Advanced Foundation Trust Programme

Guide for applicants consultation submission

Key points

- We strongly support the government's commitment to empower and enable NHS organisations to deliver, and understand the advanced FT (AFT) programme and introduction of Integrated Health Organisation (IHO) contracts is part of implementing that commitment.
- We support the focus throughout the guidance on capabilities and welcome the balance of factors relating to readiness to support the three shifts and integration alongside core corporate and quality governance, workforce and other considerations.
- The guide does not address any implications for organisations sharing leadership and/or governance arrangements seeking AFT status individually or as a partnership. The government should also clarify how it plans to transition from awarding AFT status to a small number of high performing trusts to all trusts being an AFT by 2035.
- Given current operational and financial pressures and the need to improve services and transform models of care, it is essential that the AFT programme and IHO contracts deliver tangible benefits - for providers, for the taxpayer and most of all for patients.
- We have some concerns that within the current constrained fiscal environment, the proposed financial freedoms may be symbolic rather than practical and therefore may not sufficiently incentivise improvement.
- Beyond the guidance, DHSC and NHSE must confront the cultural challenge of designing and operating a system that enables the innovation and experimentation needed to transform NHS care, while still working in an environment that has historically prioritised standardisation and consistency. We have welcomed recent changes to the capital regime, but NHS leaders would welcome wider reforms to ensure capital funding is invested as effectively as possible.
- We strongly believe that a capability-based regulatory approach is the optimal arrangement for all. However, as we have argued in our joint response to the recent CQC consultation and publications on AFTs and IHOs, improvements must be made to the NHS Oversight Framework metrics and CQC's assessments so they can provide a more accurate picture of performance and capability so that organisations that would most likely benefit from AFT

status are eligible. Given the operational challenges facing the CQC, we believe NHSE's assessment of provider capability and quality should be given adequate weight in the assessment until CQC's ratings are more regular and robust.

- We strongly support plans to introduce additional criteria to guide the designation of IHO host providers. We also support the criteria outlined, including the emphasis on collaboration and working across organisational boundaries, driving the left shift and contracting and commissioning skills. But we believe the guide should include clearer expectations that governance models include a robust process for collective problem-solving and conflict resolution. Population health and inequalities expertise should also become explicit criteria for IHO designation. We strongly agree with the proposal to review and revise criteria after the first IHO contract is developed.
- Healthcare leaders are concerned that the current IHO designation process may fail to identify the most capable host organisations. They argue that the AFT only eligibility route is too narrow, that ICBs and system partners should have a stronger role in identifying local need and suitable hosts, that systemwide capabilities – especially those of ICBs – are not sufficiently considered, and that inconsistent language about IHOs creates confusion by implying they are organisational forms rather than contractual mechanisms.

1. **Are you responding as an individual or on behalf of an organisation?**

- [ ] Individual
- [x] Organisation

2. **If responding on behalf of an organisation, please describe the organisation or group you belong to:**

NHS Providers is the membership organisation for NHS hospital, mental health, community and ambulance services that treat patients and service users in the English NHS. We help NHS foundation trusts (FTs) and trusts to deliver high-quality, patient-focused care by enabling them to learn from each other, acting as their public voice and helping shape the systems they operate in. NHS trusts in England collectively account for £132bn of annual expenditure and employ 1.4 million people.

The NHS Confederation is the membership organisation that brings together, supports and speaks for the whole healthcare system in England, Wales and Northern Ireland. The members we represent employ 1.5 million staff, care for more than 1 million patients a day and control £150 billion of public expenditure. We promote collaboration and partnership working as the key to improving population health, delivering high-quality care and reducing health inequalities.

3. **What is the name of your organisation?**

NHS Providers and NHS Confederation, responding jointly.
Our organisations will merge in April 2026.

4. **Paragraph 13 to 22 of the guide set out the freedoms and flexibilities that advanced foundation trusts will benefit from. To what extent do you agree or disagree with the broad freedoms for advanced foundation trusts?**

- [ ] Strongly agree
- [x] Agree
- [ ] Neutral
- [ ] Disagree
- [ ] Strongly disagree

Please add any additional reflections:

Before addressing the specific questions, we set out our view of the advanced FT (AFT) programme itself, to articulate the context for our responses.

We strongly support the government's commitment to empower and enable NHS organisations to deliver, and understand the advanced FT (AFT) programme is part of implementing that commitment.

We are also highly supportive of board-led developmental review processes that add value and drive meaningful improvement.

Given current operational and financial pressures and the need to improve services and transform models of care, it is essential that the AFT programme delivers tangible benefits – for providers, for the taxpayer and most of all for patients.

This guide for applicants sets out what is essentially a process for the revalidation of existing FTs and a pre-validation of NHS trusts, pending legislative changes that may lead to the removal of councils of governors. The new assessment criteria reflect the aspirations of the 10-year health plan (10YHP), marking a departure from the original FT authorisation process, though guided by some of the same principles and seeking some of the same benefits. We support the guide's emphasis on collaboration over competition (while noting that other aspects of government policy still pull in the opposite direction) and note the guide's assertion that this process should not distract from core care delivery.

