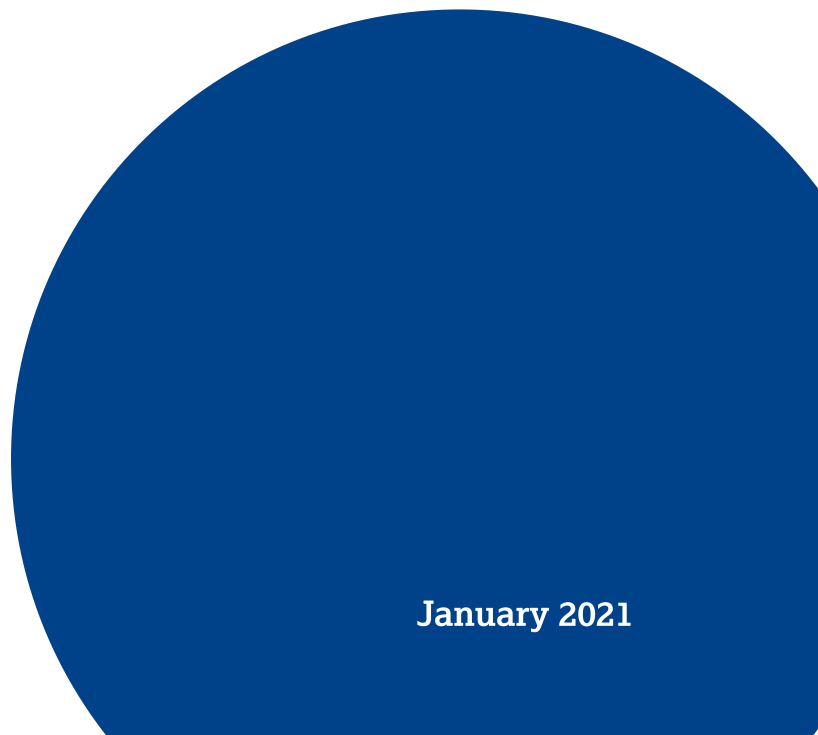
NHS CONFEDERATION

Consultation response

Integrating care: Next steps to building strong and effective integrated care systems across England



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About the NHS Confederation

The NHS Confederation is the membership body that brings together and speaks on behalf of organisations that plan, commission and provide NHS services in England, Northern Ireland and Wales. We represent hospitals, community and mental health providers, ambulance trusts, primary care networks, clinical commissioning groups and integrated care systems.

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Introduction

Over the past 18 months, we have undertaken extensive work on the future of integration in England. This has included setting up the ICS Network for senior leaders within systems, working in partnership with NHS England and NHS Improvement (NHSEI) to develop the initial legislative proposals in 2019, and engaging extensively across our membership to produce our recent report The Future of Integrated Care in England. This set out where there is consensus among leaders across the NHS regarding the future of integration and included a series of recommendations for policymakers, including that systems should become statutory but on the basis that they embed partnership working.

We are proud of the unique perspective that we are able to offer in response to NHSEI's proposals. Speaking on behalf of the organisations that plan, commission and provide NHS services in England (and drawing on the insights of our members in Wales and Northern Ireland), this document builds on our previous work in this area and presents views from across all parts of the NHS on the future of integrated care systems (ICSs).

As you will read, there is a good degree of consensus on many issues, some of which are set out in the section outlining our overall response. However, there are equally some areas of difference between parts of our membership, and we draw attention to these throughout.

Methodology

Since NHSEI's proposals were announced in late November, we have conducted extensive engagement with members across the organisation. Through our various member networks, we have convened webinars, one-to-one conversations and roundtable events to gauge member reaction to the proposals.

This process has culminated in this response, which sets out our organisational position on various issues relating to the future of ICSs, as well as our response to the four questions posed in NHSEI's paper.

For more detail on the positions of our member networks, individual responses can be read in the appendices at the end of this document. They feature as follows:

Appendix i	Response from the ICS Network
Appendix ii	Response from NHS Clinical Commissioners
Appendix iii	Response from the PCN Network
Appendix iv	Response from acute, community, mental health and ambulance service provider members

Overall response

The direction of travel set out in the paper has been widely welcomed and there is consensus across our membership that now is the right time to further embed collaboration and integration into the NHS architecture through legislation.

Particularly welcome are the emphasis on the primacy of place within systems and the principles of subsidiarity and increased autonomy for system leaders. Overall, there is broad support for the notion of new primary legislation to support option two, as it provides the necessary formalisation of the real benefits that organisations report through their collaborative work together, not least during the present pandemic.

For decades, across successive governments, the legislative framework governing health and care in England has centred around the principle of competition between organisations to improve the quality of services. Yet there is now wide recognition that we need to look to integration to improve population health, deliver better quality care, and make more efficient use of resources.

There are, however, some issues that NHSEI must act on if the vision for ICSs is to be achieved. These include the following:

- **Collaborative system leadership must be underpinned by clinical engagement and public and patient involvement and oversight**

  There is agreement across our membership that each aspect of this triumvirate is vital if systems are to work effectively and if they are to have robust decision-making processes. This will mean explicit investment in capacity, especially for clinical engagement, and leadership from all areas of clinical practice and organisations. There is a lack of reference to lay oversight in the paper and this must be addressed as the detail is developed. It will also be vital that there are clear mechanisms for public accountability and engagement, drawing on the experience and infrastructure of trusts, foundation trusts (FTs) and clinical commissioning groups (CCGs).

- **Need for radical reform of oversight model**

  As we have argued through our NHS Reset campaign, development of the future model for system working must be accompanied by radical reform of oversight processes for all regulators and arm's-length bodies, but particularly for NHS England and NHS Improvement and the Care Quality Commission (CQC). Our members across all types of NHS organisation are clear that a lighter, leaner and more agile approach is required. The translation of any legislation into practice will need to be supported by comprehensive reform of the approaches of national organisations towards systems, providers and independent contractors.

- **The need to strengthen partnership with local government**

  It has been noted that many of the measures set out in the paper relate specifically to the NHS. The new statutory duty, for example, will only apply to health partners within ICSs and there is not enough in the proposals to ensure mutual benefit and involvement for local authority as well as health bodies. We are aware that the Local Government Association has raised concerns on this in its response to the paper, and we strongly advocate the establishment of joint committees between health and local authorities at place level to start to address this question.

- **Financial arrangements and risk sharing**

  NHS England and NHS Improvement is implementing new system-level financial settlements from April 2021, and there will be a need to support the transition to new financial arrangements and risk sharing over the coming years. There is particular concern for sectors of the NHS that have historically experienced relative underinvestment, that this will be exacerbated by the experience of the pandemic. The fundamental issue remains that much of the pressure must be alleviated by the government properly investing for the longer term in all areas of NHS spend, including public health, capital and workforce.

