Written evidence submitted by NHS Providers (ICS0034)

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 foundation trusts and 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 England in voluntary membership, collectively accounting for £104bn of annual expenditure and employing 1.2 million staff.

Summary

- Integrated care systems (ICSs) are being created at a challenging time for the health and care system, with a constrained financial envelope, insufficient access to capital, workforce shortages, and unprecedented levels of operational pressure. Creating space for ICS leaders, and their partners, to drive forward their strategic objectives as well as supporting providers, places and provider collaboratives, to rise to operational challenges, remains important.
- ICSs vary considerably in geographical footprint, population size, levels of deprivation and composition of health and care providers. Trust leaders support the enabling national policy and legislative framework underpinning ICSs, which leaves system partners the autonomy to design what works in their local context and the flexibility to decide how best to meet the specific needs of their local communities. Maintaining this approach throughout implementation will be essential for ICSs to successfully deliver their four key aims.
- However, the landscape is arguably becoming more complex with the development of provider collaboratives, place-based arrangements and the component parts of the ICS. Maintaining clarity about the respective accountabilities held by trusts, integrated care boards (ICBs) and other parts of the system remains critically important. NHS England (NHSE) will also need to monitor and mitigate the risks of ICBs becoming an additional layer of bureaucracy, including clarifying the roles of ICBs and NHSE regions in overseeing trusts.
- Trust leaders want to see a balance between national priorities and sufficient local flexibility to define delivery models and meet population needs. NHSE's new operating framework marks a good opportunity to review culture, relationships and behaviours and to take a proportionate approach to oversight. Our engagement with trust leaders has highlighted some key enablers to system working, including employing the principle of subsidiarity and focusing on enablers rather than structural changes.
- Despite a challenging operational context, trust leaders see significant opportunity for provider collaboratives to take on additional responsibility and to help reduce unwarranted variation in quality, improve efficiency and tackle care backlogs within a new system context. Many trust leaders are also committed to integrating care in new place-based partnerships.
- Trusts are also enthusiastic about the role ICSs can play to reduce health inequalities, invest in prevention, and provide a forum (via the integrated care partnership [ICP]) to engage constructively with social care and wider partners, in complement to their own roles. Clear national guidance on new ICS statutory duties around health inequalities, and support to prioritise this in the context of current pressures, will be critical to ICSs' ability to make progress.
- There is an important role for ICSs to play in driving up quality across the health and care system. Regulators have a key role to play in ensuring national frameworks support systems and trusts to prioritise continuous improvement and quality of care.

1/ How best can a balance be struck between allowing ICSs the flexibility and autonomy they need to achieve their statutory duties, and holding them to account for doing so?

What does a permissive framework for ICSs look like in practice?

1. Trust leaders support the permissive national policy and legislative framework underpinning ICSs. The Health and Care Act 2022 (the Act) sought to balance national action with local autonomy. It set minimum requirements for ICSs, with ICBs taking on the statutory duties previously held by clinical commissioning groups as well as some new duties, such as tackling health inequalities. This provides flexibility for ICBs to develop – with system partners – the optimal local arrangements to discharge their statutory responsibilities, progress the priorities set locally and by national bodies, and pursue the four high-level purposes of ICSs[1].

2. However, the Act has arguably created a more complex landscape across health and social care. Maintaining clear accountabilities across trusts, ICBs, ICPs, places and provider collaboratives within this flexible framework remains a key challenge. It is also important to note that the component parts of the ICS – the ICB (NHS body) and the ICP – will not follow the same lines of accountability. The ICB will be accountable to the Department of Health and Social Care (DHSC) via NHSE, and local authorities will remain accountable to the Department for Levelling Up, Housing and Communities and their local populations. While not insurmountable, it is worth noting that the Act has not simplified accountabilities in the health and care system.

3. Trust leaders are also concerned that national NHS bodies maintain the flexibility of the operating framework throughout the implementation of system working, and point to several aspects of a permissive framework.

    - Firstly, the national NHS bodies need to be comfortable with subsidiarity and how this will shape delivery. Trust leaders want to see a balance between national priorities and outcomes ("the what") and local flexibility to deliver them in ways that meet local population needs ("the how"). In the recent integration white paper, *Joining up care for people, places and populations* (February 2022), the government committed to developing a focused set of national outcomes alongside creating a framework supporting places/ICSs to develop local shared outcomes. Trusts would like to see national NHS bodies maintain an outcomes focus in their interactions with systems. In addition, they highlight the value of places/ICSs being able to complement national priorities with locally defined shared outcomes. In practice, over time, this is likely to require rationalising national priorities and ensuring regulatory frameworks support local, innovative approaches to address local communities' needs and strengths.