We understand the rationale for reassessing provider readiness for greater self-governance, especially after a decade of centralised oversight. The guide's commitment to AFTs undergoing revalidation every five years implies that the NHS oversight framework (NOF), board capability assessment and Care Quality Commission (CQC) inspection regimes do not and will not sufficiently assure the centre of providers' organisational fitness: we agree that in their current form, these tools are not fit for this purpose. However, we would note that the AFT process adds a further evaluation process to the NHS at a time when there is a commitment to streamlining bureaucracy and reducing duplication, and a pressing need to focus on improvement.

There is a key policy question that remains unanswered around whether greater organisational autonomy is seen as a driver of organisational effectiveness and efficiency, or a reward for good performance. We would argue that it is the former.

NHS trust and foundation trust leaders' feedback on the AFT concept to date suggests:

- Strong support for reduced micromanagement, with reservations about the impact on performance that the freedoms outlined can have in practice. Members are more likely to point to reforming financial flows, improving crumbling estate, enhancing digital capacity and capability, resolving workforce supply and wellbeing issues, among other enablers, as the real drivers of better performance.
- Interest in AFT status as a pathway to an integrated health organisation (IHO) contract, though clarity on the IHO contract and how it sits alongside other delivery models, including population-based contractual models, is still needed.

- Capital freedoms are welcome, although there is scepticism about their viability and therefore value in the current climate. Elizabeth O'Mahony's comments from the Healthcare Financial Management Association (HFMA) conference in December captured this point well – see here. We say more about this below.
- Doubt about the likelihood of increased autonomy, especially in the context of NHS England's (NHSE's) abolition and likely centralisation of regulatory and oversight powers under the secretary of state. The tight financial situation over the spending review period similarly casts doubt on whether financial autonomy can become meaningful in practice in the short to medium term.
- Trusts are likely to take up AFT status where it is available to them, especially where they are encouraged to apply by their regulator.

5. What freedoms within the areas of strategic and operational autonomy, greater financial flexibility and a capability-based regulatory approach, should be considered to help advanced foundation trusts deliver better organisational performance and to support delivery of the 10 Year Health Plan?

Enhanced autonomy would allow boards to better focus on what matters most to local populations, reflecting their accountability to the public. Greater autonomy should allow boards to prioritise longer-term health outcomes rather than only focusing on a small number of short-term performance metrics.

When asked, provider board members identified the following beneficial freedoms for trusts.
To be free to:

- Plan over many years, taking a truly long-term view of community needs.
- Reduce interactions with the centre that do not add value to patient care.
- Use capital funds innovatively, with some of the strict parameters currently in place removed.
- Invest in infrastructure and technology.
- Take strategic action to reconfigure services to reduce fixed cost bases.

Points 3-5 are explained in more detail in Q6, below.

6. What additional freedoms should be considered to help advanced foundation trusts deliver better organisational performance and to support delivery of the 10 Year Health Plan?

Planning cycles with far longer horizons and more flexibility in relation to capital are consistent themes from members wishing to plan strategically for population health. We've welcomed the government's recent moves towards a longer term more strategic view.

Within a constrained fiscal environment, the proposed financial freedoms may be symbolic rather than practical and therefore may not sufficiently incentivise improvement:

- Capital investment remains subject to the capital departmental expenditure limit (CDEL), which requires central management and limits flexibility. We have collectively called for ways for this to change, or for trusts to be allowed to raise non-fiscal CDEL through public private partnerships.
- The plan promises capital allocations for maintenance based on need, not provider discretion.
- Providers are committed to delivering break-even, but given significant financial pressures it may be unrealistic for providers to generate large surpluses that can be re-invested on capital projects.

Many trust and FT leaders do not foresee a near-future in which they will be able to generate a surplus sufficient to make the financial freedoms on offer truly impactful. For those which do succeed, delivering a surplus could involve making difficult trade-offs. NHS Providers financial reset survey showed that reduced spend would need to be achieved via reductions in headcount and reduced service provision, and the impact of such measures on patients might outweigh any benefits of additional capital flexibility in the medium term.

Simply granting AFTs greater financial freedom to re-invest surpluses on capital projects may not necessarily transform their ability to deliver more effective capital schemes. NHS leaders think that the current capital approval process has recently been too complex, slow and risk-averse, stifling innovation and restricting their ability to deliver transformative benefits to their local populations. We therefore welcomed the recent changes set out in the 2026/27 – 2029/30 capital guidance, however, NHS leaders would welcome wider reforms to the capital regime to ensure capital funding is invested as effectively as possible. The NHS Confederation's report makes 18 proposed changes to the NHS capital regime.