- **Clear communication to health leaders is vital**

  It will be essential to ensure that those staff working across health and care are properly informed of developments relating to the future of systems and its direct impact on their work and roles. There is disappointment, upset and concern, for example, among hardworking staff within CCGs that they read about the potential abolition of their organisations in the media before hearing it from NHSEI via their leaders first. If the ambitious vision set out for systems is to be achieved and backed by those across health and care, leaders must have the opportunity to keep their staff properly and directly informed.

- **Diversity across system leadership**

  It has been noted that the leadership of systems, both in regard to executive leads and independent chairs, has had a significant lack of diversity thus far. With ICSs set to become statutory bodies, it must be ensured that they reflect and represent the diversity of the population they serve. This is especially true for representation from black and minority ethnic (BME) communities and women. The Action for Equality: The Time is Now report we published in 2020 sets out clear actions which must be followed in establishing the leadership teams for all NHS organisations, including ICSs.

Individual question responses

Question 1: Do you agree that giving ICSs a statutory footing from 2022, alongside other legislative proposals, provides the right foundation for the NHS over the next decade?

- **Yes**. Overall there is agreement across our membership that systems becoming statutory is necessary to address the limitations of the existing legislative framework and to embed collaboration and integration into the NHS architecture. The successes of recent years in developing collaboration and system working risk plateauing without the proposed legislation, and there is much more that systems wish to achieve together. Of the two options, there was broad support across our membership for option two.

- There is optimism about the opportunity that ICSs present to reimagine commissioning, with widespread support among our membership for moving towards strategic commissioning at system level. NHSEI should work with CCGs to develop a single national narrative on what the commissioning sector is evolving to at ICS level – which is strategic planning, resource allocation and population health. Further detail on this point is set out in NHS Clinical Commissioners' (NHSCC) response in Appendix ii.

- A notable area where there is concern, however, is timescales. While system leaders broadly wish to "get on with it" (ICS Network response, Appendix i), our wider membership feel that the timescales proposed leave little time to establish shadow boards and authorise ICSs to take on statutory functions. As such, and as argued in our recent report on the future of integrated care, we believe that if the proposals do come into effect in 2022, there should be a period of implementation that gives individual ICSs the flexibility to move at a pace suited to their local needs, while also giving a definitive 'end date' for implementation of new statutory requirements.

- We believe it will be crucial that the knowledge, skills and supportive relationships offered by CCGs must not be lost in the move to ICSs. Many primary care networks (PCNs) have found that the ability to "pick up the phone" to their CCG has been invaluable and there is some anxiety about losing this key source of support. CCGs offer expertise across several areas, including in mental health, and this expertise must be harnessed properly within ICSs. Further detail on these points can be found in the NHSCC (Appendix ii) and PCN Network (Appendix iii) responses.

- There remains uncertainty around the role of NHS regions in future. What responsibilities will they have compared to systems? Will resource transfer to ICSs to support the roles they will be given? How will the relationship change and will a new approach to oversight and regulation be set out?

- While there is broad support for the new statutory duty to collaborate that will be placed upon foundation trusts, there is a desire for clarity about how the distinct and important FT governance requirements will fit within the system partnership context as it develops.

- It is unclear how decision-making and commissioning powers will be devolved down to integrated care partnerships (ICPs) at place level and PCNs at neighbourhood level without these bodies having formal and/or statutory form. As such, we would strongly recommend a statutory committee model at place. This would help to ensure both that powers, such as those mentioned above, can be taken on at place level with the full involvement of local partners. Importantly, this would address the very real concern of our members that the proposals do not address the need to strengthen and establish formal partnership with local government.

Question 2: Do you agree that option two offers a model that provides greater incentive for collaboration alongside clarity of accountability across systems, to parliament and most importantly, to patients?

- **Broadly, yes**. Option two is clearer in terms of accountability and will give the autonomy to local leaders needed to improve population health at system level.

- There is, however, a lack of clarity so far on what residents' and patients' roles will be within systems, and NHSEI and/or the government should set minimum standards around lay involvement and robust public accountability mechanisms. In practice, this can draw on the experience to date of trusts, foundation trusts and CCGs

in developing patient and community engagement both in service development and governance. There is a brief reference to a role for health and wellbeing boards (HWBs) within places, but this is vague and it is not clear how public scrutiny will work at system level.

- We are concerned about whether there is enough in the proposals to incentivise local government collaboration. Ultimately ICSs, as set out in the proposals, will integrate health services but not formally establish partnership working across health and care. This feels to members to be an important gap in the proposals as they currently stand. It is also unclear how place will be defined and developed in areas that have two-tier local authorities.

- As mentioned above, we believe that a solution to better engage local government would be to actively enable a statutory committee model at place. This would allow local authorities and NHS partners (together with third sector and others) to effectively share the accountability for their local populations' services. This represents a type of 'option one hybrid' specifically at place level, noting that ICSs will have the powers to delegate functions to such committees under option two.

- There also remains the question as to how the present oversight arrangements in place for the Department of Health and Social Care (DHSC), NHSEI, the CQC and other national organisations are reframed and reset in light of the proposed move to a statutory footing for ICSs. As our NHS Reset report set out, our members believe there is a real need to find a leaner, lighter and more agile system of oversight, inspection and performance management. More thinking is required about the balance between system and organisational level regulation, and NHSEI must commit to reviewing the role of its regional tier in light of the legislative changes envisaged. This is not an argument for there to be no accountability, but a very real concern that the opportunity to work differently, as set out in the legislative changes, will not be embraced by national actors to the same extent as they expect of our members.

- There is some concern that mandating provider collaboratives within the proposals is a 'one size fits all' answer to an unclear question. More flexibility is required with regards to this particular aspect of the proposed changes. Further, there is a need to recognise the importance of the contribution of all types of providers to the place-based arrangements that are being put in place. The key role that community health services play, for

instance, at ICS and even multi-ICS level, with many community providers working across systems and in at-scale provider collaboratives, must not be overlooked as the detail of system working is developed.

- The question refers to clarity of accountability and one of the reasons for introducing legislation is to simplify the complex existing legislative framework. However, there is a risk that the new landscape is equally, if not more, complex to clinicians, patients and the public alike if not managed carefully. Under the system set out by NHSEI, there will be a wide range of bodies operating both individually and with each other. These include, but are not limited to ICSs, NHSEI regions, PCNs and neighbourhoods, ICPs, FTs and NHS trusts, provider collaboratives, place-based partnerships, HWBs and local government. An opportunity will have been missed if there is as much confusion around the 'new' system as there was following the reforms of 2012.

