



Legislating for Integrated Care Systems: five recommendations to Government and Parliament

February 2021

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1. Introduction and summary

1. Following the publication of the NHS Long Term Plan, and informed by a major public engagement exercise, in October 2019 NHS England and Improvement (NHSE/I) made a number of recommendations to Government for targeted reform of NHS primary legislation. These were widely supported within the NHS, by our partners and by Parliament's cross-party Health and Social Care Committee.
2. We subsequently heard a growing desire – particularly from NHS leaders - to strengthen our original legislative proposals specifically in relation to Integrated Care Systems (ICSs), following enhanced experiences of system working during the NHS's successful response to the coronavirus pandemic. We worked up further legislative options in *Integrating Care – the Next Steps*, published in November 2020. These were rooted within the much wider context of how ICS are continuing to develop in practice – for example through partnerships at place level, the development of Primary Care Networks (PCNs) and emerging provider collaboratives. Our ICS plans have been the product of several years of extensive co-production and discussion with stakeholders. They built on a widespread consensus in favour of greater partnership working and closer integration of planning and service delivery between NHS organisations, local councils and other important partners such as the voluntary sector.
3. Our engagement attracted a significant response. Bringing together the NHS and local government and wider stakeholder views gathered through this latest engagement exercise, we now make five specific recommendations to Government on the narrow question of how to legislate for ICSs. The Government has now agreed to legislate to give effect to our proposals. Separately we will continue to engage widely on the development of ICSs.
4. A minority of respondents sought an extension which would have prevented NHS's own views being offered in a sufficiently timely way to inform and influence the Government's thinking about a prospective NHS Bill.
5. A number of responses were concerned with ensuring the NHS continues to operate as a public service. NHSE/I's wider set of proposals for legislative reform, published in October 2019, already included (i) abolishing Section 75 of the Health and Social Care Act 2012, (ii) removing the Competition and Markets Authority functions created by that Act, and (iii) developing a bespoke NHS regime to replace current procurement requirements. During this most recent engagement exercise we heard impatience about how and when they will be implemented. Today NHSE/I is also publishing, earlier than originally planned, our draft proposals for selecting NHS providers and we invite responses by 7 April 2021: <https://www.engage.england.nhs.uk/consultation/nhs-provider-selection-regime>.

Legislative recommendation 1: The Government should set out at the earliest opportunity how it intends to progress the NHS’s own proposals for legislative change.

6. We asked if now was the right time to seek to put ICSs on a stronger statutory footing. From the NHS, the response was a clear yes. We saw a marked absence of support for sticking to the October 2019 legislative proposal for ICS to be voluntary committees.
7. Responses to this and the other questions were nuanced and qualified. The message we received was proceed, but carefully. At the same time as supporting the aim of a more collaborative system, think tanks such as the Nuffield Trust and the Health Foundation observed that over many decades, successive different Governments had oversold the scale of the likely potential benefits of NHS legislative changes, and not paid sufficient attention to mitigating the potential risks of local disruption and staff uncertainty. In line with this, we heard strong support for our proposed transitional employment commitment for all staff working below board level who are affected by the legislative changes – including, but not limited to, CCGs.
8. We heard a strong appetite for ICSs to integrate care and improve population health, in line with the wider vision we described – at the same time, we also heard an equally clear desire for legislative underpinnings to be as short, simple, and enabling as possible. Legislation should be carefully designed to recognise the heterogeneity of ICSs – what works best in a large ICS like North East and North Cumbria is not the same as what works best in Dorset ICS. The more extensive the legislative provisions, the more disruptive they are likely to prove. We also heard that over-specifying arrangements at a whole ICS level is likely to undermine the importance of place-based arrangements.

Legislative recommendation 2: ICSs should be put on a clear statutory footing, but with minimum national legislative provision and prescription, and maximum local operational flexibility. Legislation should not dictate place-based arrangements.

