8 January 2021

Written submission to NHS England and NHS Improvement on *Integrating Care: Next steps to building strong and effective integrated care systems across England*

NHS Providers is the membership organisation for the NHS hospital, mental health, community and ambulance services that treat patients and service users in the NHS. We help those NHS trusts and foundation trusts to deliver high-quality, patient-focused care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate.

NHS Providers has all trusts in voluntary membership, collectively accounting for £87bn of annual expenditure and employing more than one million staff.

Introduction

We recognise the importance of the proposals set out in NHS England and Improvement's (NHSE/I) engagement document on system working, and we are pleased to respond on behalf of our membership. In our response we deliberately seek to set out clearly the unanswered questions which the document raised in our minds, and that of trust leaders, as well as to answer the four consultation questions. Our response therefore includes key messages, the principles which we believe must underpin any legislative change, a section summarising trust leaders' support for the strategic direction and questions about the underpinning 'plumbing and wiring'.

Our response is informed by extensive engagement with trusts and foundation trusts across England, which includes in depth consultation with chairs and chief executives in the form of virtual breakout sessions with 151 individuals, 15 conversations with trust leaders keen to share their detailed thoughts, several roundtables (some of which colleagues from NHSE/I very helpfully supported) and written feedback from our newly created NHS Bill Member Reference Group which is representative of the trust sector. Our response also reflects feedback from member network meetings, which cover all trust board positions, and input from a small number of primary care colleagues. We know that many of our members, and Integrated Care System (ICS)/Sustainability and Transformation Partnership (STP) teams, will submit their own response to this engagement exercise and we have encouraged them to do so.

Key points

1 Trust leaders support the spirit and aims of NHSE/I's proposals, which seek to promote collaboration across organisational boundaries to improve population health, tackle health inequalities and deliver the best use

of resources. Trust board members, in both executive and non-executive roles, were keen to emphasise the importance of retaining a clear focus on delivering better joined up, person-centred care and improved outcomes for local communities.

2 We welcome the considerable opportunity set out within the proposals for trusts to step into key roles as leaders and co-leaders of local systems. Trust leaders welcome the emphasis on provider collaboration and place in the document, as well as the recognition that trusts will remain the key unit of high quality secondary care delivery. They see an immediate opportunity for providers to work collaboratively to recover from the impacts of the pandemic, and sustainably deliver high quality frontline care services more efficiently.

3 However, trust leaders would welcome a clearer, and consistent articulation of the primary role and purpose of an ICS, co-developed with the sector. There are different interpretations of the role of the ICS as described in the document. Many trust leaders see a potential tension in the current objectives set out for the ICS. They are particularly unsure whether the objective for ICSs to drive strategic transformation to improve population health outcomes on a system footprint – a collective endeavour across a wide range of health and care players – is compatible with becoming an NHS commissioner, performance manager and principle funding channel.

4 Trust leaders also have a range of views about whether, and to what extent, ICSs should have a statutory basis, and how the 'plumbing and wiring' that underpins system working should operate, including governance, accountabilities and funding flows. At this stage of policy development, the paper lacks detail on how these changes will operate in practice. Further engagement will be needed to work through the detail with the provider sector and other frontline health and care organisations.

5 Trust leaders are clear that statutory alignment between the ICS and providers is key. The statutory basis of the ICS must not only reflect their agreed purpose but also avoid any overlap with NHS trust and foundation trust statutory accountabilities. ICSs must empower providers to deliver, not create additional bureaucracy.

6 Given that ICSs and STPs have evolved their priorities, functions and form depending on local circumstances, national policy and legislative frameworks must provide clarity without creating a 'one size fits all' blueprint. An enabling, permissive framework that takes full account of significant, legitimate, local variation in the development of system working is key to ICSs' success.

7 NHSE/I needs to consider more fully whether the proposals enable different partners within the provider sector to lead and contribute fully to improving outcomes. Acute, community, mental health, specialised and ambulance trusts all face sector-specific opportunities and challenges – as do their colleagues in primary care and social care. Many trust leaders, including those in mental health, community and ambulance settings, do not feel that the current proposals sufficiently acknowledge the breadth and depth of their contribution in the health and care system. Our members also think that the proposals could better reflect the key partnership role of local government and primary care colleagues.

8 We must not underestimate the scale of change that these proposals represent against a backdrop of unprecedented operational pressure. These proposals from part of a steady and welcome policy progression towards collaboration and integration as the core driver of improvement in the health and care sector. However, government and NHSE/I must not underestimate the impact of current operational pressures given change must be owned and led by the frontline.

Support for the strategic direction of travel

1 **Trust leaders support the strategic direction of travel** and spirit of NHSE/I's proposals: to integrate health and care more rapidly at local levels through stronger collaboration and system working. The COVID-19 response has accelerated mutual aid and collaboration across the country, building on work that was already underway to develop more integrated care for patients, improve population health and reduce inequalities. Our members recognise that the time has now come to set out a clear policy path to more rapid and consistent local health and care integration and welcome the opportunity to engage in dialogue with NHSE/I and other stakeholders on these issues.

2 **There is strong agreement among trust leaders on many of the key concepts** underpinning NHSE/I's proposed approach, including:

- The intention to establish an enabling, permissive framework that supports the different models developed across the country in response to population need and the different levels of progress made by ICSs/STPs.
- The commitment in the document to avoiding creating ICSs as a new, additional, "fully powered", regulatory tier in the system, akin to the old tier of Strategic Health Authorities (SHAs).
- The emphasis on the importance of place and neighbourhood level integration, as well as system, with functions only pulled up to ICS level (or multi-ICS level) where it makes sense to do so for local populations and services.
- The importance of providers working together collaboratively – be it in horizontal or vertical collaboration, at place or system level – as a key building block of better system working.
- The fact that trusts and foundation trusts, overseen by unitary boards, will remain the vehicle for secondary care provision and a key unit of delivery in the health and care system. Trusts are large organisations that manage the highly complex delivery of safe, high-quality healthcare services daily, employ the significant majority of NHS staff and spend the significant majority of the NHS budget. Trust leaders welcome the intention to preserve robust governance structures in the form of dedicated, locally responsive, unitary board oversight.
- The move towards a more strategic commissioning function, at ICS level, which could reduce the fragmentation introduced by the Health and Social Care Act 2012, with some commissioning functions (e.g. system transformation and pathway redesign) taking place at provider/provider collaborative/place level.
- The proposed alignment of the NHSE/I oversight model with system working.

3 However, while trust leaders support the long-term strategic direction of travel and the concepts underpinning system working, they are concerned about what many of the detailed changes will mean in practice. As a key starting point, many are concerned that the **NHSE/I document is insufficiently clear about the core purpose of ICSs and whether the objectives for ICSs currently proposed are compatible and deliverable**. NHSE/I has set out a broad set of objectives including both transformation and population health management, and the roles of NHS performance manager, CCG replacement and NHS funding channel. The

purpose of the ICS will, of course, influence views of its form and governance. We therefore think it is important to ensure there is complete alignment across the health and care sector on the purpose of ICSs, informed by open debate across the sector, before finalising future policy and legislative proposals.

4 Trusts also hold a range of views about the detailed 'plumbing and wiring' underpinning system working for example, on key issues such as governance, accountability, funding flows, and how they might best operate in support of the ICS and its constituent organisations. Within this response, we have sought to set out the most important and complex questions which the paper raises in our view. We hope this is constructive as intended, and would be happy to work with NHSE/I colleagues to engage the sector in developing appropriate solutions.