    - Secondly, there needs to be a balance between short- and medium/longer-term outcomes. National strategic documents including the *NHS long-term plan* (2019) and the operational planning guidance 2021/22 set out a number of priorities for the health system. Alongside these, trust leaders point to longer-term opportunities for ICSs to positively influence population health and better support people experiencing health inequalities. An enabling framework will involve national bodies recognising that a balance needs to be struck between achieving these longer-term ambitions, while also delivering short-term objectives such as tackling care backlogs, reducing delayed discharges and managing pressure on the urgent and emergency care pathway. It will be important to ensure that outcomes frameworks and oversight/regulatory approaches are aligned, and support systems to balance both short- and longer-term priorities.

[1] National guidance states that ICSs four key purposes are to: 1) improve health and care outcomes; 2) tackle inequalities in outcomes, experience and access; 3) boost productivity and value for money; and 4) support broader social and economic development.

- Thirdly, trust leaders emphasise the importance of a coherent oversight and regulatory system, which streamlines the demands made of trusts and ICSs, and delivers on the principle of earned autonomy for the highest performing organisations. Trust leaders and ICBs need an oversight framework which clearly delineates between organisations' responsibilities, minimises duplication and avoids creating additional bureaucracy. Trust leaders also note that NHSE and the Care Quality Commission (CQC) could improve how they work together to align their approaches. With ICBs working with NHSE regional teams to oversee local organisations including trusts, information requests will need to be aligned and behaviours must be constructive. For trusts, as our recent annual regulation survey shows, the cumulative effect of the regulatory and performance management burden needs to be understood, considered and minimised.

- Finally, but perhaps most significantly, the behaviours and culture set by the national NHS bodies will impact how the policy and legislative framework for ICSs works in practice. Having worked to establish a national architecture that strikes a balance between national direction and local delivery, it will be important that NHSE and other national bodies model behaviours that respect systems' and trusts' expertise and capabilities to determine how best to deliver locally against high-level priorities. NHSE regional teams are at the frontline of this interface and are likely to play an important role in modelling enabling behaviours over the coming years.

2/ Are central targets consistent with local autonomy in this context?

4. In a taxpayer funded health system, trust leaders recognise the role of political and national priorities, and take seriously their ultimate accountability to the public, to parliament (for NHS foundation trusts) and to central government. Over the last couple of decades, trust leaders have seen how central targets – accompanied by proportionate resources, national support and appropriate incentives – can support improving care for patients and service users. For instance, reductions in waiting times for elective care delivered during the 2000s were achieved in a context where national leadership and stretching central targets provided focus and mobilised resources to support local improvement. The recent elective programme has seen similar resources and support centred on the key priority of reducing waiting times.

5. However, central targets also come with risks. Too many national targets, accompanied by a performance management focused regime, can materially limit local autonomy, innovation, creativity and the ability of systems and trusts to respond to population needs. Alternatively, a focused set of central targets, sensibly calibrated, can support local leaders to make prioritisation decisions while determining how best to deliver in their local neighbourhoods, places and systems. In seeking to strike this balance, trust leaders highlight a few key factors explored below.

    - Firstly, targets can be process- or outcomes-focused. Trust leaders emphasise that where possible, targets are most empowering and impactful where they focus on high-level goals which enable local services to determine how to improve outcomes and performance.

    - Secondly, trust leaders highlight that the cumulative impact of targets is key to understanding their effect and the extent to which they constrain local autonomy. If national bodies are to hold firm to the ethos of local empowerment (as articulated

in the white paper and the Act), it will be important that they recognise the total extent of asks and targets which are placed on trusts and systems.

- Thirdly, the national and regional approach to managing performance against targets is an important factor in determining autonomy. Trust leaders report that they expend substantial management and leadership bandwidth responding to this oversight, which can minimise the autonomy trusts can feel to innovate or establish a learning culture. NHSE is undertaking a programme of work to refresh its operating framework, in light of the Act and formation of statutory ICSs. We understand that work is partly focused on calibrating a proportionate approach to oversight that maintains necessary national assurance while also empowering local leaders to lead their organisations and partnerships effectively.