9. We put forward two alternative statutory models. The first model was a mandatory statutory committee. The second model was to repurpose CCGs as the statutory local NHS ICS body, with revised governance arrangements – we indicated this was our preferred model.
10. There was, on balance, agreement – particularly from NHS organisations. This included the NHS Confederation and NHS Clinical Commissioners, who felt that this supported a clearer and more collaborative model of decision-making and accountability within the NHS. NHS Providers supported the overall direction of travel, but did not express a preference between the options.
11. There was also support for the first model. Without disagreeing that the NHS would benefit from the second model, many respondents, including the Local Government Association (LGA), local authority leaders, and the voluntary community and social enterprise (VCSE) sector, questioned whether an NHS statutory body, with its clear national NHS and political accountability requirements, could also cover the entirety of the health and care system, given the separate statutory functions, funding and political accountability of local

government, as well as the need for enhanced community voice. They argued that the functions and statutory accountabilities of the NHS body needed different governance from that of the vital partnership between the NHS and local government.

12. The LGA went further and argued that the choice between the first and second models was not an either/or – and that a separate statutory body should bring together the NHS statutory body with local government in a partnership of equals. We assess that this view best represents the overall balance of opinion. Strongest support exists for progressing both models in combination, ahead of the second model alone (our original stated preference) or the first model alone.
13. Each system is different and each should be free to establish its own best way of satisfying statutory partnership requirements. We heard – and agree – that statute should not cut across the ability for the NHS and its partners to choose to continue existing models for partnership working across ICSs, for example to take account the role of the mayor of Greater Manchester as part of the agreed devolution arrangements.

Legislative recommendation 3: ICSs should be underpinned by an NHS ICS statutory body *and* a wider statutory health and care partnership. Explicit provision should also be made for requirements about transparency.

14. Some national representative organisations sought a guaranteed seat for their own constituencies on the board of the ICS. We also heard the need to ensure effective governance for NHS statutory functions and accountabilities and how this is different from inclusive engagement of partners.
15. Many respondents with a clinical or professional interest asked the NHS to provide clarity on how the voice of clinical and professional leaders would be reflected in every system, including a role for GPs through primary care networks at place and system level. We agree that clinical leadership is fundamental to the success of ICSs. We commit to producing national guidance on this later in the year, working with all interested organisations.
16. We also heard exactly the same challenge in relation to creating deeper partnerships with patients and local communities, in order to personalise care and tackle health inequalities. Chapters 1 and 2 of the NHS Long Term Plan directly address these issues and we recommit to continuing to achieve their implementation. Our October 2019 legislative proposals also included a commitment of community engagement for NHS organisations, linked to the new triple aim.

Legislative recommendation 4: There should be maximum local flexibility as to how an ICS health and care partnership is constituted, for example using existing arrangements such as existing ICS partnership boards or health and wellbeing boards where these work well.

The composition of the board of the NHS ICS body must be sufficiently streamlined to support effective decision-making. It must be able to take account of local circumstances as well as statutory national guidance. Legislation should be broadly permissive, mandating only that the members of the NHS ICS Board must include a chair and CEO and as a minimum also draw

representation from (i) NHS trusts and Foundation Trusts, (ii) general practice, and (iii) a local authority. As with CCGs now, NHSE/I should approve all ICS constitutions in line with national statutory guidance.

17. We sought views on transferring or delegating NHSE commissioning functions to the new ICS statutory body. Many Local Medical Committees (LMCs) and PCNs sought a clear public commitment on primary care budget protection. Some primary care respondents were concerned that the arrangements could involve moving away from national contractual arrangements. We reaffirm our continued commitment to national contractual arrangements across the primary care contractor professions and also to the primary and community services funding guarantee – alongside the mental health investment standard – in the NHS Long Term Plan. Some GPs were concerned about the loss of the GP membership model, whilst others welcomed the clearer focus placed on the role that general practice plays in integrating care at neighbourhood level through PCN development.

18. We also heard clear support for moving commissioning and planning functions closer to the populations they serve.

Legislative recommendation 5: Provisions should enable the transfer of primary medical, dental, ophthalmology and pharmaceutical services by NHS England to the NHS ICS body. Provision should also enable the transfer or delegation by NHS England of appropriate specialised and public health services we currently commission. And at the same time, NHS England should also retain the ability to specify national standards or requirements for NHS ICSs in relation to any of these existing direct commissioning functions.