NHS Providers principles for legislative change

5 The government needs to seriously consider the timing of this proposed legislative change given the scale of the operational challenge at the current time, the difficulties this will present in securing full engagement with the sector and the additional resources required to manage this transition. While trust leaders want clarity about accountabilities and the purpose of the ICS, some are concerned that this will distract from the restoration and recovery of services which will continue well into 2021/22 and beyond. Now more than ever, the NHS and its staff need stability. While legislative change remains a question for government, we would strongly encourage NHSE/I colleagues to reflect carefully on the timing of such significant change for the sector in its conversations with DHSC and ministers.

6 The current fragmented commissioning arrangements, created by the 2012 Act, are deemed by the majority of trust leaders to be sub-optimal; trust leaders therefore support the shift towards collaboration as the key driver of service improvement. However, NHSE/I and DHSC must also set out clearly why legislation is the preferred route given a number of system partners have delivered significant change within the current framework. The paper raised a series of questions in our mind around:

- what barriers the legislative proposals are trying to overcome?
- what their impact will be on trusts' accountabilities in statute?
- how they will achieve the stated ambitions when so much depends on non-legislative factors?

It would also be helpful to see a list of regulations that need retaining or replacing, and an assessment of the potential costs, savings and patient benefits associated with legislative change of the scale proposed ahead of the publication of the Bill.

7 If the government does proceed as expected, then we will advocate for legislative change to adhere to the following principles:

- Patient first – any legislation must improve the outcomes and experience of patients and service users. The public would benefit from a more integrated health and care system which is more person centred

and responsive to individual needs. The original focus on ICSs providing more joined up care for local populations is therefore welcome and we must not lose sight of this aim.

- Reducing complexity and adding value – given the continued important role for providers and NHSE/I, ICSs, places and provider collaboratives must not create unnecessary additional tiers of bureaucracy in an already highly complex system architecture. The role and value of all organisations that form part of our health and care system need to be assessed to ensure the health and care system runs efficiently and makes best use of public funds, with scarce resources being directed to service delivery rather than overheads.
- Enabling – The government must learn from the experience of the 2012 Act and avoid a top-down reorganisation of the NHS. The variation between geographic circumstances, population needs and pre-existing collaborative arrangements across the country necessitate a permissive, enabling framework. There is no 'one size fits all' for system working. ICSs should function as a means of empowering frontline providers (trusts and their partners) and clinical teams to deliver high quality care and drive improvements, as seen in the COVID-19 response. ICSs should be responsive to, and owned by, their constituent organisations.
- Based on good governance, accountability and the principles of subsidiarity – ICSs should be organised according to the principle that decision making must take place as close to the people affected by the decision as possible. This empowers trusted local leaders with sufficient autonomy to oversee the provision of high quality care which is responsive to local needs. Clear corporate governance and public accountability is essential, with unitary boards at trust level providing the best vehicle for good corporate governance. ICS decisions and accountability structures should be transparent. Those who make decisions, including on public expenditure, should be held accountable for them. It is vital that there are no mixed or overlapping lines of accountability.
- Consultative – Those responsible for delivering and receiving health and care services should be appropriately consulted and engaged in any proposals for change.

NHS Providers' response to the four consultation questions

Q1. 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?

The case for change

8 While there is strong agreement on the direction of travel, the spirit and underlying concepts of NHSE/I's proposals, there is a broad spectrum of views on the detail of how best to achieve the ambitions of system working. While trust leaders support the intention behind removing the barriers to integration currently in the 2012 Act, they are not as unequivocal as NHSE/I that putting ICSs on a statutory footing is the right foundation for the NHS.

- Some trusts prefer the option of not legislating for ICSs at all, given they have progressed system working and integration within the current framework and see the potential risks of unnecessary structural reorganisation.
- Others feel putting ICSs on a statutory footing is both inevitable and beneficial, particularly as they are now effectively managing public funds, and prefer a light touch approach to legislative change.
- Other members see ICSs as needing 'more teeth, but not total power' to require constituent organisations to reach agreement on difficult decisions and follow through on decisions outside the board room.

Overall, there is a range of views among trust leaders as to whether or not ICSs should be placed on a formal statutory basis, although we note that the number of trust leaders open to this option seems to be increasing and recent engagement suggests a majority would favour an appropriate statutory underpinning subject to agreement on aspects of the 'plumbing and wiring.' The diversity of views reflects the diversity of experience, population need and local structure currently supporting system working across the country – and different interpretations of the core purpose of the ICS.

There is universal agreement that any change must be done on the basis of clarity and alignment on the purpose of ICSs and avoiding overlap, confusion and duplication with the responsibilities, accountabilities and governance of individual trusts and foundation trusts.

9 While there may well be a case for legislative change to provide ICSs with a formal, statutory underpinning (see paragraph 6), the paper could set this out more clearly, linking the proposals to an agreed articulation of the principal purpose of ICSs, which we feel must be to provide better joined up care and improved outcomes for patients and service users. Trust leaders are concerned that failing to align the proposals to this core purpose (and indeed diluting this purpose with multiple objectives more closely aligned to performance management) could fail to deliver the desired improvements to patient care, negatively impact staff energy, fragment local authority involvement and simply polarise people along new organisational boundaries rather than bringing them closer together.

As part of the legislative proposals, and equally if no legislative change occurs, some trusts felt it would be helpful to have a clear mediation or arbitration process so that if an individual organisation disagrees with an ICS decision, then it would be clear where accountability for any outcome rests. This would enable trusts to accept and work to system decisions even if sub-optimal for their own organisation. In the case of arbitration this can be binding. This would bring clarity of accountability and good governance, ensuring that any potential overlap in accountabilities is mitigated against, and would be supported by the focus on population health outcomes.

10 The document articulates a number of objectives for ICSs which include driving population health management and improving outcomes, as well as acting as a performance manager, NHS service commissioner and NHS funding channel across the system footprint. Many trust leaders believe these objectives potentially conflict. The core purpose of the ICS will, of course, also determine its membership, as well as the statutory underpinning required. If ICSs are to focus on reducing health inequalities, prevention and proactive population health management, they will need a broader membership across health and care, in addition to colleagues from other public services such as housing, education and criminal justice to really work together on shared issues. The interdependencies across health, care and wider public services need to be given greater consideration.

If ICSs are, however, primarily designed to help 'performance manage' the NHS, and likely to focus, in reality, on internal NHS performance, financial flows and contract management issues, their membership should perhaps be more internally focussed. A further challenge will arise in terms of membership, and form, if ICSs are genuinely expected to straddle both of these objectives. Trust leaders feel there needs to be a deeper and better debate on whether these two sets of objectives are compatible and, if they are, how they can both be delivered by the same organisational construct. Resolving this issue is fundamental to getting the right detail on ICS accountability, governance, and composition.

11 While the government's focus on 'busting bureaucracy' is welcome, trust leaders are also concerned that the proposals create an additional tier in the system architecture which risks duplicating or cutting across what is best undertaken at provider level. Instead of looking for a structure that makes sense from the top down, it would be helpful to build the vision of system working from the bottom up to understand how systems are delivering the required collaboration and integration without having to create an additional legal entity with all the cost and reorganisation that entails. This would ensure compatibility with the role of trusts and their boards, as well as connectivity between national ambitions for ICSs and bottom up integration at neighbourhood and place level.

