Integrated Care System Design Framework

NHS England and NHS Improvement (NHSE/I) published the Integrated Care System (ICS) Design Framework on 16th June 2021. This briefing sets out the operating model for ICSs from April 2022, after the enactment of the Health and Care Bill which will place ICSs on a statutory footing. It also acts as interim guidance for how ICSs need to continue developing and preparing for new statutory arrangements over the next ten months. The design framework will be supplemented by further information and guidance later this year to support detailed planning. For any questions on this briefing, please contact georgia.butterworth@nhsproviders.org.

Key points

- The ICS design framework sets out the next steps for how NHSE/I expects NHS organisations, working with system partners, to continue developing ICSs during 2021/22, in anticipation of establishing statutory ICS NHS bodies from April 2022. The framework sets out the core arrangements that NHSE/I will expect to see in each system, as well as some key elements of good practice. We expect further information and guidance to be issued later this year.
- As set out in the government's *Integration and Innovation* white paper in February, ICSs will be made up of two parts: the ICS partnership, and the statutory ICS NHS body. NHSE/I expects the ICS partnership to be a committee, rather than a corporate body. Its role will be to align the ambitions, purpose and strategies of partners across each system. It will be established by the relevant local authorities in collaboration with the ICS NHS body, and have a specific responsibility to develop an "integrated care strategy".
- The ICS NHS body will be a statutory body, whose functions will include planning to meet population health needs, allocating resources, and overseeing delivery. ICS NHS bodies will have a unitary board. The statutory minimum membership of the board will be confirmed in forthcoming legislation but is expected to be comprised of: a chair and at least two independent non-executive directors; a chief executive and three executive directors; and a minimum of three "partner" members, representing trusts, primary care and local authorities. Partner members will be expected to bring a perspective from their specific sectors, but not act as delegates of those sectors.
- The ICS NHS body will be expected to agree with local partners the membership and form of governance at place level. The design framework sets out five potential place-based governance arrangements: a consultative forum; a committee of the ICS NHS body; a joint committee of the ICS NHS body and one or more statutory provider; an ICS NHS body director with delegated authority; or a lead provider contracted to manage resources at place level.

- The design framework reiterates that all trusts providing acute and mental health services are expected to be part of one or more provider collaborative. Community and ambulance trusts and non-NHS providers should participate in these where it makes sense to do so.
- Providers will continue to be accountable for quality, safety, use of resources and compliance with standards, as well as the delivery of any services or functions delegated to them by an ICS NHS body. Executives of providers will remain accountable to their boards for the performance of functions for which their organisation is responsible.
- The final 2021/22 System Oversight Framework (SOF), which is expected to be published in the coming weeks, is expected to confirm ICSs' formal role in the oversight of organisations and partnership arrangements within their system. NHSE/I will retain its statutory regulatory responsibilities, so any formal regulatory action with providers will be taken by NHSE/I.
- NHSE/I also sets out the key features of the financial framework that will support system working, including some further detail on how resources will be managed at system level. It is envisaged that ICS NHS bodies will be given a duty to act with a view to ensuring system financial balance, and meet other financial objectives set by NHSE. This duty would also apply to trusts.
- The framework includes a roadmap to implement new arrangements for ICS NHS bodies by April 2022, including appointing leadership teams and ensuring a smooth transition of staff from CCGs.

Summary of the framework

Context

This framework builds on NHSE/I's renewed vision for ICSs in the Integrating care paper published in November 2020, which set out their four core purposes: improving outcomes; tackling inequalities; enhancing productivity; and supporting social and economic development. It also builds on the two-part statutory ICS model proposed in the government's white paper, Integration and Innovation: working together to improve health and social care for all, which stated that ICSs will be comprised of an ICS partnership – bringing together a broad alliance of organisations related to improving health and care – and an ICS NHS body – bringing together organisations that plan and deliver NHS services to improve population health and care.

The ICS partnership

Under the two-part statutory ICS model, each ICS will have a partnership, established by the NHS and local government "as equal partners". NHSE/I expects the ICS partnership to bring partners from local government, the NHS and wider organisations within the ICS together to align purpose and ambitions, and improve the health and wellbeing for their population, including influencing the wider

determinants of health. NHSE/I expects the ICS partnership to have a specific responsibility to develop an "integrated care strategy" covering health and social care for the whole population. NHSE/I indicates that the legislation for how partnerships should operate will not be prescriptive.