The difference between the freedoms proposed for AFTs and those in NOF 1 and NOF 2 is that surpluses can be retained (and rolled over) by AFTs for an indefinite period, whereas NOF 1 and NOF 2 trusts must use any surplus in the following financial year. This distinction is valuable, but

while trust leaders are likely to seek AFT status if encouraged by their regulator, finance directors tend to believe the difference would not on its own be enough to incentivise doing so.

On freedom to use capital funds more innovatively, members reference CDEL and how all capital spend – at a national level – must fall under this. As a result, granting AFTs greater discretion to reinvest any surpluses they generate risks proportionately reducing the amount of CDEL headroom available for other trusts looking to invest in upgrading their estates. It is imperative that trusts, of all sizes and from all sectors, have sufficient access to the capital funding they need to ensure their estates are fit for purpose. Any additional capital freedoms granted to advanced foundation trusts should still preserve, and not undermine, parity of access for all other trusts.

Trust leaders consistently say that the current capital regime is not working effectively. Very often capital spending is backloaded to the end of the year, with pots of strategic capital funding becoming available at short notice. This results in inefficient spending decisions being taken to avoid capital budgets being underspent but does not always enable the right investment at the right time. As such, it represents less than optimal value for money for taxpayers. The time required for spending approvals poses a significant barrier, leading to increased project costs and operational inefficiencies.

Government announced £10bn of investment in NHS technology which will go some way to helping the health service to deliver the shift from analogue to digital. In recent years, digital transformation budgets have been continually raided and so it is important that such investment is protected and will support trusts to digitise quickly. Trusts will need to balance investment in new digital infrastructure with the ongoing requirements to renew software licenses and train staff to improve operability of new technologies. This will require government to ensure that the make-up of technology investment is sufficiently balanced between revenue and capital budgets. For this reason, it would be beneficial to grant AFTs powers to transfer funding between revenue and capital budgets at a local level to ensure that technology investment delivers the best possible value for taxpayer's money.

With appropriate autonomy, AFTs could take ownership of decisions that will best support their local populations and are likely to be at the vanguard of efforts to develop new models of care and shift care into the community. Government must recognise that there will need to be a period of 'double running' as the NHS continues to improve performance against key targets, while also investing more in measures to reduce demand in the future. It will take both time and resources before we see the true return on investment from preventative initiatives. It may therefore be worth granting AFTs greater leniency on delivering break-even plans to incentivise them to invest upfront to transform how care is delivered for their local populations.

There is also a cultural challenge in designing and operating within a system that enables the innovation and experimentation needed to transform the way the NHS delivers care, while working within a culture that has historically prioritised standardisation and consistency.

When new approaches are tried, not everything will succeed and this will need to be recognised and learned from. Boards may need to guard against excessive risk-avoidance and consciously foster a culture of strategic, managed risk-taking.

Whether providers will be able to use their enhanced autonomy to take calculated risks will depend on having a degree of security about their status: this includes ensuring that earned autonomy cannot be withdrawn too frequently or easily. The system's risk tolerance, and tolerance of variation, needs calibrating appropriately to enable the benefits of enhanced autonomy to be realised in practice.

7. Paragraph 17 in the guide for applicants sets out the capability-based regulatory approach advanced foundation trusts will be subject to. Are there any views or reflections you would like to share on the proposed approach?

We strongly believe that a capability-based regulatory approach is the optimal arrangement for all providers. Capability-based regulation encourages organisations to take ownership of their own improvement, reflecting the principle of subsidiarity and the government's commitment to reaping the benefits of enhanced autonomy.

It enables an adult-to-adult approach rather than a parent-child relationship, facilitating supportive interactions between regulators and NHS organisations, rather than punitive ones, and it supports strategic improvement rather than compliance-focused decision-making. It is more likely to be proportionate and 'right-touch'.

To enable this to work, trust leaders believe that the prevailing culture of command and control, whether enacted through central routine performance management, published guidance, or direct political intervention, must also be addressed.

Having more time to address issues that arise is hugely welcome and the timescales for intervention should be risk dependent. Where a trust has clear plans in place to improve and it is clear this will take time for good reasons, this should be acknowledged and accepted by the regulator.

Our concern is that the quarterly publication of NOF segmentation and league table positions will not afford such space in the face of public and therefore political demands for urgent remedial action, even where the regulator may know time is being taken for good reason and where the board is capable.

There is also **a practical concern about the potential removal of the AFT designation** – it will not be feasible to withdraw foundational freedoms (eg capital freedoms or the ability to retain surpluses) if performance and NOF segmentation slips temporarily, since this would make it impossible for AFTs to plan, invest, or build. The expectation of intervention can hamper innovation and reduce risk appetite, and is therefore likely to stifle progress.

The government should also clarify how it plans to transition from awarding AFT status to a small number of high performing trusts to all trusts being an AFT by 2035. Given the proposed requirement for AFTs to be in NOF segment 1 or 2, either this criteria will need to be broadened or the approach to segmentation will need to change so it is no longer based on a quartile approach (in which it is methodologically impossible for all trusts to be in segment 1 or 2).