12 All parts of the provider sector – acute, community, mental health, specialised and ambulance -must be appropriately considered in the strategic aims and operating model of ICSs. There is a risk that NHSE/I's proposals as currently framed do not take into account the contribution that mental health, community and

ambulance trusts have to offer as integrators within local systems. Different types of trust contribute considerably to collaborative working – indeed often leading the way – and it is important that these different approaches are recognised and lessons learned from them all.

13 While we understand the need to embed learning from the pandemic, and for providers to work collaboratively to restore services, and support population health management approaches, there is a risk in accelerating a policy framework which supports system working in anticipation of, expected legislative change which may be subject to debate and amendment in parliament. In any event, NHSE/I and DHSC will wish to allow sufficient time to consider trust leaders' views and different circumstances as they embed ways of working before a Bill is laid and, particularly over the course of 2021/22. A review of best practice and learning from partnership working during the COVID-19 response is vital to ensure national policy changes are based on robust evidence and tested beyond the immediate circumstances of the pandemic.

Conditions for legislative change

14 In our view, if ICSs are to be placed on a statutory footing, the following conditions should be satisfied:

a **There must be complete clarity on the fundamental purpose of ICSs, as agreed with providers and their partners.** As set out in paragraph 10, the proposed wide-ranging roles for ICSs risk being incompatible and introducing contradictions in how the 'plumbing and wiring' is described.

b **The statutory basis of ICSs must reflect their agreed purpose.** The form and membership of the ICS will obviously follow its agreed purpose or functions. If ICSs are intended to be strategic forums to improve population health and involve a wide range of partners across health and care, wider public services and the voluntary sector, they are likely to require a different legal underpinning than if they are designed to be NHS-focused bodies predominantly accountable for NHS financial and operational performance.

c **NHSE/I and DHSC must set out a clear description of how the ICS's role and responsibilities relate to NHS trust and foundation trust accountabilities in statute, ensuring there is no overlap, duplication or confusion and ensuring that funding flows are clear.** Our understanding is that NHS trusts and foundation trusts will retain their existing accountabilities, which is welcome and sensible, given the complexity of service delivery they are responsible for, the experience and expertise of trust boards and their staff, and the need for stability in the sector, not least in the wake of the pandemic.

However, this does mean that any new powers for ICSs must align with trusts' accountabilities. NHSE/I and DHSC must also describe what new powers ICSs may have over NHS trusts and foundation trusts. Otherwise, it implies a shift of powers upwards to ICSs and outwards to provider collaboratives, but individual trusts remaining accountable for quality of care and delivery. It also remains unclear whether places will have decision-making powers and what structure will underpin this (e.g. lead provider, pooled budgets). NHSE/I and DHSC need to formally clarify the purpose of trust statutory boards in the ICS environment, as it is

currently unclear what the consequences of leaving unchanged the current range of formal and statutory responsibilities of the individual provider organisations might be.

NHSE/I must set out the detail of any new legal underpinning for how funds will flow to and within ICSs, with regard to trust boards' statutory responsibilities, and be fully transparent about the methodology for determining ICS funding envelopes. This should account for how each constituent element is calculated, including the logic behind any provider level allocations. The importance of aligning accountability and funding flows was demonstrated by the recent Ockenden report recommendations. While trusts are rightly required to take a set of priority actions, which they are responsible for delivering, there is uncertainty about whether ICSs will provide the multi-year financial commitment required to deliver these actions.

d **The underpinning policy and legislative framework for ICSs must be enabling, flexible and permissive.** Each system is significantly different from the others – in terms of: geographic size and characteristics; the history of joint working arrangements; scale, spread and number of providers; and previous commissioning footprints. There are often good reasons for this variation in ICS development, including demographics, the local system architecture and population needs. NHSE/I should therefore not attempt to impose a 'one size fits all' structure which will deliver less benefit than a more flexible approach.

This issue is particularly important for trusts who span more than one ICS footprint. Most community, mental health, specialised and ambulance trusts work across several ICSs/STPs and in a myriad of collaborative arrangements at regional, ICS, place and neighbourhood level. Playing a full part in each ICS/STP is a particular challenge for these types of trust. It is therefore crucial that NHSE/I ensures a sufficiently permissive policy and legislative framework to allow for this variation and ensure the interests of all trusts are properly represented at ICS level. The artificial distinction of different segments of the provider sector collaborating at specific levels – such as the implication that acute hospitals have less of a role at place level or that community trusts have less of a role at system level – is very unhelpful.

Following the principle of subsidiarity as far as possible, providers should be empowered by the ICS (and NHSE/I) to run their affairs and design collaboration locally. NHSE/I, in partnership with local areas, could set certain outcomes and/or metrics that ICSs need to achieve, leaving local areas the autonomy to determine how best to achieve them. This could be a mixture of nationally and locally determined metrics. This applies to both primary and secondary care providers, with a focus on subsidiarity and devolution being essential for large scale primary care providers to deliver innovations that meet population needs and work together to take a leadership role at sub-ICS level.

e **Governance at ICS level must be proportionate, effective and accountable.** The current proposals for system governance are not clear and while local flexibility is desirable, a more detailed statement of the underlying principles would be welcome. While the paper refers to the benefits of retaining strong organisational governance, most of the supporting narrative is at risk of contradicting this, with suggestions that there will

be 'voting' rules, significant financial accountability and workforce responsibilities at ICS level for example. This is why we need a clear, well thought through, statement of how ICS and trust accountabilities align, and what assurance to non-NHS partners is needed.

A further key tenet of good governance is non-executive (and broader stakeholder) challenge at the point of decision making. At a trust level, this is provided by non-executive directors; foundation trusts also have strong local democratic accountability to their elected and appointed governors who are responsible for appointing the chair and other non-executive directors (NEDs). NHSE/I should recognise and aim to build on these governance structures and democratic accountabilities. The proposals in their current form, with NHS place and provider collaborative leaders, have no direct role for governors or NEDs. It is assumed that there is no intention to put in place governor election and NED appointment process at ICS level – this would be a significant increase in bureaucracy. It re-emphasises the point that the role of any ICS structure must be carefully defined so that it is not seen as a reduction in local accountability.

In addition, governance arrangements at place are not sufficiently clear or developed yet. Trusts will need to reflect on how they maintain their current organisational accountabilities while undertaking appropriate and proportionate accountability for work being done through collaboratives (NHS Providers, December 2020). It will also be important for provider boards to align to the system strategy and priorities.

f **High-quality system leadership is essential.** Senior leaders at ICS level must be credible to their colleagues within the footprint, appointed based on a fair, open and robust recruitment exercise, with a focus on the behaviours and skills needed to collaborate successfully. The NHS needs career development processes by which talent is equitably and transparently identified and developed, so that individuals with potential are encouraged to progress into system leadership roles. Such processes must ensure diversity and be inclusive. Nationally defined competencies for place leadership, including population health management, community resilience and experience of collaboration with PCNs/local authorities, would ensure the right people are placed in these roles.