Membership of the ICS partnership will vary between systems, and may be drawn widely from health, care and other partners such as housing providers. They will be established by the relevant local authorities and the ICS NHS body. Partnerships will be able to use sub-groups, networks and other methods to convene parties to deliver the priorities set out in its shared strategy.

The ICS partnership chair will be jointly selected by the ICS NHS body and local authorities, who will also define the chair's role and accountabilities. NHSE/I provides some flexibility in this arrangement, by acknowledging that some systems may prefer the partnership and the ICS NHS body to have different chairs while others may choose to appoint one chair to sit across both. NHSE/I describes ten principles for ICS partnerships to consider, which include: distributed leadership; collective decision-making that seeks to find consensus; and a collective model for accountability.

The Department of Health and Social Care, NHSE/I and the Local Government Association will jointly develop guidance on the partnership, including on the role and accountabilities of the chair of the ICS partnership. This guidance will be consulted on before implementation.

The ICS NHS body

ICS NHS bodies will be statutory organisations that bring together all organisations involved in planning and providing NHS services within their footprint, to take a collaborative approach to agreeing and delivering ambitions for the health of their population.

NHSE/I outlines the specific functions that the ICS NHS body will be responsible for delivering:

- Developing a plan to meet the health needs of their population, having regard to the partnership's strategy. NHSE/I highlights a focus on recovery following COVID-19.
- Allocating resources to deliver the plan across the system, including setting principles for how resource (revenue and capital) should be allocated across services and providers. This will be a balance between enabling local decision-making and harnessing the benefits of scale.
- Establishing joint working arrangements with partners to deliver priorities, including joint commissioning (possibly at place) with local authorities under section 75 of the 2006 NHS Act.
- Establishing governance arrangements to support collective accountability. This will be underpinned by the statutory and contractual accountabilities of individual organisations.

- Arranging for the provision of health services in line with the allocated resources across the ICS. This will be delivered in several ways including: through contracts and agreements with providers; convening and supporting providers (working across the ICS and at place) to lead major service transformation programmes; and working with local authority and voluntary, community and social enterprise (VCSE) partners to put in place personalised care.
- Leading implementation of the NHS People Plan and people priorities in the planning guidance, with specific responsibilities from April 2022. NHSE/I also expects ICS NHS bodies to adopt a "one workforce" approach, developing shared principles across the NHS, local authorities, the VCSE sector and other partners.
- Leading system-wide action on data and digital.
- Working alongside councils to invest in local community organisations and infrastructure, ensuring the NHS contributes to social and economic development and sustainability.
- Driving joint work on estates, procurement, supply chain and commercial strategies.
- Planning for, responding to and leading recovery from incidents.
- Take on functions NHSE will be delegating including commissioning of primary care and appropriate specialised services. Specific public health functions may also be delegated.

Once an ICS NHS body has been established, NHSE/I expects that all CCG functions and duties will transfer over, including CCG assets and liabilities, such as commissioning responsibilities and contracts. NHSE/I is reviewing its own operating model, including how its functions and resources will be deployed in the context of the creation of statutory ICS NHS bodies.

NHSE/I expects the ICS NHS body's duties to include: supporting achievement of the triple aim, improving quality of service, reducing inequalities, ensuring public involvement, obtaining clinical and public health advice, promoting innovation and research, and other duties that may be defined in law.

NHSE/I will clarify in separate guidance how the statutory duties of CCGs will transition to ICS NHS bodies. NHSE/I will work with Health Education England to produce supplementary guidance and implementation support resources for ICSs on developing their strategic people capabilities.

Governance and management arrangements

This section sets out NHSE/I's expectations for ICS governance and management arrangements, with further resources to follow throughout this year. The final composition of the board and the process of appointing partner members (as described below) is subject to the parliamentary process.

The ICS NHS board

The ICS NHS body will have a unitary board, with all board members having shared corporate accountability for delivery of the functions and duties of the ICS and its performance. The board will be the senior decision-making structure for the ICS NHS body, and will be expected to facilitate finding consensus and manage areas of disagreement. The ICS NHS body should foster constructive challenge, debate and the expression of different views. If consensus cannot be agreed, the chair may make decisions on behalf of the board, and where necessary third-party intervention from NHSE/I or peer review may be needed.

