

KEY QUESTIONS FOR THE FUTURE OF STPs AND ICSs

Introduction

This is the second in our series of briefings on sustainability and transformation partnerships (STPs) and follows a publication in February this year which set out the history of system working. This briefing summarises recent developments relevant to system working, sets out the state of play for STPs and integrated care systems (ICSs) and seeks to offer answers to a number of questions arising from the national policy focus on collaboration and integration.

Key points

- There is broad consensus that trusts and their partners need to work collaboratively to make best use of limited resources and to integrate care for patients. The forthcoming ten-year NHS plan creates a pivotal moment for the national bodies to engage the sector and provide clarity on the desired 'end state' for STPs and ICSs in order to achieve this.
- All trust boards are investing considerable time in collaborative working arrangements via STPs and ICSs. However we know that systems across the country are at different stages of their journey. We need to recognise those differences and ensure that every system has access to appropriate support.
- The national bodies, and partners within local systems, must maintain clarity about what can, and cannot, be delivered within the existing legislative, regulatory and governance frameworks. Although systems that are progressing well will, rightly, welcome additional autonomy we must ensure that those local systems willing to pioneer new ways of working are not expected to take on undue levels of risk.
- Based on our conversations with trusts we know that success is usually based on sound and trusting relationships between a 'system' leadership team which has the capacity to work together. Within this, full engagement with local authorities and primary care remains of central importance.
- Despite considerable diversity in the approaches of individual ICSs and STPs, a series of helpful characteristics are emerging in successful systems including:
 - agreeing a system-level vision, strategy and plan, underpinned by a culture where system-level working is the norm and sits comfortably with an institutional focus
 - the emergence of new governance and commissioning structures which support a population health management approach
 - developing new, integrated care models for smaller population units
 - embracing public engagement and seeking to establish a means of constructive challenge to system plans via trust non-executive directors, CCG lay members, councillors
 - beginning to move towards a single health and care leadership team in a local system and considering how to manage budgets and performance at a system level.

The context for collaboration

Political and financial

The NHS has been centre stage in national politics in recent months as it celebrated its 70th birthday. In June, the Health Select Committee published a helpful report (Parliament, 2018) on its inquiry, *Integrated care: Organisations, partnerships and systems*. The report emphasised the core benefits of integrated care at the frontline and reflected a number of our concerns, including a need for greater clarity from government and the national bodies about the 'end state' for STPs, and an improved focus on communicating the benefits of integration to the public. You can view our written submission (NHS Providers, 2018) on our website.

In July, the prime minister's long awaited announcement (Gov.UK, 2018) on funding confirmed a new ten-year plan for the service, to be followed by a new NHS assembly of stakeholders, a five-year delivery plan, and an average of 3.4% real terms funding growth for five years – or £20.5bn additional revenue for the sector. The additional funding provides welcome and much needed recognition from the government of the need for investment in frontline care. However, our analysis (NHS Providers, 2018) shows that much of the investment, which is only applied to the mandate funding provided to NHS England and therefore excludes education, training and public health, will largely be absorbed in rectifying existing gaps in performance, leaving little to invest in transformation.

A subsequent and important political change for the NHS has been to welcome Matt Hancock to the role of secretary of state, following Jeremy Hunt's promotion to foreign secretary. The secretary of state's immediate priorities across health and social care – workforce, technology and prevention – do not suggest of a lessening of the focus on collaborative working, or the STP/ICS mechanism specifically.

Legal and regulatory

Wholesale change?

With parliamentary time tied up with Brexit, there remains no window for a substantial revamp of the Health and Social Care Act (2012), although we understand the government is minded to make minor amendments to legislation where it can. Our view is that although the existing legislative framework does not prevent collaboration between NHS and care bodies, we are so far away from the spirit and letter of the 2012 Act, particularly with regard to issues of governance, that a substantial review of legislation will be required.

Accountable care organisations (ACOs)

Two judicial reviews against the draft ACO contract were launched by campaign groups, one on the basis that the draft contract diverges from the 2012 Act's stipulations about the use of tariff and one highlighting a lack of public consultation and wider scrutiny of the ACO proposals. Both of the two judicial reviews brought against the draft ACO contract have now been heard and the court has found in favour of NHS England in both cases. NHS England is now consulting on the draft contract, under a rebrand as the integrated care partnership

(ICP) draft contract. We remain supportive of ICPs as one potential vehicle to integrate services. However many trusts will seek to achieve the same outcomes for patients via other partnerships and contractual models including alliance contracting and other prime/lead provider contracts.

