shared goals across the health and care sector, without adding a further tier of bureaucracy.

An outcomes-based approach to integrating health and care requires long-term political and financial commitment. At its heart must sit realistic expectations of what can reasonably be achieved within the timescale and available resources.

The national outcomes should be broad enough to enable all systems/places to contribute to their achievement. It should provide sufficient autonomy for local systems/places to determine their priority outcomes within the context of the national framework and the associated metrics against which progress should be measured, based on evidence of their local circumstances and needs.

A national outcomes framework could incorporate minimum standards as a baseline against which outcomes could be adapted to local priorities. The emphasis should be on local priorities reflecting national outcomes, not national performance metrics driving local activity.

Place-based governance and accountability

Good governance in the public sector encourages better informed and longer-term decision making and the efficient use of public resource. It strengthens accountability for stewardship of those resources and results in more effective interventions and better outcomes for the population.

Several models have been proposed for place-based governance and accountability arrangements. The expectation is that all places will have adopted a model of accountability that meets these criteria and identifies a single accountable person by spring 2023.

Given the significant variation between places, their evolution is unlikely to proceed uniformly. This is not necessarily a function of their maturity but may be due to inherent structural factors. Thus, a 'one size fits all' set of criteria does not seem the most reasonable approach.

A principles-based approach, perhaps incorporating minimum expectations, would recognise the diversity of places, allowing for adaptation to local circumstances and over time as places evolve. It would then be for each locality to determine the appropriate and proportionate arrangements for their circumstances, and for others to assure themselves that these are sufficient.

A good starting point would be the International framework: good governance in the public sector (CIPFA, 2014). Based around seven principles, this recognises that the fundamentals of good governance remain the same for an individual organisation and the system it is a part of, such as the partnerships involved in integration.

Finance for place

The NHS and local government operate under vastly different funding and financial regimes. Fostering a shared understanding between partners is essential if they are to build the relationships and trust required to realise the aims of integration.

Current financial regimes and funding mechanisms do not support a whole system approach to improving population health and wellbeing with a focus on prevention. Achieving this will necessitate a more strategic and long-term approach to funding and financial planning.

The 2022 White Paper sets the ambition that pooled budgets will eventually cover much of the funding for health and care services at place level and commits to simplify the arrangements for doing so and produce further guidance by Spring 2023.

In practice, the complexities involved in pooling budgets can disincentivise collaboration, particularly in the current climate of tightening resources. However, pooling budgets is only one tool in the box, and a wider view should be taken of how to mobilise resources across organisational boundaries.

Delegation of functions and resources from system to place level should be underpinned by a place level financial framework to ensure that funding flows reflect decision making and support the delivery of shared outcomes. Again, this should be based on principles that can be adapted to suit local variation.

Putting the principles in place

Developing a principles-based framework for place would not only allow for the significant variation but would also be flexible to enable arrangements to adapt and become more sophisticated as places mature and evolve. Such a framework should be informed by local circumstances and aligned to the 'national ask'.

Given the evolution of places over time is unlikely to be linear, it will be helpful for places to identify where they are on this journey and chart a course for the progressive nature of integrated care in their locality.

The role of the finance profession

Bringing together services to improve population health needs to be supported by long-term planning and stripping away the barriers that prevent closer alignment of services. The finance function is a critical enabler of closer integration, helping resources to move freely and so empowering change.

This requires strong financial and collaborative leadership from CFOs in NHS bodies and local government, both in shaping the finance and governance arrangements in their local area to ensure good public financial management and in promoting and supporting the role of the finance function.

A new architecture for integration

Integrated care systems have covered every area of England since April 2021. Until 1 July 2022, these (and the sustainability and transformation partnerships that pre-dated them) were voluntary partnerships, bringing together the NHS, local government and voluntary community and social enterprise (VCSE) sector in their area. They have developed differently across the country, reflecting local geography, demography, health needs and the nature of collaborative relationships.

Four core purposes for ICSs were set out in NHS England's 2020 White Paper Integrating care: Next steps to building strong and effective integrated care systems across England:

- Improving **population health** and healthcare.
- **Tackling inequalities** in outcomes, experience and access.
- Enhancing **productivity and value for money**.
- Helping the NHS support broader **social and economic development**.

This White Paper also emphasised the principles of subsidiarity and collaboration, noting that decisions taken closer to (and in consultation with) communities were likely to lead to better outcomes. Prior to this, in 2019, the three levels of decision making in an ICS had been set out as shown below.

Table 1.1: Levels of decision making in ICSs

Level	Partners	Functions
Systems (circa 1 million to 3 million population)	Health and care partners in different sectors across whole area come together to set strategic direction and develop economies of scale.	May include planning and setting strategy, managing overall resources and performance, strategic change and improvement in areas such as estates, digital and workforce planning.
Places (circa 250,000 to 500,000 population)	Health and care providers in a town or district, connecting primary care networks (PCNs) to broader services including those provided by local councils, community hospitals or voluntary organisations.	May include re-design of local services, joining up care pathways across the NHS, local government and voluntary sector partners to focus on population health, prevention and reducing health inequalities and building relationships with communities.
Neighbourhoods (circa 30,000 to 50,000 population)	Groups of GP practices working with NHS community services, social care and other providers to deliver more coordinated and proactive services, including through PCNs.	May include delivery of community-based care services, strengthening primary care services and formation of multi-disciplinary teams through formation of primary care networks, proactive role in prevention and population health.

Source: Designing integrated care systems (ICSs) in England: An overview on the arrangements needed to build strong health and care systems across the country (NHS England, 2019).

The Health and Care Act 2022 (the 2022 Act) provides a legislative framework to better support partnership working required for integration. It removes some of the barriers to collaboration within the NHS and seeks to enable greater collaboration between partners to improve population health and wellbeing. It puts ICSs on a statutory basis from 1 July 2022, with each consisting of an integrated care board (ICB) and an integrated care partnership (ICP).

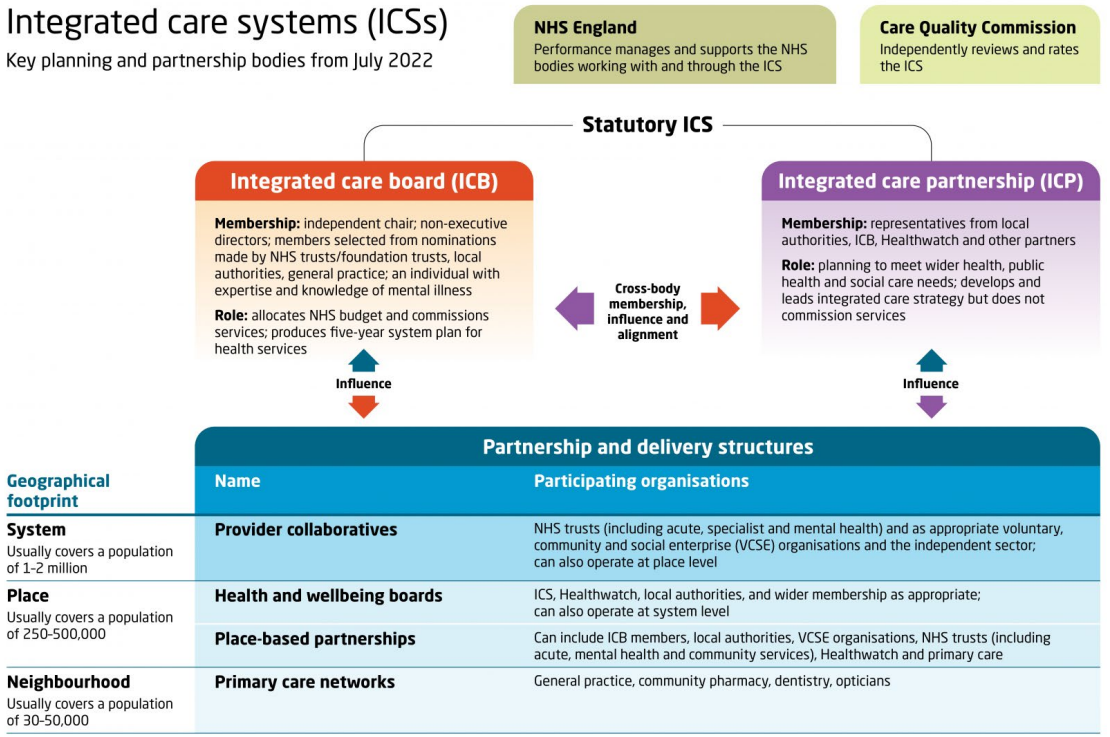
This dual structure of ICB and ICP is a new development and is intended to address concerns that an ICS would be unlikely to act effectively as both the body responsible for NHS finance and performance and as the wider system partnership. However, questions remain regarding the precise relationship between the ICB and ICP and how they will relate to each other in practice.

The 2022 Act also creates a new 'triple aim' duty for all NHS bodies to "have regard to" the wider impact of their decisions in relation to:

- the **health and wellbeing of the people of England** (including inequalities in 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.

During 2021/22, ICSs have been preparing for the statutory changes and transitioning to the new structures. To support this, extensive guidance has been published.[1]

Figure 1.1: Integrated Care Systems from July 2022



Source: Integrated care systems: how will they work under the Health and Care Bill? (The King's Fund, 2021).

1 This guidance from NHS England is published on the FutureNHS Collaboration Platform – ICS guidance workspace and requires the reader to sign up (for free) and log in to access it.

LEGISLATING FOR INTEGRATION – LESSONS FROM ELSEWHERE

In 2014, Scotland legislated to bring together health and social care as a single integrated system, with the framework set out in the Public Bodies (Joint Working) (Scotland) Act 2014. In 2016, 31 integration authorities were created. Thirty of these are integration joint boards (IJBs) and one is a lead agency model.

Functions and funding are delegated to the integration authority by the health board and local authorities. The integration authority is responsible for strategic planning of delegated functions for their local authority area and the issuing of directions to the relevant health board or local authority (who retain operational responsibility). In the area where the lead agency model is in place, the health board has responsibility for adult services, and the local authority has responsibility for children and families' services.

Despite the statutory basis, a number of reviews* found only limited progress towards the objectives of integration.

In early 2021, the Independent Review of Adult Social Care recommended the creation of a National Care Service (NCS) in Scotland. The Scottish Government have since consulted on the NCS. This included seeking views on how integration authorities could be reformed to become community health and social care boards.** These would oversee the delivery of all community health and social care services and support within their local area. They would be funded directly by the Scottish Government and accountable to the Scottish ministers. In June 2022, the National Care Service Bill was published, which proposes making Scottish ministers accountable for adult social care in Scotland.

The experience in Scotland reflects findings from across the UK that suggest creating a legal basis for integration does not in itself result in effective integration. Wider factors such as leadership, differing cultures, sufficient resources and financial planning, incentives and regulatory and outcomes frameworks also play key roles. The ability of partnerships to collaborate effectively appears to be more dependent on their ambition and relationships, which unlike their design and structure, cannot be legislated for.

Lessons from international experience also suggest that while legislation can be a powerful means of signalling intent and can help to create and/or accelerate the conditions for integrated care, it is rather a blunt tool in isolation.

***** Reviews include those by Audit Scotland (2018) and the Ministerial Strategic Group for Health and Community Care (2019).

****** Referred to as care boards in the National Care Service Bill.

Integrated care board (ICB)

On 1 July 2022, ICBs became new statutory organisations, bringing the NHS together locally to improve population health. The ICB is governed by a constitution, and its governance model reflects the need for greater collaboration and integration across the system. Each ICB must include as a minimum:

- a chair, appointed by NHS England with the approval of the secretary of state for health and social care
- a chief executive, appointed by the chair with NHS England approval (the chief executive is the accountable officer)
- at least three other 'ordinary' members:
  - one jointly nominated by NHS providers serving the ICB area
  - one jointly nominated by primary care providers serving the ICB area
  - one jointly nominated by local authorities whose areas coincide with or include all or part of the ICS area.[2]

The ICB has a duty to exercise their functions effectively, efficiently and economically, and key responsibilities include:

- securing provision of health services to meet the needs of their population by taking on the commissioning functions of clinical commissioning groups (CCGs) and some of NHS England's commissioning functions

2 Any local authorities responsible for the provision of social care whose areas coincide with the ICB's area will be eligible to jointly nominate the local authority ICB board partner ordinary member(s).

- developing a plan to meet the health needs of their population
- setting strategic direction for the ICS
- developing a capital plan for NHS providers within their geography.

Further duties include improving the quality of services, reducing inequalities, promoting patient choice, and involvement with and promotion of innovation, research, education and training. There is also a public involvement duty placed on ICBs (and NHS providers) as set out in Working in partnership with people and communities: statutory guidance (NHS England, 2022).

The ICB will contract with providers to deliver NHS services and may delegate some functions to place level to support joint planning/delivery of services. The ICB will also be responsible and directly accountable to NHS England for overall NHS finance and performance within the system (see System finance).

At the beginning of each year, the ICB must prepare a five-year forward plan setting out how they will exercise their functions and a capital plan. The plan must be open to consultation with the population they are responsible for and must "have regard to" the strategy produced by the ICP. Both plans must be shared with the ICP for the area, each health and wellbeing board (HWB) in their area and NHS England.

SYSTEM FINANCE

The 2022 Act seeks to clear away much of the 'competition' within the NHS and enable more collaborative, whole system approaches to be taken. Reforms to both the financial regime and payment system are contributing to this.

The NHS payment system is moving away from the old 'payment by activity' model, which was often criticised as being a barrier to integration. Instead, more aligned payment and incentives are being implemented with the intention of better supporting collaboration between commissioners and providers and moving towards a population-based payment system. However, there have been elements of payment by activity returning to incentivise reductions in tackling the elective care backlog (NHS, 2022).

The NHS has been moving more towards system finance for the last couple of years. NHS operational planning guidance in 2019/20 introduced the concept of 'system by default' for financial planning, where all decisions must consider the system as a whole, not just individual organisations. This was expanded in the 2020/21 guidance, which set 'system envelopes' with funding allocations provided to ICSs (via a lead CCG). These included core CCG revenue allocations and some non-recurrent funding. Capital allocations and funding for elective recovery is also provided at system level and allocated to partners based on agreed priorities. System plans must consider the alignment of commissioning and providers, as well as between the workforce, activity and finance. Plans need to set out how the priorities identified in planning guidance will be delivered.

From April 2022, NHS England is responsible for setting funding allocations for ICBs, which should include the majority of NHS spending. Under provisions of the 2022 Act, the ICB will be responsible and accountable to NHS England for the overall finance and performance of NHS organsiations within the ICS. They will have a statutory duty to remain within spending limits directed by NHS England (separate to the requirement to deliver financial balance across the system). ICBs can set delegated budgets for place-based partnerships but will remain responsible for services (and funds) under delegation arrangements.

NHS England has the power to make directions on ICB management or use of resources and may set financial objectives for ICBs and their partner trusts. As statutory organisations, ICBs will be accountable to NHS regional teams for discharging their functions and arrangements have been put in place via the NHS oversight framework. Each ICB must prepare an annual report and accounts, as directed by the 2022 Act and NHS England respectively.

Further information on systems finance can be found in NHS England guidance on Management of ICB resources and ICB financial framework FAQs (both require a FutureNHS login).

Integrated care partnership (ICP)

Within each ICS, the ICP is a statutory committee, acting as a forum to promote partnership working by bringing together the NHS and local authorities with stakeholders from across the system and community.

The ICP must include one member from the ICB and one member from each of the local authorities[3] whose areas coincide with or include all or part of the ICS area. Other members can be determined locally and may include NHS providers, public health, social care providers, housing providers, VCSE representatives and local Healthwatch organisations.

The ICP must develop a strategy to address the broader health and care needs of the population, address inequalities and consider the wider determinants of health and wellbeing. The ICB and local authorities must "have regard to" the ICP's strategy when making decisions. The strategy should be informed by joint strategic needs assessments (JSNAs),[4] and in developing the strategy, the ICP must involve Healthwatch, the VCSE sector and the people/communities within their area. Further guidance is available from NHS England as set out in guidance from NHS England on partnerships with the VCSE sector and with people and communities.

The Department for Health and Social Care (DHSC) has produced guidance setting out the statutory requirements for integrated care strategies (2022). Initial strategies must be published by December 2022 (in order to influence the ICB plan due spring 2023), with the expectation that strategies will be refreshed and updated as ICPs develop. Alongside this, further guidance was also published:

- Adult social care principles for integrated care partnerships (DHSC, 2022), which explores how ICPs and adult social care providers are expected to work together.
- Health and wellbeing boards: draft guidance for engagement (DHSC, 2022).

Further information on the expectations of ICPs can be found in the summary of ICP engagement conducted by DHSC, NHS England and the Local Government Association (LGA) in 2022.

Place-based partnerships

There is no legislative provision or solid definition for arrangements at place level, as this is rightly for local determination. They will generally operate at local authority level. Some areas already have such partnerships in place and these vary – some are informal collaborations, while others involve more formal arrangements with underpinning contractual agreements and/or pooled budgets.

They will likely build on existing relationships to form multi-agency partnerships, which could involve the NHS, local authorities, VCSE organisations, social care providers, local communities themselves and other partners to align decision making, planning and delivery of services in the interest of the local population. It is expected that ICBs will delegate functions and resources to place level and that this will increase over time as systems and places evolve.

Such partnerships are well placed to understand the needs of the local population and so are able to form coalitions across a range of community providers to improve the quality, co-ordination and accessibility of health and care services. This local understanding means they are also well placed to focus on improving population health and wellbeing through the prevention of ill-health and health inequalities.

Further details of the expectations for arrangements at place level can be found in the 2022 White Paper Health and social care integration: joining up care for people, places and populations and in Thriving places: guidance on the development of place-based partnerships as part of statutory integrated care systems (NHS/LGA, 2021). These expectations and other challenges at place level are discussed in more detail in later sections.

3 Excluding town and parish councils.

4 Prepared by health and wellbeing boards (HWBs), JSNAs consider the current and future health and care needs of local populations to inform and guide the planning and commissioning of health, wellbeing and social care services within a local authority area.

Provider collaboratives

As well as working at place level, the ICS design framework (NHS, 2021) set the intention to secure the benefits of working at scale. This is intended to be achieved through provider collaboratives of at least two NHS providers across one or more ICSs with shared objectives, operating across multiple places.

Provider collaboratives are expected to play a key role in service transformation and enable shared objectives and planning. Governance arrangements are for local determination, but possibilities include ICBs contracting with a provider collaboration through a lead provider or individually with each partner. There is more on this in the 2021 White Paper and Working together at scale: guidance on provider collaboratives (NHS, 2021).

Primary care networks

Primary care networks (PCNs) bring together general practice with other primary care services and can include community, mental health, social care, pharmacy, hospital and voluntary services. PCNs typically operate at neighbourhood level and aim to provide more personalised, co-ordinated care close to home, while being able to work at scale through better collaboration across the local health and care system. Next steps for integrating primary care: Fuller stocktake report (NHS, 2022) recommends that PCNs should be empowered to evolve into integrated neighbourhood teams.

KEY POINTS: A NEW ARCHITECTURE FOR INTEGRATION

- The Health and Care Act 2022 provides a legislative framework to support partnership working required for the closer integration of health and care, putting ICSs, consisting of a board (ICB) and partnership (ICP), on a statutory basis.
- The Act removes some of the barriers to collaboration within the NHS and seeks to enable greater partnership working to achieve the 'triple aim' of improving the health and wellbeing of the population and quality of services and ensuring that the sustainable and efficient use of resources improves population health and wellbeing.
- There are also provisions for data sharing and powers for the secretary of state to make direct payments to social care providers and new duties for the CQC to review and assess the provision of services by ICBs and the performance of local authorities' adult social care duties.
- Below ICB/ICP level:
  - place-based partnerships will operate across organisational boundaries to align decision making, planning and delivery of services for their local population
  - provider collaboratives will bring together NHS providers to work at scale across places
  - PCNs will bring together primary care and other services to operate at scale and provide more co-ordinated care closer to home at neighbourhood level.

Other provisions

As well as putting ICSs on a statutory basis, the 2022 Act also makes some other provisions of relevance to the integration of health and care. These include formally merging NHS England and NHS Improvement, as well as making changes to procurement and competition rules relating to health services. There are also provisions that directly relate to learning from the experience of the pandemic. These include powers for the secretary of state to make direct payments to social care providers and provisions for more effective data sharing, and the government has since published Data saves lives: reshaping health and social care with data (DHSC, 2022).