Trust leaders support a **shared clinical leadership approach at neighbourhood, place and system level**. This must ensure leadership across clinical and professional groups, and across sectors including mental health and learning disabilities. It would be helpful to understand which clinical forums NHSE/I envisage influencing and informing the ICS and place leadership forums. Clinicians in providers will play a key role in informing strategic planning and decision making, such as prioritisation of treatment. Some trust leaders are concerned about the clinical leadership capacity in recently formed Primary Care Networks (PCNs) and want to ensure the clinical leadership in their organisations, as well as in primary care, plays an important role in leading and co-leading service improvements at system and place levels.

g **The developing role of the ICS must be compensated by a corresponding change in the role of the NHSE/I regional tier.** The roles of NHSE/I and the ICS need to be carefully defined to ensure that ICSs do not become

an SHA-like tier of performance management. The fundamental aim must be to avoid increased bureaucracy and a duplicative tier of governance or performance management. While NHSE/I regional teams could keep some functions (e.g. some specialised commissioning, medical revalidation, leadership development, communications and emergency planning), other functions could be devolved to ICSs/providers along with the necessary resources. Trust leaders support NHSE/I developing new models of oversight to hold systems to account for the collective performance of their constituent organisations, but clear accountabilities and assessments of individual organisations must be maintained. A new system oversight framework should provide clarity over who is being held accountable for decisions made at different levels of the system and avoid duplicative and conflicting judgements.

h **More clarity is needed around the proposals for provider collaboratives, which need to be flexible and permissive rather than constraining and prescriptive.** Trust leaders are enthusiastic about the potential that provider collaboration opens up, particularly as there seems to be an immediate opportunity to manage recovery from COVID-19 across a system. We welcome the fact that trust boards will remain responsible for quality, funding and activity.

But there is an important distinction to be made between providers collaborating together and formalised provider collaboratives, with trust leaders supporting greater emphasis on the former. All trusts are currently part of a range of different collaborative arrangements. These cover a wide array of different purposes, geographic footprints and sets of partners, reflecting clinical, patient and service need. Trust leaders would be very concerned if the proposed approach shoe-horned all collaborative activity, for example, into a single provider collaborative that had to be based on an ICS footprint.

How provider collaboration is designed and how collaborative arrangements interface with the ICS structure therefore needs to be permissive, with some larger providers delivering services on behalf of other system partners or aiming to become sub-regional providers where it makes sense for local populations and services. The challenge for NHSE/I will be accommodating and optimising place-based leadership and at scale provider collaboration without introducing further fragmentation or layers. While the minimum standards for provider collaboratives at ICS level and place-based partnerships could be helpful to support providers to make progress, NHSE/I will need to continue to account for the wide range of models already in operation and under development, as well as different population and service needs.

The proposals also throw up some key questions. These include concerns that the proposals are acute-focused and insufficiently clear about the role of other providers, including community service providers, primary care (including general practices, independent contractors and first contact providers) and non-NHS providers. The role of mental health trusts spans specialist, community and primary provision, and cannot sometimes be constrained simply to either place or ICS-level.

The specific position of primary care as a core provider and key partner at place and ICS level needs to be clearer in NHSE/I's proposals, with due consideration to the different capacity for risk management and financial contributions across the primary and secondary care sectors. There are concerns from primary and secondary care providers that the proposals in their current form do not provide for a strong primary care voice at ICS or place level which will be essential if we are to tackle health inequalities and maximise the support primary care can offer to improve the quality and efficacy of a number of services. Given the diversity of the primary care sector, comprising PCNs and larger scale providers, local flexibility will be essential. Some ICSs/STPs are already developing Primary Care Boards or other governance structures to represent the primary care sector at different levels of population.

The proposals also seem to imply the that the structural reforms focus primarily on the reorganisation of CCG functions and NHSE/I regional teams, with changes to the provider landscape (at least for now) catered for via different ways of working. It would be helpful for NHSE/I to clarify certain aspects of these proposals for providers. For example, the reference to 'voting arrangements on the ICS board' for place and provider collaborative leads suggests that there is no place for individual providers at the ICS decision making table. This, coupled with the potential removal of organisational veto at ICS level, represents a significant shift for our members. Does this mean that smaller organisations, such as the voluntary sector or hospices, could have an equal say on the board as a provider collaborative? Moreover, if provider collaboratives at place/ICS level are managing budgets, does this mean they will have statutory accountabilities? Some trust leaders are concerned that this risks replicating previous CCG fragmentation if community health, primary care and potentially local acute services are commissioned at place level.

Q2. Do you agree that option 2 offers a model that provides greater incentive for collaboration alongside clarity of accountability across systems, to Parliament and most importantly, to patients?

15 As set out in the response to Q1, trust leaders have a broad range of views about whether and how to put ICSs on a statutory footing. If NHSE/I and the government decide to pursue either options 1 or 2, then the proposals must satisfy the principles set out on page 5. NHSE/I must also clarify certain policy proposals before deciding on a legislative option. For example, it is crucial that strategic commissioning is defined and tactical commissioning functions, alongside adequate resources, transferred to providers/collaboratives before any new ICS statutory body is established, otherwise the operational model will be sub-optimal.

16 The tables below set out some pros and cons of both options, to add to NHSE/I's thinking.

Option 1: mandatory, statutory joint committee/partnership board at ICS level	
Pros	Cons
Closer to the voluntary joint committee model developed by NHSE/I in 2019, which was supported by the health and care sector	Mandatory, not voluntary, joint committees/partnership board so risk losing important spirit of coalitions of the willing

Brings together providers and commissioners to make binding decisions	Complex governance structures, especially if ICSs will be further amalgamated into bigger footprints
Lighter legislative changes will cause less disruption for the sector and build on current ways of working	Insufficient scrutiny and independent oversight of decisions as non-executive challenge still missing and public accountability unclear
Retains existing accountability structures which work well	Formalises ICS without giving clarity to how accountabilities would work (e.g. what would happen if a trust board disagrees with a decision taken by the joint committee?)
More inclusive of wider system partners e.g. local authorities, voluntary sector	Risk of unwieldy partnership board which is not agile enough to take decisions quickly (particularly problematic if ICSs will increase in size in future)
	Possible overlap with role of Health and Wellbeing Boards

Option 2: statutory ICS body, subsuming CCG functions	
Pros	Cons
'Neater' structure bringing CCG into ICS and better enabling strategic commissioning	Key partners like local authorities will become disengaged if the ICS focuses on NHS commissioning, finance and provision decisions
Flexibility to add additional members to ICS board e.g. NEDs, other partners	Risk that adding as many members as wanted would make more of a partnership board rather than dynamic decision-making board
If providers are on the board, this could guard against the risk of ICSs becoming extensions of NHSE/I and effectively new SHAs	ICSs need to remain accountable to their members and local population, not NHSE/I
ICSs fully liable and accountable for decisions their directors make. This will involve removing power from others or distributing powers differently across a greater number of partners	Giving the ICS the primary duty to secure effective provision of health services to meet the needs of the local population, delegating responsibilities to providers/provider collaboratives where necessary, seems to give a set of wide-ranging powers to ICSs in a similar vein to that of SHAs. It is unclear how these powers would fit with trusts' accountabilities.
	Wide-ranging impacts on current statutory duties and accountabilities
	Non-executive challenge is missing and public accountability is unclear

	Organisational veto removed, with possible implications for trust/FT statutory duties such as duplication and overlap
	Risk that streamlined approach thwarts ambition to tackle wider determinants of health

17 As NHSE/I prefers option 2, we have set out the areas that warrant further exploration with the provider sector:

a **Purpose:** The current proposals describe potentially incompatible roles for ICSs across population health and health inequalities, and formal NHS commissioning, financial and performance management (see paragraph 10). The latter puts the ICS into a very different relationship with the other organisations in its footprint. For those trust leaders concerned about this incompatibility, the ICS must remain focused on empowering providers across secondary and primary care and social care, to work together to drive strategy, deliver change and improve patient care.

b **Accountability:** As set out in paragraph 14.c, there needs to be careful thought given to defining how ICS powers and responsibilities sit alongside trust accountabilities without overlap or duplication (including financial governance and management of clinical and financial risks). ICS accountability is insufficiently clear in both NHSE/I's legislative options, which do not explain how ICSs are held accountable and by whom. For many trust leaders, the ICS must remain a sum of its parts, with primary accountability outwards to the local population and its constituent organisations, rather than upwards to NHSE/I.

