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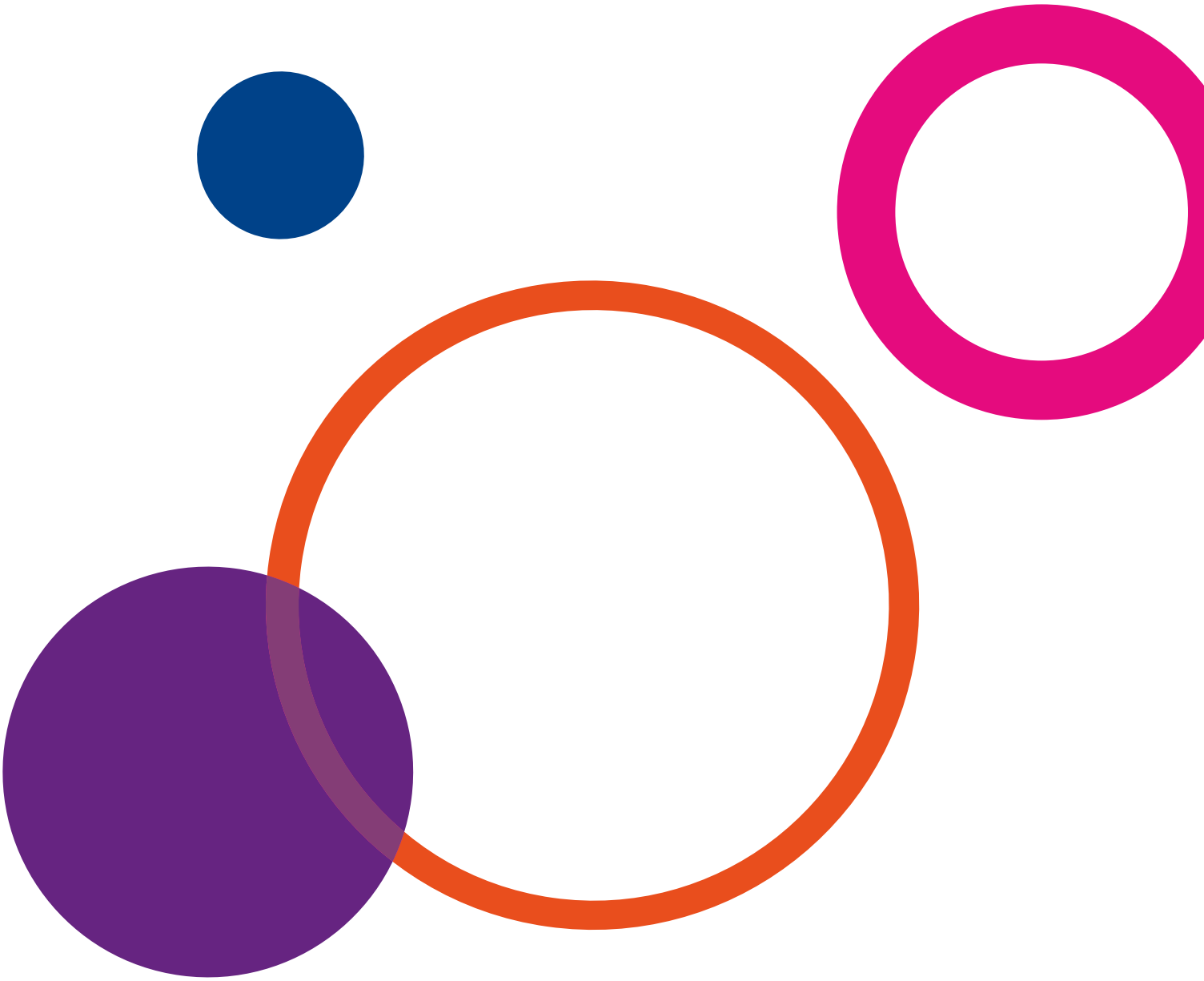
NHS CONFEDERATION
Integrated Care Systems Network

Delivering together

Developing effective accountability in integrated care systems



What is the Integrated Care Systems Network?

A critical part of delivering the ambitions of the NHS Long Term plan will be empowering local systems and giving them the autonomy they need. At the NHS Confederation, we are supporting emerging systems and helping local areas on the journey to becoming integrated care systems by April 2021. We believe the ambitions of the plan can only be met through greater collaboration, partnerships and system working.