The Act also contains new duties for the Care Quality Commission (CQC). As well as the requirement to review and assess the provision of health and care services by ICBs, ICSs will also have a new responsibility to review and assess the performance of local authorities' adult social care duties. The Act also gives the secretary of state powers to intervene where a local authority is judged to have failed to discharge these duties. DHSC are working with the CQC, the LGA and Association of Directors of Adult Social Services (ADASS) to develop the assurance framework and have earmarked £70m over three years for improvement activity, as set out in People at the Heart of Care: adult social care reform White Paper (2021).

Integrating care: what and why?

The term ‘integration’ has been used in relation to health and care for many years, yet still it seems to mean different things to different people, and questions remain on exactly what it is seeking to achieve. Integration might be used to refer to organisations coming together, service redesign, bringing teams together, or having a shared vision and understanding. However, these concepts represent a ‘view from the inside’ and fail to capture what integrated care means from the perspective of the service user.

There have been many attempts to define integrated care and its aims:

> Integrated care is a concept, bringing together inputs, delivery, management and organisation of services related to diagnosis, treatment, care, rehabilitation and health promotion. Integration is a means to improve services in relation to access, quality, user satisfaction and efficiency.

Integrated care: a position paper of the WHO European Office for Integrated Health Care Services (2001)

> Integrated care aims to improve patient experience, achieve higher levels of efficiency and extract value from health delivery systems.

Integrated care (The Health Foundation)

> [Integration] is a means to better health and care support, better health and care outcomes and better use of resources.

Must Know: Integrated health and care (Local Government Association, 2021)

> Integration is the combination of processes, methods and tools that facilitate integrated care. Integrated care results when the culmination of these processes directly benefits communities, patients or service users – it is by definition ‘patient-centred’ and ‘population oriented’. Integrated care may be judged successful if it contributes to better care experiences; improved care outcomes; delivered more cost effectively.

The evidence base for integrated care (The King’s Fund)

Given the various definitions, it is unsurprising that even the partners involved in an ICS may have different interpretations and expectations, depending on their perspective.

Although integration has been a common feature in health and care policy for many years, how it is described has developed over time.

Table 2.1: Defining integration in policy

Policy	Description of integration
NHS Five Year Forward View (2014)	Refers to integrating care locally within the NHS and across health and social care via new partnerships with local authorities and communities to integrate care around the patient.
NHS Long Term Plan (2019)	Emphasises consideration of the wider determinants of health and wellbeing, with a focus on prevention and population health, and recognises the wider impact of the NHS on local economic development. ICSs are central to this vision to bring together local organisations to redesign care and improve population health as a "pragmatic and practical way of delivering the 'triple integration' of primary and specialist care, physical and mental health services, and health with social care."
Integrating care: next steps to building strong and effective integrated care systems across England (2020)	Emphasises the principles of subsidiarity and collaboration. It set out four core purposes for ICSs: • Improve outcomes in population health and healthcare. • Tackle inequalities in outcomes, experience and access. • Enhance productivity and value for money. • Help the NHS support broader social and economic development.
Health and social care integration: joining up care for people, places and populations (2022)	Sets out the vision for integration that makes "a significant positive impact on population health through services that shift to prevention and address people's needs promptly and effectively", but that is "also about the details and the experience of care – the things that often matter most to people, carers and families."

Over time, there appears to have been a widening of the scope from closer integration within the NHS (and between the NHS and social care) to a much broader view encompassing the wider determinants of health and wellbeing to positively impact on population health management, with a focus on prevention and reducing health inequalities. This is further reflected in the triple aim within the 2022 Act.

Closer integration could be viewed as identifying ways of working differently at three levels:

- **Within an organisation** itself to deliver more proactive and joined-up care. For example, in the NHS between primary and secondary care, or within a local authority between adult and children's social care or adult social care and housing.
- **Across health and social care** to provide more integrated management of complex, chronic conditions and improved transitions between different care settings.
- **Across whole systems** (or places), involving a wider range of services to improve population health by tackling the wider social determinants of health and wellbeing.

The NHS was established to provide treatment for acute illness, but it is now increasingly required to provide support for growing numbers of older people with long-term, complex conditions. Partners across the health and care sector need to work differently to break down barriers between services and deliver seamless, joined-up, person-centred care closer to home, but also to deal with the ever-increasing pressures of tightening budgets, workforce shortages and increasing demand to ensure that health and care services remain sustainable into the future.

Population health is in decline

The COVID-19 pandemic has brought the issue of health inequalities into sharp focus. However, recent evidence suggests that improvements in population health have been in decline for some time.

> From the beginning of the 20th century, England experienced continuous improvements in life expectancy but from 2011 these improvements slowed dramatically, almost grinding to a halt. For part of the decade 2010-2020 life expectancy actually fell in the most deprived communities outside London for women and in some regions for men. For men and women everywhere, the time spent in poor health is increasing...Put simply, if health has stopped improving it is a sign that society has stopped improving.
>
> Health equity in England: The Marmot Review 10 years on (Institute of Health Equity, 2020)

A comparative study by CIVITAS in 2022 ranked the performance of the UK health system with that of 18 comparable countries since 2000. It considered 16 measures, including level of health spending, overall life expectancy, health care outcomes of major diseases and outcomes for treatable mortality and childbirth. The UK ranked bottom on four measures and was in the bottom three for half of the measures. In this study, no other comparable country had such a poor record.

However, the causes of poor health and disease are influenced by more than just the healthcare system. The World Health Organization's Social determinants of health and Robert Wood Johnson Foundation's Healthy communities suggest that wider social determinants of health such as income and social protection, education, employment, social inclusion, housing and the built environment have a greater impact on health and wellbeing outcomes than health services themselves.

The NHS increasingly recognises the need to focus on the wider determinants of health and population health management as a critical building block of integration, and it has developed a Population Health Management programme. This is intended to aid in the understanding of current health and care needs and predict what local populations will need in the future, using data to understand what factors drive outcomes in different population groups. As discussed earlier, the NHS financial regime is also moving towards a more population-based payment system.

Partners to influence health and wellbeing

Despite this increased focus on population health management, when it comes to influencing the wider determinants of health and wellbeing, the role the NHS can play is limited. It simply does not hold all the required levers.

The health and wellbeing needs of the population and associated service pressures are not homogeneous across the nation. Clearly, different areas have different needs based on their wider circumstances – as has been brought into sharp focus by the recent highlighting of health inequalities as a result of the pandemic.[5] However, the NHS tends to operate at a national level, following national priorities and targets, in the quest to avoid a 'postcode lottery'.

Where the NHS does consider different subsets of the population, this tends to be along the lines of patient groups (eg diabetes or cancer) rather than the needs of different areas or population groups, as is the case in local government (eg children and young people or the elderly).

It is essential that wider partners who can understand and influence the health and wellbeing of the local population are equally engaged in policy and planning and that a more joined-up, 'whole system' approach is taken.

The 2022 White Paper placed a welcome emphasis on 'place' as the engine room for integration and stressed the importance of local government and the NHS acting as equal partners, stating: "Among the lessons of the pandemic is the need to do more to bring the resources and skills of both the NHS and local government together to better serve the public." The White Paper puts more emphasis on the role of local government as equal partners, although continues to refer to local government as a whole.

5 Health inequalities during COVID-19 and their effects on morbidity and mortality (Journal of Healthcare Leadership, 2021) and Integrated care systems: what do they look like? (The Health Foundation, 2022).

Local government, at all levels, holds many of the levers that influence health and wellbeing. Councils have responsibilities, powers, and perhaps more importantly the experience that is key to improving population health. Upper-tier responsibilities such as social care and public health are clearly critical to integrating care. However, functions where lower-tier councils play a role – such as housing, local environment, local economy, green spaces, leisure services and active travel – are all important influencers of health and wellbeing, as highlighted in High time for districts to weigh in on integrated care systems (ICSs) (Good Governance Institute, 2021) on the role of district councils in ICSs.

To take a truly integrated approach to population health, systems need to understand and engage with the places and neighbourhoods they serve. In this regard, local government's knowledge, experience and democratic mandate is key to success, as recognised in Working in partnership with people and communities: statutory guidance (NHS England, 2022). This demonstrates the importance of collaborative approaches and highlights the value of working with local authorities and their councillors.

Historically, there have been concerns that the vital role of local government in integrating care has not been fully understood and that the agenda has been dominated by the NHS. Conversely, in some areas, there have been concerns that attempts have been made to engage local government, but they have declined to be involved.[6]

Figure 2.1: The role of local government in health and wellbeing

Source: Social determinants of health and the role of local government (LGA, 2020).

6 Concerns highlighted in Integrating health and social care: sixtieth report of session 2016/17 (House of Commons Committee of Public Accounts, 2017) and Integrated care: organisations, partnerships and systems: seventh report of session 2017 to 2019 (House of Commons Committee of Public Accounts, 2018).

The 2022 Act puts ICSs on a statutory footing and, in doing so, includes local authority representation on both the board (statutory body) and partnership (statutory committee), ensuring that both these bodies have a link through to local democratic accountability, which, it has been recognised, could have a positive impact on the NHS in A more democratic NHS? (NHS Confederation, 2022).

Despite the increased emphasis on the NHS and local government as equal partners in integration, this does not mean that everything in the garden is rosy. In some areas, there are remaining tensions and fears across both the NHS and local government. See Further reading for additional resources.

Although the 2022 Act puts the ICB in place from July 2022, over time the partnership and place-level arrangements will continue to evolve and mature. It is at these levels of ICP and place that **all** tiers of local government will have vital roles to play.

Prevention is key

> Prevention can be the most cost-effective way to maintain the health of the population in a sustainable manner, and creating healthy populations benefits everyone.
>
> The case for investing in public health (World Health Organization, 2014)

The renewed focus on integration as a result of the 2022 Act and the wider policy landscape of reducing inequalities and levelling up presents an opportunity to truly do things differently. In the current climate of increasing demand on public services and tightening budgets, there is a growing consensus that a stronger case needs to be made for preventative interventions.

The importance of prevention in improving population health is increasingly being recognised and has been identified as a priority in integration policy in recent years. While few will argue that taking a greater focus on prevention is the right thing to do, in the face of scarce resources and immediate pressures, investing in such long-term initiatives is often seen as an easy tap to turn off. In the words of one ICS chief executive: "Systems know the right way to go about reducing pressures on secondary care… and to get more out of public spending is by better primary and secondary prevention. That's always been true and always been hard to make real."

In March 2022, the then secretary of state Sajid Javid set out a vision for further health reforms, in which he made the commitment to baseline, report on and assess the extent of investment in prevention.

> It's self-evident we need to increase spending on prevention, yet we don't accurately know how much we spend. A baselining exercise is a vital first step towards agreeing how much our investment in prevention will increase year-on-year. My department and NHS will also work together to look at where barriers can be removed, and incentives improved to focus on prevention.
>
> **The Rt Hon Sajid Javid MP**

At the time of writing, it remains to be seen if this commitment will be taken forward by the current secretary of state.

In 2019, CIPFA's work with Public Health England (PHE) Evaluating preventative investments in public health in England sought to address exactly this issue to improve evaluation of preventative investment and better make the case for a greater shift to preventative approaches. This proposed a framework to improve the evaluation of preventative investment across local systems to:

- support better decision making on the use of resources in a whole system by evaluating the costs and benefits across different organisations
- bring longer-term costs and benefits to light, as these often lack visibility
- increase transparency and accountability for how resources are currently invested
- improve incentives to invest in prevention relative to acute interventions across local systems, including where costs and benefits fall on different agencies or sectors.

Robust and consistent evaluation would enable more systematic prioritisation and make any short-termism transparent. It could enable a view of the overall extent of preventative investment and the future revenue liability that would amass if such investment were not made, ultimately providing better information upon which decisions can be based. Given the context of devolution and integration, there is a need to adopt a whole system view, unrestricted by organisational focus, to enable consideration of how the public pound is used in a place rather than the local government pound or the NHS pound.

Overall, the ambition is to change the way that prevention is viewed. Rather than being seen as a way to generate savings, it should be considered as a true investment, yielding benefits across time and place. Such future benefits may manifest in terms of avoiding financial costs (eg on acute care), reducing demand in the system, improving financial sustainability or achieving greater health benefits from existing resources.

The renewed focus on integration presents the opportunity for systems and their places to take a wider, long-term view and be more focused on prevention. Rather than treating illness when it arrives, an increased focus on upstream initiatives to prevent illness, improve health and wellbeing and enable people to lead healthier, independent lives could help improve outcomes for the population, but also ensure health and care services remain sustainable into the future and provide best value for the public pound in place.

KEY POINTS: INTEGRATING CARE: WHAT AND WHY?

- The term 'integration' has been used in relation to health and care for many years, yet still it seems to mean different things to different people. Over time, there appears to have been a widening of the scope to focus on improving population health.
- The renewed focus on integration presents a new opportunity for partners across the health and care sector to work differently. A more strategic, long-term focus on the social determinants of health and wellbeing, reducing inequalities and prevention would improve population health, but also help ensure that health and care services remain sustainable for future generations.
- Taking a truly place-based and preventative whole system approach could make a huge contribution to achieving the core purposes of ICSs and the 'triple aim' duty set out in the Health and Care Act 2022.
- The recognition of local government as equal partners is welcome. All levels of local government hold many of the levers that are key to influencing population health and wellbeing. They also have a deep knowledge of and engagement with the places and neighbourhoods they serve.

Where are we now?

Although the 2022 Act puts ICSs on a statutory footing, they have existed in one form or another for some time. CIPFA has charted the evolution of integration through the development of sustainability and transformation plans in 2014, the establishment of sustainability and transformation partnerships (STPs) in 2016 and their development into ICSs (see Further reading). Even prior to STPs, the drive for integration has been apparent through various policies, legislative provisions and pilot programmes.

The original STPs were voluntary 'place-based' partnerships, bringing together NHS bodies, local authorities and other partners with the aim of planning improvements in health and care. These evolved into ICSs, where NHS providers and commissioners, in partnership with local authorities and others, take collective responsibility for managing resources, delivering NHS standards and improving the health of the populations they serve. ICSs have formed an increasingly large part of the policy vision for health and care but have remained non-statutory, with no formal powers or accountabilities, until July 2022.

Variation in integration

Given the way ICSs have evolved at different rates and in different forms, it is unsurprising that not all ICSs are equal – there is considerable variation between systems and even between places within a single ICS. A recent study by The Health Foundation entitled Integrated care systems: what do they look like? considers the extent of variation across ICSs.

This variation is the result of several factors:

Geography – the size and nature (urban or rural) of the areas covered.

Demography – population size, level of deprivation and the level/nature of health and wellbeing needs of the population. This will also impact on the level of resources available to the ICS.

Partners – the partner organisations involved and the extent of co-terminosity between them.

Maturity – the nature of relationships, history of collaboration and progress made on integrated approaches.

Figure 3.1: A map of ICSs (from 1 July 2022)

North East & Yorkshire

1 NHS Humber and North Yorkshire
2 NHS North East and North Cumbria
3 NHS South Yorkshire
4 NHS West Yorkshire

North West

5 NHS Cheshire and Merseyside
6 NHS Greater Manchester
7 NHS Lancashire and South Cumbria

East of England

8 NHS Bedfordshire, Luton and Milton Keynes
9 NHS Cambridgeshire and Peterborough
10 NHS Hertfordshire and West Essex
11 NHS Mid and South Essex
12 NHS Norfolk and Waveney
13 NHS Suffolk and North East Essex

Midlands

14 NHS Birmingham and Solihull
15 NHS Black Country
16 NHS Coventry and Warwickshire
17 NHS Derby and Derbyshire
18 NHS Herefordshire and Worcestershire
19 NHS Leicester, Leicestershire and Rutland
20 NHS Lincolnshire
21 NHS Northamptonshire
22 NHS Nottingham and Nottinghamshire
23 NHS Shropshire, Telford and Wrekin
24 NHS Staffordshire and Stoke-on-Trent

London

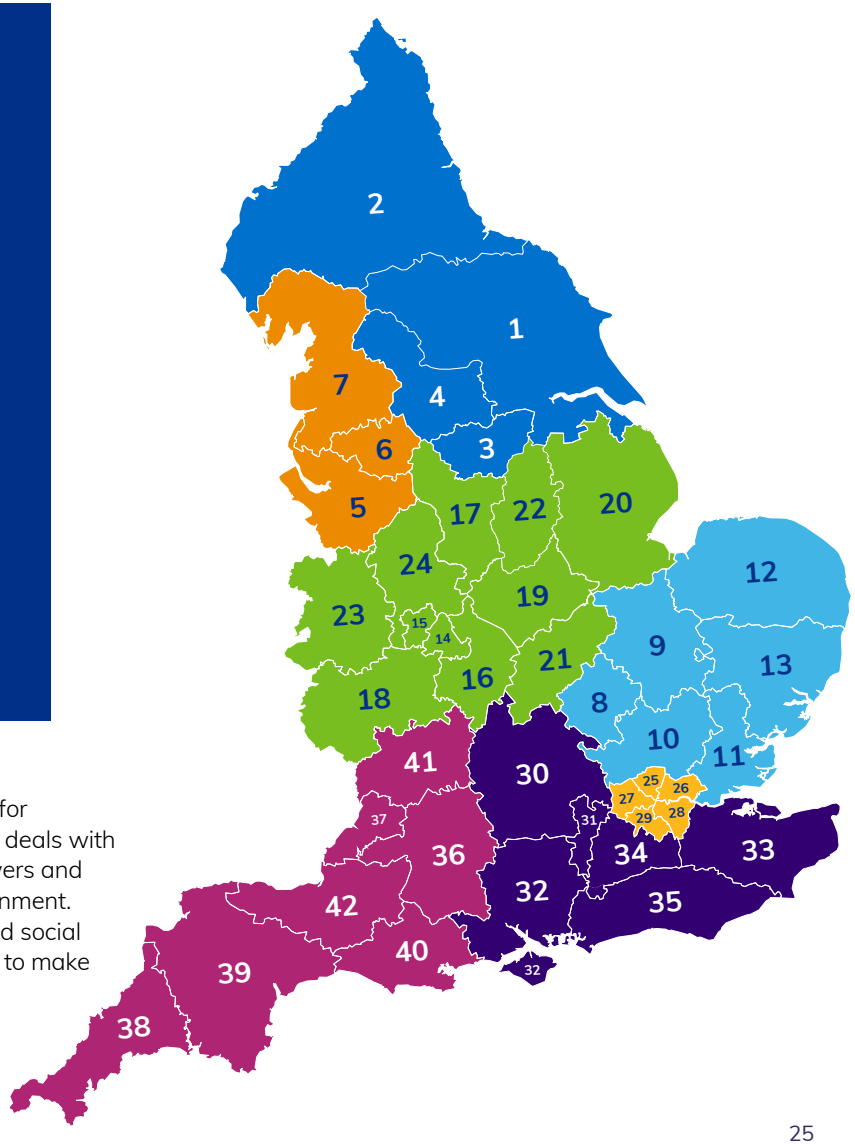
25 NHS North Central London
26 NHS North East London
27 NHS North West London
28 NHS South East London
29 NHS South West London

South East

30 NHS Buckinghamshire, Oxfordshire and Berkshire West
31 NHS Frimley
32 NHS Hampshire and Isle of Wight
33 NHS Kent and Medway
34 NHS Surrey Heartlands
35 NHS Sussex

South West

36 NHS Bath and North East Somerset, Swindon and Wiltshire
37 NHS Bristol, North Somerset and South Gloucestershire
38 NHS Cornwall and The Isles Of Scilly
39 NHS Devon
40 NHS Dorset
41 NHS Gloucestershire
42 NHS Somerset



Source: Integrated care boards in England (NHS England, 2022).

As systems have evolved and developed over time, the terminology used to refer to system, place and neighbourhood and the partnerships involved may also vary. For example, some ICSs are referred to as health and care partnerships, which may lead to confusion between the ICS and the ICP.

In some areas, devolution has acted as a catalyst for integration. Combined authorities have devolution deals with central government through which additional powers and funding are transferred from central to local government. For example, in Greater Manchester, the health and social care devolution deal has provided the opportunity to make decisions on a regional basis.

