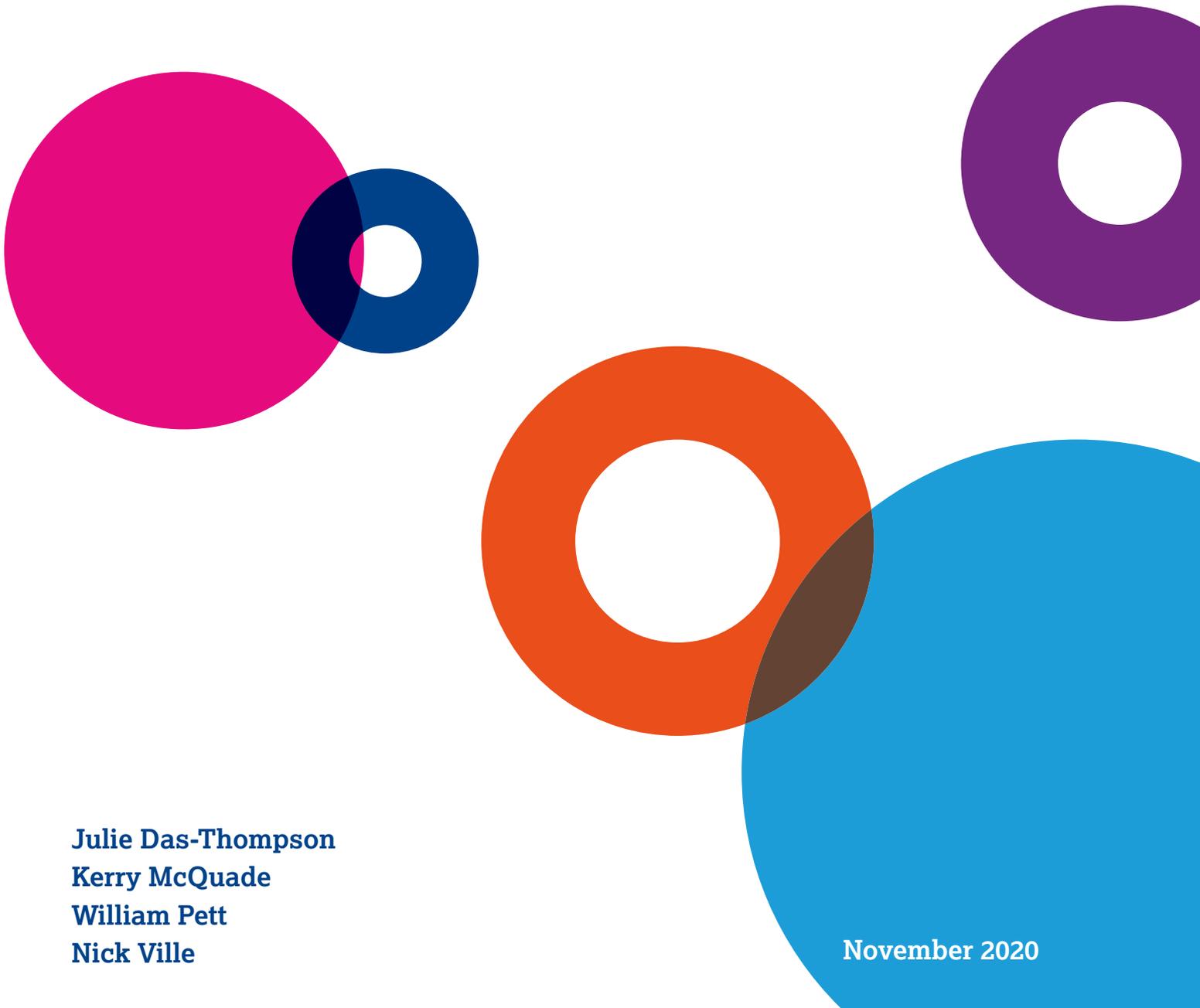


The future of integrated care in England

Health leaders' views on how to make system working a success



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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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Key points

- Over the coming 12 months, the government is expected to table new primary NHS legislation for the first time in nearly a decade. It is anticipated that this will set out a legal framework through which NHS organisations will continue to work together and with others as integrated care systems (ICSs), to deliver the ambitions of the NHS Long Term Plan
- To support the development of new policy and legislation relating to the future of systems, the NHS Confederation has undertaken an extensive six-month engagement process with our members across England. This has included a series of roundtable events with the many different stakeholders across our English membership, a consultation with systems and a cross-member survey.
- The results of this engagement process gave many insights into the extensive progress that has been made with system working over the last five years and the ambition for the future. It is clear that there is a strong appetite among our members for strengthening system working and embedding it permanently into the architecture of the health and care system. The pandemic has reinforced this view further, as the importance of working together has been all too evident. Therefore, any proposed changes to the national policy and legislative framework must build on what has been achieved and support systems to develop further. With this in mind, we believe a future framework for ICSs should be structured around two key pillars:
 - 1. That ultimately ICSs should be given a statutory footing through legislation. We are clear, however, that whatever form ICSs take they must embed partnership working and recognise the key role that local government, independent and charitable providers, voluntary sector organisations and community representatives must play in systems alongside NHS services.**

That said, the NHS Confederation considers that more time is needed to work through a number of practical questions about how best to do this and build more agreement about the way forward. For instance, one model that appears to have support among some of our membership is one of statutory partnerships supported by a strong executive team. Local organisations also need time to adjust and work up local ways of working in advance of any new statutory framework. Hence, we would suggest ICSs are introduced in shadow form for a significant period of time before they are given statutory footing.

There is a strong sense among our membership that there should be greater joint commissioning of health and care, however this should not be mandated through a statutory framework. We believe that it should be made as easy as possible for health and care services to be commissioned jointly should they wish to, but forcing them to do so through legislation would be counter-productive in areas where there is little history of joint working.

2. To incentivise greater joint working across health and care services, a new statutory duty should be introduced on all partners within systems (including local authorities) to deliver against shared objectives. For example, this could centre around health inequalities or some variation on the 'triple aim' set out in the NHS Long Term Plan.

Our survey found that 8 out of 10 members support the creation of a shared statutory duty on system partners. This shared duty would seek to build on existing partnership working to develop a sense of shared accountability for improving population-level outcomes. A duty of this nature would have implications for foundation trusts. While we do not believe that the foundation trust model should be fundamentally changed, members tell us that a new statutory duty would help clarify expectations of foundation trusts in system working.

- **Any new measures to strengthen system working must be accompanied by radical reform of the current model of NHS oversight. Our members were clear that ICSs need much greater autonomy and head space to focus on delivering what local communities need.** This is not an argument against having clear national priorities and accountability for the NHS, but for oversight to support local solutions and to be outcomes focused, proportionate to each system, risk based, and grounded in the principle of self-directed improvement. The recent pandemic illustrated that when the regulatory burden was reduced, local leaders innovated at speed and developed more agile ways of working. We need a lighter, leaner oversight model to be inbuilt into the NHS that permanently unleashes this energy and creativity.
- The rest of this report explores these issues in more detail and makes further recommendations about the changes to national policy and legislation that might help. We start in section 1 by setting out the views of our members on the purpose of ICSs and then move in section 2 to examine what specific policy and legislative changes they believe might help ICSs to deliver these objectives. And in section 3, we begin to explore what wider enablers the government and NHS England and NHS Improvement (NHSEI) should consider to support system working in future. Where there is general agreement on the direction of travel by all parts of the NHS, we have set that out. But, we have also been transparent about the areas where support is less strong or opinion is divided. Clearly there is more to do in these areas to work through the issues and narrow down areas of difference. Hence, we would encourage the Department of Health and Social Care (DHSC) and NHSEI to make an early start on developing a workable and comprehensive set of specific proposals and to engage with all system partners to draw on their views and expertise.

Introduction

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 collaboration and integration to improve population health, deliver better quality care, and make more efficient use of resources.

The NHS Confederation welcomes this shift. For too long, the NHS and local government have had to work within an environment that has encouraged the fragmentation of services and a culture of working in siloes. This, in turn, has left us with a landscape that is confusing for patients and insufficiently responsive to the health and wellbeing needs of local communities.