We are undertaking a number of activities to support local systems. Alongside tailored support for ICS/STP independent chairs, programme directors, clinical leads, mental health leads, workforce leads, non-executive directors and lay members, we have now established a national network for ICS and STP leaders. This was set up in response to feedback from ICS/STP leaders across the NHS and local government who told us they wanted an independent safe space to exchange ideas, share experiences and challenges, and develop solutions.

Stay in touch by:

- contacting your regional lead – see page 24 for details
- signing up to our Integrated Care Bulletin by subscribing at www.nhsconfed.org/newsletters
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About the NHS Confederation

The NHS Confederation is the membership body that brings together and speaks on behalf of the whole NHS. We represent over 500 members across health and social care, including hospitals, community and mental health providers, ambulance trusts, independent sector organisations providing NHS care, and clinical commissioning groups.

We have three roles:

- to be an influential system leader
- to represent our members with politicians, national bodies, the unions and in Europe
- and to support our members to continually improve care for patients and the public.

All of our work is underpinned and driven by our vision of an empowered, healthy population supported by world-class health and care services; and our values of voice, openness, integrity, challenge and empowerment.

To find out more, visit www.nhsconfed.org

About Solace

Solace is the leading members' network for local government and public sector professionals throughout the UK. It offers a range of services including personal and organisational development, events and interim and executive recruitment through its profit-for-purpose subsidiary, Solace in Business. In addition to these services, the organisation has an active policy team, who along with policy leads, influence debate around the future of public services to ensure that policy and legislation are informed by the experience and expertise of its members.

To find out more, visit www.solace.org.uk

Key points

Integrated care systems (ICSs) bring together local providers, commissioners and local authorities to improve population health and wellbeing. Every area of the country is to be covered by an ICS by April 2021, but there remains considerable uncertainty about the accountability and governance arrangements of these systems.

This paper summarises the views of senior leaders from the NHS and local government on how they would like system accountability to develop.

What we heard:

1) Internal accountability within systems

- Better internal accountability can be achieved through greater clarity about the function of ICSs, developing a clear set of outcomes to deliver collectively and by working through locally how the roles of the constituent organisations can fit together to deliver them.
- Local relationships and ways of working should be given time to develop further and this should be key to any future consideration of statutory change.

2) Regional and national system accountability

- There needs to be a shift to a more mature oversight and regulatory relationship with systems driven by local needs and aspirations. This should take a broader-based approach beyond delivery of healthcare and be open to challenge about legitimate national aspirations for improving services.
- ICSs should be "smart, ambitious, translational systems" which are "confident enough not to need to ask for permission, but able to ask for forgiveness if necessary".
- The NHS's national improvement goals should be developed much more closely with local systems to ensure their ambition is closely informed by local intelligence and thinking.

3) Accountability to local communities

- Local accountability should be driven "from the ground up" within an ICS, incorporating a clear role for elected members of local authorities and accompanied by more acceptance of 'managed difference' of services if they are to be tailored to meet local need.
- Primary care networks and integrated care partnerships should be used to drive forward an agenda of improving the lives of local people. However, they should not be "smothered" by attaching too many objectives to them at an early stage.

Much more thinking is needed locally and nationally on this subject. We hope this report will support the local development of ICS accountabilities alongside further national thinking about the future direction of travel needed to allow ICSs to operate to their full potential.

Background

The NHS Long Term Plan set out an ambition for the NHS and its partners to create integrated care systems (ICSs) everywhere in England by April 2021. ICSs bring together local organisations to redesign care and improve population health, creating shared leadership and action. They are also 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.

However, they are a partnership that has been introduced into local communities to bring together a pre-existing set of organisations and stakeholders interested in improving population health. It is not surprising that there remains considerable uncertainty about the accountability and governance arrangements of ICSs, which local and national leaders continue to grapple with.

In light of this challenge, the NHS Confederation and Solace convened a group of senior leaders from the NHS and local government to explore how they would like system accountability to develop. The discussion was conducted under the Chatham House rule and co-chaired by Paul Najsarek, chief executive of the London Borough of Ealing, and Dr Claire Fuller, senior responsible officer at Surrey Heartlands Health and Care Partnership.

The group considered three dimensions of accountability: the internal accountability of the health and care system itself (including the model of mutual accountability, particularly for those with statutory responsibilities), the health systems accountability to national arm's-length bodies and government, and its accountability to local communities.