All these factors will therefore play into the nature of the system and its places, as well as the extent to which functions (and resources) are delegated. The 'maturity' of a place may not be the only factor involved in deciding on delegation of functions. For example, in some places, partners' co-terminosity may make it easy to delegate some functions to place level, while in others, the remaining statutory structures may make it problematic. Thus, the trajectory of evolution for places is likely to differ based on their circumstances.

Such variation is illustrated in the following examples:

NORTH WEST LONDON ICS

North West London ICS consists of eight local borough-based partnerships – or places.

We are:

- Eight boroughs
- One Clinical Commissioning Group
- Eight London councils
- Nine NHS Trusts – Four acute trusts, four community and mental health trusts, one ambulance trust
- 350 GP Practices
- 46 Primary Care Networks
- 276 care homes
- Over 1,500 voluntary organisations
- 50,000 NHS employees

Harrow

Population: 252,338
Deprivation (IMD rank): 156
Life expectancy at birth: Women 62.2, Men 63.8
GP practices: 33
Primary Care Networks: 5
Hospital: Northwick Park Hospital

Brent

Population: 327,753
Deprivation (IMD rank): 65
Life expectancy at birth: Women 71.3, Men 61.6
GP practices: 52
Primary Care Networks: 8
Hospital: Central Middlesex Hospital

Hillingdon

Population: 309,014
Deprivation (IMD rank): 142
Life expectancy at birth: Women 60.1, Men 61.6
GP practices: 45
Primary Care Networks: 6
Hospital: Hillingdon Hospital

Westminster

Population: 269,848
Deprivation (IMD rank): 101
Life expectancy at birth: Women 64.4, Men 65.7
GP practices: 33
Primary Care Networks: 4
Hospital: St Marys Hospital

Ealing

Population: 340,341
Deprivation (IMD rank): 94
Life expectancy at birth: Women 63.1, Men 62.7
GP practices: 73
Primary Care Networks: 8
Hospital: Ealing Hospital

Hounslow

Population: 271,767
Deprivation (IMD rank): 111
Life expectancy at birth: Women 61.6, Men 59.9
GP practices: 46
Primary Care Networks: 5
Hospital: West Middlesex Hospital

Hammersmith & Fulham

Population: 183,544
Deprivation (IMD rank): 88
Life expectancy at birth: Women 67.2, Men 66.5
GP practices: 28
Primary Care Networks: 5
Hospitals: Charing Cross Hospital and Hammersmith Hospital

Kensington and Chelsea

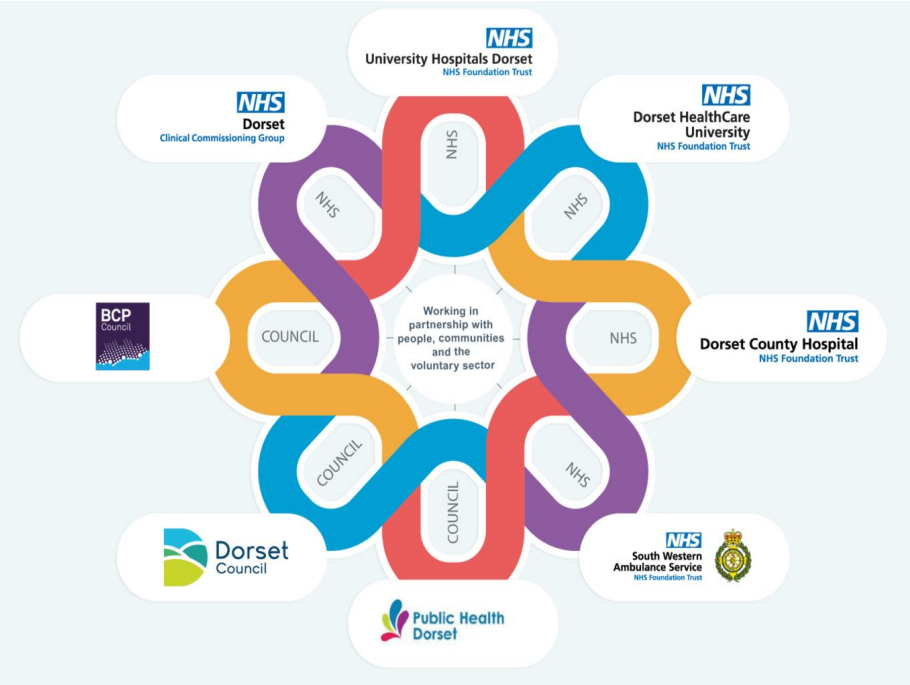
Population: 156,864
Deprivation (IMD rank): 137
Life expectancy at birth: Women 66.7, Men 61.2
GP practices: 40
Primary Care Networks: 5
Hospital: Chelsea and Westminster Hospital

Source: North West London ICS.

OUR DORSET ICS

Our Dorset ICS has two place-based partnerships – one in the Bournemouth, Christchurch and Poole Council area and one in the Dorset Council area.

Our system



- 810,000 registered practice population
- 422 GPs / 80 practices
- 2 Unitary Local Authorities
- 194 town and parish councils
- 2 Acute Hospital Trusts (over 4 sites)
- 1 Clinical Commissioning Group
- 1 Community and Mental Health Trust
- 18 Primary Care Networks
- 1 Ambulance Trust
- 7300 voluntary and community organisations
- 1 Police and Crime Commissioner and 1 Police Authority
- 1 Fire Service

Our Dorset
Your Local NHS and Councils Working Together

Source: Our Dorset.

NORTH EAST AND NORTH CUMBRIA ICS

North East and North Cumbria ICS is made up of four local partnerships built around the main centres of population. These local ICPs provide forums for NHS, councils and other partners to assess needs in their constituent local authority places.

North Cumbria ICP	North ICP	Central ICP	Tees Valley ICP
327,000 population	1,025,000 population	92,000 population	847,000 population
Cumbria County Council, Carlisle City Council, Eden District Council, Allerdale Borough Council and Copeland Borough Council	Gateshead Council, Newcastle City Council, North Tyneside Council and Northumberland County Council	Durham County Council, South Tyneside Council and Sunderland City Council	Darlington Borough Council, Hartlepool Borough Council, Middlesbrough Council, North Yorkshire County Council, Redcar and Cleveland Borough Council and Stockton-on-Tees Borough Council
8 PCNs	**24 PCNs**	**24 PCNs**	**17 PCNs**
Northumbria Integrated Care NHS Foundation Trust	Northumbria Healthcare NHS Foundation Trust, Gateshead Health NHS Foundation Trust and The Newcastle upon Tyne Hospitals NHS Foundation Trust	Country Durham and Darlington NHS Foundation Trust and South Tyneside and Sunderland NHS Foundation Trust.	Country Durham and Darlington NHS Foundation Trust, North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust
North West Ambulance Service NHS Trust	North East Ambulance Service NHS Trust	North East Ambulance Service NHS Trust	North East Ambulance Service NHS Trust

Source: North East and North Cumbria ICS: who we are.

Such variation is unsurprising – and in fact necessary – given the multitude of different local factors involved. However, it does complicate matters, as it means there is unlikely to be a linear template for how systems and places will evolve over time. As a result, the legislation is intended to be permissive, and much of the language in policy and guidance is quite 'loose' in an attempt to cover all eventualities. While this is understandable, it can lack clarity.

Progress of integration

Considering we have been on a quest for closer integration of health and care for many years, we still have very little clarity on what the impact of these efforts has been. That doesn't mean no progress has been made. Indeed, there are many specific examples demonstrating positive impacts of integration. However, many of these tend to focus on particular programmes or projects.

What is lacking is any consistent or comprehensive national evaluation of systems' overall impacts on their population. Where evaluation has been conducted, the measures considered have varied and have often focused on those related to NHS performance rather than the overall performance of local areas.

This lack of consistent evaluation has long been recognised. The 2017 Public Accounts Committee report Integrating health and social care recommended that there should be a set of criteria for measuring the success of integration. In their 2017 report on Health and social care integration, the National Audit Office (NAO) suggested it was "essential" that the government maintain "accurate and up-to-date information on the progress being made."

In 2017, NHS England published a STP progress dashboard, which was intended to provide a baseline view of each STP. It was designed to track 17 performance indicators over nine priority areas, each falling into three core themes: hospital performance, patient-focused change and transformation. These metrics were mainly focused on traditional NHS performance measures. For example, under the prevention priority, measures included related to emergency admissions and delayed transfers of care. Although it was intended that this dashboard would be used to monitor progress over time, it was updated only once in May 2018.

Subsequent NAO reports on the health and social care interface (2018) and NHS financial management and sustainability (2020) have reiterated that difficulty in assessing progress due to a lack of national evaluation. In the foreword to their 2018 report on the interface between health and care, the then Comptroller and Auditor General stated:

> There are lots of people across health and social care working hard at both the local and national levels to address these challenges and improve the help, care and support offered to individuals and local communities. In this report, we point to the progress being made, despite the barriers and limitations created by current legislation. I can imagine that the points we make may be taken by some as discouraging, but they are made now because if they are not thought through in advance, it is likely that we will still be agreeing violently on the need for integrated care and wondering why it has not progressed further and faster, in another few years' time.

There have been various attempts to assess the progress made, but many of these focus on specific pilot programmes or take a focus on specific issues. Such reports include the following:

- A 2012 study by RAND Europe and Ernst & Young evaluating the integrated care pilots.
- CQC's reviews of local health and social care systems, which identifies how services are working together to care for people aged 65 and over.
- In 2021, the Nuffield Trust considered the progress of integration across the four nations of the UK.
- The King's Fund's reviews of a year of integrated care systems and STPs in London.
- The 2021 study Integrated care in England: what can we learn from a decade of national pilot programmes? (International Journal of Integrated Care) considered a range of national pilot programmes, including integrated care pilots, pioneers and new care model vanguards.
- Solving the puzzle: delivering on the promise of integration in health and care (Institute for Public Policy Research, 2021) in which the IPPR and Carnall Farrar constructed an integrated care index, which found considerable variation between ICSs.

There are some common themes that can be identified from such evaluations, including culture, leadership and relationships; clarity of intention (insufficient regulatory and outcomes frameworks); the need for realistic expectations and timescales for what can be achieved; competing priorities and accountabilities; competing or inadequate incentives – the need for sufficient funding and resource; and the impact of the broader political and economic context.

Current proposals for evaluating the progress and performance of ICSs moving forward is unclear, with commitments made to a range of potential mechanisms including:

- a revised oversight framework from NHS England
- a new duty on the CQC to assess ICSs
- commitment in the 2022 White Paper to develop an outcomes framework.

Alongside these mechanisms, the NHS England operating framework (2022) describes the roles that NHS England, ICBs and NHS providers are intended to play alongside partners in the wider health and care system, setting out how accountabilities and responsibilities are intended to be allocated.

It is crucial that national policy and mechanisms for assessing performance and progress recognise the significant variation in ICSs, their places and the local circumstances and be realistic about what can be achieved with reasonable timescales and the resources available to them.

KEY POINTS: WHERE ARE WE NOW?

- There is huge variation between systems and places due to local factors and the way they have developed over time.
- Such variation is necessary, given the many unique characteristics of each locality. However, it does mean that the trajectory of evolution for places will differ depending on their circumstances and is unlikely to be linear.
- There has been little consistent or comprehensive evaluation of the impact of integration at national level. Where evaluations have been conducted, they tend to be focused on specific programmes or issues.
- Current proposals for evaluating the progress and performance of ICSs in the future remain unclear.
- It is crucial that national policy and mechanisms for evaluating performance and progress recognise the significant variation among systems and places and are realistic about what can be achieved with reasonable timescales and the resources available.

Integration in the context of the wider landscape

Integration is far from the only thing on the minds of those across the health and care sector. Both the NHS and social care were already facing enormous challenges, which have only been exacerbated by the COVID-19 pandemic, as highlighted in our work with Institute for Government on Performance Tracker.[7] However, there are many lessons to be learned from the pandemic experience, perhaps none more relevant to the integration agenda than the improvements in partnership working and collaboration that it necessitated.

As well as dealing with these existing pressures and recovery from the pandemic, there are many other policy, political and economic pressures looming large for the wider health and care sector.

Competing priorities and pressures

The past 12 months have been extremely busy with several major reforms proposed that could impact, directly or indirectly, on the integration agenda, which will compete for scarce resources.

The Health and Care Bill was published in July 2021 and was finally enacted (after much 'ping-pong' between members of the House of Commons and House of Lords) in April 2022. There has also been a huge amount of guidance produced during the passage of the Bill and following its enactment.[8]

In addition to this:

- September 2021 saw the publication of Build Back Better: Our Plan for Health and Social Care (DHSC et al), which put forward proposals for adult social care charging reform, including a cap on care costs and introducing a 'fair cost of care'. It also introduced the Health and Social Care Levy, which has since been cancelled in HM Treasury's Growth Plan 2022.
- Since the publication of Build Back Better, there have been a number of other documents released providing further detail and guidance on elements of social care charging reform, including Operational guidance to implement lifetime cap on care costs and Market Sustainability and Fair Cost of Care Fund 2022/23: guidance (DHSC, 2022).
- In November 2021, a major review of health and social care leadership was launched by the DHSC (the Messenger review), which then reported in June 2022.
- December 2021 brought the People at the Heart of Care: adult social care reform White Paper (DHSC). This presented a ten-year vision and a three-year plan to invest £1.7bn in priorities such as housing and adaptation, workforce training and support for unpaid carers.
- December 2021 also saw the publication of NHS England's priorities and operational planning guidance for 2022/23, which sets out ten priorities for the NHS. This was then updated in April 2022 to reflect planning for elective recovery.
- February 2022 saw the publication of the NHS's delivery plan to tackle the backlog of elective care as a result of COVID-19, as well as the White Paper on levelling up (Department for Levelling Up, Housing and Communities) with its 12 missions, and a further White Paper on health and care integration (DHSC).
- In March 2022, the then secretary of state Sajid Javid made a speech on further health reform focused on prevention, personalisation and performance. The same month also saw publication of the NHS mandate for 2022/23 (DHSC), which sets out a further five objectives for the NHS.
- May 2022 brought the final report of the independent review of children's social care, as well as the Fuller report on integrating primary care.

7 The CIPFA/Institute for Government Performance Tracker is a data-driven analysis of the performance of a range of public services.
The 2020 edition considered how public services were coping with COVID-19, including emergency measures introduced.
The 2021 edition assessed the costs of COVID-19 on public services and considered the pressures they will face in future years.
The 2022 edition considers the state of public services after two years of COVID-19.

8 At the time of writing, over 80 pieces of guidance have been published on FutureNHS (FutureNHS login required).

Amid all this, we have also seen reform of public health at the national level with the demise of Public Health England and the establishment of two new national bodies – the UK Health Security Agency and the Office for Health Improvement and Disparities. It is expected that there will be a 'refresh' of the NHS Long Term Plan, and at the time of writing, there is some speculation as to whether the long-awaited White Paper on addressing health inequalities will emerge. We are also in the midst of a cost of living crisis, with rising inflation and energy costs hitting the public sector hard, in addition to the existing pressures of demand, workforce and scarce funding.

This means the landscape of health and care is extremely crowded. While some aims may be mutually reinforcing, together with wider pressures, it does make it difficult to prioritise, plan and resource appropriately. For those involved in health and care integration, whether in the NHS or local government, navigating a clear path through these sometimes competing priorities will be challenging and may lead to further tensions and distractions. This was highlighted in a survey of senior local government figures, where one of the concerns raised was the ability to deliver several reforms simultaneously.

In the current minefield of competing priorities and pressures on both the NHS and local government, it is difficult to see how integration has any chance of progressing "further and faster" as set out in the 2022 White Paper. Indeed, some are now wondering whether they face an 'impossible task'.

A shared understanding between partners is essential, and not only of the different systems and frameworks within which they operate – an openness and honesty about the priorities and pressures they face is also crucial to building the relationships and trust required.

Government departments should lead by example and demonstrate a more integrated or corporate approach to coordinating policy and clarifying priorities in a more coherent and joined up manner. For example, there are clear parallels between health and care integration, prevention, addressing health disparities and the levelling up agenda. DHSC and the Department for Levelling Up, Housing and Communities (DLUHC) should work together to better link these mutually reinforcing policy areas to provide clarity on the common expectation of the outcomes of closing the gap on social inequalities. Even within DHSC itself, there could be greater clarity provided on the overall impact/expectations of currently fragmented policies around social care reforms, integration, prevention and health disparities.

Short-term versus long-term view

Achieving the vision of integration having a positive impact on population health and wellbeing and reducing health inequalities, with a focus on prevention, will necessitate commitment and investment over the long term, which to date has been lacking. Unfortunately, such long-term commitment is not always compatible with either the funding and finance regime or the length of the political cycle.

There are many long-term policy visions presented that are seldom backed by certainty of funding over the same timescales. For example, the 2019 NHS Long Term Plan set goals over ten years, yet the 2021 spending review set out indicative NHS allocations to 2024/25. Similarly, the 2021 White Paper on social care reform presented a ten-year vision, but only a three-year plan for investment of £1.7bn. While it is perhaps not always feasible to back such long-term policy goals with detailed spending plans, there must be a reasonable amount of certainty over funding to enable medium-to-long-term financial planning for these visions to be delivered.

The following examples appear to illustrate the disconnect between the long-term policy goals and shorter-term funding priorities:

- The NHS is moving towards a more population-based financial regime, yet some of the additional funding made available recently to deal with the immediate pressures on elective and emergency care has been dependent on levels of activity, reflective of the old 'payment by results' mechanisms.
- In adult social care, there have long been calls for additional funding to deal with existing pressures, yet this has not been forthcoming, with authorities increasingly reliant on the social care precept. There has been some additional funding for proposed charging reforms, yet the consensus across the sector is that this is unlikely to be sufficient to deal with the scale of the challenge.
- Throughout the White Paper on integration and in wider policy on health and care reform, there is a common focus on prevention. Yet earlier this year, it became apparent that NHS England would need to cut core funding in 2022/23, with the suggestion that this would involve 'slowing down' transformation programmes, including the prevention programme.

In their evidence to the Health and Care Select Committee's inquiry on the integration White Paper, the NAO recognised that risks to financial sustainability would be a cause of tension for integration:

> Pre-existing risks to financial sustainability in local authorities and the NHS, which the NAO has identified in both sectors but most acutely in local authorities, make for inherent tension between the overall goal and these three aims [reference to the triple aim]. In practice, a fourth aim is also likely to be unavoidable: continuing to cope with expanding demand for health and social care. The financial sustainability of the NHS and local authorities could well be a check on the system's ability to deliver other aims. In a context of expanding demand, there is a particular risk of some services deteriorating rather than improving. Understanding these interdependencies and being realistic about their implications for what the system can achieve will be important.

As ICBs come into being and the 'rubber hits the road' in a climate of tightening finances, increased demand and rising cost pressures, there are already fears and concerns being raised, from both the NHS and local government.

NHS Providers conducted a survey of NHS trust leaders in June 2022 that demonstrated the tight financial position, with 85% saying they were not confident their system would deliver a balanced financial position. Following the resubmission of ICB financial plans for 2022/23, 37 out of 42 ICBs had plans to deliver a balanced budget, but five systems did not sign up to deliver financial balance but instead submitted deficit plans, with combined deficits of around £100m. In response, NHS England suggested that these systems may face 'further measures', including potential restrictions around capital approvals.

Despite additional funding of £1.5bn to cover rising inflation costs, the NHS faces its first real-terms funding cut for many years. There are further risks that are likely to impact significantly on financial plans, including pay awards, energy costs, as yet unknown levels of demand, service pressures over the winter period, and the potential for under-delivery on planned efficiencies.

For some time, there has been widespread concern regarding the lack of adequate funding for adult social care. The lack of funding to deal with existing pressures and the proposals for charging reform seem to be fuelling this concern in the NHS and acting as a potential barrier to integration. In areas where close collaboration and pooled budget arrangements have been established for years, we are hearing of NHS partners backing away from these arrangements, citing that risks associated with the potential financial implications of charging reform are too great (see Pooling and risk in Oxfordshire).