The recent experience of coping with a pandemic has further reinforced the importance of this move. COVID-19 has proven to be the greatest challenge that NHS and local government services have faced in their history, requiring extraordinary efforts from staff across the health and care sector. However, the pandemic has also demonstrated what can be achieved when we move away from individual organisations working in silos and towards true collaborative working within systems. As the NHS Confederation set out recently in [NHS Reset: A New Direction for Health and Care](#), many of the solutions developed in response to issues such as PPE and resource shortages, patient discharge and community outreach have centred around collaboration and partnership working across primary, secondary and community services, and with local government and community partners.

In the words of one executive lead of a system: “We have seen transformation that many people have wanted for ten or 15 years!”

With new legislation expected over the coming 12 months, there is a real opportunity to embed the collaboration we have seen in recent months across the health and care sector in England. The NHS Confederation has therefore sought to gauge health leaders’ views on what a future policy and legislative framework for system working should look like.

To do so, we have had an extensive period of engagement on the future of systems with our membership. This has included a cross-member survey that asked a series of questions relating to the principles, objectives and functions of ICSs and how they should help to deliver the ambitions of the NHS Long Term Plan. We have also conducted qualitative engagement with leaders from all parts of the NHS through roundtable meetings and webinars. This has allowed us to understand the nuances of where different stakeholders stand on issues relating to system working and what their fundamental concerns are. Put simply, this report is the culmination of six months of listening.

At the time of writing, our members are set to face some incredibly difficult months ahead, with a second surge in COVID-19 cases adding to existing winter pressures. As ever, the first priority of services must continue to be to meet the health and wellbeing needs of the public. However, with a new model of system working having the potential to significantly improve the capacity and efficiency of health and care services, it is vital for our members that we get it right.

Methodology

To gain a clear understanding of the views of our entire membership on issues relating to system working for this report, we conducted several different methods of research.

In June 2020 we hosted an online event for leaders and chairs of ICSs and sustainability and transformation partnerships (STPs). We undertook live polling at the event and produced a report, [Time to be Radical? The View from System Leaders on the Future of 'System by Default'](#). Since then, we have carried out a member survey through August and September 2020, including a series of questions relating to the future of system working. We received 252 responses from NHS leaders across all parts of the health system: hospital; mental health; community and ambulance service trusts; clinical commissioning groups (CCGs); primary care networks (PCNs); and STPs and ICSs.

We also conducted qualitative engagement with leaders from all parts of the NHS through roundtable meetings and webinars. This has helped to reveal not just where NHS leaders stand on issues relating to system working, but crucially why they hold certain positions. Those who have contributed to the research in this report include NHS Clinical Commissioners, the Mental Health Network, NHS Employers, the PCN Network, the ICS Network and the NHS Confederation's equality, diversity and inclusion groups. Bespoke sessions have also been undertaken with providers, programme directors of provider collaboratives, CEOs and chairs.

Finally, the Confederation's ICS Network distributed a [discussion paper](#) to all systems asking for detailed responses on different aspects relating to 'system by default.' This enabled us to gain a clear picture on where there are areas of disagreement between systems in different areas, in turn allowing us to develop policy asks that address, and try to bridge, competing perspectives across systems.

1. The principles of system working: what are we trying to achieve?

The success of ICSs will rest on whether they deliver clear benefits for the public in their local communities. It is therefore important to be clear from the outset about what ICSs are seeking to achieve, so that energies are focused on the task at hand and people are brought together around a shared endeavour. Without this, there is a risk that ICSs will in time be consigned to a long list of failed reorganisations in the NHS that did not realise the ambitions of their creators.

Locally, many systems have already articulated the outcomes they are seeking to achieve for their populations. Building on this emerging consensus, we tested a question in our member survey defining four purposes of ICSs, with respondents invited to agree, partially agree, disagree or state that they didn't know. Overall, 8 out of 10 agreed or partly agreed with the purposes of an ICS that we set out. In particular, there is a strong preference for ICSs to address the wider determinants of health in partnership with local government. Those who felt the definition of the purposes of ICSs was not quite complete suggested other purposes that they felt we had missed. The most common among these was that systems should have a role in improving the allocation of finance and resources, given their ability to oversee a large geography of services. As such, we'd suggest this should be included as a fifth objective.

Example responses from individual members:

“ We feel that the core role of ICSs should be to integrate health, public health and social care but with a clear focus and strong links to key partners on working together to tackle the wider determinants of health, in particular recognising the impact of deprivation on health outcomes. We feel that the ICS should engage with housing, education, police etc on shared initiatives that impact on health or where health can support other partners, and that much of this would in practice happen at the ICP/place layer of the system rather than at the ICS.”

“ In considering the purpose of an ICS, local government should be considered equal, core, fully participating founder members of the ICS, not something the ICS decides to ‘adopt.’ We would want a strong relationship between health and local government anchored in s75 agreements (and building on long history of strong formal partnership working) and so forth, but not structural integration.”

“ An all-inclusive approach is needed to tackle health inequalities and improve health outcomes. The practicalities on integration require working at an ICS level and an ICP level.”

“ Imagine the possibilities when you bring a devolution agenda together with an ICS agenda. The difference you can make to local communities cut across economic growth, health and prosperity.”

Therefore, there seems to be general support for the purposes of an ICS to be summarised as follows:

The purpose of an ICS is to deliver tangible improvements in five areas:

- 1. Overall health outcomes for their population.**
- 2. The reduction of health inequalities through a targeted, evidence-based approach.**
- 3. The integration of primary, community and secondary services, physical and mental health services and health with care.**
- 4. The quality of health and care services and the reduction of unwarranted variation.**
- 5. Efficiency in how funds and resources are allocated.**

In the next section we go on to consider the specific policy and legislative changes members consider might help ICSs to deliver these objectives.

2. How should systems evolve further to deliver these objectives?

Most of the work to develop system working has necessarily been led locally. Much has been achieved through closer working relationships and developing new ways of working that promote integration and tackling shared issues and problems. This process has developed organically over the last five years through a combination of local collaborative clinical, professional and political leadership and a change in the direction of national policy.

However, there is a strong sense among our members that it is now time to consolidate this shift and embed system working permanently into the architecture of the health and care system. How best to do this is not straightforward and views are emergent in parts.

In this section we set out what our members have told us about how national policy and legislation could help systems evolve further and deliver against the ambitions stated in section 1. First, we outline two recommendations that would support the overall delivery and success of ICS objectives: that ICSs should ultimately become statutory bodies that embed partnership working within them, and a new statutory duty should be introduced for all partners within systems. As we will outline, many of the issues relating to system working could be addressed through these two recommendations.

We then explore individual objectives in more detail, proposing some more specific recommendations about how systems should develop further to deliver against them.