8. What other approaches, if any, should be considered to help advanced foundation trusts deliver their objectives?

All trusts (not only AFTs) could be supported to deliver their objectives more effectively if the centre consistently took the approach that experienced NHS board members recommended to their colleagues at NHS Providers' annual conference: provide sustained clarity about accountabilities and the extent of autonomy, and create and reinforce the conditions in which people can be expected to do the right thing by ensuring they have the resources, training and support they need, and are operating within an effective safety culture.

The **centre must legislate for and model autonomy**, limiting ministerial powers of direction appropriately and enabling leaders to act in their populations' best interests. A board member comments:

"It strikes me that what is being looked for by providers is an attitude – rather than an absolute. We trust you to get on and do the right things. But you need to take into government priorities. And work collaboratively."

9. The assessment criteria and process (set out in paragraph 33 through to paragraph 98) are intended to avoid duplication with other published frameworks and trust submissions while retaining the rigour and developmental aspects of the original foundation trust assessment approach. Are there any changes to the proposed assessment criteria and process which might help meet these goals?

Overall, we welcome that the AFT assessment intends to draw on supporting evidence that already exists, aligns with the board capability/insightful provider board, and broadly reflects the CQC's approach to quality oversight.

However, the AFT assessment amalgamates elements of the three components of provider oversight and performance management (NOF, board capability and CQC assessments – and it should be remembered that CQC already duplicates elements of the board capability assessment). The AFT assessment overlays the longer-term aspirations of the 10YHP and medium-term planning framework on top of what is already a complex monitoring landscape.

This multi-layered approach runs counter to the government's commitment to streamlining bureaucracy and removing non-value-adding processes from the system.

This question asks about the process in relation to duplication, but we have comments on the process in general that do not fit under any other question.

It is welcome that both trusts and FTs can apply for AFT status if they meet the criteria. But there are two questions that are currently unanswered by the guide, and which trust leaders would find it useful to understand.

Firstly, how and when will high-performing providers be informed they are eligible to apply for the status, and will there be an expectation that they apply within a certain timeframe?

Secondly, notwithstanding the welcome caveats around taking a proportionate approach and giving providers time to improve, are NHSE clear about the likely trigger mechanisms for AFT status to be revoked? Are there any 'red lines' for NHSE or indeed for ministers – such as CQC rating falling to inadequate, or segmentation falling to NOF 4? How will a reasonably consistent approach across the regions be assured?

10. Are the eligibility criteria to apply for advanced foundation trust status, described in paragraph 29 to 32 in the eligibility criteria section, sufficient to ensure that only high performing, capable and financially sustainable trusts delivering high quality care are chosen?

☐ Yes
☒ No
☐ Don't know

Are there any other criteria that should be considered?

We have selected 'no' above because both NOF segmentation and CQC rating are rigid criteria for entry to AFT assessment, yet the NOF is not currently robust enough to inform AFT eligibility and the CQC's methodology is under review and many assessments out-of-date.

It is welcome that the eligibility criteria seek to assess against three components when determining readiness for AFT status: satisfactory performance, quality of care and provider capability. **Whether the proposed eligibility criteria can provide adequate assurance about suitability will depend on the reliability of the three assessments used.**

In an ideal world, a single performance and oversight mechanism would enable decisions to be made by the centre about the degree of intervention, support and scrutiny providers require. However, we do not yet have such a mechanism.

Using these three thresholds together should mitigate some of the risks associated with assessing trusts against the NOF in its current form and over the timescales proposed.

Taking NOF segmentation for two consecutive quarters is a short window to get a reliable indication of delivery of the public's priorities and value for money – although combining this with CQC and capability assessments should give a more rounded picture of performance, leadership and quality of care.

It remains vital that the measures of performance are sufficiently accurate and are measuring the right things. A trust board member comments:

"Recognising that "good" boards may preside over poor performance, and poor boards preside over good performance is important."

While the NOF is structured so as to reflect the core purposes of integrated care systems (ICSs), the selected metrics are for the most part focused on short-term delivery of selected operational priorities rather than achieving outcomes related to the longer-term ambitions of the 10YHP, including greater system working, population health improvements and delivery of the left shift.

Even then, feedback from mental health, community and ambulance leaders indicates many do not feel the 2025/26 metrics provide an accurate or reliable view of operational and financial performance. We are pleased work is underway to improve these for 2026/27 and support a more fundamental shift planned in the future to ensure the NOF assesses providers' performance against the outcomes sought around population health.

As noted above, we recommend a NOF that places greater emphasis on delivering system objectives, improving population health and shifting care from hospital to community in line with government policy, with greater weight given to capability assessments. While a full transition to this approach by April 2026 may not be practical, consistency in the interim is essential.