Fears around the financial implications of social care charging reform are shared by colleagues in local government. A 2022 survey of upper-tier authorities conducted by the LGA showed that only 2% of respondents expressed confidence that the funding provided by government will be sufficient. A report from County Councils Network and Newton Europe (2022) considered the regional impact on local authorities of the proposed reforms to social care charging and estimated that costs could be at least £10bn higher than estimated over the next ten years.

In July 2022, the ADASS budget survey reported that only 12% of directors of adult social care are confident they have the resources to deliver on their responsibilities in 2022/23, dropping to only 5% next year. A range of cost pressures are biting, including workforce challenges, rising costs and inflation pressures. At the same time, levels of demand for services are soaring, some of which are due to challenges in the NHS. Market sustainability is also a concern, with around seven in ten directors reporting that providers in their area have ceased trading or handed back contracts.

It has long been the case that a lack of medium-to-long-term funding certainty, scarce resources, existing pressures and a tendency to focus on political priorities mean that the emphasis is on finding short-term fixes for immediate problems. It is also understandable that in the current climate, this is amplified. However, while long-term investments may be perceived as easier to defer in the face of immediate pressures, such disinvestment has an associated opportunity cost, both in terms of finance and impact on services.

Continuing on this trajectory will necessitate the need for short-term fixes in the future if we do not transform services and invest to manage demand and relieve future pressures. There is a need to take a twin track approach to ensure that public services are adequately funded to deal with the existing pressures they face, as well as making these long-term investments to ensure public services are cost effective, achieving best value and are financially sustainable to meet future needs.

Good public financial management requires a focus on the full extent of responsibilities in the long term to ensure that outcomes are achieved and value for the public pound is maximised. This requires certainty of funding in the medium to long term, as well as coherence of policy and priorities. This is true of any organisation but is even more crucial when taking a whole systems approach. All partners need to know what they can bring to the table and contribute to achieving the overall outcomes.

Remaining policy misalignments

While the 2022 Act removes some of the barriers to collaboration within the NHS, there remain areas of wider government policy that are not aligned with integration. These remaining inconsistencies continue to impede progress and require complex workarounds, which distract and drain resources from the national policy priority for closer collaboration and partnership working across organisations.

The ideal solution would be to remove the need for workarounds by improving the alignment of such policies within and across government departments to ensure that there are no barriers to this national policy priority. However, simply sharing experience and improving the understanding of these potential solutions would be a helpful interim step to avoid the need for undue focus on these issues, which distracts from the aim of integrating further and faster.

Universal versus means-tested care

Perhaps most obvious is the steepness of the differential between the NHS as largely free at the point of use based on clinical need and social care as means tested and subject to eligibility criteria.

While NHS services are in the main funded by central government, local authorities are increasingly reliant on raising their own funding through local taxation, fees and charges to pay for services, including social care. The means testing of social care also means that some individuals will pay for their own care, some may receive local authority funded care, and others will involve an element of co-payment.

The vastly different finance systems, separate funding mechanisms and payment processes lead to confusion and misunderstanding across organisations and can add complexity. Such differing financial incentives across health and care organisations can lead to variances with partner organisations in the broader system and distract from the shared vision and outcomes to be achieved, as highlighted in Can the NHS deliver integration? Lessons from around the world (Good Governance Institute, 2014).

Problems can also arise in relation to statutory responsibilities relating to the need to means test for social care. While most social care and public health functions of councils are included in partnership arrangements under Section 75 of the National Health Service Act 2006 (NHS Act 2006), some local authority functions are excluded. These exclusions include powers of assessment of financial resources and recovery of charges and interest under the Care Act 2014. This means that where the NHS and a local authority are working collaboratively in the provision or commissioning of services, only the local authority would have the power to assess the financial resources of an individual and be responsible for the recovery of any charges.

Differential VAT regimes

Local authorities and NHS bodies are governed by different value added tax (VAT) regimes as set out in the VAT Act 1994:

- Local authorities can reclaim most of the VAT they incur in carrying out their statutory (non-business) functions under Section 33 of the 1994 Act, provided this does not exceed the 5% partial exemption limit.
- NHS bodies fall under Section 41 of the 1994 Act and in general cannot reclaim VAT they incur. There are some exceptions to this where services fall within the contracted-out services (COS) headings.

This means that NHS bodies are funded to pay VAT on the goods and services they purchase, while local authorities are not but can reclaim VAT incurred.

Therefore, partners need to ensure they are clear on how they will account for income and expenditure, including VAT, before any partnership agreement comes into effect. There are two broad approaches to treating VAT within a partnership between local government and an NHS body:

- The lead partner's VAT regime will apply – simplest when a local authority is leading, as they can recover VAT in the usual manner.
- The lead partner acts as 'agent' for the other partner (the 'principal') – usually preferred when the NHS body is acting as lead.

Both options can cause additional complexities, create a potential obstacle to partnership working and divert time and resources from the goals of improving outcomes.

Further information on dealing with differing VAT regimes can be found in CIPFA's Pooled budgets and the Better Care Fund: a practical guide for local authorities and health bodies (2017).

In August 2020, HM Treasury published VAT and the public sector: reform to VAT refund rules, which recognised that differing VAT regimes can act as a barrier. It sought views on proposals for a full refund model, extending the scope of the current Section 41 arrangements. In July 2021, HM Treasury published a response paper summarising views received from stakeholders. Several responses proposed that NHS bodies should be given the same partial exemption treatment as local authorities to make the tax implications for collaborative projects easier and allow greater certainty when budgeting for the costs of such partnerships. The paper clarifies that the full refund model remains the preferred option, but the government will consider this, and wider views, before making a final decision on implementation.

The differing VAT regimes also create complexities where there is a desire to create joint arrangements that involve sharing staff (eg joint commissioning of services). Currently, local authorities can recover VAT incurred on secondments of staff from NHS bodies, but the reverse is not true (unless covered by COS). This means that any attempt to second staff from local government to the NHS results in an additional expense from the health budget. Even where NHS staff are seconded to local government, there is the risk that VAT on associated costs may risk breaching, or greatly reducing, the council's 5% de minimis allowance, which could have serious implications for their financial planning and ability to deliver other services.

STAINES HEALTH AND WELLBEING CENTRE

In 2021, Surrey Heartlands CCG was successful in a bid to NHS England to become a pioneer site for primary care redesign of estates and services. The ambition for this programme is to build community-based facilities that consider not only health and care needs, but also economic and environmental factors such as green spaces and housing. The aim is to improve the way the primary care estate is managed, with the model owned and controlled by the wider health and care system rather than individual GP partners.

The intention for Staines Health and Wellbeing Centre is to bring together three PCNs, children's and adult services, mental health support, community dentistry services, citizens' advice and other wellbeing services to:

- boost out-of-hospital care and aid in dissolving the historic divide between primary and community health services
- bring together different professionals to coordinate care better
- give people more control over their own health and care
- encourage more collaboration among health and care partners to develop appropriate services for local people
- provide an innovative space for current health and care staff to work together to address the wider determinants of health
- attract students and those in training to join the health and care workforce by providing a vibrant, holistic workplace
- get the most out of taxpayers' investment in the NHS
- accelerate estates transformation and making best use of the NHS and wider public sector estate.

The centre will be constructed alongside the development of 182 affordable homes and will help regenerate part of Staines-Upon-Thames.

The project is being led at place level by the North West Surrey Health and Care Alliance and Spelthorne Borough Council. The intention is that the scheme will be land-owned by the council and let to NHS partners on a long lease.

The development will require NHS funding of around £35m. The differential VAT treatment across the council and NHS means that the project is potentially 20% more expensive for NHS partners. VAT advisors for the project are exploring with HMRC the case that:

- when a council engages with partners to discharge statutory duties under Section 2b of the NHS Act 2006, it is acting as a public authority in line with Section 41(A)1 of the VAT Act 1994, thus Section 2B of the 2006 Act is a special legal regime
- when acting under these powers to provide NHS with accommodation, the non-business treatment of any supplies made to NHS will not lead to a significant distortion of competition, as per the VAT Act 1994 Section 41A(3).

At the time of writing, a decision from HMRC was pending.

Source: Personal communication.

COMMISSIONING HEALTH AND CARE IN MANCHESTER

In 2017, following the devolution deal, the ten local authorities in Greater Manchester worked to develop integrated commissioning and delivery arrangements for health and social care.

Manchester Health and Social Care Commissioning (MHCC) was developed as a committee in common with the Manchester CCG, underpinned by a Section 75 agreement with responsibility for commissioning local health, adult social care and public health services. This was a formal board with NHS executive and non-executive members, the local authority executive portfolio holder and senior managers.

Manchester Local Care Organisation (LCO), the delivery arm, was formed as a partnership between Manchester University NHS Foundation Trust, Manchester Health and Care Commissioning and Manchester City Council. The Manchester LCO was hosted by Manchester University NHS Foundation Trust, and arrangements are governed through Section 75 agreements (as provided for in the NHS Act 2006). Section 75 delegates some statutory functions to the NHS trust to enable the Manchester LCO to act as if it were a single organisation with responsibility for social care and community health. It also has an aligned budget.

Initially, the preferred solution for local residents was to have a separate delivery organisation for health and social care services. Several models were considered to enable the council and NHS partners to bring together funding to facilitate this. However, each option presented a similar issue – the divergence from current funding flows creating additional VAT liability. Sharing management resources or secondment of staff from the council to NHS partners would attract an additional VAT charge, as they were treated as a business supply. There were also issues with some services potentially impacting on the council's VAT de minimis threshold.

The options considered were:

- **A single autonomous organisation – special purpose vehicle (SPV)** established by partners to deliver integrated health and care. The SPV would be classed as a private company and so not enjoy the benefits afforded by councils or NHS bodies and would be unable to reclaim VAT on exempt supplies. This would result in significant irrecoverable VAT, which can currently be reclaimed by the council and between NHS bodies. This would have been achieved via a procurement process.
- **A single autonomous organisation – new NHS foundation trust**. In this model, the amount of recoverable VAT would be much lower than that recovered by the council under its VAT regime. The secondment of council staff would result in significant VAT costs, additional terms and conditions and pensions issues around TUPE if staff were transferred. Local government has a statutory override for the treatment of pension fund surpluses and deficits, which an NHS body would need to apply for.
- **Council services delivered under contract by Manchester Foundation Trust**. Barriers similar to those presented under the creation of a new NHS foundation trust model above.
- **Community health services delivered under contract by Manchester City Council**. Barriers include issues around terms and conditions of staff and loss of inter-group NHS recovery on supply.
- **Creation of Manchester LCO as a division of Manchester Foundation Trust**, co-ordinating aligned commissioning but no integration of staffing or budgets. This is the model that was adopted, with health and council budgets remaining separate and financial activity remaining with relevant host organisations.

Interpretation of the VAT legislation under the Section 75 agreement does address some issues around the secondment of staff, meaning staff can be shared across organsiations and attract no VAT liability. This allows for greater flexibility at managerial level. However, it is crucial that there is balance in these roles between the partner organisations – any transactions would be considered supply and VAT would be applicable. However, in this scenario, the council has greater flexibility to recover VAT if additional staff are employed by the LCO and charged rather than vice versa.

These models have evolved with the move to the ICB with a local care partnership and place-based lead. The Manchester LCO remains in place and is successfully delivering improved services for residents and patients.

Source: Personal communication.

The 2022 Act provides that NHS England can publish guidance on joint appointments between NHS bodies and local authorities. Such guidance should clarify whether any joint appointments are intended to be on a secondment basis or truly joint employment arrangements. Either way, it should seek to clarify and resolve the wider VAT issues to remove this barrier to closer collaboration.

KEY POINTS: INTEGRATION IN THE CONTEXT OF THE WIDER LANDSCAPE

- Both the NHS and local government are facing huge challenges – existing pressures, recovery from the pandemic and the cost of living crisis sit among wider policy reforms, political and economic pressures.
- For those involved in integration, navigating a clear path through this crowded landscape will be extremely challenging and will likely lead to further tensions and distractions.
- Achieving the vision for integration necessitates commitment and investment over the long term. However, there is a clear disconnect between this and the emphasis on immediate pressures.
- A twin track approach is required to ensure services can deal with the existing pressures they face, as well as making these long-term investments to ensure services are cost effective, achieving best value and are financially sustainable to meet future needs. This requires certainty of funding and coherence of policy priorities.
- Good financial management depends on consideration of the entire breadth of responsibilities over a long-term horizon to ensure outcomes and value for money are achieved. This is even more crucial when taking a whole systems approach. All partners need to be clear on the contribution they can make to achieving shared outcomes.
- There remain areas of government policy that are misaligned with national integration policy. Developing complex workarounds drains resources and distracts from the goal of closer integration.
- The ideal solution would be to improve policy alignment within and across government departments. However, sharing experience and improving understanding of potential workarounds would be a welcome first step.
- A shared understanding between partners is essential, and not only of the different systems and frameworks within which they operate – an openness and honesty about the priorities and pressures they face is also crucial to building the relationships and trust required for successful integration.

Shared outcomes

The 2022 White Paper on integration recognises that "priorities tend to be more focused when they are outcomes focused" and commits to developing a set of national outcomes, alongside an approach for prioritising shared outcomes at a local level. It sets the expectation that implementation of shared outcomes will begin from April 2023.

Outcomes-based approaches can aid in clarifying and assessing the purpose of a policy or programme, thus helping ensure that the public services meet the purpose for which they are provided. They can help to answer questions of particular relevance to integrating health and care – what are we trying to achieve, why and for whom?

A focus on outcomes in partnership working can highlight the dependencies between services and organisations, helping to foster a shared vision and common purpose and improve understanding between the partners. The benefits of taking an outcomes-based approach include:

- improved understanding of the impact of services on people's lives
- enhanced service design
- a more holistic view of the benefits of services and programmes that provide support and link together
- evidence to support service improvements
- improved accountability
- stronger support from stakeholders based on increased service value.

A potential barrier is how resources are allocated and how accountability operates, particularly when multiple organisations are involved. However, creating a link between resource allocation and the required outcomes provides a better focus across partners on achieving their shared goals and establishing value for money.

In practice, an outcomes-based approach requires a number of changes at all levels – at place level in support of local outcomes or at national level to support overarching services or national policy:

- Resources should be linked to outcomes to support more direct measurement and costing of services to support intended aims.
- Outcomes should be linked to and supportive of more preventative approaches, not only to improve population health and wellbeing, but also to provide opportunities to drive longer-term value for money from current spending, assist in avoiding more costly downstream interventions and ensure services are sustainable.
- Effective governance and scrutiny must underpin the delivery of outcomes that cut across sectors, and leadership must own the delivery of the benefits.
- Existing spending and control frameworks must be flexible to accommodate sharing of resources and pooling of budgets.
- Political support for outcomes is required through stated policy objectives and commitment to reporting and measuring progress towards outcomes.

Further information on outcomes-based approaches can be found in CIPFA's Delivering outcomes in the public sector (2020).

As highlighted earlier, there is currently some confusion regarding priorities for integration. There are the core purposes for ICSs, the triple aim priorities set for the NHS via the mandate, operational and planning guidance, the Long Term Plan, separate frameworks for public health and social care, and a range of policy priorities and reforms on the table across the wider sector.

A national outcomes framework that brings together and clarifies the overarching aims for health and social care would be a helpful way to navigate these wider policy objectives. However, it must not add a further tier of bureaucracy on top of existing sector-specific national priorities. This would require a truly integrated approach to be taken from the centre, with different government departments coming together to clarify priorities across national policy and the related outcomes to be achieved through integration. It would also need to be reviewed and refreshed as national policy priorities evolve.

If the overarching aim of integration is to improve population health and wellbeing, with an emphasis on prevention and reducing inequalities, then a national framework should not be based on closed and sector-specific performance metrics but rather a broader, comprehensive approach, which consolidates existing frameworks and priorities. Perhaps reflecting the original Marmot Review (2010) and its outcome indicators may be more helpful.

Given the extent of variation between integrated care systems and their places, the national outcomes must be broad enough to enable all systems/places to contribute to their achievement in a manner appropriate to their local circumstances. It should allow for more detailed, tailored frameworks to be developed in each ICS, reflecting the local priorities highlighted in ICP plans, which can then be further translated down to place level. As highlighted by the NAO in their 2017 report Health and social care integration,

local areas need to have "a clear definition of what they are working toward."

This could be achieved by formulating national minimum standards, which can be adapted and interpreted to local circumstances at system and place level rather than a detailed set of performance metrics that drive local activity. **The emphasis should be on local priorities reflecting national rather than national prescription stifling local need and innovation**.

In setting outcomes – whether at national, system or place level – there is a need to recognise that outcomes tend to play out over long periods of time, particularly those relating to complex issues such as the wider determinants of population health and wellbeing. This means making a commitment to the delivery of achievable outcomes, measuring progress at key stages and evaluating the long-term impact of interventions. Any outcomes framework must reflect a realistic expectation of what can be achieved within the timescale and resources available.

Lessons from elsewhere

The following examples from Scotland, Wales and New Zealand demonstrate how national frameworks have been developed to provide overarching goals for the public sector, which can then be interpreted and adapted to reflect local priorities.

SCOTLAND – NATIONAL PERFORMANCE FRAMEWORK AND HEALTH AND WELLBEING OUTCOMES

The Scottish Government introduced the National Performance Framework (NPF) in 2007. The NPF is intended for the whole of Scotland, encouraging national and local government, businesses, voluntary organsiations and its residents to work together towards a shared purpose and values. To achieve this, the NPF sets out 11 national outcomes.

81 national indicators are used to measure and report on progress against the national outcomes. These indicators provide a measure of national wellbeing and include a range of economic, social and environmental indicators. In 2020, the Scottish Government reported on the impact of COVID-19 on the national outcomes. This also looked at potential future impacts to aid in considering how to reset progress towards the national outcomes in light of the pandemic.

The Scottish Parliament's Finance and Public Administration Committee are currently undertaking an inquiry on the NPF. This will consider how the national outcomes shape government policy and spending decisions and how this drives delivery at both national and local levels.

In 2015, the Scottish Government published an outcomes framework for health and wellbeing, which applies specifically to integrated health and social care under the Public Bodies (Joint Working) (Scotland) Act 2014. The nine overarching outcomes are intended to guide the planning and delivery of health and care services, with a focus on improving experience and quality of service for people using the services, their carers and families. Each integration authority in Scotland is required to publish an annual performance report setting out how these outcomes are being improved. These include reports on core indicators/measures identified by the integration authority, in line with Scottish Government guidance on core indicators.

Source: National Performance Framework (Scottish Government).

WALES – WELLBEING OF FUTURE GENERATIONS

The Well-being of Future Generations (Wales) Act 2015 aims to improve the social, economic, environmental and cultural wellbeing of Wales. It requires public bodies to consider the long-term impact of their decisions, to work better with people, communities and each other, and to prevent persistent problems such as poverty, health inequalities and climate change.

The Act provides seven wellbeing goals to guide public bodies in meeting their duty. It also sets out the sustainable development principle, which states that public bodies "must act in a manner which seeks to ensure that the needs of the present are met without compromising the ability of future generations to meet their own needs."

To demonstrate that they have applied the sustainable development principle, there are five ways of working that public bodies need to consider to enable them to work better together to tackle long-term challenges.