The statutory minimum membership of the board will be confirmed in the legislation, but NHSE/I expects it to be comprised at least by the following roles:

- Independent non-executive directors (NEDs): This will include the chair plus a minimum of two other independent NEDs. These individuals will normally not hold positions or offices in other health and care organisations within the ICS footprint.
- Executive roles (employed by the body) This will include the chief executive, who will be the accountable officer for the funding allocations of the ICS NHS body, as well as a director of finance, director of nursing and medical director. These individuals will normally be full-time ICS employees.
- Partner members: a minimum of three additional board members, including at least:
    - One member from trusts and foundation trusts which provide services within the ICS;
    - One member from primary care providers within the ICS footprint; and
    - One member from the local authority, or authorities, with statutory social care responsibility whose area falls wholly or partly within the ICS footprint.

Partner members will be expected to bring knowledge and a perspective from their specific sectors, but not act as delegates of those sectors. NHSE/I expects the partner member(s) from trusts and local authorities will often be the chief executive of their organisation. The appointment process of partner members and rules for qualification will be set out in the constitution of the ICS NHS body. The constitution, which may also include the appointment of additional members, will need to be agreed with NHSE/I.

The framework highlights the need for the board and its committees to ensure it considers the perspectives and expertise of all relevant partners, including those across the local health and care system covering physical and mental health, primary care, community and acute services, patient and carer representatives, social care and public health, with directors of public health having an official role in the ICS NHS bodies and the ICS partnership.

NHSE/I will provide further guidance on the composition and operation of the board, which will include a draft model constitution. Additional guidance on the management of conflicting roles and interests to enable effective joint working will also be published.

Committees and decision making

NHSE/I expects ICS NHS bodies to put in place arrangements for committees and groups to advise and feed into the board and to exercise functions delegated by the board. These arrangements should also enable the involvement of clinical and professional leaders, leaders of place-based partnerships and providers, including relevant provider collaboratives.

Each board will be required to establish an audit committee and a remuneration committee. Other decision-making or advisory committees may be established by the board if they decide. It is expected that the legislation will give ICS NHS bodies flexibility in how committees are established, including how members are appointed and responsibilities delegated.

Place-based partnerships

The framework positions 'place' as central to the coordination and improvement of service planning and delivery, as well as addressing the wider determinants of health. The ICS NHS body will be expected to agree with local partners the membership and form of governance at this level, building on/complementing existing arrangements. The ICS NHS body will remain accountable for NHS resources deployed at place-level. At a minimum NHSE/I proposes that place-based partnerships should cover leadership from primary care, local authorities including directors of public health, providers across acute, community and mental health services, and representation from communities.

The framework sets out the following potential place-based governance arrangements:

- Consultative forum, informing decisions by the ICS NHS body, local authorities and others;
- Committee of the ICS NHS body with delegated authority to take decisions about the use of ICS NHS body resources;
- Joint committee of the ICS NHS body and one or more statutory provider;
- Individual directors of the ICS NHS body having delegated authority; and
- Lead provider managing resources and delivery at place under a contract with the ICS NHS body.

Supra-ICS arrangements

This section outlines functions where multiple ICS NHS bodies will need to work together to develop a shared plan across these systems. This includes, for example, the commissioning of specialised services and ambulance services. The governance arrangements to support this should be co-designed between the related providers and the ICS NHS bodies' clinical networks or alliances, and, where relevant, NHSE/I's regional teams.

Quality governance

NHSE/I sets the expectation for ICSs to build on existing quality oversight arrangements and work collaboratively with system partners to maintain and improve the quality of care. The ICS NHS body will have statutory duties to act with a view to securing continuous improvement in quality and will lead System Quality Groups (previously Quality Surveillance Groups). NHSE/I will provide support in line with the National Quality Board's guidance.