Regulation and the resurgence of the regions

Meanwhile NHS Improvement and Care Quality Commission (CQC) continue to refine the existing regulatory frameworks to allow them to regulate organisational duties, and provide an assessment of system collaboration. CQC's outgoing chief executive, Sir David Behan, used his final months in office to provide a clear steer on the need for new powers (HSJ, 2018) to enable CQC to assess 'system' working routinely alongside the quality of care delivered by individual providers. CQC has been using special powers to resource its pilot work on system regulation to date. The results from our annual regulation survey (NHS Providers, 2018) endorse Sir David's views with 81% of respondents agreeing that NHS Improvement and NHS England need to develop new models of oversight to hold systems to account for collective performance.

NHS England and NHS Improvement recently announced (NHS Improvement, 2018) their intention to work much more collaboratively, underpinned by a series of joint board appointments and joint posts as well as the development of seven new joint regional offices. This is a significant decision in terms of the national architecture as it essentially symbolises the blurring of the commissioner/provider split at a national level. Trusts certainly welcome the prospect of more joined up messaging from these two key national bodies. However, we are also keen to understand how the new regional offices will relate to STPs, ICSs and local systems – as well as to organisations, notably trusts and CCGs – and to ensure that NHS Improvement's provider sector focus continues to influence and inform national policy making.

A sustained focus on collaborative working

Throughout this period of flux, the theme of collaborative working has remained consistent as the core mechanism for change in national policy making. Following the introduction of ICSs in the planning guidance (February 2018), in May 2018, NHS England confirmed four more ICSs had joined the national programme. We understand preparations are underway to develop support for future 'waves.'

In anticipation of a new engagement approach to develop the five and ten-year plans, Simon Stevens, chief executive, NHS England, has set out a number of priorities (cancer, cardiovascular disease, children's services [plus prevention and inequality as they affect children], and health inequalities) (HSJ, 2018) all of which rely on a collaborative approach to succeed. He has also been clear that he sees 'integration' and the next five year plan as a continuation and 'acceleration' of the original *Five year forward view*. We therefore expect a focus on collaborative working to remain central within the ten and five-year plans, building on the following features of national policy to date:

- continued support for the evolution of ICSs, with the expectation ICSs take on a greater degree of autonomy in agreement between local partners and NHS England and NHS Improvement in return for adopting a system performance management role
- using STP/ICS footprints as an “aggregating footprint” sitting between individual institutions and the national level which will develop an important relationship with the seven new regional NHS England and NHS Improvement offices
- increasing clarity about the roles and functions of STPs and ICSs with regard to leadership, planning, performance and resource management and care delivery versus their sub footprints i.e. sub systems within a wider ICS/STP footprint at the level of ‘place’ (say 250-50,000 population) and neighbourhoods (up to 50,000 population) playing a prominent role in the design and delivery of integrated care models
- increasingly seeking to establish STPs and ICSs by using these partnerships as a vehicle for policy delivery such as capital prioritisation and creation of IT and estates plans. The secretary of state recently confirmed that almost £500m funding for technology will be devolved via STPs for example.

Although STPs provide one vehicle among many for local partners to drive more integrated ways of working, we would be disappointed if the five and ten-year NHS plans failed to build on the investment trusts and their partners have made in system working via ICSs and STPs – or created yet another acronym! We will therefore be promoting the five and ten-year plans as a key opportunity to engage and work with trusts and their partners to build on progress to date, and to offer additional clarification around the role and functions of ICSs, STPs within the national system. We would also welcome greater acknowledgement of the role played by local or place based systems within an STP or ICS footprint, not least as this is the level of population where changes to the delivery of care, and vertical integration are most likely to take place.

The state of play for STPs and ICSs

Diversity of approach

One of the benefits of the national policy focus on system working is that it has allowed for the 'bottom up' development of local plans, particularly in those areas with a history of strong partnership working. There is also considerable diversity across the size of ICSs (in terms of geography and population) and perhaps unsurprisingly, the drivers for change are different in different STP/ICS areas. For example, two of the fourteen ICSs are pursuing a devolution approach; three STPs in the north east are collaborating and seeking to merge under shared leadership with a view to creating a strategic commissioning footprint at scale across a largely rural geography; in contrast smaller ICS footprints, such as Frimley, often focus largely on place-based vertical integration.