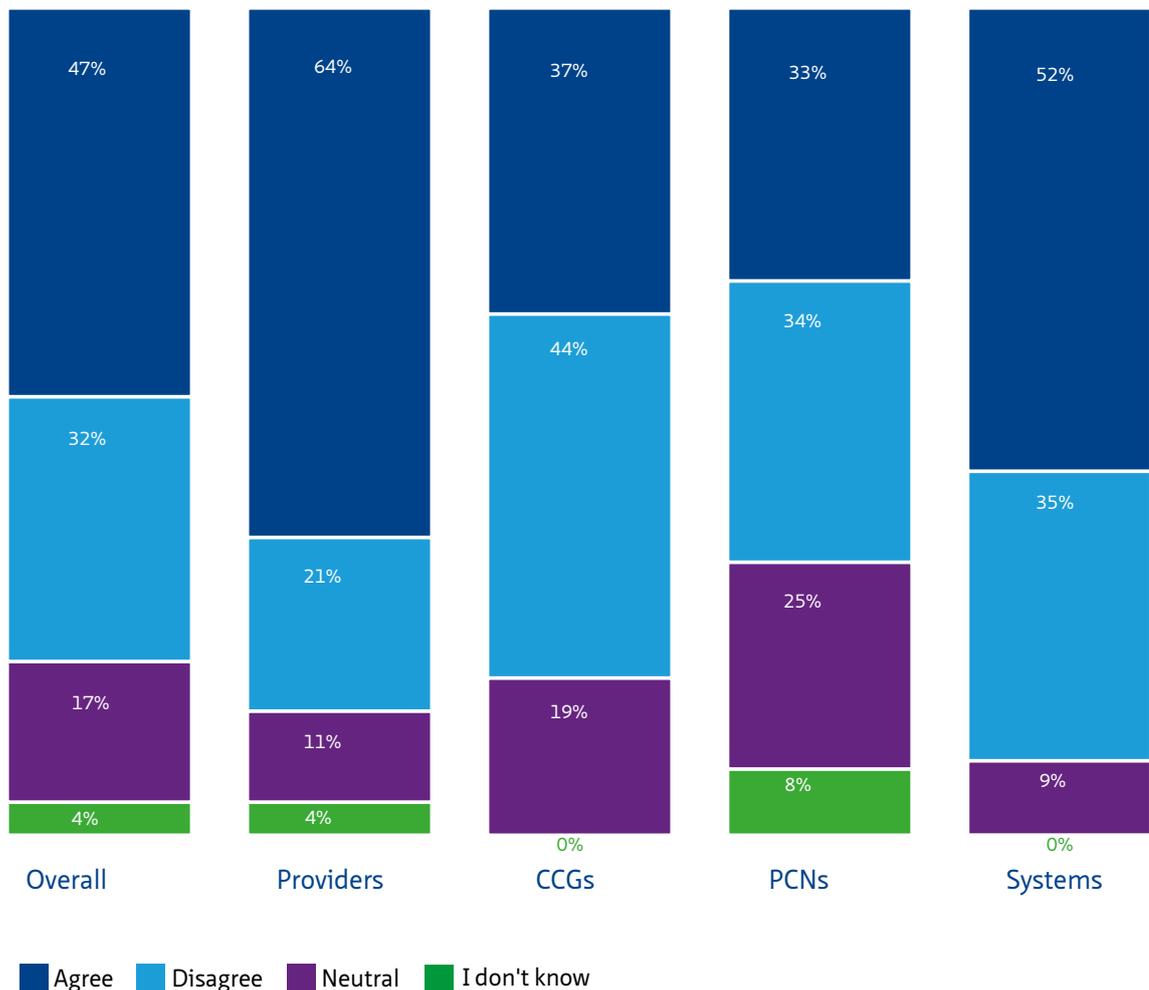
i) The two pillars of a new model for system working

A statutory footing for ICSs that embeds partnership working

Our members are clear that at their heart, ICSs need to enable partnership working where the system 'serves its constituent parts' and its population's needs, and not build a hierarchy of authority. This respects the existing core responsibilities and accountabilities of the partner organisations whilst also acknowledging the need to work together to deliver integrated services to meet the needs of the local population.

Through the survey of our membership, we tested the notion of systems becoming new statutory bodies. While overall this showed significant (but not overall majority) support, there is variation across different stakeholders within our membership:

ICSs should be set up as new statutory bodies and the commissioning functions of CCGs incorporated into them, effectively ending CCGs in their current form.



In the qualitative feedback we received from those who were unconvinced, three issues became clear. First, there was uncertainty around what form a statutory body might take, and this uncertainty influenced support for this proposal. Second, our members are concerned about the potential disruption of another top-down NHS reorganisation. And third, many are concerned that if ICSs were to be created as new NHS organisations, then they would not enable the input and investment of time, resources and enthusiasm from the local government, community and voluntary sectors that will be crucial if systems are to achieve the objectives laid out in section 1.

Given the growing appetite for formalised system working, but in light of the above concerns, we would therefore recommend that ICSs are established as statutory bodies but on the basis that they facilitate and embrace partnership working across the wide range of organisations involved in health and care. This will ensure that ICSs remain bodies that are driven by the expertise of stakeholders across health and care and are not simply a delivery arm for the NHS.

There should be an open and transparent consultative process with all partner organisations across health and care in the coming months to determine exactly what such bodies should look like in practice. There are various potential approaches that could be taken to embed partnership working through legislation. For example, one model that some of our members have already indicated support for would be to set up ICSs as statutory partnerships. Whichever form they take, we believe ICSs should be supported and enabled by a strong multi-disciplinary executive leadership team and associated support functions.

The NHS Confederation would encourage DHSC and NHSEI to develop their thinking and ideas on the way forward as soon as is possible, so that we can make a collective early start on addressing these issues. However, we will stress-test any government proposals against the aspirations and concerns identified by our members as outlined above and discussed further below.

Recommendation

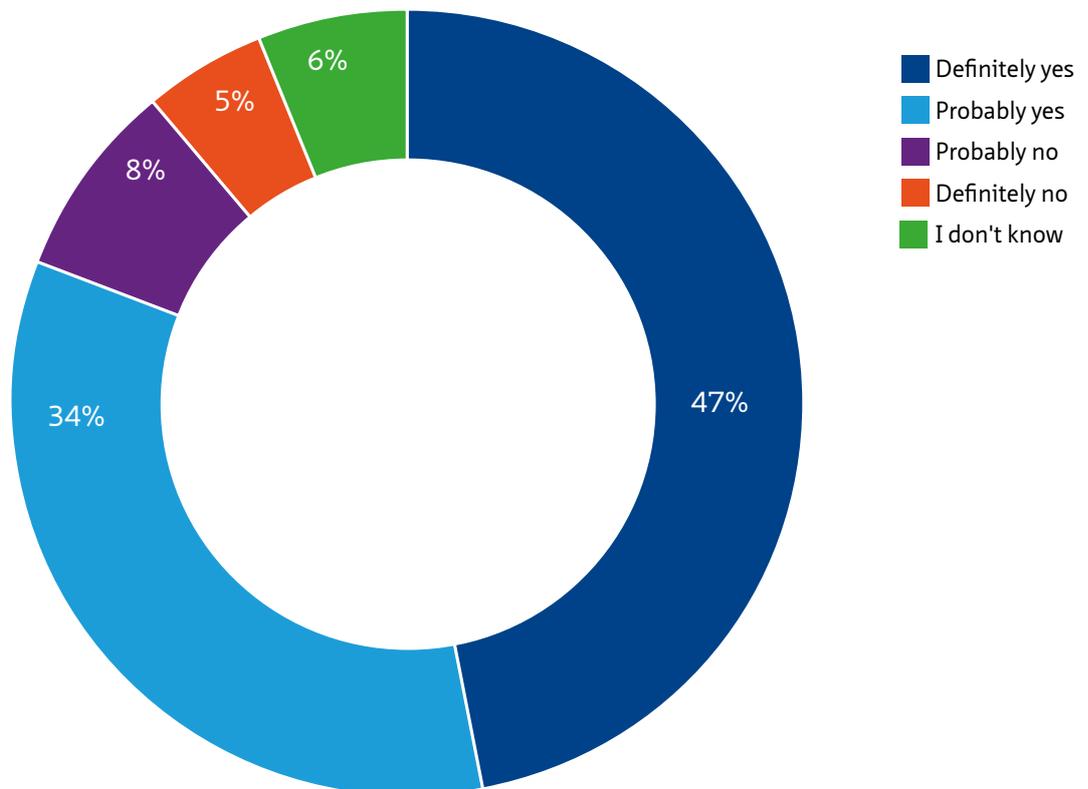
ICSs should ultimately become statutory to fulfil the purposes for which they have been created but this must embed an inclusive model of partnership working with a wide range of stakeholders.

A shared duty on system partners

Many of our members have identified that in their system it has not always been possible to reach agreement and make the progress needed on shared issues. Historically, poor relationships are often cited as the central cause and where it is not possible to overcome this problem, more formal powers are needed.

To support stronger collaboration, we tested, through our member survey, the statement that there 'should be a shared statutory duty on all partners within ICSs to deliver the triple aim set out in the NHS Long Term Plan.' This was first proposed by NHSEI in its recommendations to government for an NHS bill.¹ There was very strong support for this, with 8 out of 10 members supporting the creation of a shared statutory duty.

The NHS Long Term Plan sets out a triple aim to give CCGs and NHS providers shared new duties to promote the triple aim of better population health, patient experience, and financial sustainability. Do you think there should be a shared statutory duty on all partners in ICSs to deliver this triple aim?



¹The NHS's Recommendations to Government and Parliament for an NHS Bill, NHSEI (2019).

The survey question we posed to members asks about a statutory duty in relation to the triple aim, and this is in keeping with what NHSEI has already proposed. However, NHSEI and government may want to consider alternative shared duties too. Some of our members are concerned that the language around the triple aim is very NHS-focused and that a focus on reducing health inequalities and improving population health may be more appropriate for uniting NHS, community, voluntary and local government organisations. It may be that health inequalities are weaved into the 'better population health' component of the triple aim. Another alternative is that the shared statutory duty on system partners mirrors the purposes of a system that we set out in section 1.