The role of providers

NHSE/I states that each ICS partnership and ICS NHS body must draw on the expertise and ambition of providers, given their critical role in the delivery, transformation, and improvement of services and outcomes within places and across and beyond systems. Trusts will be expected to work alongside system partners at place level to tailor their services to local needs and integrate pathways. They will have a role in agreeing how resources should be used and how they can best contribute to population health improvement as both service providers and as local "anchor institutions". There is flexibility in what this will look like locally and ICS NHS bodies will be expected to work with all providers to agree arrangements at different levels. In future, the ICS NHS body may delegate "commissioning" functions to providers for certain populations, which builds on the NHS-led provider collaboratives model for specialised mental health, learning disability and autism services. Trusts will increasingly be judged against their contribution to the objectives of the ICS alongside their existing duties, including delivering their agreed contribution to system financial balance.

NHSE/I also sets out the important role of primary care (including Primary Care Networks), independent sector providers and the VCSE sector in ICSs. NHSE/I expects primary care to be represented in all levels of ICS decision-making and by April 2022, the ICS will need to have a formal agreement for embedding the VCSE sector in system level governance arrangements.

Provider collaboratives

From April 2022, all trusts providing acute and/or mental health services are expected to be part of one or more provider collaborative. NHSE/I now states that community trusts, ambulance trusts and non-NHS providers should participate in these collaboratives where it makes sense for patients/the system. Provider collaboratives will be expected to agree specific objectives in line with the ICS's strategic priorities and help facilitate the work of alliances and clinical networks. The ICS NHS body and provider collaboratives will be expected to define their working relationships and governance arrangements, which will include their participation in committees through partner members as well as other local arrangements.

NHSE/I will publish additional guidance on provider collaboratives this summer.

Clinical and professional leadership

NHSE/I states that all ICSs should develop a model of distributed clinical and care professional leadership. This should build on clinical leadership within clinical commissioning groups, although the specific model will be determined by ICSs locally. Such leadership should be fully involved in decision-making, supported with sufficient resources and reflect the health, social care and VCSE sectors. ICSs will be expected to use forthcoming guidance to support a self-assessment of their clinical and professional leadership model, and implement mechanisms to measure progress and performance. The ICS NHS board will be expected to sign off a model and improvement plan.

NHSE/I will provide best practice guidance describing features of an effective professional leadership model for ICSs in due course.

Working with people and communities

The ICS will be expected to agree how to involve people and communities in developing plans and priorities. The framework reiterates seven principles for how ICSs should work with people and communities, including working with Healthwatch and the VCSE sector as key partners. The ICS NHS body should use these principles as a basis for developing a system-wide strategy for engaging with people and communities. As part of this, ICSs should develop arrangements for:

- representation on the ICS partnership and in place-based partnerships; and
- gathering intelligence about the community's experience of, and aspirations for, health and care.

NHSE/I expects there will be a legal duty for ICS NHS bodies to make arrangements to involve patients, unpaid carers and the public in planning and commissioning services.

NHSE/I will provide more information in guidance on the membership and governance of ICS NHS bodies and in the implementation support resources for how ICSs work with people and communities.

Accountability and oversight

As set out in the planning guidance for the first half of 2021/22, NHSE/I regional teams will agree the constitutions and plans of ICS NHS bodies and hold them to account for delivery through the chair and chief executive. NHSE/I clarifies that providers will continue to be accountable for the quality, safety, use of resources and compliance with standards, as well as the delivery of any services or functions commissioned from or delegated to them, including by an ICS NHS body. Executives of providers will remain accountable to their boards for the performance of functions for which their organisation is responsible. If a provider executive sits on the board of the ICS NHS body, they will also be accountable for the ICS NHS body and ensuring its functions are discharged. When acting as an ICS body board member, they must act in the interests of the ICS NHS body and the wider system, not that of their employing provider.

Approach to NHS oversight within ICSs

NHSE/I confirms that the oversight arrangements for 2022/23 will build on the final SOF, which was consulted on earlier this year and is expected to be published in the coming weeks. NHSE/I expects these arrangements to confirm ICSs' formal role in oversight, including leading oversight and support of organisations and partnership arrangements within their system. The newly formed NHSE will retain NHSE/I's statutory regulatory responsibilities, so any formal regulatory action with providers will be taken by NHSE. NHSE will work with each ICS NHS body to ensure "effective and proportionate oversight of organisations" that avoid duplication. However, the framework does not set out what the role of NHSE/I regional teams will look like or whether any functions/resources will be transferred to ICSs. NHSE/I envisages that ICS NHS bodies may over time decide to take the role of provider collaboratives and place-based partnerships into account when determining how to address issues through system oversight. CQC, NHSE/I and DHSC are working together to agree the process and roles for reviewing and assessing systems, which will aim to avoid duplication and overlap.