Importantly, most footprints, if not all, seem to be focusing on breaking down their STP/ICS wide 'umbrella' into smaller, place or neighbourhood based sub systems where the majority of frontline change to integrate care for patients takes place. However the 'boundaries' of these smaller footprints vary – either based on health and wellbeing boards, local authority boundaries or another sense of place based identity. Some footprints are also using horizontal integration at scale as a vehicle for change within the STP banner particularly where there is support, or a need for, CCG and/or provider consolidation. Equally, there are some systems where the local pressures are so great that it is difficult to see much progress in moving away from traditional, institutionally focused models of care.

While this degree of diversity of approach is not necessarily negative, it gives rise to interesting (and largely undebated) policy questions about how much diversity we wish to tolerate as a national system, and indeed which models will endure and stay the course.

Emerging, common characteristics of system working

Despite considerable diversity in the models, and the drivers for change, within different STPs and ICSs, some helpful, common characteristics are emerging in those systems which are making progress.

The role of the STP or ICS

For those involved in a more evolved ICS, the system infrastructure is a developing means to maximise collective resources in support of a more ambitious approach to population health management, prevention and integration, to support system performance management and to act as an interlocutor with the emerging NHS England/NHS Improvement regional structure. NHS England and The Kings Fund's (2018) work with the ICSs is proving helpful in codifying their approaches.

However many trusts, and partners, involved in STPs which are progressing more slowly seem to see the STP as a convener to corral a shared vision and priorities for the wider population

(but perhaps as little more). Increasingly, trusts within partnerships across the spectrum tell us that their partnership has moved away from the language of 'the STP' to a locally developed 'brand' which is more meaningful for the public and often for local authority colleagues.

The blurring of the commissioner/provider split

The commissioner/provider split requires a political decision (and parliamentary time) to reform. However, the recent, rapid consolidation of CCGs (either via mergers or through new collaborative arrangements to share executive teams) supports a move towards enabling CCGs to develop into a more strategic commissioning function. Work is also underway in a number of systems to consider what activities providers could take on from CCGs within new forms of ICP or integrated care organisation (ICO). Approaches range from collaborative approaches in which CCG and provider colleagues both share expertise to inform new service specifications to an increase in alliance contracts across local provider partners, to the development of more innovative open book and risk share arrangements between providers and CCGs.

Most of the existing financial framework still encourages a focus on individual organisational performance within a single year, however a reset is due to take place in time for 2019/20. We believe that the new framework must provide trusts with a realistic and achievable ask. In doing so it should directly support system working (and provide a route out of central control) for those areas ready to adopt this approach. This could involve more clarity on local variation and autonomy, and a clear definition of the roles and responsibilities of NHS Improvement, NHS England and the regional teams.

New and integrated care models

Different systems are trying different approaches to integrate care. However, drawing on the experience of the new care model vanguards, there is a growing and very interesting focus on the development of:

- primary care networks or community hubs and ICPs which focus on populations of circa 30-50,000 at a neighbourhood level
- ICPs and a smaller group of systems developing ICOs more likely to focus at the level of 'place' i.e. for populations of 250-50,000.

In each model, partners strive to:

- bring together primary care, community care, social care, community mental health services and 'acute hospital outreach services' (e.g. physiotherapy) into a single integrated service
- seek to use 'whole population health' management techniques
- often invest in a single care record which aims to combine GP, social care, acute, community provider and mental health community team patient records. This can act as a tool to risk stratify the population:
 - proactively supporting patients to manage their own health and wellbeing more effectively
 - identifying those most at risk of needing emergency care and seeking to avoid unnecessary hospital admissions

- create a single, integrated multi disciplinary team composed of a variety of different 'existing' healthcare professionals and often including 'new style' care co-ordinators or navigators. This team will:
 - seek to ensure patients receive a single joined up diagnosis covering physical and mental health and social wellbeing
 - provide a single service to meet these needs, integrating previously separate and disparate services from different organisations
 - join up the different elements of care for the patient, with a particular emphasis on ensuring the service is patient focused and minimises the number of interactions with different health and care professionals
 - act as the first and main point of contact / single point of access for as many care services as possible
 - act as a navigator of a range of services including third sector and socially prescribed services
 - work out how to make best use of existing NHS estate.

