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Integrated Care Systems lessons

Three months on from the commencement of the new statutory Integrated Care Systems (ICS) Anja Beriro and Gerrard Hanratty reflect on the main themes and issues that have come from the new relationship between local government and health.

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As a reminder, there are now various statutory elements of an ICS that bring the two parts of the public sector together:

- the Integrated Care Board (ICB) that has assumed responsibility for the commissioning and other functions of the CCGs. This has a representative from "responsible local authorities" i.e. those councils that have social care responsibilities;
- the Integrated Care Partnership (ICP), a joint committee whose founder members are the ICB and each of the responsible local authorities. The founder members can invite other members such as representatives of the voluntary and community sector, district councils and healthcare providers. The ICP has the statutory responsibility for developing an integrated care strategy (the Strategy).

While local government and health partners have worked together for many years, often very closely under arrangements such as section 75 agreements and the Better Care Fund, ICSs present more opportunities for closer collaboration. There is also the requirement to work to the same Strategy.

So what are some common themes that have come out of questions from our local government clients that are involved in ICSs?

- the voting rights of different members on the ICP and how the local authority representatives take part in decisions as part of the ICB. The lack of detail in the Health and Care Act 2022 around what is meant by a joint committee and which members have voting rights has raised some questions. The approach taken by the majority of ICRs is that all members of the joint committee have equal voting rights but that does not sit comfortably with the usual approach of local government. Local government is accustomed to there being strict frameworks to manage the membership and voting of joint committees. In relation to the voting position of a local authority sitting on an ICB, we have advised a number of our local government clients as to how to set up the appropriate delegations and approvals for the representative to take an active role in decisions of the ICB. Bearing in mind that the legislation anticipates one or more members representing the viewpoint of local government so the member will not be making decisions solely on behalf of their own Council. Therefore, it is important that the wider view of local government is understood and that the representative does not push forward the opinion of its own local authority if that is not in the wider interest of other responsible local authorities in the same ICS
- the replacement of local government policies with those of the ICB. We have been asked whether a new policy of an ICB, that is for the same subject matter should replace that of its local authority member, even though it has a duty to put that policy in place. We can see no reason why policies of the ICB should replace those of a local authority. They are likely to focus on different priorities, as the commissioning body for healthcare and not a provider of services. That is not to say that policies of the responsible local authorities should not take account of the Strategy produced by the ICP, they are statutorily obliged to do that
- the commissioning of services by the ICB, for use by the constituent (and possibly other) local authorities. We have been made aware of situations where the ICB has commissioned services which are to be used at least in part by the responsible local authority, but the local authority has deemed them too expensive, so they are not being used. This suggests that both local government and health need to have good open communication that allows them to understand:
  - the budgets that are available for the services in question. The onus is on officers in local government to have this information available.

- if there are other reasons why the services are not being used
- if arrangements such as section 75 agreements have the right level of clarity or need updating
- the needs of local government, and sometimes if it is an elected member from a responsible local authority then their role is not to understand all the details so they will need to ensure that they are taking views of their officers into account so that they can have informed discussions at the ICB
- the impact on providers and what both local government and health can do to provide the right level of information to the market and take its views into account

As we have been saying to our clients from before 1 July, these are still early days of the ICS. The legislation and guidance recognises that there needs to be a bedding in period. For some ICS, there will only recently have been the first meeting of the ICR, and possibly only a couple for the ICB, so we would encourage all partners in the ICS to think about:

- what is working well?
- are we able to make decisions in a timely and efficient way? For this, think about who is round the table and what powers they have to take part in decision making, where does the technical or professional information come from, and are the recommendations in reports clear and easy to understand?
- do we all understand the Health and Wellbeing Strategy of our area(s)?
- are we able to hear from all parts of the communities we serve?
- then review in three months' time how well the first six months have gone and whether everything that was set up on day one is fit for purpose or whether there are adjustments to be made.

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