Financial allocations and funding flows

ICS allocations

In line with the current direction of travel, NHSE will allocate funding to each ICS NHS body, which will decide how such funds should be spent. This will include budgets for CCG-commissioned primary and secondary care, as well as running cost allowances. This may also include the allocations for NHSE functions, including primary care budgets, specialised services, national transformation funding, the Financial Recovery Fund, and funding for digital and data services. Full capital allocations will be made to the ICS NHS body, based on the outcome of the 2022/23 settlement.

Increasingly, funding will be linked to population need. Allocations will be based on supporting equal opportunity of access and contributing to the reduction of health inequalities. NHSE/I's approach will continue to be informed by the independent Advisory Committee on Resource Allocation. Allocations will be set in a way that avoids large swings in funding that would risk destabilising local health economies.

NHSE will allocate funding to ICSs taking into account the needs of their population and how quickly they move towards their target allocations. NHSE will not set allocations to place within the ICS. The ICS NHS body will have the freedom to set a delegated budget to place-based partnerships to spend ICS NHS resources, but it must focus on equal access for equal need and reduce health inequalities. The ICS NHS body should explain any variation from previous CCG budgets and enable pooling with local authority budgets.

Distribution of funds by the ICS NHS body

The ICS NHS body will agree how the allocation will be used to perform its functions, in line with its priorities. Money will flow from the ICS NHS body to providers largely through contracts for "services/outcomes", which may be managed by place-based partnerships or provider collaboratives.

In conjunction with ICS leaders, NHSE will consider supporting provider collaboratives to take on further responsibility for use of resources to deliver population health outcomes.

The ICS NHS board and chief executive will be ultimately responsible for services under delegation arrangements with place-based partnerships or through lead provider contracts.

Each ICS will have an agreed framework for collectively managing and distributing financial resources within the system's financial envelope to address the greatest need and tackle inequalities in line with

the NHS system plan, having regard to the strategies of the ICS partnership and the health and wellbeing board(s). Every ICS will be required to meet the mental health investment standard and the primary and community health services funding guarantee.

Financial and regulatory mechanisms to support collaboration

These measures build on existing financial and regulatory mechanisms to support collaboration, including system financial envelopes and changes to the SOF. NHSE/I envisages that further policy and legislative enablers will support these developments, including: a duty to collaborate; a duty on the ICS NHS body to act with a view to ensuring system financial balance and meet other financial objectives set by NHSE (this would also apply to trusts); and powers to ensure organisational spending is in line with the system capital plan.

The legislation will enable NHSE direct commissioning functions to be jointly commissioned, delegated or transferred to ICS NHS bodies as soon as they are ready to do so. Commissioning of primary medical services is currently delegated to CCGs, so will transition immediately into ICS NHS bodies when they are established.

NHSE/I will review the NHS provider licence in light of the new legislation and policy developments.

Data and digital standards and requirements

NHSE/I expects digital and data experts to have a pivotal role in ICSs. The What Good Looks Like framework is due to be published in the first quarter of 2021/22. This will set out a common vision to support ICS leaders to accelerate digital and data transformation with their partner organisations. From April 2022, ICSs will need to have smart digital and data foundations in place. ICS NHS bodies are expected to: have a named SRO with the appropriate expertise; implement a shared care record; and agree a plan for embedding population health management capabilities, among other things.

Managing the transition to statutory ICSs

In this section, NHSE/I sets out how CCG staff and functions will transfer into the ICS NHS body. This change process will be guided by NHSE/I's Employment Commitment[1] and a set of core principles, and will be managed by current ICS and CCG leadership, with increasing involvement of the new leaders who may be appointed on a shadow or designate basis, pending the legislation. Plans will be agreed with NHSE/I regional teams. NHSE/I sets out indicative outputs expected in every ICS during 2021/22, subject to legislation and other factors (including pending any potential changes to ICS boundaries).