Below, we set out the important messages from the discussion, describing how the system is working at present, how participants in the discussion would like it to work, the immediate local steps that can be taken to improve accountability and governance of ICSs, and discussion of what might need to change over the medium term.

As the NHS Long Term Plan sets a goal for all systems to achieve ICS status by 2021, meaning sustainability and transformation partnerships (STPs) will ultimately be phased out, we have used the term ICS to refer to systems in this document.

Internal accountability within systems

What does this mean?

Ideally, every ICS will comprise a mixture of provider (health and care) and commissioner organisations, local authorities and other stakeholders (such as councils with housing responsibility), each with differing duties to fulfil and differing degrees of accountability to other organisations. For instance, within any given ICS there will be multiple provider/commissioner relationships underpinned by contracts that are subject to statutory duties, and which must meet performance and quality targets and standards.

NHS ICS policy requires these organisations to come together as constituent parts of a local health and care system, in order to jointly own a local strategy. For this local system to work effectively, it must be sufficiently flexible to allow constituent organisations to fulfil their existing contractual and statutory duties alongside local democratic structures, while holding themselves accountable collectively for the performance and strategic direction of the system.

How is the system working at present?

There is an existing statutory accountability infrastructure for both the NHS and local government. The three main components are local Healthwatch organisations, which represent the views of patients; health and wellbeing boards, which are hosted by local authorities and provide strategic direction for NHS services, and local authority-commissioned services relating to health and care; and health overview scrutiny committees.

Health and wellbeing boards have statutory responsibilities that include significant elements of the non-statutory roles of ICSs. Specific examples include oversight of commissioning plans, joint strategic needs analysis and responsibility for developing local strategies for health and wellbeing. This includes local authority-commissioned services such as social care and public health. Local authorities also have overview and scrutiny committees or subcommittees for health and care. These pre-date the Health and Social Care Act 2012 and can make recommendations to NHS organisations or central government, but do not have powers to require change.

Participants in our roundtable discussion reported a lack of clarity over aspects of ICS 'internal' accountability, including the role of constituent organisations, the relationship of constituent organisations' statutory roles to ICS roles, and the relationship of ICSs to health and wellbeing boards. In addition, there is a sense that there are too many "circular" conversations about governance, and too many national and regional meetings to discuss ICS accountability. These can seem to be an exercise in anxiety management, rather than serving a specific and local purpose.

Summary of participants' views on how internal accountability should work

Agreeing a clear set of shared outcomes to deliver, and clarifying locally how the ICS role fits with the existing roles performed by constituent organisations and stakeholders, were viewed as critical tasks for achieving more robust internal accountability. Through giving a sense of shared purpose around the needs of local communities, it would be possible to build a sense of mutual accountability.

Participants thought ICSs should be "strong local voices" and should exert "ownership" of systems, while retaining the ability for constituent organisations to lead on particular policy areas (such as homelessness).

They suggested, in line with Long Term Plan guidance, that ICSs should have a focus on population health outcomes and wellbeing, and that each ICS should be accountable to its local population and local democratic structures, as well as being a space where relationships are built and cultures established.

They felt that the form of the ICS should be determined by what it needed to achieve, acknowledging different communities will have different priorities, and therefore that there would be some differences from ICS to ICS. To enable this, the system should be "permissive", but there should be "collective ownership" of the approach at national level.

During the discussion, a view emerged that the extent of the ICS role should be carefully delimited, alongside its governance functions. The ICS board was viewed as an "engine" for tackling system-wide issues. One participant said: "The purpose of the board is how we work together on big issues across big geographies". Another suggested that 80 per cent of the change to how services are provided would happen in the integrated care partnership of provider organisations (ICP), rather than the ICS itself.

Participants argued that systems need to be clear about what the ICS is there to do and develop work programmes to achieve this. ICS accountability should be based on outcomes rather than processes (i.e. "what difference are we going to make?"). All governance and accountability structures in place should exist for a clear reason and ICSs should not end up "doing too much". Instead, they should adopt an enabling, facilitative model. One critical challenge was how to achieve a culture of internal challenge within the system. The view was that internal relationships would have to be strong enough to accept that culture of challenge.

Based on this articulation of the ICS role and internal accountabilities, the group identified some immediate actions that can be taken to support improved internal accountability.