2. How we involved and engaged stakeholders

19. The *Integrating Care* paper was not the beginning of our engagement and it will not be the end. It built on more than four years of incremental policy co-design: with people who use and work in our services, with system leaders, with key partners such as local government and the voluntary sector, and with organisations that represent all of these interests nationally and locally. During this time, NHSE/I established regular working groups and one-off sessions with system leaders from across the NHS, Local Government, independent and voluntary sectors.
20. Written engagement on the paper's specific policy and legislative proposals closed on 8 January 2021. 7,167 individuals, or organisations representing different parts of the health and social care system, responded in writing. Specifically, there were:
- 6,769 responses, mostly to our online survey, clearly setting out a position of agreement or disagreement on our proposals
 - 5,171 of these responses predominantly were concerned with ensuring the NHS continues to operate as a public service
 - 85% of NHS organisations – NHS trusts, FTs, ICSs, STPs and commissioners – clearly expressed support for giving ICSs a statutory footing
 - further substantive written responses from organisations and individuals providing detailed feedback and
 - 27 responses from LMCs concerned about timing and the impact on General Practice.
21. NHSE/I ran more than 30 online sessions to discuss the work with interested stakeholders from November 2020 to January 2021 and the implications of the document's proposals. This included:
- discussing proposals with the [NHS Assembly](#), whose co-chairs jointly authored a Health Service Journal article welcoming the proposals
 - virtual sessions with executive and clinical leaders from every ICS and sustainability and transformation partnership (STP)
 - bespoke sessions with clinical commissioners, staff representative groups including GPs and allied health professionals, local government officers and councillors, and local Healthwatch and meetings with smaller community and voluntary sector organisations
 - presenting the work at pre-existing meetings of networks of various organisations' executive groups or networks, including the NHS Confederation and NHS Providers, the Shelford Group, the LGA, Society of Local Authority Chief Executives (SOLACE), and NHSE's VCSE Health and Wellbeing Alliance

- meetings with the medical Royal Colleges, trade unions and other clinical and professional leaders; as well as a national session with local Healthwatch Groups, and two sessions with local community and voluntary organisations, arranged in partnership with the National Association for Voluntary and Community Action (NAVCA).

22. We supplemented these larger sessions with smaller-scale, meetings with interested organisations and individuals: to understand their priorities, to hear any questions or practical suggestions, and to test the feeling from potentially affected colleagues and networks. A partial list of many organisations and networks who attended sessions, helped to arrange conversations for us with their members, or gave advice to us directly is published alongside this document.

23. We thank all organisations and individuals who have taken time to provide feedback to this engagement. The volume of response and level of engagement, at a time of significant pressure, demonstrates the importance people attach to getting legislative arrangements right and learning lessons from the past. The strength of feeling of respondents expressed in this document as statistics are based on the denominator of those who clearly expressed a view.

24. We have reflected carefully on what we have heard. A number of stakeholders raised specific policy questions that were not obviously matters for primary legislation. Engagement on many of those issues will continue through the various regular forums. Whilst this document is only focused on the legislative aspects of ICSs, many of the priorities and suggestions raised in the events and meetings will directly inform policy guidance that NHSE/I will publish in 2021/22.

3. Legislating for Integrated Care Systems

A statutory basis for Integrated Care Systems?

25. The first question on which we sought views was whether now is the time to move ICSs on to a statutory footing. A range of organisations responded to this question. 5,171 came via our online survey from people identifying as members of the public or patients concerned about “privatisation” of the NHS in some way. These comments were identified as a response to a national campaign group and involved speculation about the creation of statutory ICSs, including:
- concern about “collaboration” and contracting with independent sector providers;
 - the need to ensure private companies do not sit on ICS boards, directing decisions for their own benefit;
 - the need to ensure ICSs themselves are public bodies;
 - concerns about the future of a publicly funded NHS; and
 - the need to avoid poor purchasing practice similar to those highlighted in the media about Government procurement of Personal Protective Equipment (PPE).
26. We welcome support for the NHS to remain a universal national healthcare system free at the point of delivery. We propose that NHS ICS bodies should be statutory public NHS bodies; not private entities. The NHS ICS body should be an evolution of existing CCGs, retaining many of the responsibilities and functions, but working across a bigger footprint, allowing a greater role for both NHS statutory providers and local authorities in how NHS services are arranged and delivered.
27. Our wider legislative proposals set out in October 2019 included:
- rebalancing the focus on competition between NHS organisations by reducing the Competition and Markets Authority’s role in the NHS and abolishing Monitor’s role and functions in relation to enforcing competition;
 - simplifying procurement rules by scrapping section 75 of the 2012 Act and removing the commissioning of NHS healthcare services from the jurisdiction of the Public Contracts Regulations 2015;
 - providing increased flexibilities on tariff;
 - reintroducing the ability to establish new NHS trusts to support the creation of public sector integrated care providers;
 - ensuring a more coordinated approach to planning capital investment, through the possibility of introducing FT capital spend limits;

