# Next steps to Integrating Care
## Snapshot view

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### The proposals in the consultation paper are designed to serve four purposes:

- Improving population health and health care
- Tackling unequal outcomes and access
- Enhancing productivity and value for money
- Supporting broader social and economic development

### Places

- 'Places' will be the 'building block' for health and care systems
- Local councils should have an important role through joint appointments or shared budgets
- Primary care leaders should have a lead role
- Every place will have a "place leader" who will work with partners to join up care
- Systems should ensure that each place has appropriate resources, autonomy and decision-making capabilities
- Working with VCS and involving local residents

### Commissioning

- CCGs become more strategic, with a clearer focus on population-level health outcomes
- A reduction in transactional and contractual exchanges within a system
- Service transformation led in future by places and provider collaboratives
- Flexibility for local areas to make use of the local relationships and expertise currently residing in CCGs


### Provider Collaboratives

- All NHS provider trusts will be expected to be part of a provider collaborative which will vary in scope and scale
  - Provider collaboratives will operate between places where similar providers share common goals
  - Provider collaboratives will operate within places through place-based partnerships
    - Agree proposals from clinical and operational networks and implement resulting changes
    - Enact mutual aid arrangements to enhance resilience

### Data and digital

- Connect health and care through share care records and national standards for data and digital
- Use digital technology to reimagine care pathways and join up care
- Develop a road map for citizen-centred digital channels and services
- Have clear board accountability for and clear system plan for data and digital transformation

### Embedded clinical and professional leadership

- ICSs should embed clinical and professional leadership through the partnership board and other governance.
- Primary care leadership through critical roles such as Clinical directors in PCNs. Existing clinical networks at system level have important roles advising on the most appropriate models and standards of care.

## Legislating to support ICSs

### Option 1: A statutory ICS Board

A mandatory statutory ICS Board through the mechanism of a joint committee, enabling partners to take decisions collectively

- The AO would be recognised in legislation and would have duties in relation to delivery of the Board's functions
- New powers to allow CCGs to delegate many population health functions to providers
- Retains individual organisational duties and autonomy

### Option 2: A statutory ICS body

ICSs would be established as NHS bodies partly by "re- purposing" CCGs and would – among other duties – take on the commissioning functions of CCGs

- The CCG governing body and GP membership would be replaced by a board of representatives from ICS partners
- The power of organisational veto would be removed
- The ICS's primary duty would be to secure the provision of health services to meet the needs of the population

## Options analysis within the consultation paper

Option 1 would mandate existing ICS arrangements but leave many questions about accountability and clarity of leadership unanswered. Furthermore, many may not consider this model to be the "end state" for ICSs and opportunities for legislative change are relatively rare.

Option 2 avoids the risk of complicated workarounds to deliver the LTP vision for ICSs. Although there would be a representative for primary care on the Board, there would no longer be a conflict of interests with the current GP-led CCG model