Immediate actions

- Instead of simply "inviting local authorities to the table", work together to define what the local system wants to achieve and how it should work.
- Build into the role of the ICS independent chair a requirement to ensure that the ICS focuses on the whole system, rather than just NHS organisations.
- Identify the ambition of the ICS using an outcome-based approach for local communities (draw on local government experience in doing this).
- Describe goals in a way that gives them traction with local authority, social care and voluntary sector partners and the public – such as "saving 180 lives a year" versus "meeting constitutional standards for cancer".
- Clarify the relationship with health and wellbeing boards, elected members and non-executive directors within the health and care system's governance.
- Clarify the role of sub-ICS groups (sometimes known as local delivery groups) as forums for district councils and local voluntary and community sector.

What needs to change?

Based on the discussion, it appears that a lack of clarity over function, roles and relationships, and confusion over the interaction between ICS objectives and existing statutory duties (notably those held or led by local government), are the main barriers to achieving stronger internal accountability at present.

There is a case for clarifying the ICS system leader role by building on the strategic development remit initially envisaged for health and wellbeing boards at a local authority level, but in some situations maybe expanding it to cover a much larger geography, with a stronger and clearer focus on population health outcomes and wellbeing, specifically across health and care. This remit should be clearly specified and limited to ensure clarity of focus within the ICS, and it should be enforced by the independent ICS chair.

Leaving the exact structure of the ICS open to local determination allows for greater flexibility from system to system and makes sense if the structure of the body is viewed as secondary to its purpose. However, to do this successfully will require some flexibility from arm's-length bodies (see section on regional and national accountability), as well as a genuine commitment from all constituent organisations within the ICS to participate in the work of the system and support its goals. There was limited appetite for statutory change to structures at present and a sense that local relationships and ways of working should be given more time to develop further in ways appropriate to their local context.

Under such an approach, articulating meaningful strategic outcomes, and measuring these effectively, will be critical to the ability of ICSs to drive change and demonstrate their effectiveness, both to members of the public and to constituent organisations.

Being outcome-focused and targeted at improving wellbeing, it is likely that ICS strategic objectives will operate across longer timescales than the existing statutory requirements that apply to NHS organisations. It is possible that achieving an ICS strategic objective (such as preventing a set number of instances of ill health) may come at the expense of a constituent organisation's statutory duties (such as maintaining financial balance).

In such situations, it would be preferable to tolerate planned divergence from immediate organisational goals, as part of a multi-year ICS strategy, in order to support the achievement of outcome goals. The group recognised that this specific issue may require adjustments to legislation. If not, statutory requirements could disincentivise constituent organisations from pursuing ICS strategy if the pursual of a strategy that benefits the health and care system overall potentially conflicts with an organisation's statutory duties.

Regional and national system accountability

What does this mean?

NHS organisations have historically had very strong and clearly drawn lines of accountability to Whitehall and parliament. Changes to national and regional structures and regulatory processes over the last decade have sought to weaken these links, for instance by creating a new arm's-length body, NHS England and NHS Improvement, and shifting much of the responsibility for national-level management of the NHS out of the Department of Health and Social Care. By contrast, there is a limited level of national oversight of local government.

How is the system working at present?

The NHS Long Term Plan has set out a valuable strategic framework for ICS activity, but participants in our roundtable discussion felt it was too NHS-focused, notably given the absence of something similar for adult social care.

Participants highlighted a risk that ICSs would only be held accountable for performance by NHS England and NHS Improvement when other bodies whose remit is relevant to ICS activities (for instance, the Care Quality Commission, Ofsted, local police forces and the criminal justice system) were absent from discussions about the performance or regulation of ICSs at present, or had pre-existing regulatory and democratic powers that precluded this.

Seven regional NHS England and NHS Improvement "structures" have now been put in place, but these were not viewed as having a clear remit at present and were not consistent with pre-existing local government regions. There were some concerns that they could revert to being an enforcement mechanism for performance metrics set out in the NHS Long Term Plan, of which there are more than 350.

A recent shift in the role of the ICS senior responsible officer from convening to taking part in NHS performance management conversations had been observed by roundtable participants. Crucial to addressing some of the challenges this presents would be the ability of ICSs to find a way to manage anxiety from the "centre".

Expectations of significant levels of "top-down" management and national consistency persist, both within the service itself and within wider public opinion. This relationship will need to be redrawn if systems are to operate effectively – this process of redrawing national accountability relationships is underway, but not yet complete.