- the ability to establish decision-making joint committees of commissioners and NHS providers and between NHS providers;
- enabling collaborative commissioning between NHS bodies – it is currently easier in legislative terms for NHS bodies and local authorities to work together than for NHS bodies themselves to do so;
- a new “triple aim” duty for all NHS organisations of ‘better health for the whole population, better quality care for all patients and sustainable services for the taxpayer; and
- merging NHS England and NHS Improvement – formalising the work already done to bring the organisations together.

28. During this most recent engagement exercise we heard impatience to learn more about how and when they will be implemented, and the response to our previous recommendation that the Department of Health and Social Care (DHSC) may wish to undertake a review to clarify workforce accountabilities and responsibilities.

Legislative recommendation 1: The Government should set out at the earliest opportunity how it intends to progress the NHS’s own proposals for legislative change.

29. Today NHSE/I is also publishing, earlier than originally planned, our draft proposals for selecting NHS providers and we invite responses by 7 April 2021: <https://www.engage.england.nhs.uk/consultation/nhs-provider-selection-regime>.

30. The remainder of this document presents the breakdown of those who stated a clear opinion on each of the questions via our online survey, but with the Keep our NHS Public (KONP) campaign clearly captured separately.

| Survey question | 1,747 unique responses (KONP responses: 5,155) |
|-----------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1 | Do you agree that giving ICSs a statutory footing from 2022, alongside other legislative proposals, provides the right foundation for the NHS over the next decade? |

31. Of the unique and clearly identifiable responses received 49.2% agreed or strongly agreed with our proposals, with 43% disagreeing or strongly disagreeing. 7.8% of respondents were neutral towards the proposal.

32. Overall, there was a high level of support from most representative bodies that it is right to now consider establishing ICSs in statute. For example:

- *“We support the spirit and ambition set out in these proposals. To date, progress in joining up local services has often been achieved via workarounds to the current legislative framework, many of which are inherently complex and bureaucratic, and can lead to duplication and protracted decision-making processes. We have long argued that legislative changes will eventually be needed to re-establish coherence between local practice and the statutory framework.”* (Kings Fund)

- *“Yes. Overall there is agreement across our membership that systems becoming statutory is necessary to address the limitations of the existing legislative framework and to embed collaboration and integration into the NHS architecture. The successes of recent years in developing collaboration and system working risk plateauing without the proposed legislation, and there is much more that systems wish to achieve together. Of the two options, there was broad support across our membership for option two.”* (The NHS Confederation)
- *“The Academy and its member organisations strongly support the direct of travel towards greater integration of care systems. We have consistently believed that healthcare is better delivered through a collaborative approach and with systems working together rather than in competition with each other. There is broad consensus that giving ICSs a statutory footing from 2022, alongside other legislative proposals, provides the right foundation for the NHS over the next decade.”* (The Academy of Medical Royal Colleges)
- *“Overall, there is a range of views among trust leaders as to whether or not ICSs should be placed on a formal statutory basis, although we note that the number of trust leaders open to this option seems to be increasing and recent engagement suggests a majority would favour an appropriate statutory underpinning subject to agreement on aspects of the ‘plumbing and wiring.’ The diversity of views reflects the diversity of experience, population need and local structure currently supporting system working across the country – and different interpretations of the core purpose of the ICS.”* (NHS Providers)
- *We support the view of the majority of our members and agree that option 2 is a positive step forward for the next phase of integrated care. However, in agreeing this position – we have some significant concerns that must be addressed to avoid any negative impact on CCG transition and therefore ICS establishment. These focus on the interpretation and enactment of what is outlined in option 2.”* (NHS Clinical Commissioners)
- *Overall, we agree that putting ICSs on a statutory footing from 2022 would provide a positive basis for a wide range of long-term developments, and that your second option would provide greater clarity than the first. We also support in principle the proposed permissive approach to local governance arrangements, within a clear overarching framework. NHSE/I would, however, have an important responsibility to maintain an overview of the effectiveness, appropriateness and transparency of locally-determined governance systems.*(The Richmond Group of Charities)
- *“As the BMA has argued previously, the lack of statutory footing for ICSs has severely limited their accountability and transparency and, in so doing, has reduced confidence in them as nascent institutions. We believe that enshrining ICSs in statute would, in part, help to resolve these issues, particularly in respect of ICSs’ transparency and their accountability to clinicians, patients, and the public. [...] We endorse neither option set out in the consultation for the future of CCGs. Instead, we call for positive elements of CCGs to be retained in any new model. This includes their vital function in ensuring accountability to clinicians and patients, their invaluable local*