Whichever approach NHSEI and the government pursue, our members are clear that some form of shared statutory duty between partners would support a sense of mutual accountability, would incentivise joint commissioning (as we outline in more detail later in this report) and should become a fundamental pillar of future system working.

Recommendation

There should be a shared statutory duty on all partners within systems, including local authorities, that incentivises both commitment to system goals and joint working between partners.

ii) Objective – To improve population health and wellbeing and reduce health inequalities

The important role that commissioning can play in supporting improvements in the health of the population, reducing health inequalities, and preventing illness has been long understood.² Yet in practice the traditional view of commissioning in the NHS has been focused on transactional activity between commissioners and multiple providers in the form of routine procurement and contract monitoring. Our members have told us that system working provides a unique opportunity to reposition commissioning as a set of strategic functions at ICS level in keeping with this original intent. These should specifically concern population health, planning, outcomes commissioning and resource allocation. Yet it is also about facilitating new behaviours: collaboration, partnership and shared responsibility.

Evolving commissioner functions to a more strategic level could ensure that the technical expertise of commissioners to plan for different

²Purchasing for Health John Ovretveit 1995

populations is used to best effect. In practical terms, CCGs are on a journey, a period of transition where they are merging or establishing joint committees to increasingly work at scale. They are also in the process of streamlining their commissioning functions, agreeing which are undertaken at a system level and what can be more meaningfully done at a smaller population size – either place or neighbourhood. CCGs are increasingly having to balance the demands of their statutory duties with newer system functions. Our NHS Clinical Commissioners (NHSCC) network has developed a support aid for CCGs to support them in this task, titled [Creating A New Normal for CCG Business as Usual: Preparing for System by Default in 2020/21](#).

One of the key questions for the future form of ICSs is whether this strategic commissioning function as it emerges should be brought together with the current executive leadership capacity of ICSs. We tested this within our member survey, as shown above. While many are supportive, there are clear concerns among some networks within the NHS Confederation. This may be because the scale of an ICS is perceived to be too big for the planning of primary care provision (particularly general practice), with CCGs seen as a more viable footprint at place level. Notwithstanding that CCGs were established with a defined membership of GP practices, many systems reflected that maintaining a strong local link with primary care, to ensure its integration to the wider out of hospital care offer, will be critical as CCGs merge.

There are also several other issues that remain unresolved about the future of CCGs:

- There are concerns about the ‘loss of place’ with the merger of CCGs. In particular, this came through our conversations with local government stakeholders, who value place-level working with CCGs via existing partnership structures such as health and wellbeing boards (HWBs). The combination of political and clinical leadership in times of crisis or to make difficult decisions around service design has proved invaluable for some local areas.

A good example of this can be seen in Greater Manchester’s COVID-19 response, where a combination of local authority and CCG leadership led to a [rapid policy](#) of testing patients for COVID-19 prior to discharge to care homes, created a £500,000 COVID-19 recovery fund for the voluntary and community sector (VCS), and joint work to respond to the disproportionate impact of COVID-19 on different communities in the city.

It is clear that as CCGs merge there needs to be a system-level consideration of the local government footprints involved to avoid

local authority partners perceiving these mergers as harmful to localised decision making, i.e. by 'taking it up' to an ICS. While there are only 44 STPs and ICSs, there are several times more local authorities currently delivering public health and adult social care functions. To support CCGs to work this through at a local level, NHSCC and the Local Government Association (LGA) have developed a [toolkit for CCGs](#).

- We have also heard mixed views from members about moving to a one CCG and one ICS footprint. In some systems, having a one-to-one arrangement works and clearly makes sense due to the coterminosity of the local authorities and those provider collaborative boundaries operating at place level. However, for others it may not work because the proposed ICS has a large geography and/or large population. The move to one CCG per ICS is a positive ambition, but some flexibility is needed on how it is applied if there is a strong local rationale to do so. Furthermore, it should be local decision-makers who determine the size and footprint, not a top-down, one-size-fits-all edict.
- Another area to work through will be the role of specialised commissioning for system working. Some ICSs will have the scale, patient flows and appetite to take on the commissioning of some specialised services, others will not. The key to making this work is finding an enabling national framework for delegation which gives areas the flexibility to decide their role, possibly using population size as a guide.

With a variety of views about the way forward, more time is needed to work through these issues and for CCGs to work in partnership with ICSs and their local partners to do this. This includes the design and move to strategic commissioning, building on existing joint committees, merging CCGs, supporting the development of PCNs, work with provider collaboratives, helping develop system strategies, removing or moving transactional functions to integrated care partnerships (ICPs) and acting as the legal conduit for funding to flow to the system.

The process of moving to ICSs in statutory form must not be rushed and so we would suggest that they are run in shadow form with new arrangements for a significant period before being formalised as statutory. This will allow partners within systems and executive teams the time that they will need to sufficiently prepare for what may represent a significant culture change in many areas.

“ In the interim [until statutory footing] we could use the CCG shell/wrapper. The reshape of CCGs into one across the ICS footprint helps and we can integrate the commissioning focus with the local authority and the delivery support functions within our delivery partnerships. Cost of any further significant change i.e. closing down CCGs, may be unnecessarily disruptive at this stage.” **(A system lead)**

Recommendations

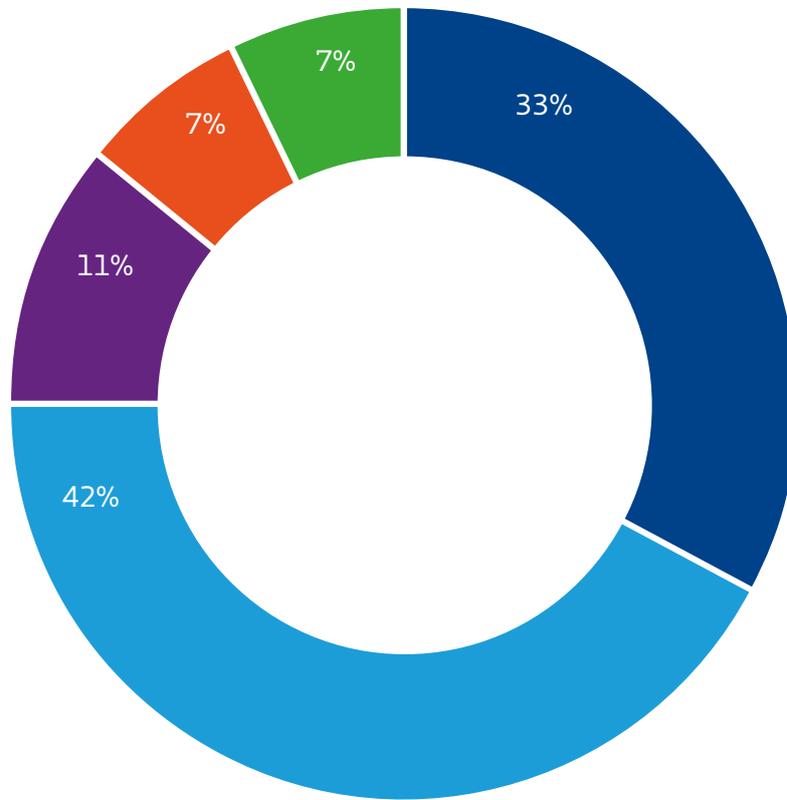
- **The process of moving to statutory ICSs must not be rushed and they should be run in shadow form for a significant period of time before they are formalised as statutory.**
- **CCGs should be supported over the next 18-24 months to transition key strategic functions to an ICS level.**
- **We advocate the move to one CCG per ICS as an ambition but there should be flexibility in how this is applied if there is a strong local rationale for a different approach.**

iii) Objective – To improve the integration of health, care and wellbeing

The recent pandemic has brought home the close interdependence of health, care and wellbeing. In our communities there is a vulnerable population of children, adults and the elderly who need person-centred co-ordinated services delivered by a wide range of health and care professionals. Our members have told us that they have a significantly increased appetite for close collaboration with local authorities on the delivery of health and care to these groups.

In our member survey, this was reflected in the extent of support for joint commissioning. Exactly three quarters believe that the commissioning of health and social care should ‘definitely’ or ‘probably’ be merged in some form. This is also reflected in the qualitative responses we received, which highlight that CCGs and local authorities were keen to align their commissioning strategies where it made sense. The preferred form that this should take was joint committees of the NHS and local authorities that respected the differing accountabilities but that planned services together.