Summary of participants' views on how regional and national accountability should work

ICSs have been developing their own local system plans as part of the NHS Long Term Plan implementation process. Participants felt that these plans should set the agenda for conversations with regulators about how and where systems will make a difference, rather than being evaluated in relation to the delivery of a large number of centrally determined priorities that may differ in significance from area to area.

But in return, systems should be open to challenge. Several participants highlighted the importance of ICSs being held to account in such a way that legitimate national aspirations about service development – particularly relating to clinical areas – are appropriately addressed in local delivery. There was a clear recognition that the NHS is currently accountable nationally for what it delivers.

Participants called for a mature relationship between ICSs and the region/centre, built around robust ICS plans and clear but limited accountabilities. They described a future approach consisting of "smart, ambitious, translational systems" that were "confident enough not to need to ask for permission, but able to ask for forgiveness if necessary". Finally, and related to the earlier point about the NHS focus of the Long Term Plan, they pointed out that the activities stemming from the Long Term Plan should be viewed as one component of a broader local strategy.

Based on this view of how national and regional accountability should work, the group identified some actions that can be taken now to move in the right direction.

Immediate actions

- ICSs should proactively create a narrative to explain to regulators what ICSs want to do differently (instead of hearing what regulators want ICSs to do) – in other words, have an ambition that rises above successful regulation.
- ICSs should draw on experiences of local authority, voluntary sector and other partners to shift focus to health and wellbeing issues such as addressing deprivation, housing and social justice, among others.
- In every system, a memorandum of understanding should be drawn up between the system and the region, setting out which national priorities should be areas of focus, and which local priorities should be included.
- ICSs should design approaches in conjunction with NHS England and NHS Improvement regional teams to provide sufficient information to satisfy national and regional colleagues with regulatory roles, without allowing regulatory issues to dominate the conversation.
- ICSs should be given sufficient "air cover" or permission to be able to push back against disproportionate requests from staff in arm's-length bodies or regulators.
- National and regional regulators need to ensure that their short-term regulatory asks are consistent with longer-term aspirations for service delivery.
- ICSs must still deliver on legitimate national priorities (for instance in mental health) as these are important to patients and service users – there will still be a need for regional and national challenge to guard against local service shortfalls.

What needs to change?

Clear accountability routes will always be essential for public services, such as those provided by ICS constituent organisations. But an overly "top down" approach to regulation by national and regional regulators and arm's-length bodies risks cancelling out any potential improvements by health systems, by forcing them into patterns of provision that do not take into account local need or circumstance. Such an approach also sets up conflict with the local democratic accountability of local government.

The most effective approach to national/regional regulation is therefore likely to be an inversion of this traditional regulatory approach, with ICSs instead setting out outcome goals, presumably via ICS plans, with the agreement of regional and national regulators, and with regulators holding them to account for them. This will require further changes to the oversight model currently operating by NHS England and NHS Improvement.

In areas of provision where regulatory bodies exist but are not engaging or permitted to work with ICSs, there will need to be a route to involving these organisations in the ICS agenda in a proportionate way.

Finally, it will be important to ensure a better route for agreeing national-level improvement priorities. With the development of increasingly mature and informed local partnerships, national improvement goals should be developed more closely with local systems to ensure their ambition is informed by local intelligence and likely to deliver the desired impact. National-level policy teams need to develop a much more transparent process for prioritising issues in order to address systemic underperformance at a national level, once problem areas have been identified via data analysis and feedback from systems.

Accountability to local communities

What does this mean?

As well as being accountable to the organisations which make up its constituent parts (see section on internal accountability), ICSs must have accountability routes into local government, their local community and wider stakeholder base. Here, local authorities have well-developed systems for engaging the public across a local authority footprint and hold the democratic mandate. But the NHS has historically not established deep roots in local communities, with the main exceptions being foundation trust governor programmes, clinical commissioning group lay members and specific consultation exercises for service changes.

The NHS Long Term Plan describes two new levels within a system that ICSs should be planning for: the place and the neighbourhood/locality. While there are often emerging links between organisations providing services at the locality level, understanding the significance of the 'place' level for ICSs has proved more challenging.

To date, the NHS has described 'place' as meaning geographies comprising populations of 250,000 to 500,000. In many areas, there are existing geographies at the scale of upper- and lower-tier local authorities that already have a significant degree of coherence. Often, there are already established structures such as health and wellbeing boards, safeguarding boards (for both children, adults and safer communities) and locality boards within local authority areas, which could be helpful to ICSs.