Question 3: Do you agree that, other than mandatory participation of NHS bodies and local authorities, membership should be sufficiently permissive to allow systems to shape their own governance arrangements to best suit their populations needs?

- **Broadly, yes**. It is welcome that the proposals are not overly prescriptive and will allow flexibility. As one ICS Network member argued, we need a "menu, not a recipe" and so far the proposals meet this requirement.

- There is widespread support for the notion that there should be a good degree of flexibility in governance arrangements. New models of clinical engagement and leadership across all disciplines and organisations are already emerging within systems and these approaches will bring real benefit to delivering the Long Term Plan and addressing health inequalities. Too often in the past the default interpretation of 'clinical leadership' has been medical and our members recognise the need to strengthen and broaden the wider, multidisciplinary clinical leadership contribution both in their organisations and in their collaboration with each other.

- That said, there is some concern about systems becoming too distant from primary care. The requirement for PCN 'representation' at system level is vague and suggests only a small number of PCNs in a system will have influence and voice. The PCN Network will recommend minimum standards for PCN engagement at system and place level in the first half of 2021.

- There is a need for greater clarity on what 'mandatory participation' actually means in practice and what repercussions there will be for breaking the new statutory duty, with a feeling among some that the proposals raise as many questions as they answer. Further detail on this point is set out in the submission from provider members in Appendix iv.

- Members are also concerned to ensure that there is a real change and improvement in the visible diversity of the leadership of their own organisations and ICSs. There is continued underrepresentation of BME leaders in most board-level roles in NHS organisations and there is underrepresentation of women in non-executive, medical director and finance director roles. In 2020, we published a report by Professor Ruth Sealy from the University of Exeter, Action for Equality: The Time is Now, which sets out clear actions which must be followed in establishing the leadership teams for all NHS organisations, including ICSs. We are currently leading a taskforce reviewing non-executive appointments and its first report will be published in early 2021.

- The successful implementation of collaborative system working relies on the trusted partnerships within each ICS. While there is variation in size and co-terminosity of patient flows and local authority boundaries, any dramatic boundary changes at this point in time risks destabilising systems at a crucial stage in their development, causing further disruption to their primary objective of tackling health inequalities and enabling effective system working and integration. Any decisions on this issue must be undertaken transparently, with a thorough review of the potential risks and benefits of the approach.

Question 4: Do you agree, subject to appropriate safeguards and where appropriate, that services currently commissioned by NHSE should be either transferred or delegated to ICS bodies?

- **Partly**. There is support for some transferring of NHSEI commissioning responsibilities, but not all. We welcome the opportunities that come with moving certain direct commissioning responsibility out to systems. Having further influence, for example, over services such as pharmacy, dentistry and optometry will help to target inequalities in access for system populations. The ICS Network response outlines this in further detail.

- However, while some specialised commissioning services lend themselves well to devolution to system level or clusters of systems regionally (such as renal dialysis), others are rare within populations and high cost and so would be better retained at regional or national level. The variation in ICS size and maturity offers the opportunity for systems to collaborate on a 'supra ICS' scale for specialist commissioning, which will reduce financial risk. Importantly, greater scale will enable an improved match between tertiary provider and ICS commissioner footprints.

- We accept there is good reason for specialised commissioning being presently held at national level, not least to ensure national consistency in service quality for the most difficult and most expensive conditions to treat. As such, if elements of specialised commissioning in future fall to systems, some of our members believe this should come with nationally-set clinical standards and membership to the national clinical networks in order to maintain academic and research rigour.

- All areas of membership describe concerns over how the financial arrangements for system working will be developed and the potential impact on their organisation. The arrangements are being implemented ahead of any legislation, and with the backdrop of continued under investment from the government, financial arrangements need careful implementation and transition so as not to undermine the desire to collaborate and improve services for all. There is particular concern among services which have experienced relative underinvestment, (in particular mental health and community network members) that system-level financial allocations may be dominated by priorities more focused on acute colleagues. This reflects in particular the impact of the pandemic on waiting times for patients for diagnostic and elective care.

- Community and mental health provider members continue to highlight the destabilising impact of local authority tendering of many of their services. An agreement is required to ensure that such arrangements are paused (and reviewed) while any legislation and supporting financial arrangements are implemented.

- The PCN Network response outlines particular concerns about the future of primary care funding falling within the remit of individual systems (and primary care competing against others for a share of a 'single pot' of funding). The contracts that primary care providers hold with NHSEI represent a guaranteed 'baseline' of funding and there is concern that this will be lost. As such, PCNs ask for a commitment to primary care budget protection.

- Equally, ambulance trusts are concerned about the absence of information on ambulance services within the proposals. The changes to specialised commissioning need to reflect their needs and the scale of delivery, recognising the range of services they provide across multiple ICS geographies

Next steps

It should be reiterated that we are supportive of, and optimistic about, the direction of travel set out by NHSEI. Our members report very real benefits to their patients and communities of their increased collaboration with each other and with key partners in local authorities and other public services, as well social care providers and community organisations. There is real ambition to achieve more, and statutory footing will support the realisation of that ambition. Having considered the merits of the two options put forward, we therefore support option two.

We have, however, highlighted where elements of option one may be helpful (such as joint committees at place) as well as areas where further development is needed. We will continue to work with members to explore solutions to the issues highlighted and look forward to working with NHSEI and the government to further develop the detail of the future of the NHS architecture. This will help to ensure that our members' concerns are addressed in future policy and legislation and in day-to-day delivery by NHSEI and its fellow regulators, at a national and regional level.

For any further information on our response to the legislative proposals set out by NHSEI, please contact William Pett at: william.pett@nhsconfed.org

Appendix i: ICS Network response

Key points

- The NHS Confederation's ICS Network has engaged extensively with integrated care systems (ICSs) on the future policy framework for systems, both prior to and since the publication of NHSEI's paper Integrating Care: Next Steps to Building Strong and Effective Integrated Care Systems across England. In June 2020, for instance, we reported on the growing appetite for legislative reform among systems, and this appetite has continued to grow.

- There is now clear consensus among systems that the proposals set out by NHSEI represent a significant and positive step forward, and that it is the right time to address the limitations of the existing health and care framework through new primary legislation.

- Many aspects of the paper are welcome. The focus on place as the point at which integration makes most sense to local authorities and the public is right, and there is enthusiasm for the emphasis on the principle of subsidiarity. If embedded effectively into the future framework, systems will feel driven from the bottom up, as the NHS Confederation has consistently called for.