The challenges the CQC faces in completing timely assessments are well-documented, and we understand the proposal to address the lack of timely CQC assessments for many providers via a letter of assurance as part of the assessment itself. This mechanism may also be necessary at the eligibility stage if improved providers with out-of-date assessments are not to be penalised, and the AFT programme is to move forward at the pace ministers want to see. Where more-recent quality assessments under the NOF and provider capability assessment are more positive than historic CQC ratings, it will be important that such trusts can in any case be considered eligible to apply for AFT status.

We believe the potential return of single-word CQC ratings present a heightened risk of oversimplifying or misrepresenting performance. This adds to our caution about giving too much weight to CQC ratings when making future eligibility decisions.

Both the NOF and the CQC's proposed assessment framework focus on individual organisational performance. Both frameworks must be updated to reflect the capability of providers in working across organisational boundaries where this will help deliver service transformation.

The provider capability assessment is new and in its first iteration. NHS Providers and the NHS Confederation have broadly welcomed the approach, but it may require later revisions based on feedback from boards. The triangulation carried out by NHSE around providers' self-assessment will need to be robust.

It makes sense that local ICB(s) should support a provider's eligibility – particularly in the case of a trust being put forward by NHSE for IHO designation. We explore this further in our responses on IHOs. It would be helpful if the guidance articulated a simple dispute resolution mechanism in case of disagreement between providers and ICB(s) about readiness.

It is welcome that trusts sharing leadership and/or governance will be assessed as separate legal entities, recognising their independent statutory duties around corporate and financial control, and that care will be taken to avoid duplication of effort where possible. The guide does not address any implications for organisations sharing leadership and/or governance arrangements when they apply for AFT status, nor if one partner were to achieve the status and the other(s) did not. There would presumably be implications around financial freedoms and the level of regulatory scrutiny that those trusts would need to work through with NHSE. The guide might helpfully acknowledge this.

11. Are the advanced foundation trust assessment criteria set out in Annex 1 appropriate to determine suitability for advanced foundation trust status?

☒ Yes
☐ No
☐ Don't know

Please add any additional reflections

We strongly support the focus on provider capability throughout and welcome the balance of factors relating to readiness to support the three shifts and integration alongside core corporate and quality governance, workforce and other considerations. It is helpful that the criteria explicitly align with the expectations in The Insightful Provider Board, which the provider capability assessment is based on.

We welcome the use of criteria that can apply across providers of all sectors and the commitment to recognise relevant sectoral differences, and avoid an overly bureaucratic process. Learning from the first cohort of applicants should be used to streamline and improve the process as required.

While overall we believe these are appropriate criteria in the current context, there are four points which raise questions about whether these criteria will be effective in identifying suitability for AFT status:

- We query whether the CQC currently has the capacity and capability, and information, to participate in the assessment process via a CQC letter of assurance, and whether the CQC can provide adequate assurance about a prospective AFT's ability to work towards integration and delivery of the government's transformative aims. For these reasons, and as set out in the eligibility section above, we would like to ensure that NHSE's own assessment of provider capability and quality is given adequate weight in the assessment until such time as CQC is able to provide adequate assurance.
- Expecting providers to submit plans demonstrating how they will use their new freedoms presupposes that the proposed freedoms are essential to deliver trust and system plans with respect to greater integration and achieving the left shifts. This may not necessarily be the case.

- We agree with the suggestion to establish an independent panel to undertake the final decision-making board to board assessments. However, more detail is needed on how the panel will be selected, who it is accountable to, and what powers it will have to guarantee its independence.
- We note again the requirement for applications to be supported by ICB(s) and query how any disputes might be resolved.

12. Are the expectations of the advanced foundation trusts board statements set out in Annex 1 appropriately stretching yet achievable for high performing and well-led trusts?

☒ Yes
☐ No
☐ Don't know

Please add any additional reflections

We are generally supportive of these board statements.

Elements within the assessment process will necessarily require subjective judgement. Clarity for boards in making and evidencing statements such as those around 'commitment and contribution to date in enabling and delivering improved outcomes…' would support board submissions. What degree of commitment and contribution is expected? Adopting a fair and consistent approach to the assessment will also be important.

Strategy, leadership and planning:

Throughout, reference to provider collaboratives might be broadened to reflect the use of other effective partnership models that might demonstrate a strategic partnership approach, including for example joint ventures, alliances and lead provider models.

Productivity and value for money:

Caution should be taken when assessing the ability of trusts to improve productivity measurably and sustainably. There are many things trusts can control but also many that they cannot control entirely – for example demand, local social care capacity, recruitment of staff, condition of estate.

Financial performance and oversight:

'The financial plan projects an adjusted surplus position in year 1, and it achieves a sustainable adjusted surplus position by year 3 of the projected period', is a little unclear. This implies that the trust might be in deficit in year two. It would be helpful to clarify expectations.

'System financial performance, and the organisation's contribution to system breakeven' will be problematic for some high performing trusts that are in challenged systems. Trusts cannot control their system's financial position and so this should not be a criterion.