knowledge, their role in providing a strong clinical voice, and their skill and experience in commissioning services.” (The British Medical Association)

33. There were a number of caveats associated with support for the intention, including requests for more clarity on the role of local government, the voluntary sector and patients:

- *“We support the direction of travel of the proposals towards joining up health and care support around the individual, based on collaboration between organisations, and where decision-making is at the most local level. [...] It is essential that there is local government representation on ICS boards, whatever legal structure it takes. In our view, the ICS as currently proposed will be an NHS body with local government representation, not a partnership of equals across the whole system. (LGA)*
- *“ICSs cannot both be at the same time a statutory corporate NHS body, and a true and equal partnership with non-NHS bodies. Our NHS colleagues explained clearly and convincingly to us that NHS organisations in a system (both commissioners and providers) need to be brought together in order to deal with unhelpful competition, inefficiencies and obstacles to better service integration. In our view, it is therefore probably advantageous to enable this 'NHS internal' integration. Our hope would be that the NHS would therefore also become easier to partner-up with, easier to hold to account and easier to engage with (in fact, whether VCSE organisations or other external partners report that the NHS is in fact now easier to work with, should be used as a benchmark for whether any legislative change has been a success). But we also think there is a need for creating powerful partnerships that local authorities with their various functions can be members of- and not just through social care: this needs to include public health, housing, children's services, education, and so on.” (National Voices)*
- *UNISON does not have a definitive position on whether and how integrated care systems (ICSs) should be enshrined in legislation [...] However, UNISON does believe that enshrining ICSs in legislation is more likely to head off some of the problems that staff, unions and patient/public groups experienced with the development of sustainability and transformation partnerships (STPs).” (UNISON)*

34. Responses to this and the other questions were nuanced and qualified. The message we received was proceed, but carefully. At the same time as advocating a statutory footing for ICSs, think tanks such as the Nuffield Trust and the Health Foundation observed that over many decades, successive different Governments had oversold the scale of the likely potential benefits of NHS legislative changes, and not paid sufficient attention to mitigating the potential risks of local disruption and needless uncertainty for staff. In line with this, we heard strong support for our proposed transitional employment commitment for staff working below board level affected by the legislative changes – including in CCGs.

35. We heard a strong appetite for ICSs to integrate care and improve population health, in line with the wider vision we described – at the same time, we also

heard an equally clear desire for legislative underpinnings to be as short, simple, and enabling as possible. Legislation should be carefully designed to recognise the heterogeneity of ICSs – what works best in a large ICS like North East and North Cumbria is not the same as what works best in Dorset ICS. The more extensive the legislative provisions, the more disruptive they are likely to prove. We also heard that over-specifying arrangements at a whole ICS level is likely to undermine the importance of place-based arrangements.