It is not clear in either option how independent scrutiny and public accountability – which is currently in place through non-executive directors on unitary trust boards and NHS foundation trust governors and members – will work in ICSs. If CCGs are subsumed into the ICS, and their lay representatives abolished, NHSE/I should commit in principle to working with appropriate bodies (CCGs, providers, local authorities, Healthwatch etc) to establish a distinct mechanism of public accountability and engagement at ICS/place level. This is critical as public/lay involvement is crucial when delivering public services, particularly when consulting on major service change. Some systems are exploring creating a People's Board at ICS level, while others are focusing on place as a meaningful footprint for local people to engage in service provision. NHSE/I could help share existing good practice so that ICSs/places/provider collaboratives avoid reinventing the wheel.

c **Oversight and regulation:** NHSE/I describes an increased role for ICSs in supporting improvement among their component organisations, which is an important step towards recognising the mutuality inherent in quality and performance across a patch. However, moving towards a model of self-assurance and collective accountability marks a radical cultural shift for the NHS, and risks either being seen as ICSs 'marking their own homework' or as the creation of an additional tier of performance management and control at odds with the

other aspirations of the ICS to drive improvements in population health outcomes and reduce health inequalities. NHSE/I implies that having providers around the table at the ICS board will mitigate this risk.

They further imply that proposals for an intensive recovery support programme will provide a helpful framework for identifying the roles each different tier (ICS, regional and national teams) will play in monitoring and improving performance. But this warrants further investigation and scenario testing. There will need to be careful consideration as to how all system partners will be brought into scope to enable a full picture of performance within a system, and a clear mechanism for 'collective accountability' and assurance to non-NHS partners such as the local authorities involved. If ICSs take on more of the responsibility to monitor the performance of their component organisations, NHSE/I would need to consider how their national and regional role in oversight could be streamlined, and closely aligned with the work ICSs were doing to support providers locally with their performance.

d **Commissioning:** Some trust leaders have similar concerns about the proposals around the ICS becoming the strategic commissioner (option 2). It remains unclear how the ICS and its performance management functions will interface with commissioning functions if providers sit around the decision-making table. Trust leaders also wonder how this will support joint commissioning across the NHS and local authorities, which is particularly important for community and mental health trusts, and how primary care will inform commissioning at ICS level. NHSE/I must ensure that changes to commissioning do not result in unwarranted variation.

e **Leadership, skills and expertise:** Strategic planning at ICS level and system-wide improvement will require a significantly different skillset, leadership style and level of expertise than have currently been developed in CCGs and regional NHSE/I teams. There needs to be proper consideration of the role and skills required, and an open, transparent and robust recruitment process, which protects diversity and inclusion. This will ensure the right teams are in place in ICSs. There also needs to be sufficient leadership capacity at trust board level to engage in the myriad collaborative arrangements that the paper alludes to, which is a particular challenge for trusts working across several ICSs/STPs, for example ambulance trusts and large mental health trusts.

f **Good governance:** Many trust leaders believe that the ICS must continue to be owned by its constituent organisations, if it is going to achieve its goals around health inequalities and transformation. This could be supported by the ICS having a legal duty to stand for its 'owners', which could potentially be a system partnership forum and some form of local public accountability mechanism. NHSE/I must clarify whether the ICS is a decision-making board, which would necessitate fewer members, or a representative partnership forum. In addition, governors in NHS foundation trusts must approve significant service changes and are the responsible authority for appointing directors, so NHSE/I needs to consider their role properly. If the ICS appoints directors, then the purpose of an NHS foundation trust governing body risks being lost – it would be helpful for NHSE/I to clarify publicly that this is not their intention and set parameters for governors' role in the context of increasing system accountability. We understand that NHSE/I is reviewing guidance for NEDs

and governors in light of the context of system working – we hope to engage in detail on these documents and welcome this detailed focus on the implications of the current proposals.

g **Local authority involvement:** The paper is unclear about the membership and role of local authorities in ICSs, which is troubling given their full participation is essential to achieving improved population health. This question comes back to our core query about whether the purpose of the ICS is to genuinely transform health and care in local systems or to act as 'internal NHS performance manager and funding distributor'. Depending on what purpose, and legal form ICSs take, the relationship between the NHS and local government will be significantly impacted. Making the ICS a legal entity, NHS body and successor to the CCG will firmly position the ICS as an NHS construct; some trust leaders are concerned that this could negatively impact existing partnerships between the NHS and local government, and risk losing the engagement of councils if ICSs are seen to be an internally focussed NHS entity, or an endeavour which moves away from the spirit of true partnership working.

Local authorities are concerned that the proposals represent a tight NHS framework which will "bypass or replace" existing collaborative arrangements (Local Government Association, December 2020). While local authorities would be represented on ICS boards in both options proposed by NHSE/I, some trust leaders report that their local authorities are extremely concerned about option 2 and prefer a statutory joint committee model. If ICSs are going to make the shift to addressing the wider determinants of health and tackling health inequalities, they need to be true partnerships that go beyond local government having a seat at the table to embracing wider partnerships with the housing sector, police and other public services.

NHSE/I needs to set out what mechanism, governance and accountability framework will support partnership working, including with other public and voluntary services, to support these aims. It would also be helpful for NHSE/I to set out what being a member of the ICS means for broader partners, including the role of voluntary, third and independent sector organisations, and how the proposals impact the statutory role of Health and Wellbeing Boards. Finally, will local authority members on ICS boards have voting rights regarding decisions about allocating NHS resources, or is their role focused on informing and influencing plans?

h **Reducing bureaucracy and complexity:** While we applaud the aspiration to reduce bureaucracy, the proposals could be read as reducing commissioning and regulatory burdens, only to replace them with system working requirements. This is an issue for trusts delivering services that span multiple ICSs/STPs, or providers which will need to invest in management and leadership time to lead, or support, large scale, complex collaboratives on different services at different levels of population. It is also an issue in 'simpler' systems where an ICS bureaucracy coordinating only one or two trusts seems like an unnecessary additional layer.

The development of ICS governance structures must not stifle the innovation seen during the COVID-19 pandemic, which showed that ICSs as a strategic planning layer worked well. There is also a risk that the provider collaborative proposals become confused, as they add to the system architecture which is already

crowded with providers, PCNs, neighbourhoods, places, ICSs, collaboratives at ICS or pan-ICS level and NHSE/I regions. In formalising system working, there must be greater clarity as to how partners and the regulator will be assured that robust governance arrangements are properly introduced.