Governance

Our sense is that governance is rising up the agenda for all systems, including those which are most advanced and based on robust, constructive working relationships. Although it is clear that the current frameworks offer a number of approaches to pursue collaborative working (on a wide spectrum from merger to partnership arrangements), system governance requires a different approach to identifying and managing risk as boards seek to balance organisational level risks with those at the system level. Several trusts have commented that system governance arrangements are clunky and inefficient, or that they feel they have pushed the bounds of the existing legislation to its limit, and cannot progress with their vision further without some change.

Despite best efforts, integrating non-executive challenge into system governance arrangements is proving difficult. Although the most advanced systems have created reference groups for non-executive directors (NEDs), lay people and councillors, and some trusts have allocated a NED lead for the different place based systems within the STP footprint, we have not come across a robust example of an STP/ICS integrating the challenge and scrutiny function provided by NEDs within a provider board setting, at system levels. NEDs of course continue to play a central role in supporting and challenging decisions made by their trust board with regards to system plans. Another interesting characteristic is the increasing emergence of executive chairs or STP chairs, with some STPs making use of independent individuals to help facilitate agreement and direction.

What works?

Feedback from trusts suggests that the factors underpinning success appear to be:

- a 'comfortable' main footprint which matches a 'natural' footprint for the local system in which local system players are used to working, rather than an STP footprint which feels artificial – for example, too big or cuts across the key footprints that system players are used to working in
- good long standing relationships that often predate the establishment of STPs, or investment in relationship building to overcome tensions
- a senior leadership team committed to prioritising 'the system' alongside institutional working and which is not distracted by significant organisational challenges such as large financial deficits or performance issues which can prevent key partners having the capacity to contribute at the 'system table'
- appropriate investment of time and resource in system-level working, from individual institutional senior leaders, but also from a growing team working for and at the local system level.

Key features of advanced systems (at all population levels):

- a clear system vision, strategy and plan and a culture where system level working is the 'way we do things round here', which also sits comfortably with the required institutional level focus
- clarity, therefore, on exactly what will be done at system level and what at institutional level
- increasingly influential system level governance structures and approaches. In the most advanced systems we are beginning to see structures that:
 - oversee integrated commissioning across health and care
 - bring all relevant providers together in a single forum (with similar fora for other key partners)
 - involve trust non-executives, CCG lay members, councillors as far as possible and embrace public challenge and scrutiny
 - are beginning to move towards a single health and care leadership team in a local system (including embracing joint positions such as a single person acting as CCG accountable officer and council chief executive or director of social services).
- an increasing blurring between commissioning and provision with commissioning often becoming more strategic and more integrated with other commissioning in the footprint
- a move to trust boards' increasingly choosing to manage budgets at a system level, often involving moving beyond separately managed, CCG and provider finances towards a single system approach for particular services to make better use of the collective resource – and to maximise the level of sustainability funding available to the system as a whole
- rapid development of new, integrated, care models
- development of new organisational forms e.g. trusts creating joint ventures with GP federations, trusts owning GP practices, trusts becoming integrated care providers
- development of new, system level performance metrics.

Questions and (tentative) answers

It is encouraging that these common features are starting to emerge as they will help us to identify how to support STPs and ICSs to mature at pace. As the NHS gears up for a new and ambitious ten-year vision, underpinned by a five-year delivery plan, we have reached an inflection point politically and in terms of the development of system working. It would therefore be helpful to consider the following questions, in partnership with the national bodies and other stakeholders as we work out the future shape and role of STPs and ICSs.

What is the desired function of STPs?

We would welcome a more transparent debate about the desired 'end state' for STPs, and ICSs and the more granular processes of allocating responsibilities to STPs, individually and collectively particularly given their status as non statutory partnerships, resting on the voluntary commitment of their respective partners. We are concerned that at the moment the national bodies are delegating important functions like capital prioritisation and estates and IT planning to STPs without leading an open and transparent debate about the role and function of STPs and without checking the capability of individual STPs to fulfil those responsibilities. Many systems managing to engage with key stakeholders have adopted local branding for their partnership.