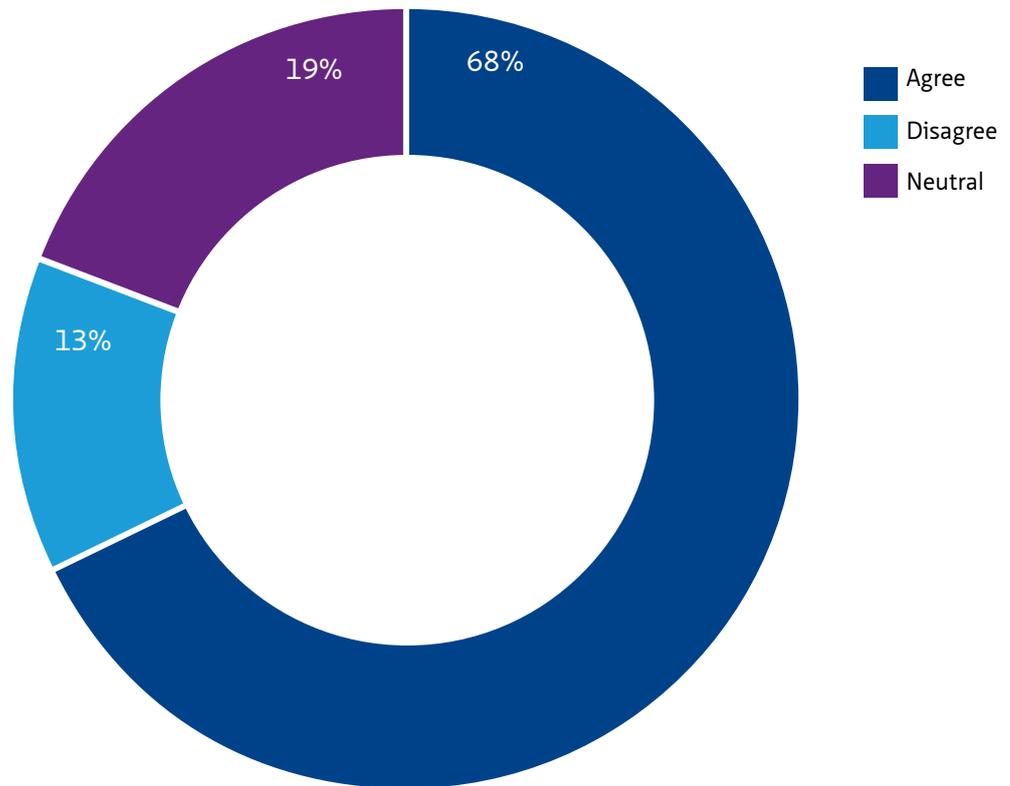
Some people suggest that the commissioning of health and social care should be merged. Which of the following best describes your view on whether this should be the case?



■ Definitely should be merged ■ Probably should be merged
■ Probably shouldn't be merged ■ Definitely shouldn't be merged ■ I don't know

Section 75 (s75) of the NHS Act 2006 already enables the NHS and local authorities to pool budgets and commission jointly. However, there is a sense that the current s75 powers alone are not sufficient to incentivise integration between health services and local authorities. Almost 7 in 10 respondents believe local authorities and the NHS need more statutory powers to pool budgets and commission services jointly beyond the current s75 agreements.

Local authorities and the NHS need more statutory powers to pool budgets and commission services jointly beyond the current s75 agreements



The qualitative responses suggested more exploration is needed of what constitute effective models of joint commissioning. There is also greater need to understand the art of the possible using s75 agreements, and specifically whether their limitations are real or perceived. Case study material of places that have successfully used s75 to enable transformative change would be helpful for promoting greater awareness of what is possible.

Beyond the above there is appetite to facilitate closer joint working by incentivising the right organisational behaviours. As we outline above, the government could consider introducing a legal duty for all system partners to deliver against a shared goal (such as health inequalities) within their populations. This would ensure this is a priority for all and encourage more joint commissioning arrangements with local authorities.

“ The issue is how people are incentivised to lead and deliver together e.g. sharing risk, joint accountabilities and common purpose.” **(A system lead)**

Importantly, the NHS Confederation does not recommend statutory integration of health and social care services. We believe that it should be made as easy as possible for health and care services to merge should they wish to, but forcing them to do so through legislation would be disastrous in areas where there is little history of joint working and would undermine the key role that local authorities play nationwide. There is much we could do to build on the mechanisms we already have to bring together the delivery of health and care services, including HWBs and their duty to promote integration and the Better Care Fund, which has seen CCGs and local authorities agreeing to share substantially more in many areas of the country.

“ It is our understanding that much can be achieved in developing and delivering high-performing integrated health and social care systems within current legislation. More fundamental to success is uniting partners behind a common purpose and creating the capacity, capability and resource (at every level of the system) for best practice care and optimal enabling infrastructure. Whilst more statutory powers for local authorities and NHS to pool budgets and commission services jointly (beyond s75 agreements) might be helpful, such legislation is not a guarantee of success.” **(A system response to consultation)**

Finally, there is a strong sense across the NHS and local government that national policy and thinking on health and care needs to be much better aligned if closer joint working at local level is to become a reality. Government policy on devolution seems to take little account of the opportunities to devolve health and care responsibilities. The continuing extreme financial pressures on social care can also place a strain on local relationships and, most importantly, on effective coordinated service provision.

Recommendations

- **Strong relationships are critical for effective joint working with local authorities, but local systems need more support to develop effective models of joint commissioning.**
- **s75 powers for local authorities and the NHS to pool budgets and jointly commission services should be reviewed to see whether they need to be strengthened or alternative arrangements developed.**
- **To make s75 more accessible, good practice guidance and examples should be developed on the use of s75 powers to improve the integration of health and care.**

iv) Objective – To optimise the use of health and care resources

In meeting the needs of their local populations, ICSs need to come together to make decisions about how they can make best use of the collective resources they have available to them: money, people, infrastructure, knowledge and expertise. Our members have told us that the most effective way of working is through strong local relationships built around shared purpose and values. This needs time and investment to achieve but can make significant breakthroughs when relationships are mature.

As outlined, however, our members also tell us that more needs to be done in creating the right incentives and duties for partners to work together if we are to ensure that system working is embedded across health and care organisations.

Finance

Our members have broadly welcomed the development that systems are to direct the financial allocations for the second half of 2020/21, with funding tied to the performance of systems rather than individual organisations. This can act as an important incentive for all partner organisations to support the overall system. Longer term, systems – statutory or otherwise – should continue to have as much authority as possible over how their funding allocations are used. More work is needed to develop and embed this approach and greater involvement from our members is required.

The move towards system-wide funding has, however, been accompanied by concerns from some member groups about fair distribution. Specifically, there is a sense among some that finance has broadly followed an 'acute first' model at the expense of investment in, for example, primary, community and mental health services. We must ensure that in future the money 'follows the patient' and supports tools such as risk-share agreements to promote mutual financial accountability between partners.

Workforce

The direction envisaged by the forthcoming NHS People Plan accepts that, as the NHS Confederation has argued in [Growing Our Own Future: A Manifesto for Defining the Role of Integrated Care Systems in Workforce, People and Skills](#), ICSs should be the default level for future workforce decision-making in health and care. They should be given greater capacity and influence over investment in the supply and development of local health and care workforce and have an improved ability to affect local labour markets. This would enable increased autonomy over the development of local system architecture, responsibility for managing strategic external relationships and, critically, control of dedicated funding streams. However, this should be subject to a consultation to allow stakeholders such as councils and social care providers the opportunity to offer their views on the notion of workforce planning across health and care.

- “ We have seen that you can achieve real integration and a whole-system approach to service delivery when staff across health, social care and our broader caring communities, such as volunteers, personal assistants and carers, are able to work differently together around the needs of local residents.

- “ So, it's clear that workforce transformation approaches that support integration must focus on all elements of this caring community. However, national policy does not consistently support whole-system approaches.” **(Alison Lathwell, Bedfordshire, Luton and Milton Keynes ICS Strategic Workforce Transformation Lead, writing on [NHS Voices](#))**

Creating opportunities to attract, train and deploy staff across a health and care system will support better workforce development, enhance service delivery and a focus for partners on the place rather than organisations. Tools such as the staff passport and widening access for online training can help, as will system-focused regulation processes.