NHSE/I will issue a set of guidance and resources to support this transition, including:

- Change and transition approach (core principles)
- Employment Commitment Guidance, including national support offer

After the legislation is introduced, NHSE/I will publish the following resources and guidance:

- HR framework (technical guidance)
- Appointments guidance for the statutory roles
- FAQs for staff
- Leadership competencies, job descriptions and proposed pay structure for ICS statutory roles.

NHS Providers view

Context

Overall, the ICS design framework begins to set out a clearer vision for how the two-part statutory ICS model – with the ICS partnership and the ICS NHS body – will operate after the enactment of the legislation. Trust leaders are fully supportive of NHSE/I's ambition to set out a coherent and flexible operating model for ICSs from April 2022. They are clear that an enabling policy and legislative framework is required for systems to design what works best for their local communities and circumstances. We will continue to engage with trust leaders to determine whether the right balance between permissiveness and clarity has been struck here, considering the implications for all trust types ranging across acute, community, mental health, ambulance and specialised.

[1] The Employment Commitment does not apply to those in senior/board level roles who may be affected by the new ICS board structure.

The framework also builds on the steps outlined in the 2021/22 implementation guidance, which set out how ICS leaders and their constituent organisations, including trusts, should prepare for new statutory arrangements in this "transition period" up to March 2022. The complexity of this endeavour should not be underestimated, as systems must prepare for legislative change without pre-empting the outcome of the Bill. The collective leadership of ICSs and their constituent organisations will also need to navigate a complex new array of policy frameworks, including adjusting to a new financial regime and oversight framework. We welcome NHSE/I's commitment to supporting the system through this coming year.

It is worth remembering that these imminent changes are taking place whilst providers remain under significant operational pressure to restore routine services affected by the pandemic, tackle the backlogs of care, and meet deferred demand across urgent and emergency care, mental health and community health services. We would strongly encourage NHSE/I to keep this context top of mind, especially in light of the expectation that ICSs will maintain momentum on improving outcomes and supporting recovery at the same time as embedding significant new planning and accountability arrangements.

Principles

We fully support NHSE/I's ambition to accelerate the current direction of system working and collaboration, and welcome the recognition of providers playing a central, leadership role in ICSs. Providers are the engine for transformation and delivery. They are responsible for employing the vast majority of NHS staff and spending the vast majority of NHS funding. However, we are increasingly concerned that the language around ICSs describes them as a separate entity to providers, rather than as genuine partnerships of all the organisations that contribute to health and care services and outcomes within the system. The model risks moving away from the founding spirit of partnership and ambitions of population health, to becoming a separate body managing those within it. This leaves the proposals vulnerable to the perception that the ICS NHS body will simply act as a larger commissioner divorced from providers, when the ICS should in fact remain a sum of its parts.

Similarly, we are also concerned that collective confidence in the ICS as currently structured could be undermined in several ways, which could hinder the opportunity and ambition of system working. For example, the founding principle of local ownership that has been central to driving improvements in collaboration and outcomes thus far could be undermined if the 'partner' members are not appointed in consultation *and agreement with* the relevant constituency. There also needs to be

parity between NHS and local authority representation. For example, if all relevant local authorities, who are already represented on the ICS NHS body by a 'partner' member, are involved in setting up the ICS partnership and selecting the chair, but no additional providers are, the ICS partnership composition could be a majority local authority decision which undermines the principle of equal partnership.

Governance

Well-functioning health and care systems need good governance and clear accountabilities. We continue to have some concerns about the proposed ICS governance arrangements:

- While we agree the board of the ICS NHS body will need to be formally accountable to NHSE/I and parliament, they should also see themselves as accountable to the communities they serve and the organisations within their footprint. NHSE/I should set this out explicitly in future guidance.
- In our view, it is crucial that non-executive directors form a majority on the board of the ICS NHS body in line with best practice drawn from all types of organisations led by unitary boards, including NHS trusts and foundation trusts. This will ensure effective challenge, risk management and assurance, which in turn will ensure the board can answer for the decisions it makes. We recommend this is explicitly defined in future guidance, rather than being locally determined as currently proposed.
- We would recommend that 'partner' members be referred to as non-executive directors drawn from the system as this would provide clarity around their status in decision making.