Many local authorities fit within the parameters of the 'place' as defined by the NHS, but this is not always the case. It would therefore be helpful to clarify that where a local authority footprint is smaller than 250,000 people or larger than 500,000 people, this should not preclude it from operating as a 'place' from the perspective of the ICS.

How is the system working at present?

Participants in our roundtable discussion felt that at the local level, partnerships were often not yet sufficiently well-developed and inclusive. CCGs were seen to be often operating "at a remove" from providers at a locality level and there were concerns that non-statutory providers (in mental health services, for example) could find themselves isolated from ICS decision-making and policy development, if key staff were not involved in the work of the ICS. Primary care networks are also not yet fulfilling a role within systems as the voice or representative of the patient, and therefore the patient voice was not as yet successfully represented within the system, in many cases.

Meanwhile, there is a lack of clarity over the role and significance of 'place', with different approaches in use from area to area. A difference in approach from system to system is not necessarily a problem, but a lack of clarity about the role of 'place' within individual health and care systems is a cause for concern. This is significant for local accountability, as if 'place' is seen as synonymous with the local authority footprint, it has the potential to offer a ready-made route to engaging patients and the public via elected council members, local Healthwatch and potentially health and wellbeing boards. However, one participant identified a need to ensure NHS and local authorities do not spend all their time "learning from each other" rather than actually doing things differently.

Summary of participants' views on how local accountability should work

There was a strong viewpoint that primary care networks (PCNs) and integrated care partnerships (ICPs) should be used to drive forward an agenda of improving the health and wellbeing of local people. However, some participants warned against "smothering" emerging PCNs by attaching too many objectives to them at an early stage.

Alongside this, a focus on "building consensus up from the local district and borough footprint" was seen as an approach with potential benefits. Participants felt there must be a role for elected members of local authorities, as these people have a direct democratic accountability to local residents. Health and wellbeing boards were viewed as a potential option for a "board at the level of place", feeding into ICS decision-making processes.

At an organisational level, there was some discussion of achieving shared responsibility for resource through delegated budgets and shared control totals, and using anchor institutions to break down barriers between commissioners and providers at a local level.

In common with points made in other parts of the discussion, participants saw health and care systems as operating as systems of "managed difference" (rather than "postcode lottery"), with appropriate accountability arrangements to support this. But there was acknowledgement that it would be challenging to explain this to the public, when people are used to the principle of a relatively uniform national service – even if this in not necessarily the case in practice. Some viewed use of patient data at system level as a route to achieving greater clarity about service usage patterns in localities.

Greater local decision-making powers open up the possibility of local disagreement about what constitutes the best way forward. Participants felt there should be a clear arbitration process in such situations, potentially using elected members, system-level senior responsible officers or accountable officers to arbitrate where there is disagreement over an appropriate approach.

The group highlighted a set of short-term actions that could help strengthen local accountability.

Immediate actions

- Create a clear framework as to the level where individual work programmes will be most sensibly led from within an ICS – such as social prescribing, which could be led at a neighbourhood, 'place' or system level.
- Clarify the meaning of 'place' – if this is to be a loose term, broadly synonymous with local government structures, and accommodating local authority geographies whose population is smaller than 250,000 or larger than 500,000 where appropriate, make this clear.
- Define and understand the role of the integrated care partnership – don't define ICS accountability until the system has thought this through properly.
- Explore the feasibility of health and wellbeing boards (and other similar structures) acting as the "board for the level of place", once the role of "place" is clarified.
- Create structures that allow integrated care partnerships to support primary care networks and involve them more closely in their work.
- Establish a clear process for resolving local disagreement – for example, use system/accountable officer level staff to arbitrate where there is disagreement over an appropriate approach.
- Use data to achieve a greater understanding of what drives local people to use particular services (over and above prevalence data).

What needs to change?

The approach most likely to deliver genuine local accountability is for consensus to be built "from the ground up" within an ICS area, much as ICS accountability to national bodies is likely to work best if ICSs themselves lead on setting out outcomes (see section on regional and national accountability).

ICSs have a lot of work to do here to improve accountability, particularly with locally elected members, patients and the public. Learning from and understanding approaches already in use in local government to involve the public and stakeholders in decision-making may help to speed up progress.

A critical task for each ICS will be to embark on a conversation with local people about the extent to which services provided under the system should reflect local need as opposed to offering a more standardised level of provision in line with other ICS areas.