13. Are there any key omissions which applicant boards should certify?

We would not seek to add further certifications to this comprehensive process.

14. Are the board statements requested in Annex 1 to support assessment applicable and workable across different trust types (mental health, community, acute, ambulance and specialist)?

- [x] Yes
- [ ] No
- [ ] Don't know

Please add any additional reflections

In our view these are broad statements focused on the activities of all boards.

15. Annex 1 gives examples of evidence that may be used by trust boards to assure themselves that the board statements can be certified. Is the evidence set out reasonable and appropriate?

- [ ] Yes
- [ ] No
- [x] Don't know

Please add any additional reflections

We strongly welcome the submission of existing strategies, plans, board reports and meeting minutes as evidence, and the focus on sharing the paperwork boards would require in order to complete their board capability assessment should reduce the burden on busy executives. Nonetheless, the paperwork will be extensive and time consuming for managers to produce and for boards and NHSE to review.

We await feedback from members in the first wave who will no doubt have reflections on whether the requirements are proportionate and streamlined enough and hope that revisions can be made if necessary.

16. Do you have any comments about the advanced foundation trust proposal and the impact on advancing equalities and or reducing health inequalities?

Members have noted concern that the AFT programme risks enhancing the ability of some providers at the expense of others. While CDEL and RDEL are in place, granting enhanced financial freedoms to some trusts based on their capability and performance rather than on clinical need or the need to address health inequalities nationally, risks further hampering trusts who provide services in areas with a higher and/or more complex level of need, including areas with high levels of deprivation. While CDEL and RDEL are in place, granting enhanced financial freedoms to some trusts based on their capability and performance rather than on clinical need or the need to address health inequalities nationally, risks further hampering trusts who provide services in areas with a higher and/or more complex level of need, including areas with high levels of deprivation.

17. To what extent do you agree or disagree that the additional criteria for IHO assessment, described in Annex 2, will support the designation of trusts capable of holding an IHO contract?

- ☐ Strongly agree
- ☒ Agree
- ☐ Neutral
- ☐ Disagree
- ☐ Strongly disagree

Please add any additional reflections:

We strongly support introducing additional criteria to guide the designation of IHO host providers.

Holding an IHO contract will involve trusts taking on significant new responsibilities alongside existing responsibilities for service delivery and organisational performance. Most notably, it will involve managing the budget for a whole population, holding higher levels of shared risk and designing models of care to improve population health outcomes. By design, AFTs will be high performing organisations, and while there is a requirement for them to demonstrate advanced partnership working, they will not necessarily be highly capable in these areas.

The initial criteria outlined in Annex 2 reflect those new IHO responsibilities well and its emphasis on provider capability is particularly welcome. We strongly agree with the proposal to review and revise criteria after the first IHO contract is developed, not least because the detail of what an IHO contract constitutes is yet to be determined. Based on early engagement with healthcare leaders, we have also suggested ways to strengthen the initial criteria further in our response to Question 18.

While supportive of the additional criteria, healthcare leaders have expressed four broader concerns about the IHO designation process, which risk undermining the identification of organisations capable of holding an IHO contract.

Firstly, the initial AFT designation process is too restrictive: Making AFT status – which is subject to a process predominantly focused on the operational and financial performance of individual organisations – a prerequisite to hosting an IHO may exclude organisations that are better suited to being a host provider. **Linking IHO designation to an AFT eligibility threshold which focuses on organisational performance and capability is also in tension with** the collaborative culture and behaviours that IHOs will require to succeed. We expand on these points in our response to Question 19.

Second, a nationally led process risks disempowering ICBs and system partners: Healthcare leaders are concerned the current designation process does not reflect the more devolved and permissive operating model described in the government's 10 Year Health Plan.

The approach to designation proposed is overly prescriptive and nationally driven. While the centre should ultimately be responsible for assessing the readiness of a trust to take on an IHO contract, ICBs and other system partners should play a more central role in identifying both the need for such an IHO contract and the trust that is best placed to host it. Annex 2 acknowledges the importance of system buy-in, but the proposal for the designation assessment to "consider the ICB's intentions and wider stakeholder support" is vague and implies only a light-touch role.

We understand a more government-led approach may be necessary for the first wave of designations. However, future waves should be initiated locally by ICBs – as strategic commissioners – with the support of wider system partners, with readiness assessed by NHSE and DHSC. An overly prescriptive approach risks undermining existing partnership models which have already begun to improve population health outcomes. In the words of one acute trust leader:

"It would be a lot more powerful if done on the basis of co-design and collaboration. The decision should be based on having the infrastructure and partners and ability to recognise the need for partnership working."

We urge the government to ensure wider system partners also have a more central and visible role in the IHO application and IHO development process, including at scale primary care and VCSE providers. As part of this, ICBs will have an important convening role to ensure appropriate involvement and to maximise the opportunities an IHO contract can deliver. Together, this approach would foster greater system buy-in and ensure decisions are informed by local system plans based on local, based on need and the capabilities required to deliver the contract.