Whilst systems should have autonomy over planning their workforce, there also needs to be recognition that there will be areas that need to be given particular attention and priority such as mental health, learning disability and community services, all of which have high vacancy levels and are fundamental to delivering the changes set out to transform the NHS as part of the NHS Long Term Plan. It is also important to recognise not all service providers fit neatly within a place and may cross multiple boundaries, for example ambulance services.

Finally, there will continue to be the need for national workforce planning and long-term investment in education and training.

Recommendations

- **ICSs should have increased autonomy and flexibility in how they use and direct funding. This would support and incentivise more innovative, efficient and collaborative working, for example alliance contracting and blended tariffs.**
- **ICSs should be the default level for future workforce decision-making in health and care. They should be given greater capacity and influence over development and deployment of local health and care workforce and have an improved ability to influence investment in supply and local labour markets. However, this should be subject to consultation stakeholders across health and care.**

v) Objective – To improve the quality of health and care services and the reduction of unwarranted variation

There are many ways in which systems can work to improve the quality of services and reduce unwarranted variation. However, it is generally understood that health and care services deliver the best outcomes when they are planned and delivered at the most local level possible and closest to the people they serve.

Place and neighbourhood levels are the centre of gravity for service delivery in most ICSs. These feel 'natural' for joint-working between local authorities and providers. They are well-understood by local communities as being where different partners come together to deliver care and support to populations of vulnerable children, adults and the

elderly. Our members are clear that this is where some of the greatest improvements in service delivery are possible. It is at place level that the best joint solutions will be found:

“ I am very clear that my system is across the city. This is where I concentrate my energy in developing partnerships and delivering change. I am part of an ICS, but my system is the city.” **(NHS community services trust CEO)**

At neighbourhood level, some of our PCN members are already working collaboratively with secondary schools in their area to discuss future health and wellbeing needs for young people.

What is clear from our engagement with members is that successful collaboration at place and neighbourhood levels is about identifying common goals, outcomes and values to work towards and involving the expertise of all delivery partners/providers including local government, primary care, community services and VCS. ICS leadership may be required to resolve issues that span large geographical footprints, for example in the provision of specialist services or agreement of ambulance service contracts. Any leadership by the ICS should, where possible, be driven by the needs of its constituent places.

However, 'place' is a complex concept. We have found through our member engagement that the definition of place can differ between systems and system partners. These were identified as:

- the footprint of provider collaboratives or ICPs
- the footprint of local authorities
- a population-level sense of place defined by a geography i.e. a city/town, etc.

These definitions are a mix of boundaries that may not be coterminous with each other – a mix of organisational groupings, populations and geographies. For local government this can be hard to navigate, especially when there are existing statutory structures in place, such as HWBs.

It is important for systems to have a shared view of place that is owned by its partners to ensure the right leaders come together to integrate delivery and improve population level outcomes. This view must, in turn, be clearly understood by the local communities that partners are delivering for.

Recommendations

- **The principle of subsidiarity is embedded in system, place and neighbourhood level working in ICSs so that the decision-making is 'local by default' i.e. anything that is best determined at the level of neighbourhood and place is done at those levels.**
- **There should be flexibility in the definition of place and the collaboration that goes around it. Local authorities must be embedded as equal partners within systems to best ensure integration of health and social care at place level.**

3. Enablers: what will help systems to be effective?

In the previous section we explored what our members have told us about the changes in the national policy and legislative framework that would strengthen system working and embed it permanently into the architecture of the health and care system. However, on their own they are unlikely to be sufficient to guarantee the success of ICSs, so wider changes are also needed.

Our members believe the model of oversight and accountability in the NHS needs radical reform for ICSs to be successful. Much more thinking is required about the role of providers in systems, so the strengths and knowledge of providers are built into future ways of working and more support is needed to develop and institutionalise the necessary leadership culture.

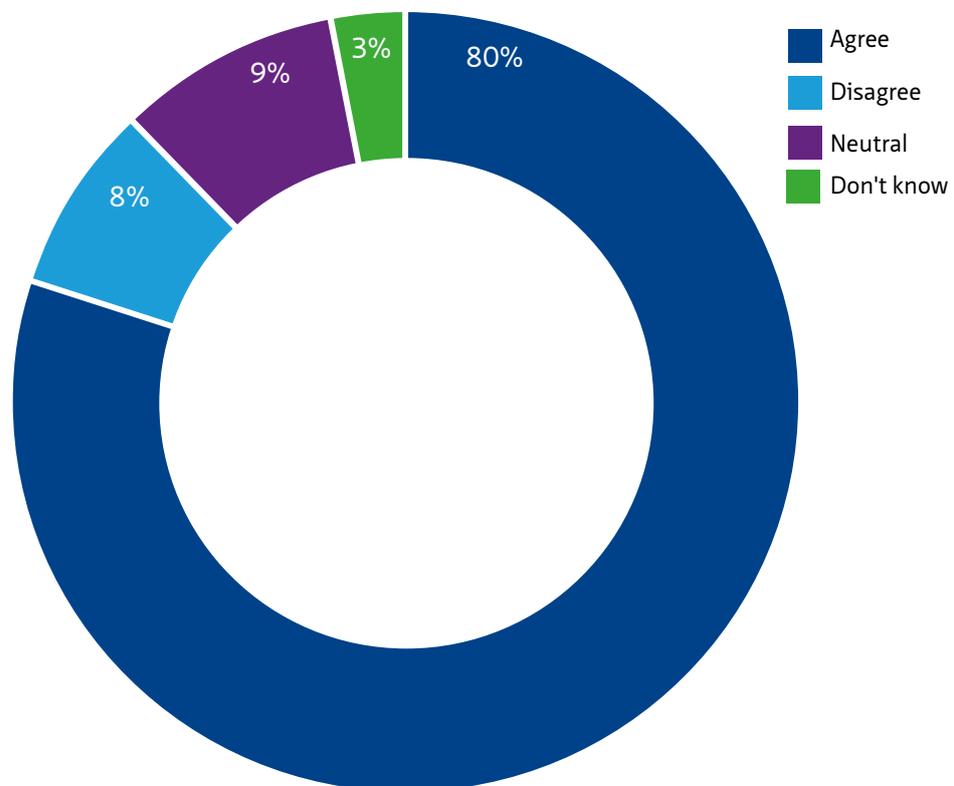
i) Moving to a proportionate and risk-based model of oversight and regulation in the NHS

ICSs bring together a set of organisations with differing accountabilities. NHS organisations are in the main accountable nationally to NHSEI via regions, although there are also lines of accountability to ministers and parliament. There are local accountability mechanisms such as foundation trust boards of governors, scrutiny committees and local Healthwatch organisations, but in practice these have less influence than the centre on most aspects of NHS activity. Local authorities are accountable to their local communities through locally elected representatives. However, there is some central government oversight of local authorities for key national priorities.

The power of ICSs lies in their ability to work together to meet the needs of their local communities and identify solutions locally to the problems

they face. But, our members tell us that the centralising tendencies of the NHS significantly undermine this vision and they are concerned that ICSs are in danger of being subsumed into a centralised NHS machine. Not only is this amount of oversight a significant and unnecessary overhead, it also undermines local partnership working and the quality of decision-making. If ICSs are to fulfil their potential, they need to be liberated to do their job. This is not an argument against accountability or intervention when it is needed, but for oversight to be proportionate, thoughtful and risk-based. Without radical reform of the oversight model in the NHS, ICSs will fail.

ICSs should have increased autonomy and greater local discretion over how national priorities are implemented.



There have been previous attempts to reform oversight in the NHS and devolve decision-making closer to the front line.³ In particular, the oversight model developed for foundation trusts by Monitor presents a potential way forward. This gave foundation trusts the freedom to self-manage and Monitor only intervened when performance fell below certain levels. A similar model could be introduced for ICSs. There are also lessons from the recent pandemic, which by necessity forced a lean, light and agile culture of regulation and oversight.⁴ This allowed the health service to make significant changes very rapidly as it gave leaders and clinicians the space to transform patient care. There is also potential to learn from

³ Shifting the Balance of Power in the NHS, Department of Health (2001).

⁴ NHS Reset: A New Direction for Health and Care, NHS Confederation (2020).

the experience of local government, which has operated under a very different oversight model for a number of years. In particular, the model of peer review might be worthy of adopting in the NHS context.