There also seems to be a mismatch between the time and delegation expected to be spent on system working, and the ultimate responsibility that lies with providers. Trust boards are expected to manage a wide range of relationships, with potential additional responsibilities for provider collaboratives at ICS/place level and no clear indication of where the extra leadership capacity will come from. While being represented on every ICS/place/provider collaborative board can be impractical for some trusts, not being represented also creates challenges. It is unclear what takes primacy between, for example, the place-based partnership or the ICS provider collaborative. It also raises the question of the risks inherent in the safe and successful management of a trust if the board becomes overstretched when servicing several different accountability mechanisms, and how these can be mitigated. System meetings need to be focused and meaningful, with assurance left at trust board and board sub-committee level without ICS intervention unless there are real issues.

Q3. 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?

18 Trust leaders are broadly supportive of some national 'guidelines' – either minimum standards or principles – to guide how ICSs are led, directed and controlled. ICSs and their constituent organisations should then have flexibility to shape their own governance arrangements and determine appropriate membership to best suit local population needs within this structure. These principles of good governance could include:

- a reasonably sized board if intended as a decision-making body rather than a partnership forum;
- non-executive involvement at the point of decision-making to ensure robust challenge;
- accountability lying with decision makers;
- the need for diversity among board members;
- clarity on the expected leadership behaviours; and
- weight given to robust and diverse patient/service user/citizen voices.

ICSs must have the maximum flexibility within these 'guidelines' to develop appropriate arrangements for their local circumstances, including the infrastructure that supports governance, such as terms of reference and committee structures, as long as they abide by the same overarching accountabilities. Flexibility is essential as there are other variable factors, including relationships and the quality of Health and Wellbeing Boards.

19 In principle, trusts would expect to be appropriately involved in the affairs and decisions of the ICS footprint(s) they are in – whether mandatory or voluntary – but this question once again boils down to the question of the purpose of the ICS. If the ICS exists to bring together health and care partners across a particular

geography, then mandating participation risks eroding the spirit of the movement, stymieing progress and contradicting NHSE/I's intention to produce a permissive framework. The phrase 'mandatory participation' needs to be clarified as it is unclear what this means in practice. In addition, the paper alludes to trusts' involvement in provider collaboratives being mandatory, but NHSE/I must be explicit what they mean by this. They also need to be clear about access to capital or improvement support resources to ensure that providers are incentivised and supported to make progress quickly and with the necessary resources.

20 Similarly, the answer to the question of local authorities' 'mandatory participation' is contingent on the purpose of the ICS being clear. If the ICS (under option 2) moves away from its original purpose and becomes an NHS strategic planning forum with NHS performance management and funding accountabilities, then it is unclear why local authorities would be mandated to participate. It remains unclear what mechanisms NHSE/I envisage to encourage local authority involvement in ICSs. In some areas, their involvement is still marginal, even if developing joint commissioning arrangements. Given it is hard to see how mandatory participation of local authorities could be achieved without primary legislation for local government (which seems unlikely), the design of any national minimum standards needs to be flexible to enable each ICS to work out their own arrangements reflecting local nuances, sensitivities and priorities. Partnership between the NHS and local authorities in a statutory body requires a reconciliation of two different governance models, and it would be helpful for NHSE/I to explain how this will be reconciled. The council is a separate legal entity with its own democratic accountability. To try to impose fundamental changes on these bodies which have their own developed governance structures does not feel appropriate.

21 It would be helpful for NHSE/I to clarify the expectations on ICSs around citizen involvement and public accountability. The current proposal is for this to take place at ICS level, given strategic planning will take place on this wider footprint, but there is a general consensus that place footprints would be more appropriate and meaningful to individuals wanting to improve their local health services. Foundation trusts have their own citizen involvement through their extensive membership and elected governors, who appoint chairs and NEDs. While Healthwatch and citizen's panels provide some helpful engagement, trust leaders feel these are insufficient on their own and the NHS could build on the existing foundation trust experience and learn more from local government about how to engage with its local communities. An enabling national framework and phased approach for these proposals would help ICSs/places engage with local communities and ensure their views are heard at the right levels. Trust leaders frequently flagged the importance of further developing proposals for public and patient involvement at the system level.

Q4. 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?

22 Trust leaders support the overall direction of travel for commissioning, with strategic planning conducted at ICS level, some of the operational commissioning activity (e.g. pathway redesign, service transformation)

taken on by providers/provider collaboratives/place-based partnerships, and a shift from transactional contracting to population health analytics and outcomes measurements.

23 Trust leaders understand the rationale behind NHSE/I's proposed incremental approach to delegating or transferring some specialised commissioning to ICS or multi-ICS level. The *Integrating Care* paper sets out some helpful principles, but trusts agree this is a very complex issue which needs to be carefully thought through with the provider sector and service by service. It would be prudent for NHSE/I to set out what they are hoping to achieve before making changes to how specialised services are commissioned and delivered. It seems logical for NHSE to retain accountability until any new arrangements are embedded, and we would encourage a managed transition with clear milestones. Any subsequent changes to the financial framework should be appropriately paced, avoid introducing unnecessary complexity or risk, and serve the best interests of patients and service users. There is much to learn from the achievements and experience of mental health specialised commissioning in terms of improving care quality and efficiency. There is also considerable learning with regard to the 'plumbing and wiring' including, for example, the need to ensure baseline assessments of patient numbers and subsequent budgets were accurate.

24 One of the key questions for discussion with the provider sector is the issue of geographic footprints. While some specialised services could be commissioned at ICS level, there is widespread agreement that some will still need to be commissioned regionally (or at 'multi ICS' level as the paper describes) and some nationally. It also depends on the geography, patient population and size of the footprint covered by the ICS itself as devolving complex specialised services to an ICS responsible for a smaller population would not be efficient or appropriate. Specialised commissioning must operate over a footprint which is appropriate to the prevalence of the relevant condition, capacity across services and existing patient flows, so it is unlikely that all specialised services should be transferred or delegated to ICSs. Some trust leaders are concerned that ICSs are not a big enough footprint to manage the financial volatility and risk that comes with much specialised commissioning, so NHSE should underwrite this while arrangements are established. NHSE/I should set out a process for making decisions about which specialised services will be planned at which level, taking into account the views of providers and their patient populations.

25 While some trust leaders are supportive of the idea of ICS-level specialised commissioning, there is a concern that this would create conflict, with ICSs having to choose between specific treatments for their own population and a specialised service for a larger population extending beyond their boundaries. This disincentive to invest in specialised services beyond their footprint risks damaging the overall national ability to provide high-quality services, reduce variation and lead innovation. Multi-ICS level commissioning may help address this issue, but it also remains unclear what this might look like in practice, as the paper refers to the majority of specialised commissioning budgets sitting at ICS level, but then implies commissioning, decision-making and accountability may sit at multi-ICS level. It is also unclear what roles and responsibilities providers (or provider collaboratives) would have in the event of ICS or multi-ICS level commissioning. The phrase 'appropriate safeguards' needs further clarification.

26 Some trust leaders would like to see specialised commissioning being delegated to provider collaboratives, in a similar vein to those already transferred or delegated to mental health provider collaboratives. It would be helpful for NHSE/I to define what they mean by 'commissioning' and set out which functions will continue to take place nationally, which functions may be delegated to ICSs/provider collaboratives, and who will hold the budget and be accountable. The experience of mental health provider collaboratives has shown that devolving specialised commissioning responsibilities cannot be expected to improve patient outcomes and experience, and service effectiveness and efficiency, if longstanding underfunding issues are not addressed first. If NHSE is to transfer or delegate more commissioning responsibilities to ICSs and/or provider collaboratives, realistic expectations must be agreed and adequate resources to deliver these services and build the commissioning infrastructure and expertise required must follow. Expertise in specialised commissioning is difficult to maintain and usually resides in NHSE regional structures, so there could be issues with splitting up this resource for ICSs and ultimately lead to cost pressure and skills gap. It would be helpful for NHSE/I to confirm that functions already transferred or delegated to provider collaboratives will maintain current arrangements.