Third, there is insufficient focus on wider system capabilities: Annex 2 focuses almost entirely on the capability of the host provider, with little mention of wider system capabilities. We welcome the proposal to develop a separate assurance process for commissioner and provider capabilities prior to any contract beginning but believe this should be an earlier and more central part of the selection process. Given the crucial role ICBs will play in commissioning IHO contracts, alongside new neighbourhood contracts, ICB capabilities must be a key consideration.

Fourth, the language when referring to IHOs should be consistent to avoid confusion: Since the guide confirms that an IHO is a contractual delivery mechanism, the guidance could also be clearer that the assessment is not to designate a provider as an IHO (i.e. as a distinct type of organisation) but as capable of holding an IHO contract. The language often implies the latter (for example, 'the IHO' and 'an IHO' in numerous places) when we know the former is intended.

18. Are the IHO assessment criteria (strategic vision, corporate governance, quality governance, contracting, procurement and commissioning oversight, and financial governance) focused on the right capabilities?

☒ Yes
☐ No
☐ Don't know

Are there other criteria that should be considered?

As outlined above, the criteria in Annex 2 align closely with the capabilities that local leaders have said an effective IHO host provider would need to possess (see below). Hosting an IHO contract would significantly broaden the focus of a trust, introducing new responsibilities, as outlined in question 17. This shift will require governance arrangements that support partnership working, manage higher levels of risk and the design and delivery of new models of care that improve population health outcomes.

As one ICB leader put it:

"Even with the best performing FT in the world, they still need to shift their mindset to be a proper integrated health organisation that cares for the population."

We therefore strongly support prioritising candidates' ability to work with others, deliver the left shift and demonstrate a proven record of looking beyond the performance of the trust's organisational boundaries. This could be demonstrated by local partners agreeing to designating an IHO host provider. Similarly, we agree that host providers will need contracting and commissioning skills and an appreciation of the additional responsibilities involved in managing an IHO contract alongside existing service delivery responsibilities.

Detailed engagement with over 30 healthcare leaders across acute, mental health, community and primary care providers and ICBs revealed the following capabilities for IHO host providers:

- Financial and organisational maturity
  - Maintains financial balance.
  - Shows organisational robustness, including dispute resolution and shared decision-making.
- Governance and risk management
  - Operates within a statutory framework that enables effective corporate structures and robust governance.
  - Capable of managing risk and making strategic decisions at scale.
- Understanding of commissioning
  - Demonstrates a clear grasp of the commissioning cycle and the ability to engage effectively with commissioning processes.
  - Has the ability to manage a range of contracts, guided by a commitment to improving population health outcomes, while managing any conflicts that arise based on organisational interests.
  - Understands how to allocate resources effectively, ensuring decisions are evidence-based, equitable, and aligned with strategic priorities.
  - Demonstrates the ability to lead or contribute to pathway reconfiguration, using data, stakeholder insight, and service modelling to redesign services that are sustainable, high-quality, and responsive to population needs.
- Collaborative leadership
  - Demonstrates strong backing from system partners and a proven track record in partnership working and prioritising place-based outcomes over organisational interests.
  - Provides infrastructure to support mature, collaborative decision-making and conflict resolution.
- Population health capability
  - Demonstrates expertise in population health management and addressing health inequalities.
  - Actively engages in prevention and left-shift strategies aligned with the 10 Year Health Plan, including evidence of redirecting resources from acute care into primary care, community, mental health services, including VCSE services.
  - Access to and ability to use comprehensive data for population health analysis.

Healthcare leaders believe that many of these competencies will require further development. As part of this, it may also be necessary to transfer staff from ICBs to the host provider, particularly so they have sufficient understanding of the commissioning cycle.

We recommend expanding the guide's criteria for the 'corporate governance' capability. The guide should include clearer expectations that governance models include a robust process for collective problem-solving and conflict resolution, with safeguards for smaller system partners including primary care and VCSE providers.

However, the guidance should avoid being overly prescriptive about the form that local governance arrangements take, especially before the first IHO contracts are developed. Our report, *Towards Integrated Health Organisations*, presents a range of possible options. Governance arrangements should be rooted in a deep understanding of local system context, including existing partnership structures and population needs. Rather than a costly and disruptive exercise, changes should be locally led, approached in the spirit of evolution and proportionate and effective. Trust boards are well-placed to manage this, including through learning from ongoing and past provider collaboration.

19. IHO designation is currently available to advanced foundation trusts. What are your views on widening eligibility where the model might solve entrenched problems in a health system?

We strongly support widening IHO eligibility beyond AFTs in the future to achieve improvements in population health outcomes, in two main ways. As well as using learnings from the development of the first IHO contracts to inform revisions to the additional criteria, these should also be used to determine how initial eligibility is widened.