36. As part of the response to the key question of the statutory basis of ICSs, enabling decision-making at ‘place’ was a key theme for a number of respondents:
- *“If option 2 is to be successful, this will be largely dependent on delegating back to place and allowing sufficient freedom to develop relationships.”* (Northumberland CCG)
 - *“A framework regarding the relationship between systems and places would also be welcomed. This is likely to be applied differently in large systems with large places compared to smaller systems. Local flexibility to develop places and the designation of functions / resources is welcomed.”* (Nottingham and Nottinghamshire CCG)
37. To achieve this, we have proposed additional legislative flexibilities. Our 2019 recommendations allowed for the creation of Joint Committees and more flexible commissioning arrangements. Our November 2020 engagement document proposed that NHSE and ICSs should be allowed to transfer or delegate their functions, alongside associated budgets. The ICS body would be able to establish place-based committees and delegate functions and money to them. Local authorities would also be able, voluntarily, to pool functions and money into these committees. The membership of these place-based committees should be determined locally. Based on developments around the country so far, we expect them to be broad-based bringing together representatives from PCNs, social care, public health, mental health services, acute care as well as voluntary sector organisations and patient groups.
38. NHSE/I will produce guidance in line with future legislative proposals to ensure both system and place-based arrangements are sufficiently clear and transparent. We do not propose legislative requirements for establishing place-based arrangements, acknowledging the different geographies of existing systems.
39. Our document proposed that any transition should minimise disruption by offering an employment commitment for all staff below board level who are affected by the legislative changes:
- *“We welcome the ‘lift and shift’ approach for CCG staff which should harness existing skills and expertise within CCGs, rather than wholesale organisational change with all the accompanying loss of productivity, focus, morale and increased costs particularly during a period when we are asking our staff to work unrelentingly on responding to the pandemic and recovery.”* (Gloucestershire CCG)

40. There was some concern about timescales raised across a large number of responses – both in agreement and disagreement. Whilst many organisations wanted pace, others felt the timeframes were tight. We heard that respondents wanted the enactment of legislation itself to trigger minimal disruption and allow for continued evolution of ICSs and CCGs prior to a potential Act, and afterwards:

- *“Our suggestion would be to secure legislative change in such a way that the vision and direction were enabled but with time to allow for the practical processes to be completed properly.”* (Bradford District and Craven CCG)

Legislative recommendation 2: ICSs should be put on a clear statutory footing, but with minimum national legislative provision and prescription, and maximum local operational flexibility. Legislation should not dictate place-based arrangements.

Which legislative model?

| Survey question | 1,711 unique responses (KONP responses: 5,104) |
|-----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 2 | Do you agree that option 2 offers a model that provides greater incentive for collaboration alongside clarity of accountability across systems, to Parliament and most importantly, to patients? |

41. Our engagement document set out two possible options for enshrining ICSs in legislation:

- **Option 1: a mandatory statutory committee** model with an Accountable Officer that binds together current statutory organisations. This Accountable Officer would not replace individual NHS organisation AOs/CEOs but would be recognised in legislation and would have duties in relation to delivery of the Board’s functions. There would be a duty for the Board to agree and deliver a system plan and all members would have an explicit duty to comply with it. In accordance with our stated ambition, there would be one aligned CCG only per ICS footprint.
- **Option 2: a statutory corporate NHS body** model that additionally brings CCG statutory functions into the ICS. The CCG governing body and GP membership model would be replaced by a board consisting of representatives from the system partners. As a minimum it would include representatives of NHS providers, primary care and local government alongside a Chair, a Chief Executive and a Chief Financial Officer. The power of individual organisational veto would be removed. The ICS Chief Executive would be a full-time Accounting Officer role, which would help strengthen lines of accountability and be a key leadership role in ensuring the system delivers.