27 Given that primary care commissioning is largely delegated to CCGs, trust leaders did not raise concerns about ICSs managing this budget as part of the wider NHS budget. However, this presupposes a substantial tier at ICS level and, from a primary care perspective, raises the importance of aligning accountability for improved population health outcomes with financial accountability.

Policy issues which warrant further consideration

28 NHSE/I's policy and legislative proposals add up to significant changes for the health and care system. While it is not possible to describe the detail of the health and care system in one policy document, the paper raises more questions than it answers about how these changes will operate in practice, and the following topics will need addressing over time with input from the provider sector and others involved in front line service delivery. As ever, we are happy to support engagement with the sector and to work with NHSE/I to ensure a solution-focused approach:

a Size and scale: The paper does not fully resolve the question of how big ICSs will ultimately be, with an opaque reference to potential amalgamations of smaller systems into larger ones in future. There is a tension here between achieving the benefits of working at scale and ensuring geographies make sense to local organisations/populations and patient flows. While some trust leaders see the benefits of joining up their ICS with a neighbouring local system, others are concerned that this would undo progress. The merits/diseconomies of scale need fuller and more specific consideration, with some trust leaders concerned about the trend to view mergers as the 'solution' to transformation.

b Voluntary and wider public sector and citizens: The voice of service users, patients and lay members is largely absent from this paper, as is the important role of the voluntary and independent sector. This is

particularly important given local authorities' democratic and public accountability to a broad population. If funding decisions are to be made "closest to communities", the proposals need to ensure patients and service users, and wider partners such as the voluntary sector, are involved in the design of services.

c Financial framework 2021/22: The NHS financial architecture is undergoing significant transformation, with planned shifts towards ICS budgets, allocation and capital planning. NHSE/I needs to set out clearly the current and future legal underpinning for how funds will flow to and within ICSs, with regard to trust boards' statutory responsibilities and robust financial governance required at system level. It remains unclear how resources could be devolved from the ICS to places/provider collaboratives and how accountabilities would follow. There need to be national and/or local safeguards to ensure fair allocation to different segments of the provider landscape (mental health, community, etc) and different priorities (e.g. moving care into the community, prevention). We are pleased to be fully engaged in this rapidly developing area of work.

d Quality and safety: It remains unclear how ICSs will scale up a system-wide approach to improvement, quality and safety, and how this will interact with trusts' statutory duties.

e Oversight and regulation: While there is a passing reference to the CQC inspection regime and NHSE/I's system oversight framework, it would be helpful to understand in the round how the regulatory landscape is also shifting to incorporate developments in system working.

f Workforce: There is very little detail on workforce in the document, and Health Education England (HEE) is conspicuous by its absence. Providers would like to see HEE resources and responsibilities delegated, but it is unclear how workforce planning by ICSs and/or provider collaboratives will interface without duplication. The health and care sector needs a workforce strategy with a clear line of sight to future recruitment and read across to system working.

g Provider collaboratives: Trusts would welcome clarity on the distinction (if any) between formal 'provider collaboratives' as referenced in the paper, and broader collaboration – and partnership working including mutual aid – between trusts and other providers. It is unclear whether the provider collaborative will run programmes commissioned by the ICS, or whether the collaborative will decide what work they will undertake. The proposals also present a risk of a tension between provider collaboratives at ICS and place level. While trust leaders see opportunities in these proposals, they do not want to lose sight of creating sustainable solutions at place level in terms of public health, prevention and population health management. This needs to involve strategic conversations with the wider public and independent sector. NHSE/I could articulate what the triple aim duty means for providers and how they will be expected to influence population health. Finally, there is a risk that effective pre-existing provider collaborative arrangements are unravelled if not supported to work across ICS/STP boundaries.

h Public health and health inequalities: Another conspicuous absence is the abolition of Public Health England and the potential transfer of local authority commissioned public/community health services back into the NHS or into ICSs. The government could helpfully set out how they envisage increasing public health and prevention budgets in the constrained fiscal environment to safeguard the implementation of public health initiatives and support collaboration/pooled budgets across the public sector.

- **Social care:** The proposals do not seek to tackle the longstanding challenges associated with joining up health and social care services. While this is understandable from NHSE/I's perspective, and there is a need for government to step up with proposals to place the social care system on a sustainable footing, it does mean there will be an ongoing disconnect between the approach of the NHS and local authority partners, given the differences in national/local decision making and funding flows.

Sector-specific considerations

29 It is crucial that NHSE/I ensure that all parts of the provider sector – acute, community, mental health, specialised and ambulance, and colleagues in primary and social care – feel appropriately considered in the strategic aims and operating model of ICSs. Unfortunately, NHSE/I's approach to ICSs and provider collaboratives seems to be acute-focused, with other segments of the provider sector left wondering what these proposals mean for them, including the implications for their neighbourhood integration and pan-ICS or regional collaboratives. If NHSE/I intends to maintain trusts' accountabilities and functions, as they suggest, trusts should be generically described throughout the paper to avoid unintended consequences, such as erroneously excluding some segments of the provider sector from their key role in the system.

30 Community, mental health, specialised and ambulance trusts often work across several ICSs and in a myriad of collaborative arrangements at regional, ICS, place and neighbourhood level. Working across several ICSs and playing a full part in all of them is a particular challenge for these trust types. It is therefore crucial that NHSE/I ensures a sufficiently permissive policy and legislative framework to allow for this variation and ensure their interests are properly represented at ICS level. Given this complexity, the definition of provider collaboratives and the different models under consideration could be clearer.

31 If community, primary, non-specialised mental health and social care services are potentially delivered at place, they must be properly connected into the secondary care pathway to ensure there is no inequality of access and avoid any new fragmentation of provision. The artificial distinction from acute, specialised physical and mental health, and ambulance services at ICS or pan-ICS level is unhelpful. The reality on the ground is a continuum, with district general hospitals playing a key role in place-based working and ambulance and mental health trusts involved at both regional and neighbourhood level. NHSE/I also needs to take account of the different contributions which differently sized primary care providers can make at different levels of scale within a system.

Community providers

32 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

collection of smaller providers delivering a myriad of services. NHSE/I'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. Large-scale community providers also play a key role as a strategic employer and maintaining the sustainability of smaller community services (both physical and mental health) in a way that smaller footprints such as PCNs could not.

Community health services do not seem sufficiently prominent in the proposals despite the NHS Long Term Plan strategic aim to move care closer to home and increasingly shift resources into the community. This omission overlooks the key role community health services play in population health management. NHSE/I 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. If community and mental health and learning disability trusts become shoe-horned into operating at place-level only, this could minimise the impact of high performing trusts that span multiple places and systems. NHSE/I will need to protect the important leadership role they play at system level and ensure parity of esteem across mental and physical health, and care in the community and in hospital. Otherwise the strategic aims of improving population health outcomes and tackling health inequalities will never come to fruition.