As part of this, careful thought will also need to be given to the future relationship of ICSs with the NHSEI regional offices. We have long heard from members that performance management, or 'oversight', processes through the NHSEI regional teams are unclear and time-consuming, often with duplication in how reporting works. The move towards system working and the prospect of forthcoming legislation allows for a fundamental re-think.

“ We could and possibly should reduce regions and performance discussions but accept they will always exist. Regions are too close to centre and not pushing back, thereby not adding anything positive to the mix for systems. Some national directors still bypass the regions and systems to talk to trusts and providers directly.” **(System consultation response)**

There are differing views about this that will need to be worked through. One view is that the current roles and responsibilities of the regions could be devolved to ICSs and that they could move to an arm's-length relationship with NHSEI HQ along the lines that foundation trusts previously enjoyed with Monitor. However, some members expressed concern that reporting into NHSEI HQ could lead to a more strained relationship between systems and the partner organisations within them, in turn jeopardising the relationships that will be crucial to the success of system working. An alternative view is for the oversight role to remain with the NHSEI regional team, so that systems can focus more on system transformation and supporting partner organisations to deliver that. The ICS would have an arm's-length role with the NHSEI regional office, who would have step-in rights where there were performance problems.

The reform of the NHS oversight model would also bring the opportunity to strengthen engagement with local communities and to strengthen links to HWBs. The NHS Confederation has long been clear that local public and political oversight is vital. Local authority HWBs already have responsibility for conducting a joint strategic needs assessment and developing a health and wellbeing strategy. Does the contribution of place-based collaboratives to HWBs (and vice versa) need to be articulated locally and promoted publicly? Should HWBs have some decision-making powers over health and care services? There is also the question of what form local accountability for health services that serve large populations and straddle multiple authorities might take.

“ We envisage that at an ICS level (the strategy is driven by population health management data) to include public decision-making and link it to HWBs. At an ICP level (delivery), public decision-making on the use of resources and clear accountability to the ICS and partnership with local councils.”
(A system lead)

In terms of regulation, our members are of the view that inspections need to remain a central pillar of future ways of working to ensure patient safety across all areas of healthcare. This should continue to be led by the Care Quality Commission (CQC) and be outside the scope of systems. Our members consider that the central focus for the CQC in future should be on how patient care is experienced across the system (i.e. from GP to acute to community). Current regulation of individual providers is acting as a barrier to integration, with limited incentives to encourage wider performance implications at system level.

“ Shifting the regulatory accountability away from individual provider organisations to system-level performance would help encourage more integrated working at ICS level.” **(A mental health foundation trust CEO)**

We have the opportunity to significantly reform the model of oversight and regulation in the NHS, but the nettle has to be grasped.

Recommendations

- **The model of oversight in the NHS should be radically reformed to give ICSs the autonomy and space they need to deliver.**
- **The future oversight regime for ICSs should be proportionate and risk-based, grounded in the principle of self-management and with transparency about the triggers for intervention.**
- **ICSs should have a clearer relationship with HWBs, although the detail of this relationship needs further exploration.**
- **The CQC’s model of regulation should more rapidly move to a focus on how patient care is experienced across the system.**

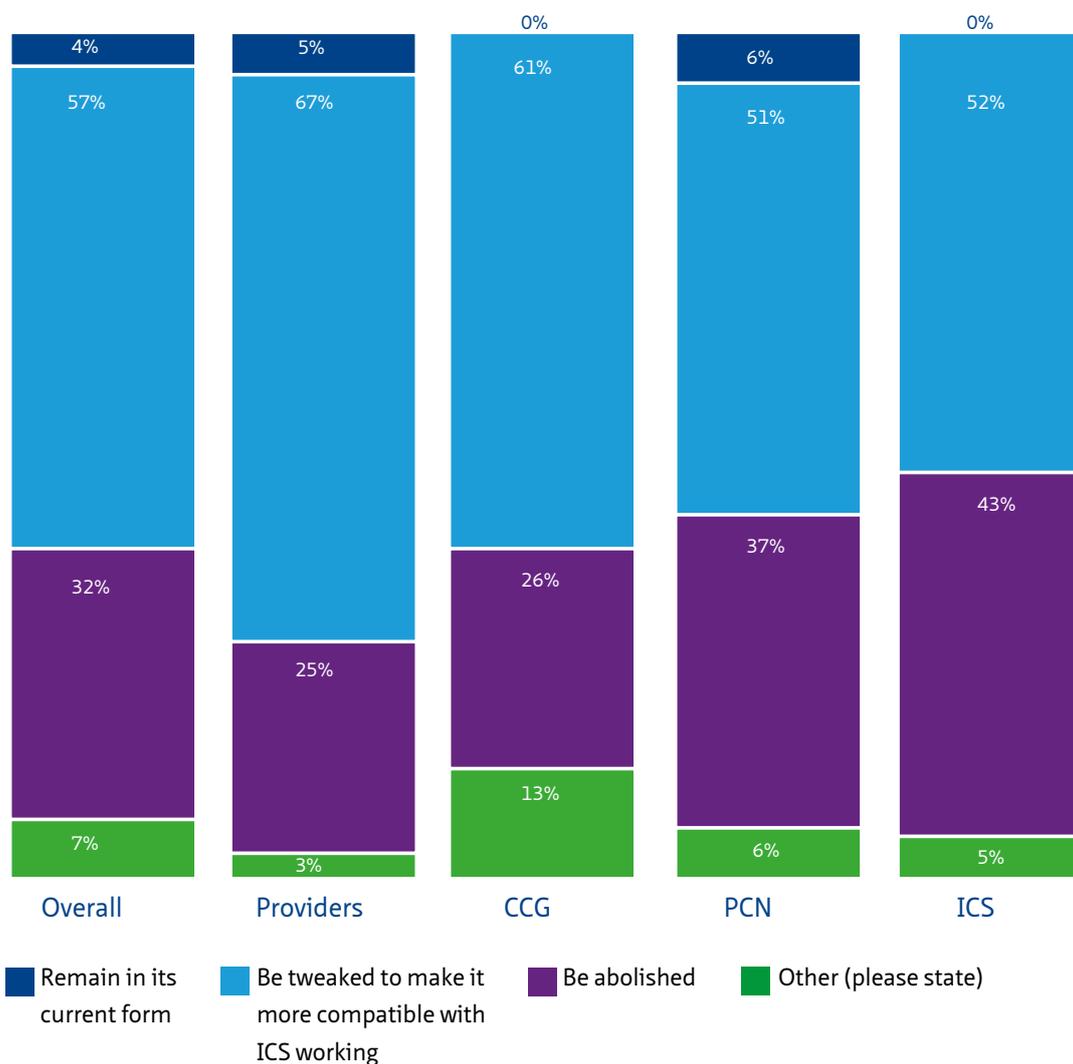
ii) Creating a positive vision for the contribution of providers to system working

One of the more potentially contentious issues for systems is the future of the foundation trust model and its compatibility with system working. The foundation trust model was created against the backdrop of a very different vision for the management of the NHS and some members expressed concerns about whether the freedoms and flexibilities that come with foundation trust status might be at the expense of wider system interests. At the same time there have been clear benefits to organisations who have been foundation trusts, and many are active participants in system working and collaboration.

At present, a majority of NHS leaders (6 out of 10) want foundation trust status to be slightly revised to support system working, rather than abolished.

“ FTs have provided significant innovation and have engagement with the public through members and governors. However, there should be tweaking to ensure that they are not pulled in different directions.” **(System response)**

Under the future of system working, some changes may be proposed to the foundation trust model. Which of the following best describes your view on the future of the foundation trust model?



Some of the areas where our membership has suggested the foundation trust model could be amended include:

- adding a specific legal duty to foundation trusts to cooperate and integrate with system priorities
- adapting the governor and membership model of foundation trusts to a broader-based system version that strengthens local accountability
- ‘levelling out’ the differences and potential benefits that foundation trust autonomy creates when put alongside other NHS providers, for example powers to form subsidiary companies.