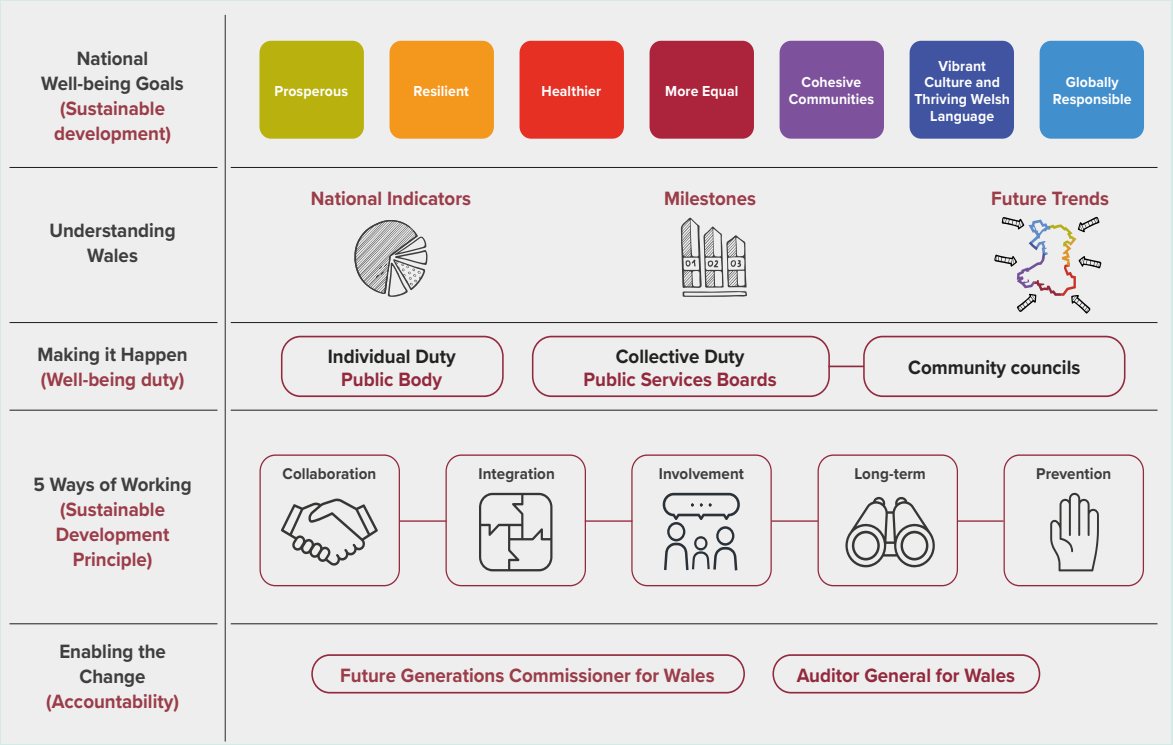
Public bodies are required to contribute to the wellbeing goals by setting their own objectives, and they must then take all reasonable steps to meet these objectives.

The Welsh ministers set national indicators against which progress towards the wellbeing goals can be assessed. They must also set milestones or expectations of what indicators should show over time. The Welsh ministers must publish an annual Wellbeing of Wales report setting out the progress made against the 46 national indicators. To aid understanding of future challenges, they are also required to publish a report on future trends after every Senedd election. The most recent report from 2021 is available on the Welsh Government's website.

The Act also established the role of the Future Generations for Wales Commissioner to act as the guardian of the interests of future generations in Wales and to support public bodies' work towards achieving the wellbeing goals. Prior to each Senedd election, the Commissioner must publish a report of their assessment of the improvement public bodies should make to achieve the wellbeing goals. The most recent report from 2020 is available at Future Generations.

The Future Generations Framework aims to assist those bodies responsible for projects in Wales that receive public funding to understand and articulate how their projects support the intentions of the Act.

Source: The Well-being of Future Generations (Wales) Act 2015 essentials guide (Welsh Government).



NEW ZEALAND – BUDGETING FOR WELLBEING

In 2019, the New Zealand Treasury introduced its first wellbeing budget, shifting the emphasis away from economic growth towards a more balanced view of the options for social, environmental and economic decisions and priorities. This approach aims to support people to lead more fulfilling lives with purpose, balance and meaning by:

- breaking down silos and working across government to assess, develop and implement policies that improve wellbeing
- focusing on outcomes that meet the needs of present generations at the same time as thinking about the long-term impacts for future generations
- tracking progress with broader measures of success, including the health of finances, natural resources, people and communities.

This approach has continued to evolve, and the New Zealand Treasury's wellbeing budget for 2021 is underpinned by five wellbeing objectives:

1. **Just transition** – supporting the transition to a climate-resistant, sustainable and low-emissions economy while building back from COVID-19.
2. **Future of work** – enabling all New Zealanders and New Zealand businesses to benefit from new technologies and to lift productivity and wages through innovation, supporting into employment those most affected by COVID-19, including women and young people.
3. **Physical and mental wellbeing** – supporting improved health outcomes for all New Zealanders and keeping COVID-19 out of communities.
4. **Māori and Pacific** – lifting Māori and Pacific incomes, skills and opportunities and combatting the impacts of COVID-19.
5. **Child wellbeing** – reducing child poverty and improving child wellbeing.

This wellbeing approach is underpinned by the applications of two frameworks, which can be used to understand wellbeing from different cultural perspectives and values:

- Living Standards Framework – application of this framework is key to embedding wellbeing into the government's decision-making process. It requires analysis of policy impacts across the different aspects of wellbeing – human, natural, social, financial and physical – across four capitals and 12 domains of wellbeing, reflecting current understanding of factors contributing to the experience of wellbeing. The domains provide a wider account of the outcomes government can affect, which helps inform investment decisions.
- He Ara Waiora – this framework helps understanding of waiora – or the Māori perspective on wellbeing – ensuring that it reflects the national and cultural context.

In 2020, the Public Finance Act (1989) was amended to require the New Zealand Treasury to produce a wellbeing report at least every four years. This report must use indicators to describe the state of wellbeing in New Zealand, how this has changed over time, and the sustainability of and risks to it. The first wellbeing report is expected to be published in 2022 and will be informed by the indicators from the Living Standards Framework dashboard.

What gets measured matters

In the context of a national outcomes framework for integration, it should be for local systems and places to determine their priority outcomes within the context of the national framework, and the associated metrics against which progress should be measured, based on evidence of their local circumstances and needs.

Good public financial management requires making evidence-based decisions on the allocation of public funds, as well as the ability to track and evaluate progress and ensure value for money is being achieved. Ensuring value for money in an outcomes-based approach requires:

- the development of suitable indicators
- allocation of resources to outcomes, taking value for money into account
- monitoring of performance and costs based on outcomes
- comparison of costs, benefits and performance to assess value for money
- the use of cost and performance data to understand the drivers and support decision making to improve outcomes and value for money.

As funding flows for integration are expected to work at system level, outcome indicators should be set at the same level to inform decision making on resource allocation. Where functions (and resources) are delegated from systems to place-based partnerships, then this level may be more appropriate for some indicators/outcomes, but these should be able to be built up to system level to provide a more holistic and strategic view.

One of the key challenges in taking an outcomes-based approach is the determination of indicators. This can be particularly challenging when considering population health, (highlighted by the King's Fund in How do you measure the success of population health approaches?), as there are numerous contributing factors and many metrics to choose from. Given many areas have already been working as systems and place-based partnerships for some time, and via health and wellbeing boards, data on local priorities and needs may already exist to provide a starting point. Further information on identifying and formulating indicators is covered in CIPFA's Delivering outcomes in the public sector (2020).

A baseline assessment of the health and wellbeing of populations at a systems level would provide a starting point from which to track progress towards defined outcomes and indicators over time. This is likely to be more meaningful than a single set of nationally prescribed metrics, which are unlikely to translate to system/place level. For example, existing data from JSNAs and health and wellbeing strategies could be used to provide an overview of population health at place level. This could then be aggregated to provide a system-wide view and considered through different priority lenses (eg health inequalities or preventative interventions) to give a view of different needs or cohorts across the entire system.

While performance against outcomes and indicators is important to provide transparency and accountability to stakeholders such as boards and the public, the primary purpose of performance monitoring should be to improve outcomes. Knowledge of past progress and performance is only useful if it helps to inform future decision making, policy and action on future interventions.

PLACE-BASED DATA TO INFORM POPULATION HEALTH PRIORITIES – NORTH WEST SURREY ALLIANCE

The North West Surrey Health and Care Alliance is one of three 'places' in the Surrey Heartlands ICS. Within the alliance, at 'neighbourhood' level, the Spelthorne Transformation Group brings together partners from Spelthorne Borough Council, Surrey County Council, the NHS and the voluntary sector to consider the needs of their local population.

The Spelthorne Transformation Group share specific baseline population health data to inform their future priorities and areas of focus for possible preventative investment.

Across the nine PCNs in the North West Surrey Health and Care Alliance, around 40% of patients registered with obesity fall within the three PCNs covering the Spelthorne area. This data is being further analysed at the level of individual practices to consider whether it is due to variation in data recording or whether there are identifiable causes and/or cohorts within these communities that may explain the high level of obesity. This includes overlaying of national data on factors contributing to obesity, as well as wider non-health correlations in comparison to the wider Surrey population (such as levels of unemployment, education, benefits and deprivation status).

Given the links between obesity and a reduction in active lives, wider health conditions and potentially early mortality, the findings of this analysis will be used to consider whether targeted actions are justified in this neighbourhood.

Consideration of baseline population data in this way will help to ensure that decisions on future priorities and investment in prevention are based on evidence obtained from that locality and so are targeted at the specific needs of the population. The underlying data will also provide a baseline against which any interventions can be assessed to track and evaluate progress in the future.

Source: Personal communication.

PLACE-BASED DATA TO INFORM POPULATION HEALTH PRIORITIES – LEWISHAM AND GREENWICH

Lewisham and Greenwich NHS Trust, in partnership with other health and care providers in the area, have invested in a population health and care management programme (PHCP). This takes data from primary, secondary and community care and mental health services to provide an integrated dataset. It enables consideration of specific patient populations by geography, demographic factors and health indicators, so can be used to identify and target underserved populations and to assess the potential impact of specific interventions.

Live projects using the PHCP include:

- **A type 2 diabetes dashboard** – developed to combine data from multiple datasets to enable proactive identification of undiagnosed diabetes and those at risk of developing the condition. This has enabled those patients to be identified to inform testing and diagnosis.
- **A COVID-19 dashboard** – developed to identify and prioritise areas and populations to focus a vaccination programme on and to qualify trends in uptake by demographic and inequalities among the local population. This has helped inform how and where to direct targeted interventions and encourage vaccine uptake among specific cohorts, as well as informing the planning for other vaccination programmes.

Further projects in development include plans to combine adult social care and health data, with the intention to use this dataset to predict future demand and better enable workforce planning, as well as improving the planning of social care services post-discharge.

Implementation and uptake of the PHCP has taken time and has not been without challenges, including the required initial investment, ongoing resource commitment and difficulties in agreeing financial risk share among partners. However, the benefits that can be accrued include:

- an ability to identify and target particular patient cohorts by geography, demographic factors and health indicators to enable any inequalities to be identified and targeted
- ensuring services are provided in the right place by improving understanding of community needs and identifying any gaps in care to increase quality
- improving diagnoses for those at risk of serious illness, allowing earlier intervention and preventing future demand.

Source: Improving population health outcomes with integrated data sets (NHS Confederation, 2022).

KEY POINTS: SHARED OUTCOMES

- Outcomes-based approaches can help ensure that the public services meet the purpose for which they are provided. In partnership working, a focus on outcomes can highlight the dependencies between services and organisations and so help foster a shared vision and improve understanding between the partners.
- Creating a link between resource allocation and outcomes provides a clearer focus across partners. Good public financial management requires making evidence-based decisions on the allocation of public funds to outcomes and the ability to track and evaluate progress and ensure value for money is being achieved.
- Lessons from other nations can demonstrate how national frameworks have been developed to provide overarching goals for the public sector, which can then be interpreted and adapted to reflect local priorities.
- Government departments should work together to clarify priorities across national policy and develop a national outcomes framework that provides a single, coherent set of shared goals across the health and care sector, without adding a further tier of bureaucracy.
- The national outcomes framework should be broad enough to enable all systems/places to contribute to their achievement. It should provide sufficient autonomy for local systems/places to determine their priority outcomes within the context of the national framework and the associated metrics against which progress should be measured, based on evidence of their local circumstances and needs.
- Incorporating national minimum standards into the framework could aid in providing a baseline against which outcomes could be adapted to local circumstances and priorities. The emphasis should be on local priorities reflecting national outcomes, not national performance metrics driving local activity.
- An outcomes-based approach to integrating health and care requires long-term political and financial commitment. At its heart must sit realistic expectations of what can reasonably be achieved within the timescale and available resources.

Place-based governance and accountability

The 2022 Act puts ICBs and ICPs on a statutory footing and charges them with responsibility for setting the plan and strategy to meet the health and care needs of their population. However, there is no legislative provision or solid arrangements provided for place-based partnerships.

The 2022 White Paper recognised place as being the engine for delivery and reform, and the need for "formal place-based arrangements to provide clarity over the responsibility for health and care services in each area." It set out criteria for place-level governance and accountability arrangements, including:

- a clear, shared, resourced plan across partner organisations for delivery of services within scope and for improving shared local outcomes
- a track record of delivery against agreed or shared outcomes over time
- a significant and growing proportion of health and care activity and spend, overseen by and funded through resources held by the place-based partnership
- clarity of decision making, covering:
  - contentious issues such as reshaping services within place (or contributing to wider reconfigurations)
  - clear, practical arrangements for managing risk, resolving disagreements between partners and agreeing shared local outcomes
  - a single point of accountability for delivery of the shared outcomes in each place, to be agreed by the relevant councils and ICB
- making use of existing structures such as HWBs and the Better Care Fund (BCF)
- providing clarity on what is done at place and system levels

The 2022 White Paper suggests a model that meets the above criteria (the place board model) but recognises specific areas of action and the best accountability arrangements will differ from place to place; therefore, it does not set out prescriptive arrangements. A number of alternative governance models for place have also been suggested in the 2021 Thriving places guidance developed by NHS England and the LGA.

Table 6.1: Governance models for place-based partnerships

Consultative forum	A collaborative forum to inform or align decisions by relevant statutory bodies (such as the ICB or councils) in an advisory role. Decisions of statutory bodies would be informed by the consultative forum.
Individual executives or staff	Statutory bodies may agree to delegate the exercise of specific functions to individual members of staff, and they may convene a committee to support them, with membership from across other partner organisations.
Committee of a statutory body	A committee provided with delegated authority to make decisions on the use of resources. Terms of reference and scope are set by the statutory body and agreed to by members of the committee. A delegated budget can be set to describe the level of resource available to cover the remit of the committee.
Joint committee	A committee established between partner organisations, who can then agree to delegate defined decision-making functions to the joint committee in accordance with their schemes of delegation. A budget may be defined by the bodies delegating functions to the joint committee to provide visibility on resources available to cover the remit of the committee.
Lead provider	A lead provider manages resources and delivery at place level as part of a provider collaborative under a contract with the ICB and/or local government. The lead provider has responsibility for delivering the agreed outcomes for the place (including national standards and priorities) for the defined set of services.
Place board model	The place board brings together partner organisations to pool resources, make decisions and plan jointly, with a single person (the place board lead) accountable for the delivery of shared outcomes and plans. Statutory bodies delegate functions and budgets to the place board, with integrated decision making achieved through formal governance arrangements. The place board lead would be agreed by the ICB and council(s) for the place.

Sources: Health and social care integration: joining up care for people, places and populations (DHSC, 2022) and Thriving places: guidance on the development of place-based partnerships as part of statutory integrated care systems (NHS England/LGA, 2021).

The requirement for a single point of accountability – or single accountable person (SAP) – in each place has generated many questions and some disparate views across the NHS and local government, particularly given the statement in the 2022 White Paper that the appointment of the SAP will "not change the current democratic accountability or formal accountable officer duties within local authorities, those of the ICB chief executive or relevant national bodies."

The 2022 White Paper sets out that the SAP can be an individual with a dual role across health and care or an individual lead for a place board, and the appointment must be agreed by the ICB and relevant local authorities. However, it does not clearly set out exactly whom they are accountable to or whether this is for local determination. It is also unclear how a single individual could, in practice, be held accountable for the decisions and actions of a non-statutory 'place' as a whole, or how the relationship between the SAP and providers (or provider collaboratives), which may cover multiple places, would operate.

There is also a question around the evolution of places over time. As arrangements and functions that are devolved to place level change, surely so will the role of the SAP, who may effectively find themself operating between moving goalposts.

The 2022 White Paper sets a clear expectation that places will adopt either the proposed place board model or an equivalent that meets the criteria (including the SAP) by April 2023, when arrangements for national and local shared outcomes are expected to go live.

Different approaches in place

In many areas, place-based partnerships have been up and running for many years, while others do not have such well-established arrangements – again, demonstrating the variability across and within systems. Even in areas where place-based partnerships are long established, these are now being revisited in light of the 2022 Act and the criteria set out in the 2022 White Paper.

Research conducted by the Health Service Journal in June 2022 showed a snapshot of place-based arrangements across England as systems prepared for ICSs to become statutory bodies. This showed that:

- 175 places were being established across the 42 ICSs
- three systems were not planning to have any subsidiary places (Gloucestershire, Lincolnshire and Somerset)
- 16 (or the remaining 39 ICSs) had selected executive leaders of their places (the SAP), with the majority being the ICB or local authority executives, with only a minority from NHS trusts
- 21 ICSs had identified the governance arrangements for their places. These represented a mixture of models, with the majority opting for committees of the ICB, while a few were planning consultative forums – two planning a lead provider model and one a joint committee between the ICB and council.

The following examples demonstrate some of the differing approaches being taken to place-based arrangements. Further information on place-based arrangements can be found in Developing place-based partnerships: the foundation of effective integrated care systems (The King's Fund, 2021) and Providers in place-based partnerships: case studies of local collaboration (NHS Providers, 2022).

GREATER MANCHESTER – LEADING IN PLACE

The Greater Manchester ICS consists of ten places, which match the boundaries of local boroughs.

In selecting place-based leads (or SAPs) for each of the ten places, three options were considered, all of which are focused on local councils as the 'leader of place'. Options included:

- the chief executive of the relevant council appointed as place lead on a joint basis, sharing their time between both roles
- the full-time appointment made by the ICB, jointly accountable to the ICB and council chief executive
- alternative proposals made by local partners, as long as they evidence the full involvement of the local authority and other partners.

The resulting appointments demonstrate the desire for councils to take prominence in leadership of place, with nine of the ten places appointing a council chief executive and only one appointing an NHS trust chief executive.

At its initial meeting in July 2022, the Greater Manchester ICB agreed the Scheme of Reservation and Delegation (SoRD) and financial scheme of delegation. This set out the delegation of functions from the ICB to the ten places.

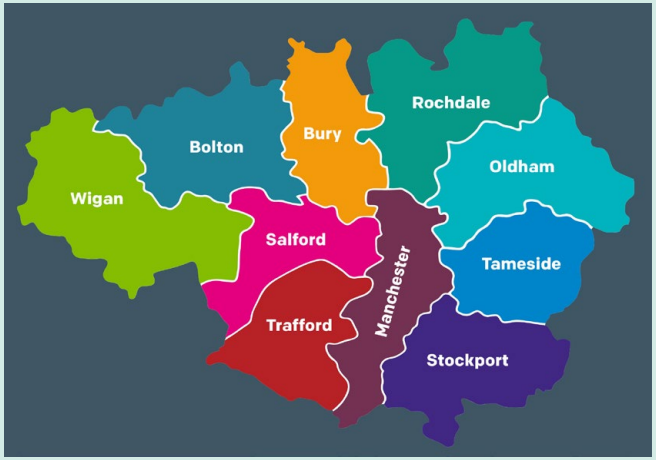
Place	Role
Bolton	Chief Executive, Bolton NHS Foundation Trust
Bury	Chief Executive, Bury Council
Heywood, Middleton and Rochdale	Chief Executive, Rochdale Borough Council
Manchester	Chief Executive, Manchester City Council
Oldham	Executive Director, Oldham Borough Council
Salford	Chief Executive, Salford Borough Council
Stockport	Chief Executive, Stockport Council
Tameside	Interim Chief Executive, Tameside Council
Trafford	Chief Executive, Trafford Council
Wigan	Chief Executive, Wigan Council

Source: Meet our people (Greater Manchester Integrated Care Partnership).

Prior to the establishment of the ICB, local authorities and CCGs had established Section 75 committees/boards to facilitate joint commissioning and partnership working at place level. The legal rights and obligations of CCGs under such arrangements transfer to the ICB by law. However, the existing delegations and committee arrangements do not.

To provide continuity of partnership working, enable delegations to be made as soon as possible and ensure that local authorities are able to participate in the decision-making process, the ICB also agreed an interim delegation position until formal locality boards are established in all places (expected by spring 2023).

Under this interim delegation position, the ICB agreed to establish Section 75 joint committees/boards with local authorities in each of their places. It was also agreed to delegate to place leads the authority to finalise arrangements for these Section 75 committees, as well as those functions delegated to locality boards under the SoRD but that fall outside the remit of Section 75 committees. This interim delegation will expire at the end of the current financial year, or upon the first meeting of the locality board, whichever is sooner.