Is it accurate to describe all STPs as moving towards becoming ICSs or should the national bodies, and the sector, distinguish more precisely between the features of an STP and an ICS?

- The refreshed planning guidance set out an expectation that all STPs will develop to become ICSs that exercise greater local autonomy and are capable of taking on a wider range of responsibilities. But 49% of trusts in our recent financial planning survey agreed that ICSs should replace STPs. We fully support the existing, and aspirant, ICSs but we would also welcome more recognition from the centre that this direction of travel may not be workable for all STPs.
- STPs and ICSs also cover a range of population sizes ranging from several hundred thousand to around 3 million. We understand that the national bodies intend future ICSs to be mapped onto an existing STP footprint (rather than covering a sub system within a wider STP as a couple of the current ICSs do). However, the range in population sizes still raises interesting questions about which levels of 'system' working will adopt neighbourhood, 'place' or ICS responsibilities, as we have set out above. In some STP footprints the relevant CCGs, providers and local authorities are acting on the basis that the STP is unlikely to work, and placing their energies at the level of more local, place based system working on smaller footprints.
- We are pleased to be working with NHS England, NHS Improvement and partners including the Local Government Association, NHS Clinical Commissioners and the NHS Confederation to develop a joint offer of support for STPs, particularly those struggling to get off the ground. However, we would also welcome a conversation with the national

1 NHS Providers financial planning survey, February 2018

bodies about how best to support those STPs which will either never be sufficiently mature to become ICSs or will take a long time to get there. For example, should challenged STPs be supported to become more effective as quickly as possible because various key responsibilities will be consistently delegated to the STP footprint level and, if STPs fail to develop, their local system will lose out? Or should national system leaders accept that it is up to local systems to decide how much and what local STPs want to undertake at STP level and be very wary of consistently delegating important responsibilities to STPs?

How far is the development of STPs reshaping the national architecture? Are we happy to accept a degree of diversity in delivery mechanisms within the national system?

- How will NHS England/NHS Improvements new joint regional structure, which seeks to create a strong regional interface between national bodies and local systems and institutions, impact on STPs and ICSs?

The new 'empowered' regions are designed to be significant sources of influence and direction, with considerable delegated responsibilities. It will therefore be important for NHS England and NHS Improvement to work with STPs/ICSs and local organisations to avoid creating too many bureaucratic tiers of activity.

- What is the relationship between STPs, ICSs and commissioning?

The national bodies need a manageable administrative infrastructure through which to oversee the system as a whole, hence the move to create 44 STPs as a 'layer' between national and local bodies. However, within this a diversity of approaches is emerging including ICSs, two devolution areas, a range of local approaches to explore closer collaboration with commissioners, and alternative payment options to the tariff.

- What are the implications for regulation and oversight?

The role of the regulators is evolving with NHS Improvement seeking to focus on improvement, CQC developing its approach to system and ICS reviews, and NHS England and NHS Improvement seeking to work more closely together particularly at a regional level. Feedback from our survey programme shows trusts feel the regulators need to go further to adapt their approaches to keep pace with system working.

Should we challenge the assumption that all STPs become the primary vehicle for system performance management given that accountability sits with individual organisations?

We want to support those trusts effectively engaged with partners in managing performance collectively within their local system but we are conscious that the STP will not always be the best route for improving sustainability or performance. Crucially, legally accountability sits squarely with individual organisations, notably providers and commissioners, so we should guard against a blanket expectation for all STPs to take on this responsibility as it may set some up to fail.

Are we happy to accept that the NHS and care sector has always operated on different footprints and will continue to do so?

The STP isn't an appropriate delivery mechanism for all policy initiatives which may not align with patient flow, historical relationships or clinical need. Our view is that vertical integration is much more likely to develop around concepts of 'place' or 'neighbourhood' perhaps building on the work of vanguards or other initiatives within an ICS or an STP. In contrast, horizontal integration (of back office or some clinical services including specialised services) is much more likely to take place across one or more STP footprints, or indeed between trusts in different STP footprints. In our view, it would be helpful for the national bodies to articulate these nuances much more clearly.

How can we ensure key partners such as local government and primary care remain engaged in STPs?

Feedback from different local government sources reflects disappointment from many councils about the 'top down' nature of NHS policy. Primary care is central to the *Five year forward view* but struggles to engage at scale within STPs. Many systems have adopted a local brand for system working which is more appealing to local partners and the public.