Conclusion

Integrated care systems need to develop a sophisticated range of accountabilities to different players and stakeholders locally and nationally, to capitalise on the potential of system working.

In order for ICSs to hold themselves to account, they need to develop clear outcomes that are meaningful to stakeholders and the public, and place emphasis on supporting constituent provider organisations to share resources, manage risk and deliver change. Clarifying the roles constituent statutory organisations are to play within an ICS will be critical to ensuring systems are able to operate with effective 'internal' accountability.

There is limited appetite for statutory change to structures at present and a sense that local relationships and ways of working should be given more time to develop further in ways appropriate to their local context. However, there may need to be some adjustment to legislation to reconcile organisational objectives with system working.

ICSs will need to build a working relationship with national and regional regulators that acknowledges the mandate for local leadership that has been invested in systems. To this end, it will be important for systems to work proactively to ensure regulatory conversations are driven by and based on their local plans. As a local plan is a mandatory requirement for each system, and subject to regulatory oversight, these should be robust documents. Therefore there is a strong case to be made that it is valid to use these plans as a basis for the regulation of systems.

Adopting a regulatory approach that focuses on the implementation of the local plan should lessen the risk of overly burdensome and templated regulatory approaches, which could hamper the ability of systems to deliver genuine locally-led change. But this is not to say that no nationally mandated improvement goals will be necessary. There was a strong message from our roundtable discussion that some national targets and goals relating to different clinical areas will still be required, and that systems should be held to account for delivering them. Stronger accountabilities should be put in place at the national level for identifying and prioritising England-wide areas of improvement.

At present, more work is needed to establish clear routes into local communities for systems. A particularly unclear element of the local accountability approach is the route that will be used to ensure the patient voice is present in discussions, and there is also a need to create a valid role for elected members of local authorities. Local authority elected members may be best placed to lead in this area.

New provider entities operating at the level of the place and the locality should be able to drive a local agenda forward, but these must not be overloaded with responsibilities before they are fully established.

It will be important for ICSs to be able to explain the concept of "managed difference" to local stakeholders, and for the NHS nationally to be able to create a clear message about why this is helpful and does not constitute a "postcode lottery". At present, there is a perception of a single, uniform service across the country, even if this is not always the case because of local commissioning and prioritisation decisions.

Key recommendations

1) Internal accountability within systems

- The role of integrated care systems should be carefully delimited and viewed as an "engine" for tackling system-wide issues that partners have in common.
- ICSs should agree a clear set of shared outcomes for the system to deliver and which form the basis of robust mutual accountability.
- ICSs should reach a clear understanding locally of how their role and function fits with the existing roles performed by constituent organisations and stakeholders.
- Local relationships and ways of working should be given time to develop further and this should be key to any future consideration of statutory change.

2) Regional and national system accountability

- ICSs should be "smart, ambitious, translational systems" that are "confident enough not to need to ask for permission, but able to ask for forgiveness if necessary".
- ICSs' local system plans should set the agenda for conversations with arm's-length bodies and regulators about how and where systems will make a difference.

- Legitimate national aspirations about service development – particularly relating to clinical areas – should be appropriately addressed in local delivery.

- The NHS Long Term Plan should be viewed as one component of a broader based local strategy for improving the health and wellbeing of the local population.

- The NHS's national improvement goals should be developed much more closely with local systems to ensure their ambition is informed by local intelligence and thinking.

3) Accountability to local communities

- Local accountability should be driven "from the ground up" within an ICS area, incorporating a clear role for elected members of local authorities and accompanied by more acceptance of managed difference of services if they are to be tailored to meet local need.

- Primary care networks and integrated care partnerships should be used to drive forward an agenda of improving the lives of local people. However, they should not be "smothered" by attaching too many objectives to them at an early stage.

- There must be a role for elected members of local authorities, and health and wellbeing boards were viewed as a potential option for a "board at the level of place".

- Health and care systems should operate as systems of "managed difference" (rather than "postcode lottery"), with appropriate local and national accountability arrangements to support this.

- Elected members, system-level senior responsible officers or accountable officers have a key role in resolving differences over how services should be tailored to local need.

Who to contact – your regional lead

Our regional leads are on hand to support ICSs and STPs across the different regions in England. They provide access to learning and good practice, support relationships and leadership development, and create opportunities to influence national policy and thinking. They also provide a stronger and more direct link between members and the NHS Confederation, acting as a conduit to transmit messages and concerns to national bodies.

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