Source: Greater Manchester Integrated Care Partnership.

DELIVERING THROUGH PARTNERSHIP IN SOUTH EAST LONDON ICS

NHS South East London ICB has agreed a principle of subsidiarity in determining roles and responsibilities across its system. To fulfil its mission, the ICB and wider system will rely upon place-based partnerships, working together to improve health and care for their communities.

There are six places or local care partnerships (LCPs) in the South East London ICS. These are partnerships between local authorities, NHS organisations and VCSE partners in the boroughs. Each LCP is a formal committee (either of the ICB or a joint committee of the ICB and borough council) and is led by a place executive lead, who sits on the ICB. These place leads come from a range of backgrounds across the NHS and local government, including executive directors from NHS providers and directors of adult social care.

Local care partnership	Committee of
One Bromley	ICB and Bromley Council
Bexley	ICB and Bexley Council
Healthier Greenwich	ICB
Lewisham	ICB
Lambeth Together	ICB
Partnership Southwark	ICB

Source: South East London ICS.

South East London local care partnerships

Although some of the LCPs have made joint arrangements for committees or place executive leads, those who have not are making other partnership arrangements to enable them to work across place. For example, in Southwark, Lambeth and Bromley, the ICB committee is chaired/co-chaired by a cabinet member from the relevant borough council. All LCPs will have partnership arrangements, bringing together partner organisations through delegated authority.

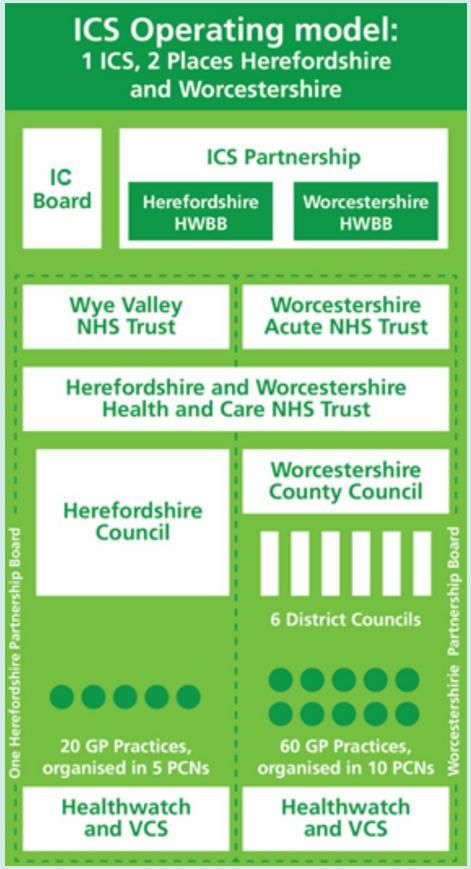
The scope of the LCPs' delegated responsibilities cover 'out of hospital services', including primary care, primary care prescribing, community service for physical and mental health, continuing health care and client groups. This includes delegated budget responsibility for these services. The place executive directors will discharge delegated responsibilities through the wider LCP and its committee, so decisions will be made by the LCP inclusively and collectively. During 2022/23, the ICB intends to further develop the approach to and scope of delegation for future years.

The LCPs will also convene the local system and take a lead responsibility in managing interactions through HWBs, borough-based local medical committees and overview and scrutiny committees.

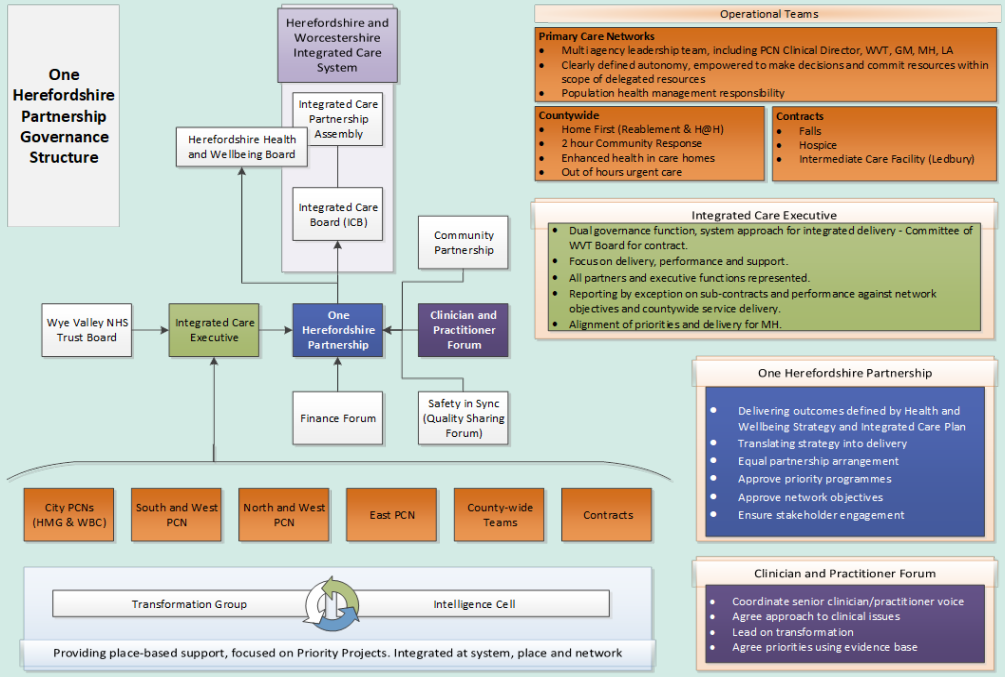
Further information can be found on the South East London ICS website, including details on ICB and LCP meetings and papers.

ONE HEREFORDSHIRE

There are two places within the Hereford and Worcestershire ICS – Herefordshire and Worcestershire.



One Herefordshire Partnership governance structure



Source: Herefordshire and Worcestershire ICS.

The One Herefordshire Partnership Board is adopting the 'lead provider' model. Wye Valley NHS Trust is the only local provider of acute and community services, alongside a single mental health trust (shared with Worcestershire). Several shared director roles have been established. The Partnership Board is chaired by the Managing Director of Wye Valley NHS Trust, and the Trust's Chief Operating Officer has also been appointed as the ICS lead director of the One Herefordshire Partnership (Chief Transformation and Delivery Officer). There are also senior joint appointments between Herefordshire Council and the local GP federation (Taurus Healthcare), with community health being jointly managed by Wye Valley NHS Trust and GPs. The partnership also has an integrated care executive, which takes the form of a joint team focused on operations, delivery and performance at the boundaries of NHS and local authority care.

EMBEDDING PLACE IN CHESHIRE WEST

Cheshire West is one of nine places in Cheshire and Merseyside ICS. Across the system, there has been a real focus on place development and the positive outcomes that can be delivered through further integration of health and social care, and by acting on the permissions that the 2022 Act enables.

The development of place has been a key focus of Graham Urwin CPFA, Chief Executive of NHS Cheshire and Merseyside ICB:

The parallel development of both system and place across Cheshire and Merseyside has been a keen focus for us. This ensures we remain locally focused, building on the great success of local integrated work to date, and above all that we remain aligned to improve health outcomes for the populations we serve.

The approach taken to place-based arrangements was around their maturity (as highlighted in Partnership Board papers in July and November 2021), and further details of place-based structures and functions have been published. The commitment to being 'locally focused' is evident in that three of the place director roles are joint appointments across the ICB and relevant local authority, one of these being Cheshire West.

Cheshire and Merseyside's nine places

Place	Place director
Sefton	Deborah Butcher*
Liverpool	Jan Ledward
Wirral	Simon Banks
Knowsley	Alison Lee
St Helens	Mark Palethorpe*
Warrington	Carl Marsh
Halton	Anthony Leo
Cheshire West	Delyth Curtis*
Cheshire East	Mark Wilkinson

* Place directors with statutory responsibilities in both the ICB and relevant local authority.

Cheshire West have approached embedding place across all partners proactively, developing governance with representation from commissioners, providers, the voluntary sector and Healthwatch to oversee, support and develop the delivery of their place-based agenda. The Cheshire West Place Plan articulates the following priorities:

1. To identify Cheshire West **population health needs** now and in the future, proactively detecting and preventing ill-health, while promoting wellbeing and self-care to our residents.
2. To **reduce health inequalities** by continuing to develop our approach to population health management (PHM), using data and analytics to prevent ill-health, address health inequalities and identify those residents who are at higher risk of their health deteriorating, enabling us to deliver preventive interventions.
3. Improving the **quality of services** that are delivered within Cheshire West, expanding on efficiencies and delivering safe and effective care.

The commitment to deliver these priorities is not new. As a place, the Cheshire West partners have a long history of collaborative working, taken to a new level as a result of the recent pandemic. The challenge now is to maintain that in a context of reduced funding and ever-increasing demand.

Innovative approaches to supporting the broader system through new 'home first' projects and pilots are being progressed in tandem with the new arrangements being rolled out. These support the ambition of bolstering community provision to reduce the pressures on the acute services.

Del Curtis, Place Director is keen that a collaborative approach is taken across local partners to reduce the pressures on the health and social care system.

All local partners are feeling the pressure from reduced budgets and increased volume and severity of demand on our front-line services. The only way to ensure we continue to deliver quality services locally is integrate operational delivery and problem-solving across health and social care. This is why we are committed to the delivery of our Integration Transformation Programme.

Source: CIPFA C.Co and Partnership Board papers (Cheshire and Merseyside).

Allowing for evolution of place

The recognition of the importance of place and the fact that there is no intention to prescribe specific governance and accountability arrangements for place-based partnerships is welcome. Indeed, the significant variation between places would make such prescription inappropriate.

Although many systems already have established place-based arrangements and others are in the process of considering such partnerships, systems and their places will develop and evolve further over time as more functions (and resources) are delegated, both from NHS England to systems and from systems to their places. This intention for further evolution of both systems and places was made clear in NHS England's guidance for ICBs on developing their scheme of reservation and delegation.

However, given the variation between systems and places, such evolution is unlikely to be consistent. As discussed earlier, factors such as geography, population, nature and level of need and the 'maturity' of places will determine the local context. In some areas, the nature of place may mean that some functions are more effectively carried out at neighbourhood level, so even the term 'place' may mean different things between systems, depending on their local circumstances.

Given the likely path of this evolution over time, any attempt at taking a 'one size fits all' approach would not be appropriate, nor in keeping with the principle of subsidiarity. However, some commonality or comparability is desirable.

An alternative may be to consider arrangements based on the 'maturity' of each place, enabling arrangements to adapt as the place develops. Such an approach could perhaps be modified from the system maturity matrix incorporated in the NHS England 2019 guidance on designing ICSs. However, even the most 'mature' places may find that their statutory structures and/or lack of co-terminosity make delegation of some functions unfeasible or impossible.

In CIPFA's 2022 briefing Integrating care: putting the principles in place, it was suggested that a principles-based approach would be more appropriate. This could incorporate some broad minimum expectations, would recognise the diversity of places and could be phased and adapted over time as places evolve differently. It would then be for each place to determine the appropriate and proportionate arrangements for their local circumstances and for others to assure themselves that these are sufficient.

A good starting point for such a principles-based approach would be CIPFA/IFAC's International framework: good governance in the public sector (2014). This aims to encourage better service delivery and improved accountability by establishing a benchmark for aspects of good governance. It recognises that the fundamentals of good governance remain the same for an individual organisation and the whole system it is a part of (funding or delivery), so it is particularly relevant to the systems and partnerships involved in the integration of health and care.

The framework is based around seven principles of good governance. It sets out the inter-relationships between them and provides guidance on their implementation. It proposes that the fundamental function of good governance in the public sector is to ensure that entities achieve their intended outcomes while always acting in the public interest.

The CIPFA/IFAC framework defines governance as "the arrangements put in place to ensure that the intended outcomes for stakeholders are defined and achieved." Thus, appropriate and proportionate governance arrangements depend not only on the particular circumstance of place – and the functions that are delegated to them – but also what local priority outcomes they are trying to achieve in the context of the overarching national outcomes framework.

Figure 6.1: Relationships between the principles for good governance in the public sector

Source: International framework: good governance in the public sector (CIPFA/IFAC, 2014).

KEY POINTS: PLACE-BASED GOVERNANCE AND ACCOUNTABILITY

- There is no strict prescription for governance and accountability arrangements at place level. However, several models have been proposed, and the 2022 White Paper identified criteria to be met and set the requirement that places have arrangements in position (including a single point of accountability) by April 2023.
- Some ICSs already have well-established places and others are currently developing such partnerships. However, the intention is that all place-based partnerships will continue to evolve over time as more functions (and resources) are delegated.
- Given the variation between places, this evolution is unlikely to be uniform. This is not necessarily related to their level of maturity or capability, as in some areas structural factors may prohibit delegation of some functions. Thus, a 'one size fits all' approach to governance and accountability arrangements would be inappropriate.
- A principles-based approach to governance and accountability arrangements could recognise the diversity of places and allow for adaptation over time. Such an approach could incorporate some minimum standards that must be met.
- With such a principles-based approach, it would be for each place to determine appropriate and proportionate arrangements and for others to assure themselves of their sufficiency.
- In developing such an approach, the CIPFA/IFAC international framework would be a good starting point. Based around seven principles, this establishes a benchmark and is designed to operate across organisations in a whole system.

Finance for place

Delegation of functions to place level should be accompanied by delegation of the appropriate resource to ensure that funding is available to support local decision making. Where funding follows function in this way, there is a greater chance of achieving shared outcomes at place level, as resources can be allocated in line with local priorities, so increasing value for the public pound in place. However, delegating resources and pooling budgets at place level does not in itself guarantee improved outcomes or greater integration of services.

The 2022 White Paper recognises that financial frameworks and incentives have a key role in enabling integration and recognise that they can often act as a barrier, as previously highlighted by CIPFA in its submission to the House of Commons Health and Social Care Committee on NHS Long Term Plan legislative proposals (2019) and others.[9]

As well as having place-based arrangements for governance and accountability established by April 2023, the 2022 White Paper sets the requirement that all places will need to develop "ambitious plans for the scope of services and spend", to be overseen by these arrangements, with the goal that all local areas should work towards inclusion of services and spend by 2026. It sets the ambition to go "further and faster" on pooling and aligning funding, with the intention that pooled budgets will eventually cover "much of [the] funding for health and social care services at place level."

In line with this, the 2022 White Paper makes the commitment to review arrangements, which enables the NHS and local government to pool and align resources (Section 75 of the NHS Act 2006), with a view to simplifying and updating the underlying regulations and producing further guidance by spring 2023.

Financial frameworks are vital in informing decision making on how to best use resources to achieve shared outcomes and as a mechanism to evaluate progress and inform planning for future resource use. The recognition that financial arrangements and incentives play a key role as enablers of integration is welcome; however, the commitment to review arrangements for pooling and aligning budgets appears too narrow and fails to recognise the broader tensions and misalignments that can impede progress.

Understanding the differences

There has been much focus on the NHS financial regime and moving towards system finance and population-based payment mechanisms. This has cleared away much of the 'competition' between NHS bodies that was previously a barrier to more collaborative working. However, there appears to be little consideration of how the differing systems across the NHS and local government interact.

Closer integration of services across organisational boundaries to achieve shared outcomes depends on relationships being established on the basis of mutual understanding and trust. The vast differences in the funding and finance regimes across the NHS and local government can act as a key constraint and add complexities to partnership working.

In addition to the policy misalignments around charging for services and VAT regimes, there are more fundamental differences. These include how services are funded and financed, how funding flows within and between organisations, the timing of the financial cycle, differences in planning and reporting requirements, and even differences in terminology used.

Differences in timing, for example, can be problematic, with local government setting their annual budget at a point in the year when NHS partners may not yet be aware of their allocation. This makes it extremely challenging to agree an aligned position to start from.

9 Integrating funds for health and social care: an evidence review (Journal of Health Services Research and Policy, 2015) and Health and social care integration (NAO, 2017).

Similar misalignments occur at the other end of the financial year in terms of reporting. While misalignment of the financial cycles may be advantageous in terms of external audit, it does create complications when aligning or pooling resources, and it could lead to resources not being utilised to best effect due to the need for quick decision making.

There are also cultural differences relating to financial management across organisational boundaries such as the approach to, appetite for and management of risk. In partnership working, some degree of risk is unavoidable, and risk transfers will need to occur. As highlighted in CIPFA's The Practicalities of Integration (2018), partners need to understand their own, and each other's, risks and related appetite.

Given the vast differences in funding flows, financial regimes, culture and terminology across the NHS and local government, a 'common language' to facilitate mutual trust and understanding will be essential to develop the productive relationships required for partnership working. In collaboration with HFMA, CIPFA have advocated for such shared understanding between partners in health and care through work such as The future financial sustainability of health and social care (2021), An introduction and glossary to NHS and local government finance and governance in England (2019) and Guidance for CFOs working in health and local government (2019).

The 2022 White Paper suggests that pooling and aligning of budgets will support long-term investment in population health and wellbeing. While this may act as an enabling factor, the ability to commit to long-term investment goes far beyond the ability to pool resources. As discussed earlier, both the NHS and local government are facing huge challenges, with tensions building on both sides, and there is a clear disconnect between the immediate pressures and the need for long-term commitment and investment.

This is exacerbated by the lack of long-term funding certainty, which stifles the ability to conduct medium-to-long-term financial planning. In CIPFA's joint briefing with HFMA on the future financial sustainability of health and social care, it was suggested that this means resources may not always be used as efficiently or effectively as government (or those working in services) may wish, so services may be operating inefficient delivery models but may be unable to take action to improve them.

The current financial regimes and funding mechanisms do not support a whole system approach to improving population health and wellbeing with a focus on prevention. Achieving this will necessitate a more strategic and long-term approach to funding and financial planning.

Pooled budgets

The 2022 White Paper sets the expectation that pooled (or aligned) budgets will become more widespread over time, supporting more integrated models of service delivery, and that they should "become routine … eventually covering much of funding for health and social care services at place level." It stops short of mandating the use of pooled budgets and sets out that this will continue to be subject to the agreement of NHS and local government partners. However, it does set the goal that places should work towards greater inclusion of services and spend by 2026.

The experience of mandating pooled budgets in Wales (see case study Pooling budgets in Wales) demonstrates that this can have limited success. While mandating may provide a helpful lever from which to encourage closer collaboration, pooling budgets for a particular purpose is better suited to local determination, reflecting the unique circumstances in each locality.

To support greater pooling of budgets, the 2022 White Paper commits to reviewing the existing arrangements (Section 75 of the NHS Act 2006) with the aim of simplifying and updating the underlying regulations. It also commits to working with partners to develop guidance for the NHS and local government on pooling budgets by spring 2023.

POOLING BUDGETS IN WALES

Health and social care partnerships have existed in Wales since 2003, but during the early years, only a few explored the potential for pooling funds.

The introduction of the Integrated Care Fund in 2014 and the requirement in the Social Services and Well-being (Wales) Act 2014 (the SSWB Act) to establish seven regional partnership boards (RPBs), and for these statutory RPBs to establish pooled funds, provided fresh impetus.

Audit Wales' 2019 report on the Integrated Care Fund found that all RPBs had pooled funds in place for areas such as integrated family support and (since 2018) the commissioning of adult care home provision. The report reflected a view from the Welsh Government that the fund had provided a basis for taking forward pooled arrangements. It also found little evidence of projects being successfully taken forward and funded as part of core service delivery.

In Audit Wales' 2021 report on care home commissioning for older people, it was highlighted that in 2020, the Auditor General raised concerns around regional pooled funds in relation to care homes for older people. These emerged from work conducted in two North Wales local authorities, which found that funding from partner organisations was placed into a pooled fund, but each contributor had their funding returned to them within 24 hours. In response to this, Welsh Government officials told Audit Wales that they did not regard this type of arrangement as a satisfactory response to the policy intention of enabling closer co-operation between care home commissioners.