Given the nature of the ICS task, especially in taking decisions around contract values and funding allocations, there will likely be different views within its membership and it may legitimately be difficult to reach consensus. We welcome NHSE/I's recognition of this potential for disagreement, which we have been calling for to ensure the framework is not designed on the basis that system partners will always agree. Legitimate challenge is a sign of a healthy system. One of the core ICS tasks, as the framework acknowledges, is to manage reasoned dissent well, reconcile differences and build consensus.

Involvement of all provider types

We continue to emphasise the need for NHSE/I to ensure the views of the full range of provider types have sufficient access and input to the ICS NHS body decision-making process. We welcome the framework's statement that the board of the ICS NHS body must ensure it takes into account the perspectives and expertise of all relevant partners. We would urge NHSE/I to take this further and ensure that each ICS has a mechanism which enables the views of trusts to feed into the decision-

making process, and ensures trusts agree with the way the board of the ICS NHS body is set up and comprised, with recourse to a challenge function if they are unhappy. This parity in decision-making is absolutely critical if a collaborative approach to planning and delivering more integrated care, is to be implemented as intended.

Missed opportunities

Finally, there are a few missed opportunities in this guidance. While NHSE/I references its intention to develop its own new operating model, it remains unclear how the role of NHSE/I regional teams will change and how resources and responsibilities will be transferred to ICSs over time. This leaves the framework open to the charge that it is adding to rather than reducing bureaucracy as intended, especially in the context of the renewed emphasis on place-based partnerships and provider collaboratives.

In addition, the framework states that trusts will need to meet system financial objectives set by NHSE under the new legislation; providers will need clarity on what this will look like in practice. For example, it will be vital to know what these requirements will be, who is responsible for judging whether a provider or system is compliant, and the consequences for providers and systems for not meeting these objectives. Finally, while we understand this is an NHS-only framework, it will be important to keep wider system partners involved in this process and ensure they have buy-in within the plans and priorities of their ICS(s). This is not only important in the context of improving wider determinants of health and tackling health inequalities, but also in ensuring wider public services are fully involved at system and/or place level.

We look forward to continuing to work closely with senior leaders and colleagues at NHSE/I as the framework is implemented and further guidance is produced. We will continue to engage with our members on key proposals outlined within this new framework and ensure their views are fed back to NHSE/I.

NHS Providers press release

New ICS design framework offers clarity ahead of major reforms to health service but questions remain

Responding to the publication of a new Integrated Care System (ICS) design framework by NHSE/I, the deputy chief executive of NHS Providers, Saffron Cordery said:

"Today's ICS design framework sets out a much needed, clearer vision for how ICSs will develop further this year and how these new statutory bodies will operate when the health and care bill becomes law. We welcome the dialogue with NHSE/I throughout its development.

"The framework addresses many of the concerns outlined by our members, who fully support NHSE/I's ambition to set out a coherent, yet flexible operating model for ICSs from April 2022. Providers will particularly welcome recognition within the framework of their central, leadership role in ICSs and their commitment to delivering the best possible care for their local communities.

"But there are big challenges ahead as ICS leaders and their constituent organisations adjust to the complexities of system working.

"A key concern is that these NHS reforms- the most far reaching for nearly a decade- will take place against a challenging backdrop as trusts work to clear backlogs of care, restore routine services, and tackle pent up demand across urgent and emergency care, mental health and community health services.

"It is vital NHSE/I acknowledges the pressures and expectations trusts face as ICSs take a greater role in efforts to improve outcomes and support recovery while simultaneously embedding significant new planning and accountability arrangements.

"Trust leaders are keen to ensure ICSs remain a genuine partnership of all the organisations that contribute to local health and care services and outcomes within the system. They are increasingly concerned that the ICS model risks moving away from being a sum of its parts to a separate body managing those within it. There must be appropriate governance measures to ensure ICSs are accountable not only to NHSE/I and parliament, but also to the communities they serve and the organisations within their footprint.

"In the coming weeks and months, we will continue to work closely with senior leaders and colleagues at NHSE/I as the framework is implemented and further guidance is produced. Alongside this, we will continue to regularly consult our members on key proposals to ensure their views are reflected as this framework progresses".

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