Are we pushing the bounds of the 2012 Act too far?

The leadership of NHS England has been open about shifting the policy focus towards collaboration and away from competition, the spirit of the 2012 Act. Trusts and their partners can collaborate voluntarily within the current legislative framework but this does make for a complex environment to navigate, not least to ensure clear lines of accountability. While much of this change is welcome, it raises legitimate questions about accountability, consultation and scrutiny at national levels, and sometimes for local partners.

Are STPs and ICSs a long term game?

It seems likely that at some point in the future, a change of political leadership, and/or eventual legislative change will alter NHS structures once again. However, although the opposition may not have supported STPs, they have long championed integrated, and person centred care, and are in favour of public sector collaboration over competition. It therefore seems unlikely at this point that the investment trusts and their partners are making in STPs and ICSs –to collaborate and integrate care - will go to waste.

In summary

The culmination of a new ten-year 'vision' for the NHS, its underpinning five-year delivery plan and the forthcoming green paper for social care provide a pivotal opportunity for local and national health and care organisations to come together and develop a shared ambition for the future underpinned by realistic projections about delivery. Within this wider discussion, it will be essential for the national bodies to take the opportunity to engage the sector in a debate about the future role and function of STPs and ICSs.

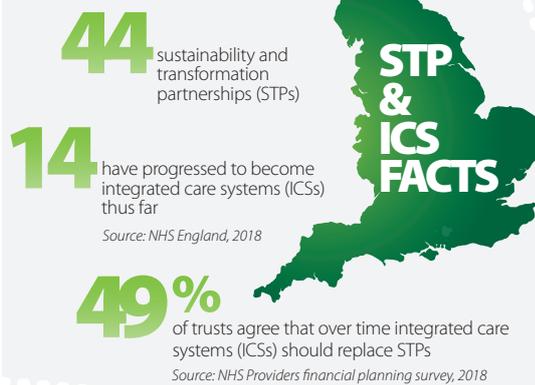
Trusts are fully committed to working collaboratively with local partners to improve population health and to integrate services for patients. Much of the work being led by ICSs with the support of the national bodies, is breaking new ground and forms the potential for a new relationship where local 'systems' and their component organisations seek a greater degree of autonomy and local flexibility in return for broader responsibilities for resource and performance management.

However, the policy questions set out in this briefing are designed to explore how we support the whole NHS provider sector, not just those at the forefront, to deliver the benefits of collaboration and integration to their local populations.



PROVIDER PERCEPTIONS OF SYSTEM WORKING

STP AND ICS FACTS



LEADERSHIP



1 in 4
chief executives

spend more than 20% of their time working on STP / ICS related work

Source: NHS Providers remuneration survey, 2017

Excellent leadership and working relationships identified as an important driver for the STP.

Source: HFMA STP survey, 2017

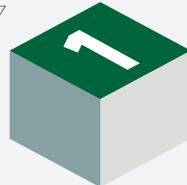


GOVERNANCE

Top three STP governance concerns
Source: HFMA STP survey, 2017



Resources - shared control totals



Decision making



Accountability



of trust finance directors are concerned about STP governance arrangements.

Source: HFMA STP survey, 2017

REGULATION



80% of trusts agreed that current legislation and accountability structures act as a barrier to system collaboration

Source: NHS Providers regulation survey, 2018

81%

of trusts agreed that NHS Improvement and NHS England need to develop new models of oversight to hold systems to account for collective performance

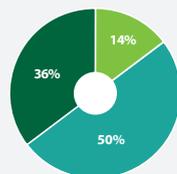
Source: NHS Providers regulation survey, 2018



FINANCE

only **14%**

of trusts were planning to sign up to a system control total in 2018/19.



■ Yes ■ No ■ Don't know

Source: NHS Providers financial planning survey, 2018

PERFORMANCE

three quarters

of trusts were worried their STP/ICS would not support them to achieve A&E performance targets

Source: NHS Providers financial planning survey, 2018



Low confidence that STPs/ICS's can support the delivery of performance targets.

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For more information:

www.nhsproviders.org/key-questions-for-the-future-of-stps-and-icss

NHS Providers (August 2018)

Key questions for the future of STPs and ICSSs