The Welsh Government published a report on a pooled budgets evaluation framework in November 2020, which assessed the progress of each of the RPBs on developing pooled budgets relating to care home accommodation for those aged 65 and over. Key observations at that time include the following:

- RPBs predominantly met the minimum requirement – all RPBs had established partnership agreements and governance arrangements to manage pooled funds.
- Many RPBs were not physically pooling budgets – five of seven RPBs did not physically pool funds and share financial risk, although their reporting, governance and decision making suggested a move towards a collaborative approach.
- RPBs' support for pooled funds – all RPBs expressed support for the use of pooled funds as a mechanism to support integrated services.
- Most RPBs highlighted that care homes for older people was a challenging first area to pool funds.
- Broadening the scope of pooled budgets – there were instances where an RPB had physically pooled funds in areas other than care homes, which indicated the RPB's openness to using pooled funds as a lever more broadly.

Audit Wales' 2021 report suggested that "although the Welsh Government has directed local authorities and health boards to work collaboratively and pool funds for older people's care homes, progress is limited with little if any benefit seen by the service user." It went on to state that merely meeting the minimum technical requirement for pooled budgets "fails to deliver any tangible benefit" and does not represent value for money. Among other things, it recommended that the Welsh Government reduce the complexity of funding arrangements to streamline activity and communicate how it expects pooled funds to operate across health and care partners.

The Welsh Government responded to these recommendations in its submission to the Public Accounts and Public Administration Committee's inquiry into care home commissioning for older people (2022).

Sources: Audit Wales and Welsh Government.

What are pooled budgets?

A pooled budget is a financial mechanism through which public sector bodies can consolidate funding into a discrete shared funding pot to be used for a particular purpose.

The formation of a pooled budget is wholly dependent on partnership working arrangements. The purpose and scope of a pooled budget must be agreed at the outset, with the aims and objectives set out in a formal written agreement, and the level of contribution to be made by each partner agreed before the pooled budget is approved.

Pooled budgets can enable partners to focus on the needs of service users and provide services in a more joined-up manner rather than being constrained by organisational boundaries, thus potentially delivering greater value for money for the public pound in place.

While a pooled budget is completely dependent on partnership working, the reverse is not true. A less formal and perhaps more pragmatic approach is aligning budgets. With an aligned budget, partners retain full accountability for their resource, but at an operational level, budgets, levels of delegation and objectives are structured so that they match. Such arrangements are sometimes accompanied by joint appointments between partner bodies, which can reinforce the alignment.

Aligned budgets have the benefit of being simpler and more economic, as they do not have the overheads associated with more formal partnership arrangements. However, this could be offset by the lack of a formal agreement, which may cause uncertainty and lead to tensions between partners.

Complexities of pooling

The legislative framework enabling pooled or aligned budgets is set out in Section 75 of the NHS Act 2006. This enables the secretary of state to make provision for local authorities and NHS bodies to enter into partnership arrangements in relation to certain functions where this would lead to an improvement in the exercise of those functions.

Provision for these arrangements is set out in the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 (the partnership regulations). These powers are also the basis on which the Better Care Fund is established.

BETTER CARE FUND

The Better Care Fund (BCF) was announced in HM Treasury's spending round 2013, with the specific aim of "delivering better, more joined-up services to older and disabled people, to keep them out of hospital and to avoid long hospital stays." The wider intention of the BCF was to drive transformation of local services to ensure people receive better and more integrated care and support. As such, it could be seen as being the precursor to STPs.

The BCF was introduced in 2015 as a fund of £3.8bn to be deployed locally through pooled budget arrangements (under Section 75 of the NHS Act 2006) between councils and CCGs. This was not new money but rather consisted of funding ringfenced from CCGs and the social care capital and disabled facilities grants to councils. Although the BCF operates as a pooled budget, the conditions attached to each of the associated funding streams must still be met. Statutory responsibilities are not delegated but are maintained by the respective bodies.

The BCF has developed over the years since its introduction and underwent a review in 2019 to understand its impact on integration and seek views on its future direction.This concluded that the fund had been effective in incentivising areas to work together more effectively, with 93% of areas reporting that it had improved joint working in their locality. It also found that there remained some confusion around the fund's aims, arising from mixed objectives and a lack of effective measures of integration. The review recommended that there should continue to be a fund, as any attempt to remove it would be a backward step for integration, and that the NHS contribution to social care should be maintained.

The BCF remained largely unchanged in 2021/22, but changes as a result of the 2022 Act and the White Paper on adult social care reform provide the context for future changes. However, there are limited adjustments in the 2022/23 BCF policy framework, with the aim of providing continuity during the transition period. However, it does state the aim of consulting with local areas in late 2022 on the future direction of the BCF in the context of these broader reforms, including the revised approach to integration at place level.

Further information on the BCF:

- Pooled budgets and the Better Care Fund: a practical guide for local authorities and health bodies (CIPFA, 2017) provides information on BCF governance, reporting, assurance and operation.
- The FutureNHS platform hosts the BCF Exchange, which supports local areas in planning and implementing the BCF and includes the BCF practice and evidence database (FutureNHS login required).
- Better Care Fund policy framework 2022/23 (DHSC/DLUHC, 2022).
- Better Care Fund planning requirements 2022/23 (NHS England/LGA, 2022).

Section 75 and the partnership regulations enable NHS bodies and local authorities to enter into joint arrangements relating to the sharing and delegation of functions in a variety of ways to provide for more integrated commissioning or provision of services. However, the statutory responsibility for the discharge of functions remains with the relevant statutory body. For example, a health body can exercise certain prescribed statutory functions of a local authority on their behalf and vice versa (see Delegation of functions).

There are some significant exclusions from the list of 'prescribed functions' in the partnership regulations, particularly in relation to NHS acute health services. NHS England have produced statutory guidance on the delegation and joint exercise of statutory functions.[10] Most local authority social care, health and public health functions are included, as are wider functions relating to wellbeing (including the environment, waste, housing and transport). Exclusions include Care Act 2014 powers relating to social care charging, such as powers of assessment of financial resources and recovery of charges and interest.

There have been many suggestions that broadening the scope of the prescribed functions could enable more substantive partnership working to achieve the aims of integration – for example, enabling a single framework agreement with a number of underlying arrangements for specific services, with a pooled or aligned budget specific to each service.

10 FutureNHS login required to access.

In 2018, the Public Accounts Committee recognised that "the current legislative framework makes it unnecessarily difficult for local areas to pool funds and work together, causing additional cost and wasted resources" in their report on the interface between health and adult social care. They went on to recommend that DHSC and the then Ministry for Housing, Communities and Local Government (MHCLG, now DLUHC) address these challenges presented by fragmented funding and separate means testing.

In practice, local authority and NHS managers are responsible for initiating and developing partnership arrangements, which can involve a complex and lengthy process of negotiation and results in a legally binding partnership agreement. It is often the case that negotiating a truly pooled budget proves too complex, with issues around risk sharing being a common stumbling block. Thus, in some cases, a Section 75 partnership agreement with aligned budgets may be more achievable.

The misalignment of policy and financial systems discussed earlier can cause difficulties that may require negotiation or workarounds – for example, VAT arrangements, timing of financial cycles, ledger arrangements and charging arrangements. In the case of a formal pooled budget, the host body has delegated powers but will need to work within the reporting and management requirements of all partners. The signed agreement for the pooled budget forms the basis of governance arrangements and must clearly set out what the overall aims are, where responsibility lies and the associated plans for reporting and accountability.

As highlighted earlier, there are increasing concerns that the current climate of service and financial pressures – in particular the as yet unknown financial implications of social care charging reform and the potential impact on risk sharing – together with these inherent complexities may disincentivise collaboration and partnership arrangements.

POOLING AND RISK IN OXFORDSHIRE

Oxfordshire is one of three places in the NHS Buckinghamshire, Oxfordshire and Berkshire West (BOB) ICB area, all of which are based on the previous CCG boundaries and co-terminous with local authorities.

Prior to the establishment of ICBs, each place had developed different collaborative partnership arrangements, which are now being built on as outlined in the September 2022 ICB board paper Developing place-based partnerships to ensure services can continue to be delivered and managed at place level.

This proposes that places are responsible for operational oversight and strategic development in a number of areas, including urgent and emergency care, primary and community services, adult and children's mental health, learning disabilities and autism. It adds that places should seek to develop pooled funding arrangements where appropriate. The paper also sets out that specific models for contracting, collaboration and delegation will be for discussion and agreement with partners at the local level.

Oxfordshire County Council and the former Oxfordshire CCG have had a Section 75 agreement in place since 2013 (which consolidated a number of separate Section 75 agreements dating back to 2009). This agreement has been extended several times and ended in March 2022. It consisted of two pooled budgets: Live Well (adults with support needs) and Age Well (Better Care Fund), giving a total pooled budget of £399m. In addition, two further budgets are aligned to the Section 75 agreement: Start Well (children's services) and public health. Taken together, this gives a joint commissioning budget of £489m.

In 2020/21, the CCG and council developed the health, education and social care integrated commissioning team to improve joint commissioning arrangements. This is hosted by the council and came into effect in March 2021. It includes 18 joint-funded commissioning posts and a joint-funded deputy director. A joint commissioning executive was also formed (comprising senior executives from each partner) to provide strategic direction to the integrated team and accountability to each partner organisation. Responsibility for the management of the finance and performance of the pooled funds transferred to the joint commissioning executive. At this point, the current Section 75 agreement needs to be refreshed to reflect the new structures.

The proposed Section 75 agreement retains many of the elements of the previous agreement, with the following key changes:

- The organisation of funds into a single pooled budget hosted by the council, reflecting the structure of the health, education and social care integrated commissioning team.
- A single financial risk share based on each party's contribution to be used to apportion over and/or underspends.
- Agreement on delegations and contributions from partners to reflect the change to a single pool hosted by the council.

- Provision for future changes to widen the scope of the Section 75 agreement to include children's services and public health budgets (currently incorporated on an aligned basis).

At the council's March 2022 cabinet meeting, a report on the refresh of the Section 75 agreement was considered, which included the changes outlined above, including the recommendation to proceed with a single, fully integrated pooled budget and risk share for Start Well and Live Well services. The cabinet approved the recommendations.

In March 2022, the CCG board considered a paper on the proposed Section 75 agreement. This set out immediate financial pressures on both the council and CCG, including the potential for "significant additional burden on local authority Adult Social Care services" and likely "indirect additional costs to health" as a result of adult social care charging reforms. It was recognised that many of these pressures would sit within the pool and that a recovery plan would be reviewed and overseen through the joint commissioning executive within the new Section 75 arrangements. The paper went on to recognise the following risk:

There are several potential financial risks … including that related to the implications of Care Reform. As noted in the finance section the intention is that risks would be managed within the pooled funds except where indicated. In the case of Care Reform, the implications are not known at this date. The agreement will be reviewed annually and any changes to the proposed financial risk share would be considered within that review.

At the June 2022 meeting of the BOB CCG governing bodies, the finance committees annual report 2021/22 set out that in relation to the duty to monitor CCG co-commissioning and Section 75 arrangements, the committee had "scrutinised the 2022/23 draft agreement and sought further assurances in relation to risk sharing."

In June 2022, the council's cabinet were asked to consider Business management and monitoring: annual report and provisional revenue outturn 2021/22, which set out that following further discussions on the agreement of a single pooled budget and risk share, in the context of the current ICS development, the existing 2021/22 risk share arrangements should continue. This proposal was approved.

Therefore, the financial risk associated with social care charging reforms has introduced a potential barrier to progressing towards a single pooled budget and risk share arrangement, as was proposed in the renewed Section 75 agreement.

Sources: Personal communications and committee/board papers from Oxfordshire County Council, Oxfordshire CCG and Buckinghamshire, Oxfordshire and Berkshire West ICB.

Finance report for the finance committee (Oxfordshire CCG, 2022).

Other mechanisms

Pooled budgets are not the only option for resources to be shared across organisational boundaries to enable collaboration. Other financial mechanisms can also be helpful.

Delegation of functions

As discussed earlier, Section 75 of the NHS Act 2006 allows for the delegation of functions from one statutory body to another, creating a partnership agreement for joint commissioning or integrating the provision of care. Transactions can then be undertaken by one agency on behalf of another. Many of the objectives of formal budget pooling may also be achieved through delegation.

Under the delegation of functions, statutory responsibility remains unchanged, ie the ICB remains responsible for commissioning healthcare for its resident population and accountable to NHS England for its use of resources, even where it has transferred part of its budget to a local authority under a Section 75 agreement. The same principle underpins other forms of partnership working, so local authorities and NHS bodies must establish and maintain monitoring, reporting and governance processes to ensure they meet these statutory responsibilities.

Grants

Section 76 and Section 256 of the NHS Act 2006 enable payments to be made between the NHS and local authorities. Under Section 256, NHS bodies have the power to award a financial grant to local authorities for the provision of health services. Councils have a reciprocal power under Section 76. Such grants are tools to enable public money to be used to best effect and do not involve either a formal or informal partnership arrangement. DHSC must be notified of the intention to use these grant-making powers.

Care trusts

Care trusts are statutory NHS bodies to which local authorities can transfer health-related functions with the aim of providing more integrated services for the local community. They are established on a voluntary partnership basis and are provided for in Section 77 of the NHS Act 2006.

Councils can transfer (not delegate) services to the care trust, and the council's contribution to the care trust's budget is set by local agreement when drawing up the application to DHSC for care trust status. Local authorities have the option to specify the outcomes to be provided in return for their financial contribution. Councils will retain decision-making powers on charging but can transfer functions related to charging, including needs assessment and charge collection, to the care trust.

Governance arrangements are prescribed by DHSC, including the composition of the care trust's board, and are based on NHS models. Care trust accounts form part of the national summarised NHS accounts. However, as councils retain statutory responsibility for certain services, care trusts report activity and expenditure transferred from local authorities separately from health activity and expenditure.

Thus, pooling budgets is only one of many tools that can achieve the goals of integration at place level, and to focus on this tool alone seems a narrow view to take.

Further information on alternative mechanisms and the complexities of pooling can be found in CIPFA's Pooled budgets and the Better Care Fund: a practical guide for local authorities and health bodies (2017). This includes further information on financial management, reporting, audit and assurance. It also includes a model scheme of delegation and financial framework.

SOUTH EAST LONDON ICS – A RANGE OF TOOLS

In the South East London ICS, the six place-level LCPs have delegated responsibility for out-of-hospital services and formal delegated budgets relating to these responsibilities (such as primary care, primary care prescribing, community services for physical and mental health and continuing health care). For 2022/23, these delegated budgets relate only to NHS services. However, for 2023/24 and beyond, each LCP and the relevant local authority are exploring the ambitions around next steps for delegation of functions and budgets.

All LCPs work closely with local authorities on integrated planning and delivery of services, including the following:

- Better Care Fund arrangements – these are not formal pooled budgets but rather closely aligned plans, with the budgets being held by the relevant statutory organisation. In some areas, the BCF incorporates only the national requirements, whereas in others there are much larger aligned budgets. For example, the Bexley LCP has a 'super BCF', which includes the whole of the Oxleas community contract.
- Section 75 agreements through which the ICB and local authorities can manage a pooled budget. The level/extent of pooling varies by LCP, depending on their local arrangements.
- Other examples of collaborative contracting arrangements across the ICS involving funding collaboration and/or delegation. For example, in Lambeth, the Living Well Network Alliance is a formal contractual arrangement that includes contributions from the ICB, South London and Maudsley NHS Foundation Trust, Lambeth Council and voluntary sector providers.

Source: Personal communication and South East London ICB.

Joint financial frameworks

The 2022 White Paper recognises that "local leaders should have the flexibility to deploy resources to meet the health and care needs of their population as necessary." Focusing on specific mechanisms such as pooled budgets does not provide a wider view on how to mobilise resources across organisational boundaries to best effect.

Financial frameworks determine how to best use resources to achieve intended outcomes, as well as providing a mechanism to evaluate and measure progress to inform decisions on future activity and spending.

Developing a place-level financial framework to underpin the delegation of functions and resources from system to place level could be an alternative approach. This would enable local determination and could include a range of possibilities appropriate for different services or models. It need not involve complex mechanisms but does need to ensure that funding flows reflect decision making and support delivery of outcomes on a sustainable basis. Governance and accountability arrangements could be based on principles to enable adaptation over time and to reflect the diversity of places.

Ideally, the conditions around such a framework would need to:

- create maximum funding certainty over long-term horizons
- ensure financial delegations match outcomes, functions and decision making
- maximise flexibility of spend while protecting long-term preventative investment – the twin track approach.

A good starting point when considering such a joint financial framework would be the principles contained in CIPFA's Financial Management Code (2019), which have been designed to assist in determining financial sustainability. The six principles of good public financial management are as follows:

- **Leadership** demonstrates a clear strategic direction based on a shared vision and financial management is embedded into the culture.
- **Accountability** based on medium-term financial planning, which drives the annual budget, supported by effective risk management, quality supporting data and whole life costs.
- **Transparency** at the core of financial management using consistent, meaningful and understandable data, reported regularly with evidence of activity and decision making.
- Adherence to professional **standards** is promoted by leadership and evidenced.
- Sources of **assurance** are recognised as an effective tool, mainstreamed into financial management, including scrutiny and the results of audit/inspection.
- Long-term **sustainability** of services is at the heart of financial management and is evidenced by prudent use of resources.

As financial arrangements are fundamental to determining appropriate and proportionate accountability arrangements, it would make sense to align the principles for both in a single principles-based framework for place, which could be adapted to become more sophisticated as places mature and evolve.

INTEGRATED PROVISION IN MANCHESTER – SECTION 75 AGREEMENT AND FINANCIAL FRAMEWORK

One of the places in the Greater Manchester ICS, the City of Manchester, has developed a locality board (the Manchester Partnership Board – MPB). The MPB comprises membership from the city council, Manchester University NHS Foundation Trust, Greater Manchester Mental Health NHS Foundation Trust, Manchester Local Care Organisation (LCO) and the Manchester Primary Care Partnership. The place lead for Manchester is the chief executive of Manchester City Council.

The MPB's role will include production and implementation of the Manchester locality health and wellbeing plan. It will report directly to the Greater Manchester ICB and to the Manchester HWB. Work to further develop the arrangements and operating model for the MPB are ongoing.

The MPB will oversee the work of the Manchester LCO, which has responsibility for the integrated provision of NHS community health and adult social care services in the city. Staff are deployed to the LCO from the partner organisations – community healthcare staff from the NHS trust and adult social care staff from the council. The long-term aim is for the LCO to become a separate organisation.

However, this has not been possible since its establishment in 2018. The LCO was formed as a partnership between Manchester University NHS Foundation Trust, Manchester Health and Care Commissioning and Manchester City Council. The Manchester LCO was formed as a division of Manchester University Foundation Trust and arrangements are governed through Section 75 agreements (as provided for in the NHS Act 2006).

In 2021 the Section 75 agreement between Manchester University NHS Foundation Trust and Manchester City Council was renewed, with the aim of strengthening the Manchester LCO and in preparation for the passage of the 2022 Act and the statutory basis for ICSs. The new Section 75 agreement builds on the existing partnership agreement that established the LCO in 2018. In parallel to this, the existing commissioner Section 75 agreement between Manchester CCG and the council was amended to reflect the scope of the new provider Section 75 agreement.

The new Section 75 agreement sets out that the council will delegate its adult social care functions to the NHS trust to strengthen integration of community and social care. This builds on existing arrangements set out in 2018. In 2021/22, health and care budgets were aligned rather than pooled. The agreement is set for an initial term of three years but has scope to be varied within this timeframe – for example, by entering into a pooled budget.

The agreement contains several schedules, including a service schedule outlining the scope of services being delegated (including statutory and legal responsibilities and service standards) and a financial framework, including the full scope of the aligned budget and the administration arrangements. Further schedules include terms of reference, information sharing protocol, HR principles and risk management. The agreement also sets out provisions for chief officers of the LCO to be jointly appointed as officers of the council and governance arrangements for the LCO.

The financial framework underpinning the Section 75 agreement sets out the principles to govern the financial arrangements for the operation of the aligned budgets within the council and the NHS trust. These include:

- the relationship between the partners and the use of aligned budgets:
  - details of the formal relationship regarding management of the aligned funds
  - the expectation that partners will continue to work closely to ensure best quality care is provided and best value achieved in use of resources
  - recognition of statutes and regulations under which aligned budgets are established (Section 75 of the NHS Act 2006 and NHS Bodies and Local Authority Partnership Arrangements Regulations 2000)
- requirements for governance and accountability of:
  - the aligned budget
  - authorities and responsibilities delegated from partners
  - financial planning and management responsibilities
  - budgeting and budgetary control (including forecasting)
- the responsibilities of each partner to:
  - support and facilitate achievement of objectives through the aligned budget
  - ensure objectives and functions of partners and aligned budgets are complementary and mutually supportive

  - enter due diligence and appropriate oversight of financial decisions
  - ensure achievement of the partners' objectives.