- One point that arose in discussions with systems, and which is not covered in the questions below, is regulation and oversight. As one system leader put it, "the proposals in the paper will mean nothing without regulatory and oversight changes to match". We accept, of course, that there are by necessity many details that will take time to develop and refine. However, this is an area that systems feel will be critical to the future success of ICSs and which they would appreciate the opportunity to input into in due course. The NHS Confederation is ready and willing to support NHSEI and the government in facilitating this.

Question 1: Do you agree that giving ICSs a statutory footing from 2022, alongside other legislative proposals, provides the right foundation for the NHS over the next decade?

- **Yes**. There is strong support across independent chairs and executive leads for systems to be given statutory footing. Many argue that the existing form of system-working is messy and leaves room for uncertainty, especially when having to consistently work around a framework that was built to promote competition rather than integration.

- That said, some systems have expressed concerns about option two and a desire not to lose certain elements of option one. On governance, for instance, there is concern that under option two there is little guarantee of robust clinical and lay input/oversight. Equally, an 'option two plus' may wish to outline that joint committees may still have an important function, not least to 'bring in' local authorities. We have heard several systems say that the paper feels very NHS-centric and that we will not achieve the vision we all want for integration without buy-in from local authorities, as well as the community and voluntary sectors, given their key role in influencing public health and the wider determinants of health. The role of local government is explored further in our response to question two.

- While there was no resistance to the notion of provider collaboratives, per se, it was noted that most providers are already members of some kind of collaborative locally. With the paper stipulating that it will be mandatory for NHS trusts to join one, it has been asked 'what problem is mandatory trust participation in provider collaboratives trying to solve?'

- On the issue of timescales, there is a strong sense that we must "get on it with it". The longer the process takes, the longer there will be an intervening period of uncertainty. That said, there is a sense among system leaders that this is dependent on a degree of stability in the wider environment. The future demands of COVID-19 may of course slow progress towards systems being ready for statutory footing by 2022, as might ongoing discussions around mergers of systems.

- Again, while many leaders welcomed the opportunity to move at pace with the changes, there needs to be significant investment in organisational development expertise if the vision for ICSs is to succeed. While lifting and shifting the CCG resource needs to happen, cultural change is required to ensure ICS partnerships do not simply become large CCGs.

Question 2: Do you agree that option two offers a model that provides greater incentive for collaboration alongside clarity of accountability across systems, to parliament and most importantly, to patients?

- **Broadly, yes**. There is consensus that of the two options presented, option two is clearer in terms of accountability and will give the necessary autonomy to local leaders.

- That said, many remained concerned about the role and input of local government. Some systems have pointed out that the prevention agenda will be key to improvements to population health, yet so many elements of prevention fall within the remit of local government. If improvements in population health are to be realised, therefore, it will be critical to have alignment between system spending and local authority spending. This may work well in systems where there are good relationships with local government leaders, but there are concerns about the lack of incentives for joint decision-making in the paper.

- This is a particularly important consideration given the replacement of Public Health England (PHE) with the National Institute for Health Protection (NIHP), and the question of what will happen to PHE's health promotion responsibilities. It is vital that the future of health promotion, particularly any changes at a local and regional level, including between the NHS and local government, are considered in this work on integrating care. Coordination between any new national bodies, and regional and local public health responsibility, will be crucial, and consultation will be needed to ensure that strong working relationships can be protected in the new ICS model. We will be working with our members over the coming weeks to gather views on the future for the health promotion elements of public health.

- There is a risk that option two could effectively bring a one-sided statutory function into system partnership arrangements with local authorities, which in turn could be disruptive to collaboration. ICSs must continue in essence as partnerships, not as a health body that local government is invited to and that, as such, the best solution would be to actively enable a statutory committee model at place. This would allow local authorities and NHS partners (together with third sector and others) to effectively share the accountability for their local populations' services. This represents an 'option one hybrid' at place level, noting that ICSs will have the powers to delegate functions to such committees under option two.

- There is currently uncertainty in the paper and in other documents in the public domain about how place will be defined and developed in areas that have two-tier local authorities. Clarity on this issue from NHSEI and/or government would be welcome.

- The question refers specifically to accountability to patients. However, there is equally a question of how systems (and places within them) will be accountable to residents, who should also have opportunities to input into the direction and priorities of their system. It has been noted that health and wellbeing boards (HWBs) currently offer a means of accountability to the public. There is reference in the paper to HWBs playing a role in ensuring public accountability at place level, but what will the equivalent be at system level?

- A question has been raised by some systems about what 'teeth' systems will have over partners within the system in future. The paper proposes a new shared statutory duty on NHS bodies in future to collaborate, yet as one system leader wryly observed "does this mean going to jail for not sticking to system plans?". Clarity on the consequences of deviating from the shared duty would be welcome.

Question 3: Do you agree that, other than mandatory participation of NHS bodies and local authorities, membership should be sufficiently permissive to allow systems to shape their own governance arrangements to best suit their populations needs?

- **Yes**. There is consensus that it should be left to systems to determine how such principles are implemented in practice through governance. It is welcome that the paper is not overly prescriptive, allowing flexibility between systems. As one independent chair put it: "we need a menu, not a recipe".

- There are, however, certain minimum standards that all systems believe should be met through governance arrangements. This includes widespread support for clinical leadership and engagement across professions and organsiations. It has equally been noted that there is a lack of reference to the role of lay members and non-executive directors (NEDs), both of whom will be vital to ensuring robust accountability and challenge.

Question 4: Do you agree, subject to appropriate safeguards and where appropriate, that services currently commissioned by NHSE should be either transferred or delegated to ICS bodies?

- **Partly**. ICS leaders welcome the opportunities that come with moving direct commissioning responsibility out to systems. Having further influence over services such as pharmacy, dentistry and optometry will help to target inequalities in access for system populations.

- However, this discussion depends on the services in question. While some services lend themselves well to devolution to system level or clusters of systems regionally, others – especially some in specialised commissioning – are so specialist and high cost, involving a very small number of patients, that they would be better retained at national level. Such services include those relating to rare diseases.

- There is good reason for specialised commissioning being held at national level, not least to ensure national consistency in service quality for the most difficult and most expensive conditions to treat. As such, if elements of specialised commissioning in future fall to systems, some believe this should come with nationally set standards.

- Specialised commissioning currently uses a different financial allocation formula and a move to population-based budgeting will need to be undertaken carefully and transparently over time. Our suggestion is for a phased approach to this work, perhaps with a shared risk framework between NHSEI and ICSs in the first instance.