33 Following the dissolution of Public Health England and years of local authority funding cuts which have chipped away at community services contracts, there should be a robust debate about whether now is the time to bring the clinical end of local authority commissioned public health services back into the NHS. This includes considering whether some health improvement functions should be devolved to ICSs.

Mental health trusts

34 An emphasis on mental health and learning disabilities at neighbourhood, place, ICS and pan-ICS level is a prerequisite of an effective health and care system. However, ICS policy development risks being too focused on acute physical health services. Parity of esteem and equity at ICS level is critical for mental health services, who still report a mixed experience of engaging with their ICS/STP. This may in part reflect the lack of ownership of mental health in some areas as a whole system issue, not simply that of the mental health trust.

35 Mental health trusts welcome the continued commitment to provide national level oversight of dedicated funding streams and commissioning intentions, which will be important as the NHS moves to 'system funding allocations'. Parity of esteem for mental health still needs to be achieved in terms of NHS funding and cannot be left behind in a CCG consolidation. It would be helpful for NHSE/I to clarify how existing sector-specific support structures fit in the proposed system architecture, such as Regional Mental Health Transformation Boards.

36 The split of functions across ICS-level provider collaboratives and place-based partnerships are not clear cut for mental health providers. While it may be true that most care will be delivered at place, specialised mental health and learning disability services need to be commissioned and delivered across pan-ICS footprints to ensure the optimum scale for delivering the best outcomes for service users. It is difficult for mental health trusts to reconcile this approach with the proposals for specialist commissioning moving to ICS level. The role of independent and third sector providers is particularly key for mental health services, and must be factored into the structures and functions of ICS/place collaborative arrangements. There is an opportunity to better integrate mental and physical healthcare at place level, working closely with PCNs.

37 Mental health trusts have a significant role to play in ICSs/STPs, given their extensive experience in partnership arrangements and expertise in supporting vulnerable people. It would be unfortunate, and a potential unintended consequence of these proposals, if we were to see the beneficial impact of the work of many mental health trusts lost due to changes in, and a narrowing of, their focus or insufficient representation at ICS board level. This includes deep expertise on how financial flows should be handled in local areas. Mental health trusts have significant experience in developing provider collaboratives and pushing at the boundaries of contemporary models of mental health and care services, which need to be maintained as ICSs evolve.

38 Many trusts are combined mental health and community organisations, which means that the impact of NHSE/I's proposals is exacerbated and needs to be carefully handled. Community and mental health providers are skilled at population health, collaboration with PCNs/local authorities/voluntary and independent sectors. These skills mean they are well suited to supporting and/or providing place leaders.

Ambulance services

39 NHS ambulance trusts currently operate on a regional footprint, while being commissioned by a lead commissioner on behalf of several CCGs. Given the changes to commissioning structures, with CCGs consolidating to match ICS footprints and potentially being subsumed by the ICS (option 2), this raises the question of how ambulance services will be commissioned in future. While ambulance trusts support the direction of travel of strategic commissioning at ICS level, it makes sense for ambulance services to be commissioned at regional level as they operate across multiple ICSs/STPs. It would be incredibly challenging, bureaucratic and burdensome for ICSs to be commissioned differently by several ICS footprints. The preferred model would be regional strategic commissioning (rather than a lead ICS commissioner model) with representatives from each relevant ICS and relevant NHSE/I regional team to ensure equal responsibility for planning, funding and decision making across the regional footprint. This would leverage the sector's capability to integrate urgent and emergency care services, whist enabling clear oversight and accountability.

40 NHS ambulance trusts are well-positioned to co-ordinate the delivery of integrated 999, 111 and out of hours services on a regional scale. This does not preclude collaboration with ICSs – indeed many ambulance trusts are realigning their divisions with ICS footprints. An integrated regional approach to commissioning 999, 111 and out of hours services would be welcome, as this would bring economies of scale, greater efficiency and

effectiveness, and quality improvements. It would also secure the sustainability of specialist teams as supply and capacity is already outstripped by demand. Ambulance trust leaders are concerned that a delivery model based on one ambulance trust per ICS might be pursued in future, reversing the necessary consolidation that has occurred over the last few years. So it would be helpful for NHSE/I to clarify that ambulance services will remain on their current geographic footprint, unless they themselves choose to consolidate further, or be commissioned at a regional level.

41 Ambulance trusts are keen to engage within and across ICSs through their involvement in place-based partnerships, neighbourhood integration and regional provider collaboratives. However, this requirement on ambulance trusts to work strategically at scale and locally at place/neighbourhood level is demanding on their boards' time, and NHSE/I will need to ensure their voice at ICS level is not diluted due to competing demands. There must be realistic expectations on how ambulance trusts can engage with ICSs effectively.

42 The Association of Ambulance Chief Executives has set out some key principles, which NHS Providers endorses, including introducing a single regional specification for integrated 999 and 111 provision, longer-term contracts and ways of facilitating ambulance trusts' involvement in ICSs/STPs. Ambulance services have knowledge and experience of identifying best practice and implementing transformation at scale, which ICSs could learn from.

Conclusion

While trust leaders support the concepts underpinning NHSE/I's proposals, and the shift towards collaboration and system working and away from competition, the *Integrating Care* paper leaves some significant unanswered questions about the 'plumbing and wiring' intended to support ICSs that need to be worked through and co-developed with the sector in much greater detail. We have raised these unanswered questions throughout our response, but in summary, the key ones include:

- What is the agreed, shared purpose of the ICS? If ICSs increasingly take on a performance management role, how does that impact their wider aims around system transformation, population health and health inequalities? How will delivering high quality care be central to the organising principles of the ICS?
- What are the respective roles of the NHSE/I national team, regional team and the ICS? NHSE/I's paper describes a 'thinned down' regional structure but does not go into detail of what functions will be transferred to ICSs.
- Are the proposals in the paper sufficiently permissive and enabling for ICSs/STPs to decide, design and deliver the right system-wide approach to meet their local population needs?
- Is NHSE/I seeking to be too prescriptive and hence describing too complex a model across providers, provider collaboratives, neighbourhoods, places, PCNs, ICSs and NHSE/I regions?
- How will local authorities, PCNs and larger scale primary care providers, and independent and voluntary sector providers contribute to ICS and place-based partnerships?

- How will NHSE/I devolve funding and resources in 2021/22 and beyond to support ICSs/STPs to deliver these significant changes?
- How do the ICS purpose, governance infrastructure and responsibilities, liabilities and accountabilities of system leadership align with those of the boards and councils of governors of NHS foundation trusts and boards of NHS trusts? This is particularly relevant given that under option 2, NHSE/I proposes removing the organisational veto.
- What does it mean in practice for individual organisations to take collective system-wide responsibility for financial and operational performance of their partner organisations?
- What is the role of, and means of engagement with, local government in the ICS, if the ICS becomes a statutory NHS body with commissioning responsibilities and NHS financial and performance accountabilities (option 2)?
- Has the impact – both immediate and far-reaching – on specific segments of the provider sector, and the potential to undermine current positive contributions and benefits, been considered?
- Will the proposals reduce bureaucracy, thereby speeding up decision making and reducing overheads?
- Has NHSE/I considered how best to support local system partners to develop the collaborative relationships required to deliver change of this nature?

Finally, but importantly, given the operational pressures facing the service at this unprecedented time, we must also be careful about the pace and scale of this ambition as we battle the current public health crisis and seek to recover services and support staff.

We look forward to working closely with NHSE/I to further develop these proposals – and with government and other stakeholders on potential legislative change.

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