- Lastly, it will be an ongoing effort to ensure national NHS-driven targets across DHSC and NHSE do not undermine or eclipse the shared priorities identified by system partners locally. For example, local authorities have a different accountability regime, which is more focused on local democratic mechanisms. ICSs will therefore need scope to develop local priorities with a view to ensuring system working remains an effective multi-agency endeavour and is truly focused on the health, care and wellbeing needs of local people.

3/ To what extent is there a risk that ICBs become an additional layer of bureaucracy if central targets are not reduced as ICBs are set up?

6. The establishment of a statutory ICS tier could risk creating an additional layer of bureaucracy and oversight. This is particularly a risk in smaller, relatively simple, systems. If ICBs are held to account for the financial and operational performance of their systems, and ICBs in turn – working alongside NHSE – hold trusts to account for their delivery of priorities and performance, this could feel like an increase in bureaucracy for trust leaders. Conversely, trust leaders see an opportunity for regions and ICBs to add real value if they focus on tackling collective issues and deploying resources and capabilities to support system partners to flourish.

7. The extent to which statutory ICSs come to resemble an additional layer of oversight will depend on a number of factors, including:
    a. The extent of the central target regime that systems are asked to operate within, as this will shape and colour the nature of interactions between ICBs and providers.
    b. The behaviours that national leaders display and the extent to which they – and the regional teams of NHSE – are minded to proactively direct ICBs.
    c. The behaviours that ICB leaders and staff model when conducting their assurance and performance management functions, as well as whether ICBs see their primary role as a performance manager or as a system convener.
    d. The extent to which NHSE regional teams devolve resources and functions to ICBs, and in turn, ICBs to places and provider collaboratives where appropriate.

4/ What can be learned from examples of existing good practice in established ICSs?

8. While there is significant variation between ICSs in terms of their size, complexity, population health challenges and pressures on services[2], there are common approaches and

[2] *Integrated care systems: what do they look like?* The Health Foundation, June 2022

enablers that can support system working. To support trusts and their partners, NHS Providers continues to share emerging practice around successful collaboration and integration, as well as lessons learned from the development of ICSs and their partnership arrangements. We have published examples of how trusts are working with each other and wider partners to improve care, services and outcomes for their local communities in several outputs including *Providers Deliver: Collaborating for better care* (June 2021), *Providers in place-based partnerships* (July 2022), and our Provider Collaboration webinar series.

9. Providers will continue to play the central role in transforming care on a practical, and patient facing level, within ICSs. Trusts are collaborating vertically with wider system partners to improve services and join up care at place and neighbourhood level. Trusts are also collaborating with each other horizontally to reduce unwarranted variation and drive efficiencies by working together at scale. Trust leaders are optimistic about the opportunities afforded by collaboration and see a distinctive role for provider collaboratives in leading the delivery of system priorities, by managing system-wide capacity and delivering programmes to tackle the backlogs of care. They also see potential for place-based partnerships to lead the transformation and integration of health and care services as well as help tackle the wider determinants of health.

10. In addition to the vital role of trusts in systems, our engagement with trust leaders has highlighted some key enablers to system working. These include:
    - **Employing the principle of subsidiarity** to ensure decisions are taken closest to the communities they will impact, particularly with regards to how ICBs may delegate budgets and resources to places and/or provider collaboratives.
    - **Focusing on developing behaviours, relationships and leadership** between system partners rather than structural change. Trust leaders are clear that cultural change will have a greater impact on the delivery of integrated care than structural reform.
    - **Having an unrelenting focus on patients, service users and local communities, which includes maintaining efforts to address health inequalities.** Trusts must ensure all voices are heard when developing collaborations and should make clear the benefits for patients, staff and the wider care pathway.
    - **Focusing on enablers to integration** such as digital and data, workforce planning and priority setting to enable the delivery of better joined up care across the health and care sector.

5/ What scope is there for variation between ICSs, to enable them to improve the overall health of the populations they serve and tackle inequalities?

11. ICSs are developing from different starting points. They vary considerably in geographical spread and population size, as well as in levels of deprivation. The provider make-up and therefore the structures of different ICSs also vary. For example, some ICSs face greater challenges around primary care access, while others face greater backlogs of care across electives, mental health and community health services. This is compounded by differences in resources between ICSs with some systems experiencing a particular shortage of staff or funding compared to other areas[3]. The challenge of determining the right scope and resource required to deliver changes amid the backdrop of continued operational pressures should not be underestimated.