Appendix ii: NHS Clinical Commissioners response

Introduction

NHS Clinical Commissioners (NHSCC) is the only membership body of clinical commissioning groups (CCGs). Established in 2012, we have more than 90 per cent of CCGs in membership. We offer a strong national voice for our members on specific policy issues and support them to be the best they can to commission services effectively for their local populations.

We have decided to provide our response to this engagement exercise in a different format (i.e. not the online survey) because we wanted to highlight the strength of the feedback and reaction we have received from our members on the legislative proposals at a national level. To develop our response, we engaged with our members in the following ways between 3 and 15 December:

- a roundtable with CCG leaders (evolving commissioning to systems)
- two webinars (with NHSEI representatives) for CCG leaders
- three network meetings (specifically our HR and OD Forum, Nurses Forum, Lay Members Forum)
- invited and received email feedback from members.

Our response is formed from the views of c.300 participants from our membership, demonstrating our strength in representativeness of the national CCG view. Below we outline our summary response and then

our detailed feedback; the latter demonstrates significant and detailed CCG insight into the implementation of the proposals. Our membership is keen to engage positively and help address and find solutions for many of the issues raised below.

A summary of our response

While we understand there was a national pressure to publish the proposals at pace, we were extremely disappointed at the style of the announcement of this paper in late November. Knowledge of its existence came to many CCG staff via the media and not CCG leadership teams. This is contrary to the principles of the NHS People Plan and caused a lot of distress to CCG staff at a time when they were under significant local pressure responding to COVID-19. There must be a strong commitment from NHSEI from this point onwards to providing clear communication and co-production with CCGs around their transition in the next 15 months.

We know that CCGs, as system planners, have long been supportive of the direction of national policy around integrated care and the ambitions of the Long Term Plan. Our members fully support the development of integrated care systems (ICS) and are already embedded in system working, seeing it as a unique opportunity to raise the collective ambition around population health, address health inequalities and improved outcomes through collaboration across health and social care.

While option one and option two were both presented in the Integrated Care paper, NHSEI has recommended option two to its board. Our members carefully considered both option one and two during the engagement period and came to the following conclusions:

- **Option one (Statutory Committee)** was seen to provide a more phased approach to CCG transition, describing the mechanisms of joint committees to enable collective decision-making with system partners, including local authorities. This option could work well in areas where partnership working is less mature and was considered by members as being a solution to enable more place-based collaboration. However, through our engagement it was clear that members felt the dual ICS and CCG accountable officer model would be extremely confusing in terms of system leadership and delegated CCG powers. Furthermore, this small step change may suit a few CCGs and systems but not all, and many members felt it had the potential to delay what is viewed as an inevitable move to an ICS statutory footing.

- **Option two (statutory footing to ICSs)** was a big step for members to consider, as it felt less place-led, the pace of change was also worryingly fast and the proposals effectively end the current governance arrangements for CCGs. However, the majority of members felt this option is the right direction of travel, as it is a greater move at pace to a more long-term solution and will provide much-needed clarity about accountability for CCGs and system partners. Above all, this option offers a more strategic approach to CCG planning and resource allocation functions, where scale reduces risk and will enable the delegation of population budgets and aligned incentives to system provider collaboratives, to improve services for the benefit of local citizens.

We therefore support the view of the majority of our members and agree that option two is a positive step forward for the next phase of integrated care. However, in agreeing this position, we have some significant concerns that must be addressed to avoid any negative impact on CCG transition and therefore ICS establishment. These focus on the interpretation and enactment of what is outlined in option two.

Immediate concerns – CCG transition

We believe a smooth CCG transition will be critical for the next phase of ICS development. Our immediate concerns for option two are below (further detail is provided in section 3):

- **Pace of change**. Our members have raised significant issues about the timescale and timing for transition under option two and the disruption it will cause. We must ensure that the implementation of option two (if agreed) offers the least disruption possible to CCG staff and their senior teams and offers integrated care systems the best start as statutory organisations. The pace of change must also match the readiness and maturity of ICSs and provider collaborations to receive commissioning functions/teams.

- **Rapid support to form shadow ICS arrangements**. A particular issue for CCG staff right now is further national clarification on the rationale for not offering employment protection beyond March 2022. If option two is agreed within the proposed timescale, our members will need rapid support to move to a shadow ICS form during early 2021 to support staff to transition. This includes mapping CCG functions across to ICSs, clarity on executive roles/skills at ICS level, an HR framework for all CCG staff and a roadmap to support the transition to ICS establishment. (All with a level of local tailoring).

CCG legacy

CCGs and their staff have a wealth of knowledge and expertise which must not be lost during transition. We found several areas of CCG legacy that must transition into the ICS if option two is to be agreed.

- **A new narrative for commissioning**. While there is an acceptance that the role of clinical commissioning needs to evolve – there must not be a denigration of the commissioning function. CCGs and their staff perform a raft of statutory (and other) functions which are important for population health and, if lost, will be to the detriment of the system. Option two should not be the end of commissioning but a new way of serving our populations. NHSEI must work with CCGs to develop a single national narrative on what the commissioning sector is evolving to at ICS level – which is strategic planning, resource allocation and population health.

- **The importance of stewardship at ICS level**. CCGs bring a role of stewardship and objectivity to systems. This is an important set of skills to uphold at ICS level (under option two) in the context of increased provider collaboration and must be reflected in the future leadership of ICSs. Our member experience has shown that the objectivity that CCGs bring to the partnership table can support the shift towards population targeted funding that can be more upstream and on out-of-hospital care rather than acutely focused.

- **A loss of clinical commissioning leadership**. Our members felt that option two was unclear about the future for CCG clinical leaders and in danger of airbrushing out the significant success that CCGs have had in developing a clinical leadership model for population health. Clinicians are trusted by local citizens and politicians and have successfully delivered difficult messages about the appropriate use of resources and the need for major service changes. Similarly, our members were concerned that option two would remove the CCG membership model and there would be a gap at place level in terms of the commissioning interface with primary care around key areas such as workforce and estates.

- **Public accountability and scrutiny**. Our members have reflected that the paper needed to provide more clarity on how ICSs (and places) will build in key functions around public accountability, engagement and scrutiny under option two. More clarity is needed on how the patient and public voice will operate in an ICS in the future.

- **Independent quality monitoring**. Our members have expressed concern around the potential loss of service quality monitoring. We believe ICSs need to move rapidly to a system-wide single governance framework that reduces transactions and concentrates on quality improvement (QI) cycles.

- **The enactment of a "single pot" of money at system level**. This area needs further clarification around the detail of what allocations this includes, with absolute transparency of spend and activity estimates. Systems will need support in ensuring this funding envelope is distributed according to population need, across providers that are only just getting used to a new non-competitive approach. In situations where the funding does not cover all demand, strategic commissioners will require further support to prioritise funding decisions and be able to explain how these decisions were made and why.