The financial framework also sets out the agreed working principles as follows:

- To secure best value for the health and social care system in Manchester.
- To direct resources within their gift to the right place to adequately and sustainably fund the right care, as defined by the agreed care model and meeting the requirements of the Care Act 2014.
- To promote positive outcomes for the population's health and wellbeing through a person-centred approach for the whole population of Manchester.
- To manage these services within the agreed financial envelope.
- To ensure proper financial systems and reporting arrangements are in place to fulfil statutory requirements of partners.

In delivering these principles, the partners agree to:

- work together on a transparent basis, with a shared commitment to information sharing, to fulfil financial obligations and statutory requirements
- work collectively for the mutual benefit of all parties
- mitigate and control risk within a risk allocation framework, with collective oversight of risk profile and exposure, while ensuring the impact of change is clearly understood between them
- be responsive and act in a timely manner
- jointly agree the opening budget control total position and initial contributions from each partner and any subsequent in-year approvals
- provide resources to support the running of the LCO
- an integrated financial reporting arrangement that meets the needs of all partners effectively and efficiently
- provide a sufficiently staffed and skilled finance team to ensure financial rigour through the deployment of effective controls
- adopt a positive outlook and behave in a collaborative, proactive manner with a spirit of 'no surprises'.

Source: Manchester City Council report and Manchester Health and Care Commissioning Governing Body.

KEY POINTS: FINANCE FOR PLACE

- The NHS and local government operate under vastly different funding and financial regimes, and there appears to be little consideration of how these different systems interact.
- Fostering a shared understanding between partners is essential if they are to build the relationships and trust required to realise the aims of integration.
- The current financial regimes and funding mechanisms do not support a whole system approach to improving population health and wellbeing with a focus on prevention.
- A lack of funding certainty stifles the ability to plan and invest in priorities with longer-term horizons, such as prevention and reducing health inequalities.
- The 2022 White Paper sets the ambition that pooled budgets will become more widespread, eventually covering much of the funding for health and care services at place level.
- In practice, pooling budgets and partnership arrangements can be complex and involve a lengthy negotiation process between NHS and local government partners.
- In the current climate of service and financial pressures, there are concerns that, together with policy complexities and misalignments, they may disincentivise pooling and partnership arrangements.
- The commitment to review Section 75 arrangements for pooling and provide further guidance by spring 2023 is welcome. However, pooling is only one tool in the box, and the proposed guidance should consider a more overarching view of how to mobilise resources across organisational boundaries to best effect.
- Delegation of functions and resources from system to place level could be underpinned by appropriate financial arrangements – a place level financial framework – to ensure that funding flows reflect decision making and support the delivery of shared outcomes. Again, such a framework should be based on principles, which can be adapted to suit local variation and circumstances.
- A good starting point when considering such a joint financial framework would be the principles of good public financial management contained in CIPFA's Financial Management Code (2019).

Putting the principles in place

Developing a principles-based framework for place would not only allow for the significant variation between places but would also be flexible enough to enable arrangements to adapt and become more sophisticated as places mature and evolve. Such a framework should be informed by local circumstances and aligned to the 'national ask'.

While we do not intend to be prescriptive on what such a framework should contain, a sound starting point reflecting best practice would be:

- the seven principles of good governance from the CIPFA/IFAC International framework: good governance in the public sector (2014)
- the six principles of good public financial management from CIPFA's Financial Management Code (2019).

Further suggestions for principles in place may include the following:

- Agreement on local priority outcomes to provide a shared vision across place for the benefit of the local population, underpinned by understanding and evidence from local data to achieve realistic, sustainable benefits.
- Agreement on interventions to achieve required outcomes based on a shared appraoch and co-ordinated activity for the greatest impact.
- Emphasis on wider determinants of population health and wellbeing, with a focus on prevention and a shift in values and priorities to reflect the shared vision.
- Continuous evaluation of progress against outcomes to inform future direction and resource allocation, supported by evidence from local data and community engagement.

- Collaborative leadership to drive the shared vision, with an emphasis on partnership within (and between) places and neighbourhoods to foster the mindset of people and place rather than organisational allegiances.
- Taking a broader view beyond health and social care to services that impact on the wider social determinants of health and wellbeing.
- Building culture, relationships and trust based on mutual understanding and honesty around the respective priorities and pressures on partners.

- Foster a shared understanding of differences and similarities across organisational boundaries.
- Promote and enable data sharing to enable evidence-based decision making and shared agreement on priorities, outcomes and metrics.
- Encourage knowledge exchange to share experience and learning between partners to promote and develop best practice.

- Appreciate the unique contribution of partners and harness the strengths of each to achieve the shared vision and engage effectively with the local population.
- Maximise on and increase existing capacity across the community, with a focus on strength-based and asset-based approaches.

- Ensure delegation of resource follows functions and decision making to the most appropriate level (place and/or neighbourhood).
- Take an overarching view of all options for mobilising resources across boundaries to best effect and for the greatest impact rather than on specific mechanisms.
- Shared agreement on approaches to risk, including appetite, management and mitigation.
- Consider a range of mechanisms to provide assurance and ensure appropriate assurance is incorporated to demonstrate that the public pound in place is used to best effect.
- Empower a twin track approach to enable flexibility to deal with immediate pressures, while maximising long-term opportunities to focus on prevention, tackle the causes of ill-health and improve wellbeing, ensuring services are sustainable for the future.

The intention is for systems and places to evolve over time, with the delegation of further functions and resources. However, given the variation involved, this evolution will not be uniform. In determining their arrangements and the principles that drive them, it will be helpful for places to be aware of where they are now, where they are going, and when they are ready to adapt further to chart a course for the progressive nature of integrated care in their locality.

Scaling Integrated Care in Context (SCIROCCO)[11] offers free-to-air tools that can support this. They have been developed to enable knowledge transfer and learning on the operation and scaling up of integrated care in European regions at national, regional and local levels.

The SCIROCCO maturity model includes 12 dimensions, covering the activities that need to be managed to deliver integrated care, including governance and finance. Each domain can be considered individually in the context of local circumstances to assess the current situation and allocate a measure of maturity within it.

This model is underpinned by an online self-assessment tool, which offers a tailored approach to facilitating progress based on understanding the strengths and weaknesses of the local context. It also provides a set of methodologies, which means the tool can be used for:

- assessing the maturity of a health and care system towards integrated care
- assessing the maturity requirements of particular good practices in integrated care
- facilitating knowledge transfer and activities between regions and organisations to improve understanding of the local conditions that enable the adoption of integrated care.

KEY POINTS: PUTTING THE PRINCIPLES IN PLACE

- A combined principles-based framework for place would provide flexibility to allow for adaptation as places mature and evolve.
- Such a framework should be informed by local circumstances and aligned to the 'national ask'.
- It should ensure robust arrangements for governance, accountability and financial management, and the wider picture.
- While not prescriptive, some suggestions are provided for these principles in place.
- The evolution of places is unlikely to be uniform, so it will be helpful for places to identify where they are on this journey and chart a course for the progressive nature of their locality.

11 NHS 24 Scotland and the Scottish Centre for Telehealth and Telecare are involved in the SCIROCCO model, and the Scottish Government incorporated this as part of the basis for their health and social care core indicators as discussed in the case study Legislating for integration – lessons from elsewhere.

The role of the finance profession

Adjustment to the new statutory structures in the 2022 Act continues, and ICBs are considering how to develop their finance teams to support collaboration and co-ordination with partners across the system, including how they interact with place level. HFMA recently discussed the development of ICB finance teams in Developing an effective integrated care board finance team (2021). Different options are being considered, including:

- business partnering models to work with place-based partnerships, recognising the need to understand the local population to enable service transformation at a local level
- aligning a specific member of the finance team to a specific place and function, enabling staff to take both a place and system view
- reflecting patient pathways and system working by taking a view across all organisations involved in the patient journey.

Similarly, the level of support available as well as what these different models look like at place level will vary. At all levels, there is likely to be substantial variation, and arrangements will adapt and evolve over time as new ways of working are tried and tested.

However, one constant theme is the key role the finance function will play in closer integration. Bringing together services to improve population health needs to be supported by long-term planning and stripping away the barriers that prevent closer alignment of services. The finance function is skilled in designing frameworks and systems that can make or break the ambition to improve shared outcomes. They also possess analytical skills that can drive the data required to evidence local priorities and decision making. They can assist in removing some of the barriers, allowing funding and resources to move more freely across organisational boundaries, thus helping to empower change.

Finance professionals should be encouraged and supported to consider and to do the right things for the whole system/place: participative budgeting, long-term thinking with a focus on outcomes, transparent presentation of the long-term impact of decisions and taking an appropriate level of risk. Supporting and encouraging the finance function to operate across the whole system/place in this way requires strong financial leadership.

The chief finance officer (CFO) occupies a critical position in any organisation, holding the financial reins of the business and ensuring that resources are used wisely to secure positive results. The quest for integration of health and care has seen many CFOs operating across both NHS and local government boundaries. The fact that these sectors operate in different financial, governance and legislative frameworks makes this even more challenging, but also highlights the fundamental importance of the role and the need for strong leadership.

The role of the CFO in public service organsiations (CIPFA, 2011) sets out that the CFO:

- is a key member of the leadership team, helping to develop and implement strategy and to resource and deliver strategic objectives sustainably and in the public interest
- must be actively involved in, and able to bring influence to bear on, all material business decisions to ensure immediate and longer-term implications, opportunities and risks are fully considered and in alignment with the financial strategy
- must lead the promotion and delivery of good financial management, so that public money is safeguarded at all times and used appropriately, economically, efficiently and effectively.

These principles apply equally across whole systems and place-based partnerships in the context of integration, as they do in any individual organisation. A key element of the CFO's financial leadership role is to be involved in shaping finance and governance arrangements, so it is essential that CFOs lead on determining these place-based arrangements, as these will have significant implications for not only the partnerships themselves, but also the partner organisations involved. Thus, it is important for CFOs to understand how these may impact on their statutory obligations.

The CFO also needs to think beyond the boundaries of organisational control – to work, and lead, across boundaries, taking a whole system/place approach. The key is to achieve best value for the public pound in place by supporting and driving for what is good for the whole health and care system in their local area.

Thus, the CFO or director of finance in both NHS bodies and local government has a powerful role in collaborative leadership, shaping arrangements in their local area to ensure good public financial management and promoting the finance function as a critical enabler of integration.

CIPFA remains committed to supporting the finance profession in this role and, in collaboration with HFMA, sought to promote a shared understanding between partners across health and care through work such as The future financial sustainability of health and social care (2021), An introduction and glossary to NHS and local government finance and governance in England (2019) and Guidance for CFOs working in health and local government (2019).

KEY POINTS: THE ROLE OF THE FINANCE PROFESSION

- ICBs are considering how to model their finance teams to support collaboration and co-ordination with partners, including how they interact with place level.
- At all levels, there is likely to be variation, and arrangements will adapt and evolve over time as new ways of working are tried and tested.
- The finance function is a critical enabler of integration. It possesses key skills to support the requirement for long-term planning, stripping away barriers preventing closer service alignment and helping resources to move freely, thus empowering change.
- This requires strong financial and collaborative, leadership from CFOs in the NHS and councils, both in shaping the finance and governance arrangements in their local area to ensure good public financial management and in promoting and supporting the role of the finance function.

Recommendations: mapping the road ahead

The 2022 Act marks a new chapter in the integration journey. It represents a new opportunity for partners across the health and care sector to truly work differently. Taking a longer-term view and encompassing the social determinants of health and wellbeing, with a focus on prevention, which maximises the strengths of all partners, could help realise the aims of integration, as well as ensuring services remain sustainable for future generations.

Key to this will be place level partnerships, but there remain challenges at this level, particularly in relation to aspects of public financial management. In moving forward on this journey and to help ensure its success, CIPFA makes the following recommendations:[12]

Section 2: Integrating care: what and why?

R1 **Local level**: Partners across systems/places should embrace the opportunity to truly work differently. Taking a more strategic, long-term and place-based approach encompassing the social determinants of health and wellbeing, reducing inequalities and with a focus on prevention could make a huge contribution to achieving the core purposes of ICSs and the triple aim duty, while helping to ensure that health and care services remain sustainable for future generations.

R2 **Local level**: All levels of local government have a key role to play in influencing the wider determinants of population health and wellbeing, as well as a deep knowledge of their places and neighbourhoods. Therefore, it is crucial that both upper-tier and lower-tier councils are engaged at place level and in the ICP.

Section 3: Where are we now?

R3 **Central government**: Proposals for evaluating the progress and performance of ICSs should be clarified. It is crucial that variation across systems/places is recognised and that proposals are realistic about what can be achieved within the available resources and reasonable timescales.

Section 4: Integration in the context of the wider landscape

R4 **Central government**: Given the crowded landscape within which integration is taking place, government departments should lead by example and demonstrate a collaborative approach to co-ordinating and clarifying policies for integration and wider reforms across the health and care sector.

R5 **Central government**: There remain areas of national policy that are misaligned with integration. Ideally, policy alignment should be improved within and across government departments. However, sharing experience and understanding of potential workarounds would be a welcome first step.

R6 **Central government**: Future guidance on joint appointments between NHS bodies and local authorities should seek to resolve, or at least clarify, the misalignment of VAT treatment, which can act as a barrier.

R7 **All levels**: Achieving the vision for integration requires long-term commitment and certainty of funding. A twin track approach is necessary to ensure services can deal with existing and immediate pressures, as well as making long-term investments to ensure services are financially sustainable and provide value for public money.

12 Where recommendations are directed to central government, this refers to the appropriate government department (DHSC, DLUHC, HMRC, etc) or to NHS England as an arms' length body. Where recommendations refer to local level, this is intended to refer to systems, places and their constituent partner organisations.

Section 5: Shared outcomes

R8 **Central government**: An outcomes-based approach to integrating health and care must be backed by long-term political and financial commitment and must be based on realistic expectations of what can be achieved.

R9 **Central government**: Government departments should collaborate to develop a national outcomes framework that provides a single, coherent set of shared goals across the health and care sector, without adding a further tier of bureaucracy. The emphasis should be on local priorities reflecting national outcomes, not national performance metrics driving local activity.

R10 **Local level**: Priorities, outcomes and associated metrics should be determined in the context of the national framework and based on evidence of local circumstances and need.

R11 **Local level**: Creating a link between resource allocation and outcomes would provide a clearer focus across partners and would assist in making evidence-based decisions on the allocation of funds, as well as the ability to track and evaluate progress and ensure value for money.

Section 6: Place-based governance and accountability

R12 **All levels**: A principles-based approach to governance and accountability arrangements in place-based partnerships (which could incorporate some minimum standards) would recognise the diversity of places and allow for adaptation as they evolve over time. Within this, it would be for each place to determine appropriate and proportionate arrangements and for others to assure themselves of their sufficiency.

Section 7: Finance for place

R13 **Central government**: The commitment to review Section 75 arrangements for pooling budgets and to produce further guidance is welcome. The proposed guidance should consider a broader view of how to mobilise resources across organisational boundaries to best effect, with a focus on removing associated complexities, which can act as a disincentive.

R14 **Local level**: Partners should seek to foster a shared understanding of the different systems in which they operate and take an open and honest approach to the pressures they face. This is crucial to building the relationships and trust required for success.

R15 **Local level**: Delegation of functions and resources from system to place level could be underpinned by a place level financial framework. Again, such a framework should be based on principles, which can be adapted to suit local variation and circumstances.

Section 8: Putting the principles in place

R16 **All levels**: A combined principles-based framework for place that incorporates robust governance, accountability and finance arrangements would provide flexibility to allow for adaptation as places mature and evolve. Such a framework should be for local determination and aligned to the 'national ask'.

R17 **Local level**: In developing a principles-based framework, places should identify where they are on the integration journey and chart a course for the progression of their locality in the future.

Section 9: The role of the finance profession

R18 **Local level**: CFOs in the NHS and local government should play a critical role in providing collaborative financial leadership, both in shaping the finance and governance arrangements in their locality to ensure good public financial management and in promoting and supporting the finance function as key enablers of closer integration.

Further reading

CIPFA resources

The role of the Chief Financial Officer in public service organisations (2011)

International framework: good governance in the public sector (CIPFA/IFAC, 2014)

From desire to delivery: CIPFA's roundtables on the integration of health and social care (2015)

Let's get together (2015)

Sorting the plans (2016)

Reality check: next steps in developing sustainability and transformation plans (2017)

Home truths – CFOs on the path to integration (CIPFA/iMPOWER, 2017)

Pooled budgets and the Better Care Fund: a practical guide for local authorities and health bodies (2017)

The Practicalities of Integration (2018)

Financial Management (FM) Code (2019)

An introduction and glossary to NHS and local government finance and governance in England (CIPFA/HFMA, 2019)

Guidance for CFOs working in health and local government (CIPFA/HFMA, 2019)

Evaluating preventative investments in public health in England (CIPFA/Public Health England, 2019)

Delivering Outcomes in the Public Sector (2020)

The future financial sustainability of health and social care (CIPFA/HFMA, 2021)

Integrating care: putting the principles in place (2022)

Other resources

Arrangements for delegation and joint exercise of statutory functions: Guidance for ICBs, NHS trusts and foundation trusts (FutureNHS, 2022)

Integration and innovation: working together to improve health and social care for all, (DHSC, 2021)

People at the Heart of Care: adult social care reform White Paper (DHSC, 2021)

Health and social care integration: joining up care for people, places and populations (DHSC, 2022)

VAT and the public sector: reform to the VAT refund rules (HM Treasury, 2020)

VAT and the public sector: reform to the VAT refund rules (response paper) (HM Treasury, 2021)

The government's White Paper proposals for the reform of health and social care: first report of session 2021/22 (House of Commons Health and Social Care Committee, 2021)

Health and social care integration (NAO, 2017)

The health and social care interface (NAO, 2018)

NHS financial management and sustainability (NAO, 2020)

The NHS Long Term Plan (NHS England, 2019)

Designing integrated care systems (ICSs) in England: an overview on the arrangements needed to build strong health and care systems across the country, (NHS England, 2019)

Integrating care: next steps to building strong and effective integrated care systems across England (NHS England, 2020)

Integrated care systems: design framework (NHS England, 2021)

Thriving places: guidance on the development of place-based partnerships as part of statutory integrated care systems (NHS England/LGA, 2021)

Working in partnership with people and communities: statutory guidance (NHS England/DHSC, 2022)

Integrated care systems: what do they look like? (The Health Foundation, 2022)

A year of integrated care systems: reviewing the journey so far (The King's Fund, 2018)

How do you measure the success of population health approaches? (The King's Fund, 2022)

Legislation

VAT Act 1994

National Health Service Act 2006 (NHS Act 2006)

Care Act 2014

Health and Care Act 2022

VATGPB9700 – Government departments and health bodies: contracted out services (COS) (HMRC)

Subscriptions and journals

To access the following resources may require a paid-for subscription.

Health Service Journal (HSJ)

'Deeply disappointing' ICS strategy criticised by council (2022)

The Integrator: Council/NHS rows flare (2022)

The Integrator: The 'integrated' in ICS (2022)

NHS England 'hasn't got long' to develop 'operating model' for system working (2022)

Primary care networks must become 'neighbourhood teams', says review for NHSE (2022)

Do ICSs face an impossible task? (2022)

Tech spend under pressure as NHSE told to 'cut core funding' (2022)

NHSE to 'restrict' spending at five deficit ICSs (2022)

Half of ICSs have no partnership 'chair' or 'place' leads (2022)

Councils always 'leader of place' says top health system (2022)

The Integrator: Provider-led 'place' perfection (2022)

Local Government Chronicle (LGC)

NHS trusts raise 'significant concerns' over 'single accountable figure' plan (2022)

Breakdown in NHS local relationships revealed as ICSs come into being (2022)

Health and care integration: 'the government has set an impossible task' (2022)

The Municipal Journal (The MJ)

The 'people's choice' for health and care leadership (2022)

Warning over ICSs becoming 'cabals of self-interest' (2022)

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