[3] *Integrated care systems: what do they look like?,* The Health Foundation, June 2022

12. Trust leaders see a significant opportunity for ICSs to add value by focusing in on improving population health and tackling health inequalities. The Act places a duty on ICBs to reduce health inequalities in access and outcomes, and national guidance puts a similar emphasis on the role of place-based partnerships and provider collaboratives in identifying and narrowing inequalities.

13. The ICP will also play a central role in tackling inequalities at system level, with the potential to bring together a wide range of partners with the power to influence the wider determinants of health in education, housing and homelessness support, planning and criminal justice, far beyond the direct control of the NHS. Ensuring that ICPs have the support required to fulfil their potential is critical to the success of the Act – as is a commitment by government to invest appropriately across public services such that individuals can access the support they require at an appropriate point and do not end up turning to the health service in a moment of crisis.

14. While there are national frameworks to support ICSs and trusts to tackle health inequalities, we welcome the scope for local variation in their application. Trust leaders welcome the autonomy systems have to develop local priorities and target funding to local initiatives in response to specific health inequalities in their area. NHSE's Core20PLUS5[4] framework is also used to generate local approaches to health inequalities. However, the presence of health inequalities varies considerably between ICSs. For example, less than 1% of neighbourhoods in Surrey Heartlands are in the most deprived fifth of neighbourhoods nationally, while nearly 50% of the population in Birmingham and Solihull ICS would fall under the 'Core 20' definition[5]. This means that trusts and systems must have scope to respond differently and drive targeted action depending on their local contexts.

15. National NHS bodies can support a flexible approach to implementation in several ways:
    a. Firstly, the new duties for reducing inequalities in the Act should be underpinned by enabling guidance which clearly sets out principles within which ICSs can determine how best to meet the needs of their population.
    b. Secondly, NHSE and DHSC must consider what support will be available to ICSs and trusts to make meaningful progress and embed health inequalities approaches into how they manage current operational pressures and plan for the longer term. This should include both financial incentives and operational requirements, similar to the elective recovery fund and guidance. Although a broader issue, ensuring sufficient capital flows from government to the national NHS bodies, via ICSs and then to providers, remains critical to improving patient safety and creating modern care environments for staff and patients to support 'levelling up'.
    c. Thirdly, ICSs need an enabling regulatory environment which supports local prioritisation on health inequalities and avoids confused or conflicting accountabilities. This should provide the right incentives to take the steps needed to reduce disparities and operate services in ways which help to reduce inequity in access and outcomes. For example, NHSE's Oversight Framework 2022/23, which applies to trusts and ICBs[6], makes reference to reducing inequalities but makes no specific asks on the types of priorities each system must address. This flexibility is welcome as it allows ICSs to tackle inequalities specific to their area, but we would still encourage NHSE to define a tangible set of metrics to ensure this agenda does not unintentionally get side-lined by more immediate priorities.

[4] Core20PLUS5 – an approach to reducing health inequalities, NHS England
[5] *Integrated care systems: what do they look like?* The Health Foundation, June 2022
[6] NHS Oversight Framework, NHS England, June 2022

d. Finally, the centre needs to support ICBs and trusts to maintain consistent attention on tackling health inequalities and mitigate the risk of shorter-term financial and operational pressures dominating ICBs' attention.

16. National NHS bodies must consider health inequalities as a core component of addressing some of the challenges currently facing the NHS, as opposed to seeing it as an ambition that sits 'alongside' other issues. For example, the elective recovery plan already sets out an expectation that ICSs will analyse their waiting list data by relevant characteristics in order to develop a better understanding of the local variations in access to and experience of treatment. Despite this, health inequalities are still framed as an additional focus in the plan rather than core to how trusts should deliver on the headline asks. In addition, care backlogs in other sectors – such as community and mental health services – do not have the mandate to prioritise care based on those most impacted by health inequalities, which risks exacerbating existing inequity.

6/ How can it be ensured that quality and safety of care are at the heart of ICB priorities? How best can this be done in a way that is consistent with how providers are inspected for safety and quality of care?

Local arrangements

17. Trust leaders see opportunities for ICSs to add value to system-wide quality improvement by driving up standards across system partners and tackling cross-organisational issues. Work is underway in local systems to ensure that system partners can collectively monitor care quality, identify risks, and plan mitigation and improvement activity.