- **Specialised commissioning**. Our members felt that delegating some specialised commissioning functions and adding greater responsibilities for wider primary care commissioning (dentistry, pharmacy, optometry) would enable more end-to-end pathway management, with increased involvement of GPs to improve patient experience of both pre and post specialist care. CCG experience has shown that in order to move specialised commissioning (or other delegated functions) into ICS budgets, it must be undertaken with a transitional approach i.e. weighted allocation and the transfer of appropriate management resources to support this work.

The interface with local government

Our members are fully supportive of 'place' as the driver for transformation and delivery in the NHS. However, the move to a statutory ICS under option two will change the dynamic between system and place and may be challenging for some areas to manage that tension, particularly around the authority to act. As far as possible, we need delegation of functions to as near to citizens as possible.

- **Seeing local government as an equal partner**. While our members recognise that local government was not in the scope of the NHSEI paper, we must ensure that we protect and build on the excellent work at place between local authorities and their NHS partners, specifically in ensuring that all partners have a voice in system decision-making. Our members supported the suggestion of a statutory committee model at place that supports current

statutory organisations, including local government, to be equal partners. In some ways we feel that elements of option one’s approach to place-based working are stronger in this area and allows for more localised decision-making.

- **The role of health and wellbeing boards (HWBs)**. We believe that there is an opportunity to review the role of HWBs in system working, in order to create stronger linkages at place level with integrated care partnerships, integrated care alliances, the local health and wellbeing strategy and public accountability and scrutiny functions.

- **Joint commissioning**. We feel more detailed work is needed with CCGs on transitioning the joint commissioning relationship between CCGs and local authorities at a place level. Our members were clear that some specific CCG functions are better delivered at place level alongside local government. For example, NHS safeguarding responsibilities are currently embedded within a local accountability structure alongside police and the local authority – this accountability may become too opaque if it is administered at an ICS level.

This is the start of the conversation

NHSCC is committed to working with NHSEI to develop an ongoing dialogue for our members at the highest levels to engage and co-produce further work on the proposals in 2021/22. We must ensure that the implementation of option two (if agreed) offers the least disruption possible to CCG staff and their senior teams and offers integrated care systems the best start as statutory organisations.

To access NHS Clinical Commissioners' full response, please visit the NHSCC website: www.nhscc.org/consultation/future-of-integrated-care-response/

Appendix iii: PCN Network response

Key points

- To produce this response, the PCN Network has engaged with PCNs across the country through a series of virtual roundtable events. These roundtables provided a platform for those working within PCNs, including clinical directors and network managers, to discuss the NHSEI proposals and offer their views and concerns.

- Overall, there is cautious optimism among PCNs about the direction of travel set out in NHSEI's paper. It is broadly felt that formalising system working and embedding collaboration at place will be beneficial for population health in the long term.

- The reason for caution is that while there is support for many of the basic premises set out in the paper, there is concern about what the detail will look like in certain areas. Notably, these include:

    - the division of responsibilities between system and place

    - governance and PCN representation within systems

    - the financial risk to primary care budgets.

More comprehensive concerns on these issues and others are provided below in answer to the four questions posed by NHSEI.

- Without knowing such details, it is difficult for PCNs to visualise how systems will operate in future and what the PCN role will be within them. Our response can therefore be summarised with a quote from one clinical director who said: "the devil is in the detail and the detail doesn't exist".

Question 1: Do you agree that giving ICSs a statutory footing from 2022, alongside other legislative proposals, provides the right foundation for the NHS over the next decade?

- **Broadly, yes**. There is a sense across the PCNs we have engaged with that to provide certainty on issues relating to finance and accountability, it is right that ICSs are given statutory footing.

- On timescales, however, there is concern among some PCNs that the proposed timeline of ICS statutory footing by 2022 will feel rushed. PCNs nationwide are at different stages of development. Ensuring that their network is operating effectively, managing vaccinations and recruiting staff through the Additional Roles Reimbursement Scheme (ARRS) are the key priorities. Many believe that PCNs are not yet mature enough to provide a 'single PCN voice' within a system. The lack of established mechanisms to ensure that PCNs across an ICS have a voice at system level has led to a sense that PCNs are 'being done to' rather than leading.

- Part of this concern relates to leadership and development. Looking outside one's PCN and to the bigger aims of the system will require a different kind of leadership from clinical directors (and non-clinical leaders), as well as the ability to think outside general practice and primary care. We must invest in leaders across primary care to adapt to these new demands. It will also require resourcing – clinical directors do not carry out their roles full time and if they are to effectively contribute to system-level working, this time commitment and additional workload needs to be recognised.

- There is some confusion and concern as to why integrated care partnerships (ICPs) at place level and PCNs at neighbourhood level will not also be given statutory footing. There is reference in the paper to decision-making powers and responsibilities being devolved down from system to place where possible, yet how this will happen without place-level structures being made statutory is unclear. This has led some to question how the principle of subsidiarity will be realised in practice.

- Crucially, the knowledge, skills and supporting function of commissioners in CCGs must not be lost in the move to ICSs. For many PCNs, a named person in their CCG is important in providing support. Clinical directors have said they will miss this and we must ensure this supportive kind of relationship is not lost in the transition, with many PCNs still developing.

Question 2: Do you agree that option two offers a model that provides greater incentive for collaboration alongside clarity of accountability across systems, to parliament and most importantly, to patients?

- **Yes**. Option two is clearer in terms of accountability and will give the autonomy to local leaders that will be needed to improve population health at system level.

- There is an expectation that systems will enable better collaboration across providers. This has, to date, been patchy and the experience during COVID-19 has seen some powerful examples and some less effective. If primary care is to become an equal partner within the system, then the system needs to facilitate this.

- There is a lack of clarity so far on what the role of residents, patients and communities will be at neighbourhood, place and system levels. Perhaps this is to be left to individual systems to clarify, but there is a sense that there needs to be more consistent reference to how future reforms will affect them, given that they are supposed to be the beneficiaries.

- To address the above, NHSEI and/or the government should set minimum standards around lay involvement and robust public accountability mechanisms. It is welcome that there is a role for health and wellbeing boards (HWBs) within place, but it is not clear how public scrutiny will work at system level.

Question 3: Do you agree that, other than mandatory participation of NHS bodies and local authorities, membership should be sufficiently permissive to allow systems to shape their own governance arrangements to best suit their populations needs?