Firstly, there should be greater flexibility over which organisations can hold an IHO contract in the future. The Secretary of State has himself indicated that an IHO contract could be held by primary care organisations. In areas which have primary care at scale with robust formal governance, risk management and devolved decision-making, these bodies should not be ruled out of becoming IHO host providers in the longer term, for example, by providing them a route to NHS Trust status.

Second, IHOs should not only be a reward for higher performing organisations, but also a potential solution for organisations with entrenched financial challenges and poor population health outcomes – provided they possess key capabilities, including strong leadership and governance.

It is counterintuitive that only organisations already achieving financial balance or surplus can access a contractual mechanism designed to improve allocative efficiency. As one ICB leader told us:

"I think we do a disservice to the leadership teams in the organisations that are challenged, who would lose an arm to have a bit more autonomy, investment and resource to try something new."

Making AFT designation a gateway sets a high bar and overemphasises short-term operational and financial performance. A capitated contract represents a longer-term transformation, for which leadership capability is a more important indicator of readiness.

We recognise that widening eligibility may reduce the incentives available as part of the AFT regime. However, it is more important that IHO contracts are available to organisations where populations stand to benefit the most and which have the capability to manage them (as defined by Annex 2).

Healthcare leaders are also concerned that linking IHO designation to an AFT eligibility threshold which focuses on organisational performance and capability could undermine the collaborative culture and behaviours required to make IHOs a success. They have highlighted the contradiction of asking organisations to 'prove' they are the most collaborative.

Beyond eligibility, NHSE should ensure co-production of IHO policy and its future IHO development programme includes both the first wave of IHO designates as well as leaders from more challenged systems who are interested in holding an IHO contract in the future.

NHSE and DHSC should also avoid positioning IHOs as the only or best option for all systems. In many areas, IHOs will not be viable or desirable in the short term, and there is growing interest in exploring IHO-type approaches in parallel with the national designation process. Many areas are already establishing partnership models with the aim of delivering care differently to improve integration of services and improve population health outcomes. In addition, the 10 Year Health Plan introduces further contractual mechanisms to transform care, including Year of Care Payments and two new neighbourhood provider contracts.

20. Do you have any comments about the IHO proposal and the impact on advancing equalities and/or reducing health inequalities?

Healthcare leaders consistently tell us that the form of an IHO should follow its function. In practice, this means starting with a clear definition of the IHO's purpose, followed by its goals and success measures. Leaders agree that the primary purpose of IHOs should be to improve population health outcomes and deliver better value for money by increasing allocative efficiency. But underpinning this, they have consistently told us that IHOs must be set up to reduce health inequalities. As one acute leader put it:

"I think the key principle for me though is whatever the vehicle is that we put together to do these things, it has to tackle some of these really stubborn health inequalities that we've got."

However, many healthcare leaders are concerned that the current approach to IHO designation could exacerbate performance variation across the country, with a scenario where the 'best performers' get better and the 'worst performers' get worse. This risk is particularly acute where performance challenges stem from local context, such as ageing populations, rural and coastal settings and higher levels of deprivation. If not considered, the rollout of IHO contracts could contribute to a scenario whereby patient choice is reduced and inequalities are deepened. It is therefore vital that as well as widening the eligibility criteria those organisations that are not yet ready to be supported through development programmes.

Similarly, the NOF – which is a key part of the AFT application process – does not at present assess providers against their contribution to reducing inequalities. This means there is a risk that trusts that are very effective in their work to reduce inequalities are ineligible to become IHO contract holders. As the first IHO contracts become operational, national guidance and the NOF should include a greater focus on health inequalities so that they support and incentivise local leaders to design models of care that focus on reducing health inequalities. Building on this, it is important that expertise and a track record in tackling health inequalities is included as part of the additional IHO criteria, e.g. under population health capability (see our response to Question 18). An understanding of population health management and designing models of care to reduce health inequalities will also be important to cover within future IHO governance arrangements.

21. Do you have any other comments about the guide for applicants?

We are extremely grateful for our ongoing engagement with both NHSE and the Department of Health and Social Care (DHSC) about the emerging operating model and provider sector, including 'new FT' (now AFT) status and IHOs, since the publication of the 10YHP.

NHS Providers has already fed back at length to NHSE and DHSC and published on the proposals for what were then called 'new FTs' and IHOs. Our Reinventing FTs and creating IHOs: autonomy, accountability and flexibility published 14 October collated our thinking and member perspectives gathered to date. The NHS Providers View section of our Next day briefing: advanced foundation trust programme – guide for applicants further establishes our initial response to the guidance and was sent to members on 13 November.

Many of the points we raise in questions 17-20 are covered in more depth in the NHS Confederation's recent report, *Towards Integrated Health Organisations*, which is based on engagement with over 30 healthcare leaders from primary care, community, mental health and acute providers and ICBs. The report also presents wider considerations for local leaders and the government to develop IHOs across four components: contractual arrangements, structural form, governance and collaborative behaviours and leadership.

We look forward to working with NHSE, DHSC and our members to support future iterations of the guidance and process.