18. ICBs will have an important role to play in overseeing trusts, alongside NHSE regional teams, establishing effective system quality arrangements, and managing and escalating quality risks in line with national guidance. The National Quality Board has developed a range of assets, including guidance on system quality groups and quality risk escalation, which can inform local arrangements. Trust leaders are keen to see this national work embedded locally, ensuring arrangements are tailored to local circumstances.

19. As systems develop, they will be able to play a growing role in overseeing care quality, and can add particular value at the interface between services and across care pathways. It will also be important to ensure strong organisational governance of care quality within and by trusts. Trust boards are central to effective safety and risk management within the NHS and they will continue to play a key role in driving care quality and improvement.

National oversight and regulation

20. Trust leaders welcome work by national regulators to refine their oversight and regulatory models to ensure they reflect how system working is supporting service performance, including care quality. The latest findings of NHS Providers' annual regulation survey (July 2022) found that trusts think regulators' approaches are moving in the right strategic direction, but that they are not yet experiencing the benefits of this shift in practice. Trust leaders report an increase in the regulatory burden over the past year and concern over the number of metrics used. For example, only 14 per cent of respondents agreed that in 2021/22 the CQC's approach to regulation encouraged providers to collaborate and integrate care.

21. Trust leaders note that there is more to be done to ensure oversight mechanisms fully reflect some of the realities of greater partnership working. For instance, trusts are concerned about the current lack of clarity around accountabilities in the new system architecture, including roles and responsibilities relating to care quality. In addition, it is not yet clear how quality oversight approaches from CQC and NHSE will align with DHSC's shared outcomes frameworks at place level. For trust boards, concerns remain as to how regulatory approaches will support them to fulfil the Triple Aim and take decisions which are in the best long-term interests of their local system(s) and populations, even if there are potentially negative consequences for their individual trust.

22. Trusts are keen to work with NHSE and CQC to embed their system-focused approaches to regulation and oversight and to continue to refine those models. Supportive behaviours among national regulators will also be vital to ensure care quality retains its upper-most importance within systems. In their interactions with providers, regulators will need to demonstrate a holistic understanding of performance and improvement and reflect that care quality demands commensurate priority alongside other national objectives.

7/ How can a focus on prevention within ICSs be ensured and maintained alongside wider pressures, such as workforce challenges and the electives backlog?

23. In order for ICSs to deliver on their core ambitions and meet growing and changing population health needs, an enhanced focus on prevention is critical. However, in an environment of constrained public sector resources, including the public health grant being cut by 24% in real terms per capita since 2015/16[7], trust leaders are concerned that the prevention agenda will continue to get squeezed if concerted action and prioritisation at national and system level is not taken.

24. Trust leaders are ambitious about the potential of ICBs to use collective resources differently and invest upstream in prevention. However, this will require the political, operational and regulatory context to support this agenda on a long-term basis as well as recognition of the need to invest appropriately in broader public services (such as housing, criminal justice, and education) with a view to supporting individuals to make healthier choices throughout their lives.

25. In addition, ICBs, and providers within systems, must have a realistic 'ask' and necessary resources to deliver that ask. At present, on the back of the pandemic, repeated COVID-19 waves and a recent heatwave, operational, workforce and financial pressures pose a significant risk to an ICS's ability to focus on prevention in a long term, sustainable way. ICBs and trusts will inevitably have to prioritise conversations about the distribution of scarce resources and immediate delivery issues such as pressure on ambulance callouts, handover delays and hospital discharge, rather than developing new models of care or addressing how funding could flow differently for the longer term.

26. System working also provides an opportunity to prioritise prevention through partnerships. Trusts are working with local government and wider system partners at place and ICS level to contribute to population health improvement and the wider determinants of health as anchor institutions. ICPs will be required to create integrated care strategies that encompass a holistic approach to addressing population health challenges. DHSC sets out in national

[7] *Cuts to public health run counter to levelling up*, The Health Foundation, October 2021

guidance that ICPs will enhance the work already underway to explore upstream prevention initiatives and support this positive shift through partnership working[8].

27. Trust leaders have an important role to play in driving forward the prevention agenda as anchor institutions in their local area. Trusts are already looking at how they can innovate and transform services to narrow health inequalities and prevent ill health, through technology, workforce innovation, and working with wider system partners such as the voluntary sector, to better meet the needs of diverse populations. In order for these initiatives to continue, trusts and ICSs must be properly resourced with national funding to avoid having to make difficult choices that risk the NHS' capacity to innovate and improve population health in the long term.

[8] *Integrated care partnership engagement document: integrated care system implementation*, Department of Health and Social Care, September 2021