- PCNs believe that governance arrangements in systems should be subject to clear minimum requirements and that systems are at risk of becoming too distant from primary care. The current requirement for PCN 'representation' at system level is vague and currently suggests a small number of PCNs in a system have influence and voice. NHSEI and the government must avoid systems being left to shape their own governance arrangements and this being to the detriment of PCN input and involvement. The PCN Network will lead a piece of work in early 2021 to develop set of minimum standards for PCN engagement at system and place level.

- As outlined in question one, there is a concern over resourcing, and we are clear that additional resources such as administrative and managerial support must be made available to help PCNs carry out their duties in contributing to their system in addition to their existing work.

- Finally, while PCNs are clear that they would like opportunities to contribute to system planning and strategy, they are concerned about having to consistently 'manage upwards' – needing to seek permission to make decisions for the local populations. Many PCNs have operated efficiently because they have not had an unwieldly framework to slow down decision-making. Systems need to have a process to understand and reflect the needs of PCNs as much as PCNs need to understand the workings of the system in which they operate.

Question 4: Do you agree, subject to appropriate safeguards and where appropriate, that services currently commissioned by NHSE should be either transferred or delegated to ICS bodies?

- **Partly**, however this will depend on the services in question. There is concern about the future of primary care funding falling within the remit of individual systems (and primary care competing against others for a share of a 'single pot' of funding). The contracts that primary care hold with NHSEI represent a guaranteed 'baseline' of funding and this must not be lost. As such, PCNs want to see a commitment to primary care budget protection.

- With regards to specialised commissioning, some services lend themselves well to devolution to system level or clusters of systems regionally (such as kidney dialysis). Devolving such services makes sense if it allows systems to plan around the entire continuum of care (improved preventative care can lead to less need for high end/cost interventions further down the line).

- However, there is good reason for certain aspects of specialised commissioning being held at national level, not least to ensure national consistency in service quality for the most difficult and most expensive conditions to treat. Some services are so specific and high cost that they would be better retained at national level. Such services include those relating to rare diseases.

Appendix iv: Response from acute, community, mental health and ambulance service providers

Key points

- There is broad agreement that the ‘end state’ is correct and that option two is the right option, but there are concerns about the lack of detail behind the proposals and the need for greater consultation.
- There is a need for the legislation to recognise the differing positions of integrated care systems across the country.
- There are questions about accountability and governance, with concerns that providers will end up with all the accountability and none of the responsibility. There is a need to get the structures right and be clear on where statutory responsibility lies between systems and organisations.

Question 1: Do you agree that giving ICSs a statutory footing from 2022, alongside other legislative proposals, provides the right foundation for the NHS over the next decade?

- Broadly, providers agree with this proposal. However, acute, community, mental health and ambulance providers are

concerned about the timescales for change, particularly in light of current operational pressures created by COVID-19, which need to be managed alongside the backdrop of transformation. However, most trusts accept that the timescales should not be prolonged and need to be managed effectively in order to avoid disenfranchising staff. As a result, we would propose that if the proposals do come into effect in 2022 there is a period of implementation that gives individual ICSs the flexibility to move at a pace suited to their local needs, while also given a definitive end date for the implementation.

- Trusts are concerned that the changes could further exacerbate the diversity challenges across the NHS, particularly in senior posts. CCGs tend to have more diverse boards than other parts of the NHS, while in contrast, leadership positions in ICSs and STPs are less diverse. The changes need to ensure that we do not take a backward step in diversity of senior positions. There is also concern about the lack of equality impact assessment, risk assessment and financial assessment and the need to ensure that there are mitigations for any inequalities created by the proposals.

- There is real concern that the delivery of the new underpinning financial model at system level needs careful implementation and carries significant risks for all organisations. Mental health providers have raised particular concerns that the needs of mental health services could be overshadowed by the physical health sector within ICSs. Strong national levers are needed to ensure that local areas increase funding for mental health and, with the impact of COVID-19 on physical health and waiting lists, there is a perceived risk that additional funding will be used to reduce this backlog rather than meet the growing demand for mental health services. There are also concerns that it could lead to increases in funding variations, with the Mental Health Investment Standard (MHIS) being met by the ICS but with significant variation sitting beneath that.

- The current proposals appear to overlook the important role that community health services play at ICS and even multi-ICS level, with many community providers working across systems and in at-scale provider collaboratives. This is a particularly important point for community providers as the landscape of provision varies greatly across the country. While some ICSs/STPs have large community providers, others will have a conglomeration of smaller providers delivering a myriad of services. NHSEI's paper only reflects community providers' relevance at place, rather than their strategic role at ICS level bringing together primary and community care into a collaborative network and developing plans

to deliver more care in the community. NHSEI needs to set out how community providers will be supported to play a full, strategic role in ICSs, as well as at the level of place.

Question 2: Do you agree that option two offers a model that provides greater incentive for collaboration alongside clarity of accountability across systems, to parliament and most importantly, to patients?

- **Yes**, however it is imperative that the role of place is considered in any new models and greater thought given to the relationships between the ICS, NHS and local government. Members also expressed significant concerns about the delivery of system-level financial management, and the balance between organisational accountability and system accountability.

- Trusts are concerned about the lack of understanding of the role of politicians in local authorities and how the proposals present a top-down, NHS view of the world. While ICSs should involve local authorities, and there is a huge benefit to working collaboratively across health and care, there is concern about how realistic the proposals are given the role of elected officials within local authorities and their responsibility to represent their electorate. Though there is a genuine desire to work more closely and collaboratively with local authorities, it is unclear from the proposals how they will be more than partners in a system and how the NHS and local government could be held jointly accountable within systems.

- ICSs also provide an opportunity to take a population health approach which will be beneficial to patients. Some drivers of health inequalities are outside of the NHS's control, so in order to take a successful health population approach, ICSs will need to work with housing, employment, education and community groups. However, trusts recognise that they do not necessarily have population health management skills and that there will need to be a conversation about what skills are needed before developing this responsibility further. It is however, noteworthy that several trusts have established strong leadership roles in this space and are already strongly involved in developing approaches at place and system level.

- While giving more control to ICSs means that local areas will have more freedom to meet the needs of their population, there is a risk of divergence in outcomes and priorities as areas focus more on what they deem most important. National oversight and outcome

targets about what ICSs should achieve, while giving local areas the flexibility in how to reach the targets, will be important. There will also need to be education of national and local politicians regarding the need for ICSs to set standards and priorities that reflect their local circumstances. The partners within ICSs will need to play their part in those discussions, but so will national leaders.

- While the accountability lines remain with individual organisations, genuine partnership working will be hindered as each organisation will, fundamentally, be concerned about the performance of their organisation, not the performance of their wider system. Putting ICSs on a statutory footing and moving lines of accountability towards ICSs will help facilitate greater integrated working. However, there is a balance to be met.