42. Of the unique and clearly identifiable responses received, 48% agreed or strongly agreed with our proposals, with 39.9% disagreeing or strongly disagreeing. 12.1% of respondents were neutral towards the proposal.
43. Positive responses focused on the benefits of clearer accountability. For example:
- *“Making Integrated Care Systems statutory bodies would be a significant step forward in terms of enabling local organisations, working in partnership, to make the best decisions for the people they serve and directing their collective resources accordingly.”* (Norfolk and Waveney Health and Care Partnership)
 - *“A single statutory body is a much cleaner way to achieve accountability. Such a body can then agree its own sub-structures at a locality level in a coherent manner.”* (PCN Managing Director)
 - *“Historically, there has been confusion among NHS leaders, staff, patients and partner organisations regarding who is accountable for what service, with variation spreading across the country. Model two would therefore hopefully deliver a clearer structure of ICSs for users of the health service, as well as for those that work within it.”* (Royal College of Obstetricians and Gynaecologists (RCOG)).
 - *“Option 2 structure supports “smoothing out collaboration and decision making processes, removing some of those bottlenecks that might be encountered when engaging across several individual organisations“ (Non-clinical NHS staff)*
44. There was a view from others that option 1 was a better model for health and care system partnership while option 2 offers a clearer model of accountability for the NHS:
- *“Some [councils] strongly favour Option 2 while others support Option 1. The LGA can see that both have merits. Option 1- that ICSs will be a statutory joint committee - has the benefit of more able to act as strategic partnership body for the whole system. With regard to Option 2, there is value of having a single corporate body across NHS organisations in a health economy. This should be effective in increasing collaboration and join up between NHS organisations in an area, with the ability to plan strategically and deploy resources to best effect. But important though this is in improving access to health care, this is a different task to leading a partnership to address the wider determinants of health, improve population health and address health inequalities. As a statutory NHS body the ICS would be a welcome and important partner within the system but the ICS is not the whole health and wellbeing system nor indeed the leader within an entire system. Whichever statutory model is chosen for ICSs, it is essential that there is a system level partnership in which local government and other partners work alongside the NHS to drive real change in health, care and wellbeing services; address the wider determinants of health, reduce health inequalities and improve health outcomes.”* (LGA)

- *“It is important to note, however, that a fundamental aim and success of many ICSs to date has been to bring partners (not just NHS partners) together in a collaborative and integrated way with collective aims so it is essential that if ICSs become statutory bodies (who also have to perform some of the assurance function that currently sits in regional NHSE/I teams) that this doesn’t preclude partnership and collaborative working.”* (St Helens MBC & NHS St Helens CCG)
- *“It is important to clarify the difference between forums for participation and engagement, and those tasked with taking decisions – governance”* (Good Governance Institute)

45. There is no clear and definitive preference for one model over the other, but there was clear support for both. We propose to adopt both in combination.
46. Recognising the strong sentiment that this body alone could not represent the entirety of the health and care system we propose the NHS ICS body and local authorities should be required by statute to establish a statutory health and care partnership. This would be made up of a wider group of organisations than the NHS ICS body and would be required to develop an overarching plan to cover health, social care and public health. There should be flexibility as to how this is done. We suggest that the NHS ICS board would have to have regard to that plan when developing their health plan, while local authorities would also have to have regard to that plan in exercising their functions.
47. As part of the proposals to legislate for ICS, we do not propose changing the accountability structures of NHS Trusts and Foundation Trusts. Some of those NHS providers working across a larger footprint – such as ambulance trusts and larger acute providers – highlighted the inevitable complexity entailed in working across several systems. We will work with the sector on this.
48. A new ‘triple aim’ duty and duty of collaboration will help provide a shared sense of focus – as will the development and delivery of a system-level plan and system-level financial allocations. We also intend to develop and issue revised guidance to explain how Foundation Trust directors’ and governors’ duties can better support collaborative system working.
49. A number of comments related to the role of voluntary and independent sector providers within ICSs and in providing NHS services more generally. These were a mix of comments supporting and advocating for an ongoing role in both provision of services and wider–system work – usually from organisations already involved in NHS provision – and broader comments expressing opposition to the private sector being involved in NHS provision and ICSs.
50. We heard that the voice of patients and residents should be heard at both system and place level. The NHS ICS body, like all statutory NHS bodies including CCGs, will have a duty to engage with communities – we recommend that statutory ICSs continue to hold CCG duties and functions, including around public engagement. Our October 2019 legislative proposals also included a commitment for community engagement for NHS organisations, linked to the

new triple aim. Patient and service user representation and VCSE representation would be expected at the health and care partnership level and on place-level committees. We would also expect Healthwatch to form part of these partnership arrangements.

51. We will work with stakeholders to develop guidance on how these arrangements can be most effectively discharged, building on learning from CCGs and ICSs to date. We also recognise the role of the VCSE as a strategic system and transformation partner: in service provision, support for community resilience, wellbeing and inequalities, advocacy, engaging communities, volunteering and person-centred care. But personalising care and tackling inequalities is about more than just strengthening patient voice and involving the VCSE as a partner in provision – Chapters 1 and 2 of the NHS Long Term Plan directly address these issues, and we recommit to continuing to achieve their implementation.