It may be the case that a shared statutory duty for foundation trusts, as discussed earlier, may be sufficient but more work is needed to explore these issues further. However, our members felt that any proposed changes should be part of developing a wider and more positive view of providers in systems rather than being 'retaliation legislation.' It is important to remember that the freedoms and flexibilities accorded to foundation trusts have in many areas enabled a stronger focus on delivering good care and improving the services they offer. Moreover, much of the expertise and knowledge about service delivery rests within provider organisations and they have the capacity to make real change happen. The needs of providers should be at the heart of ICS decision-making rather than at the sidelines.

From discussion with our provider members we know that many are keen to engage and drive transformation and integration. This is happening at several levels:

1. Providers that span multiple system geographies collaborating together to share best practice, enable innovation and reduce costs. For example, the Northern Ambulance Collaborative.
2. Similar provider organisations such as acute trusts collaborating at system level to design clinical pathways, share resources such as clinical staffing, or drive cost savings such as shared back office functions.
3. Providers collaborating at place and neighbourhood level to respond to local demands. For example, acute trust, local authority, PCNs, VCS and other partners collaborating via a memorandum of understanding or alliance model to deliver services across a place.

In conversation with provider CEOs and chairs, it was the latter of the three collaborative models that was seen by the majority to deliver some of the greatest wins.

Recommendations

- **The current statutory framework for foundation trusts and licence conditions should be reviewed to ensure it is compatible with and supports system working, but should not be fundamentally changed. The strength and quality of relationships with system partners, not the details of legislative reform, will most determine how well foundation trusts integrate into systems in the future.**
- **A vision for the future role of providers, and specifically provider collaboratives, in systems should be developed that sets out how their expertise and knowledge can be used most effectively in support of partnership working.**

iii) Support for developing a new style of system leadership and changing behaviours

System leadership

A consistent theme in our member engagement was that the leadership style of systems is a critical factor in their success. To avoid the feeling of a top-down hierarchy at system level, ICS leaders play a critical role in bringing system partners together, building the right relationships, working with complexity and ‘focusing on where the energy is’ (a commissioner) to build collaboration.

This is no easy task. Many of our members talked about the collaborative leadership skills demanded of system leaders as being among the most stretching that they had experienced in their careers. It requires a more distributive and transformative leadership style, one that is ‘earned by taking organisations out of their silos and into new ways of working – focusing on common goals and shared solutions.’ (A commissioner). More collaborative mindsets and ways of working are becoming the new norms of the NHS and partner organisations, resulting in more supportive cultures and behaviours. For example, systems having one version of the truth when reporting assurance or self-led improvement.

The building of relationships and a new leadership style and way of working takes time, support and investment. Such capacity and capability building has received some support and investment from NHSEI, but systems need more support to develop their own leadership capabilities and delivery mechanisms. This could include system leadership development, shadow boards, peer review or tailored organisation development interventions. Systems themselves should be able to shape and determine the investment and support they need and it should not be driven by the centre. Future recruitment of leadership positions should recognise the importance of system-wide transformational skills, alongside the ability to lead individual organisations. As one member commented: “It doesn’t matter so much about the regulatory framework you work within, it is about the behaviour of the leader and how they interact with the system.”

Clinical leadership across system and place

Our members believe that clinical leadership is an essential component of system working and should be fundamental to any future model of ICSs. We should strive to build a leadership triumvirate encompassing managerial, clinical and lay leadership, as all three components are complementary and essential.

The role of clinical leadership in systems is critical to ensure the design of evidence-based practice, reduce unwarranted variation and drive up quality. Effective clinical leadership should encompass a broad range of professionals (including nurses, pharmacists and allied health professionals) across secondary care, mental health and community services, as well as general practice.

CCGs are particularly keen to ensure the clinical leadership they have facilitated for a number of years is not lost in the transition towards system working, as they feel this has added a level of local credibility to planning, particularly at a place level. One way this is being managed during transition is where CCG clinical leads are moving into locality leadership roles through organisational mergers, and the emergence of PCNs ensuring that consistent clinical expertise informs place-level working with local government and primary care.

Clinical engagement in service redesign is essential. Our engagement with members has shown some areas are already in the process of establishing system-level clinical networks to align clinical strategies, standardise professional practice and prioritise pathways for redesign. The ambition being that this high-level strategy would be complemented at place level by ICPs, which take up the more detailed work around the redesign of specific clinical pathways. Members felt this was more empowering to clinical teams and embedded clinical leadership at all levels of the system. It is clear that clinical leadership is needed at all levels not only to support the pathway design, but to be involved at the strategic level. Cogent clinical leadership makes the strategy achievable.

Recommendation

The move to statutory ICSs is accompanied by a significant programme of investment in managerial, clinical and lay leadership development across health and care, to build the capacity and capability needed for ICSs to succeed. This programme should be designed and tailored by the systems themselves to meet their local requirements and aspirations.

iv) Size and governance of systems

There is a wide spectrum of population size and geographies across systems, which presents challenges and opportunities. The NHS Confederation believes this range of size is not a problem in itself and we would not advocate the imposition of minimum and maximum sizes for systems, nor do we believe boundaries should be changed unless there is a strong reason to do so and the case for change is driven by the system itself.

However, the challenge is around how systems reconcile population size with what happens at system and place levels and find appropriate solutions to navigate between them. Our members expressed a fear that 'ICSs could become too big and distant' from their populations to support place-based working, manifesting more like performance-driven strategic health authorities than a platform for partnership working and alignment to population-driven goals. For other members, some systems were 'too small to have any meaningful impact and need to be rationalised to enable systems to have real impact and a relationship with the centre.'

Regardless of size, to ensure that systems operate effectively across system, place and neighbourhood levels, it will be important that there are effective governance structures in place.

The Audit Commission (2002) defined governance within the NHS as: 'The systems and processes by which health bodies lead, direct and control their functions, in order to achieve organisational objectives and by which they relate to their partners and wider community.'

As we begin to consider what governance may look like within systems in future, the NHS Confederation believes that a one-size-fits-all approach to governance will be unworkable and ineffective. Given the significant diversity in both the geographical and population size of systems, there should continue to be flexibility in how different systems operate and the governance models they adopt.

However, some of our members have spoken about their confusion in understanding how their system works or what it is trying to achieve. As such, all governance models across systems should adhere to certain principles. Governance, for instance, should:

- be streamlined where possible to enable quick decision-making at place level
- reflect the principle of 'local by default', whereby any roles and responsibilities that can be devolved down to a more local level, are devolved down
- be transparent and clearly communicated to all partners within systems. At present, many organisations – particularly PCNs – feel uncertain about how their system works, what their role is within it and the specifics of accountability
- embrace the notion of mutual accountability between partners to foster interdependency

- include representation at system and place levels for providers (including PCNs) and local authorities. While the NHS Long Term Plan includes a commitment that these groups must be represented on partnership boards, this should be strengthened so that, for instance, such groups have a role in producing system strategies and contributing to system-wide conversations about issues such as workforce.

Recommendations

- **To ensure that there is clarity across all partners within systems, as well as between neighbourhood, place and system levels, there should be a minimum set of criteria that governance structures must meet within ICSs to be simple and transparent.**
- **The NHS Confederation recommends that appropriate governance arrangements are developed and put in place within each system during the transitional period before ICSs become statutory, to ensure that there are clear roles, accountabilities and processes for how systems, CCGs and providers interact in the intervening period.**

Conclusions and next steps

Opportunities to make significant changes to the legislative framework governing health and care are infrequent, partly due to both the political and operational sensitivities of doing so. This means it is important that NHSEI and the government get the detail of system by default right in any forthcoming legislation. The NHS Confederation understands the significance of this moment for our members and has gone to great lengths to draw on their knowledge and expertise to develop a considered view of what is needed.

In some areas, our members have a clear view of the way forward in making any changes to the national policy and legislative framework that will help strengthen system working. However, there remain issues where the way forward is not yet clear and our membership has differing views. Further work will be needed over the coming months to work through these issues to discover the best way forward. The NHS Confederation will be working proactively not only with our members, but also with stakeholders including the Local Government Association, NHSEI and DHSC, as we seek to find solutions to these issues.

This report is part of an ongoing conversation about the future of system working and we have attempted to faithfully reflect the views and opinions expressed to us on what is a difficult and complicated subject. We anticipate that there will be further discussion and dialogue over the coming year to try and find the best solutions for the health and care system, as and when DHSC and NHSEI put forward any proposals for change.

To offer your views on any of the issues explored above and/or to contribute to our future work on system working, please get in touch by emailing Nick Ville, director of membership and policy:

nick.ville@nhsconfed.org



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