- Regulators and arm's-length bodies will need to adapt their approach in light of statutory footing for ICSs. There is particular interest in the future of the regional tier of NHSEI (and Health Education England) which now deploys significant staffing resource, which might be better vested in some functions within ICSs and/or will need greater accountability to ICSs. There is also real concern to ensure that the CQC adopts a way of working which more consistently balances system-wide and organisation-specific lines of enquiry.

- Provider members have raised concerns about system finance and the need for greater clarity on governance arrangements. There was also concern about how well equipped ICSs are to administer the 2021/22 funding allocation, and a concern to ensure that there is a proper transition to new arrangements and allocations. There is a real fear of a significant destabilising of provider finances, particularly in the context of the enormous disruption caused by the pandemic.

- Community providers highlight the important role that local authority contracts and commissioning play in their work. The continuation of tendering of services by local authorities at the same time as such fundamental changes to NHS finances is a significant risk and there is a clear need to pause (and review) this approach.

- Mental health trusts in particular are concerned that because their finances tend to be in a more stable position than acute providers, their funding could be used to plug financial holes within the wider system. The care deficit in mental health is still vast – only 35 per cent of children and young people who need services receive them.

If mental health providers tend to be less likely to be in debt, it is not because there is not as much demand on them, it is because they are able to ration care more easily than the acute sector.

- The proposals around place and provider collaboratives in option two are largely welcomed but there are concerns about elements of them. In the place-based model, the inclusion of acute trusts feels like an add on. However, members believe that they have a central role within place-based partnerships and should be key partners in conversations about out-of-hospital care, workforce and connecting with local communities. The language around provider collaboratives focuses, in the main, on the acute sector and does not link the work of providers collaboratives to place.

- We welcome the duty on ICSs to draw up plans on how they will collaborate with the third sector. The third sector plays an essential role in providing health and care support, which is often more tailored to local, demographic, cultural and social needs. Third sector organisations are often better placed to provide support than the NHS in areas such as housing, employment, bereavement and substance abuse. The impact of COVID-19 will also disproportionally affect certain demographic groups, such as BME individuals and children and young people, and third sector organisations have strong track records in providing more tailored and culturally-appropriate care. It is important that the ICS plans for engaging with the third sector are meaningful and not a tick-box exercise. They need to be developed in partnership with the third sector and performance against the plans needs to be monitored.

- STPs have a variable, but generally poor, track record on patient involvement and engagement. This was sometimes due to very tight deadlines which did not give STPs the time to conduct meaningful engagement and consultation. If ICSs are to be successful, their plans, priorities and ways of organising services must reflect the needs of their populations. Plans need to be co-produced with patients who represent a variety of health needs and social and demographic groups. Areas also need to be given enough time to hold meaningful engagement with their local populations. The starkest health inequalities are often faced by groups who are less likely to engage in traditional engagement activities, so specific and targeted outreach will be needed to ensure ICSs are aware of the needs and views of their populations.

Question 3: Do you agree that, other than mandatory participation of NHS bodies and local authorities, membership should be sufficiently permissive to allow systems to shape their own governance arrangements to best suit their populations needs?

- **Members felt there to be insufficient detail on what 'mandatory participation' means to have a firm view on this question**. They also felt that a permissive approach should not be at the expense of providers in community and mental health.

- Trusts have a number of concerns in relation to the governance of systems vs individual organisations. There is a need for greater clarity on what 'mandatory participation' actually means in practice and there is a feeling that the proposals raise as many questions as they answer. What happens, for instance, if a provider is perceived to have deviated from the new statutory duty to collaborate?

- Trusts and FTs need stronger guidance on accountability and governance within the proposals. While they are keen to maintain system flexibility, there is a lack of clarity in the proposals about the role of non-executives within the new system arrangements. There needs to be greater clarity on where accountability and responsibility rests. There is also a lack of clarity on the difference between foundation trusts and non-foundation trusts – the proposals treat them as the same when they are some clear and important differences. The role of governors in the proposals is not clear, for example, and the governance of foundation trusts in a system needs to be more explicitly addressed and strengthened.

- Getting the governance and lines of accountability right is highly important and we know that many areas have taken an iterative approach to this – with governance structures evolving over time, as learning from experience is taken on board.

- While a permissive approach is preferred, there are some concerns that the language and proposals are heavily weighted toward the acute sector. This, some members (including acute providers) observe, could disenfranchise partners which have come together within systems to work collaboratively. This risk applies particularly to community trusts, community interest companies, charitable and voluntary organisations, independent sector organisations, local authorities and independent contractors.

Question 4: Do you agree, subject to appropriate safeguards and where appropriate, that services currently commissioned by NHSE should be either transferred or delegated to ICS bodies?

- **In general, members agreed with this statement**. However, they would like more detail and assurance on the commissioning of specialist services and there are specific issues raised by ambulance trusts.

- The present arrangements for commissioning specialist services from acute providers recognise the complexity of the clinical services in question and their relative high cost. Many are of national significance and providers of those services would want to ensure that there is proper national oversight and coordination to ensure effective provision and standards. Provider members recognise though that greater involvement of ICSs in the commissioning of specialist services strengthens collaboration and local accountability.

- It was recognised that many systems would most likely need to collaborate on a 'supra ICS' scale for specialist commissioning, and this will enable a more appropriate match between tertiary provider and ICS populations. There will, however, be the need to ensure that clear and consistent national standards are set to ensure the delivery of these services. The timetable for any new financial arrangements for specialist services will need careful planning and a period of transition.

- Provider members also emphasise the importance of maintaining and coordinating vital clinical research and academic links in any changes to the arrangements to specialist commissioning arrangements.

- Ambulance trusts are concerned about the absence of information on their services within the proposals. The changes to specialised commissioning need to reflect their needs and the scale of delivery, recognising the range of services they provide. The regional role of ambulance services needs to be recognised, as at present, in the new commissioning arrangements, while retaining some flexibility to allow more localised arrangements, where it makes sense. Ambulance services vary in the number of ICSs within their patch and there is a need for them to engage at regional, ICS and place level to get the voice of ambulance services heard – particularly in patches where there are multiple ICSs per ambulance service. A number of community providers report similar concerns as their footprint covers multiple ICSs.

- In mental health services, there is clear understanding that some specialised services need to be commissioned on a larger area and clarity is required about who makes the decision on the scale of the commissioning decision, and the need to ensure that there is a consistent approach across the country, which will still require some national oversight. For example, child and adolescent mental health services (CAMHS) Tier 4 will need to be commissioned on a larger area and there is a national role in ensuring that specialist beds are evenly spread across the country.

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