52. A number of responses stressed the need for transparency in appointments and decision-making. Legislation should set out core requirements in terms of openness and transparency. This could include requirements on NHS ICS Boards and health and care partnerships to hold meetings in public, publish papers in advance, maintain a register of members’ interests, hold an AGM and publish an annual report.

Legislative recommendation 3: ICSs should be underpinned by an NHS ICS statutory body *and* a wider statutory health and care partnership. Explicit provision should also be made for requirements about transparency.

What level of national prescription for governance arrangements?

| | |
|------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Survey proposal | 1,739 responses (5,112 KONP responses) |
| 3 | <i>Do you agree that, other than mandatory participation of NHS bodies and Local Authorities, membership should be sufficiently permissive to allow systems to shape their own governance arrangements to best suit their populations needs?</i> |

53. Of the unique and clearly identifiable responses received, 54.5% agreed or strongly agreed with our proposals, with 37.3% disagreeing or strongly disagreeing. 8.2% of respondents were neutral towards the proposal.

54. Responses to this question varied considerably in terms of how NHS ICS boards should be constituted. We received clear feedback to avoid overriding what is currently working locally:

- *“All ICSs are different and within a broad framework the model should be as permissive as possible reflecting different histories, geographies, institutional structures and stages of development. The biggest risk to*

success will be disempowering local partners through detailed national prescription". (SE London ICS)

- *"Each system will understand and work within a complex system that has been developed and evolved over time. The governance infrastructure should be adaptable to allow systems to establish mechanisms that recognise these complexities and enable all relevant participants to actively engage."* (The Royal Wolverhampton NHS Trust)

55. A significant number of responses focussed on different sector membership or representation. This was heard most frequently in relation to the role of primary care and clinical representation. Replacing the GP-led governance model of a CCG with a broader representation from across the health and care system, led to a number of respondents expressing that a primary care 'representative' was not strong enough. Similarly, a significant number of responses wanted to see a strong clinical voice – noting its importance as a vital link between patients and commissioning and an independent challenge. It was felt this was a key success of the current CCG model.

56. Many responses recognised the importance of PCNs as system partners, but acknowledged the need for continued PCN development to support working at place: "we should acknowledge the extent of the continued support for PCNs that will be required into the future, if they are to function both as local delivery groups and partners in the wider system." (North Kirklees CCG).

57. A specific concern expressed frequently, by similar letters submitted by a number of LMCs, related to the future of the GMS/PMS contract: *"General Practice is funded through the GMS/PMS contract. The consultation document does not give detail of whether or not GMS/PMS funding is included in the "single pot". This needs to be specified in any proposal, and negotiated with the General Practitioners Committee (GPC) of the BMA, before any proposed changes can be accepted by the profession."* (Various LMCs from across the country). We confirm that our proposals to legislate for ICSs do not propose changes to the contractual model for general practice. Nor will they impact upon nationally agreed GMS contractual terms and conditions.

58. We expect primary care to play a key leadership role in the future of ICSs, with a central role in providing joined up care at neighbourhood and place level. There will also be an important role for primary care professionals in place-level committees, working with partners to integrate services for their patients. Clinical, and wider multi-professional, involvement will be central to success at system and place level: *"Care should be taken in the implementation of either of the two options set out not to lose the clinical voice in system level decision making. This should be multi-professional and not entirely Primary Care or Acute dominant."* (Surrey Heartlands CCG). There are various possible options including professional representation in place-based committees. We will work with professional groups and emerging ICSs over the next few months to develop guidance on professional involvement. In approving the establishment of statutory ICSs, NHSE/I will expect to see proposals for professional involvement which have been developed locally with those professionals.

59. We also heard a clear message from NHS leaders that the NHS ICS body needs effective decision-making arrangements, consistent with their statutory accountabilities, to enable ICSs to take decisions on behalf of their populations. The think-tanks also pointed to the practical operational problems of having overly large, representative boards. We conclude that NHS trust and Foundation Trust, general practice and local authority officer membership should explicitly be required as minimum arrangements within the composition of the board of the NHS ICS body, alongside the Chair and Chief Executive. The body would have the flexibility to add beyond this minimum, in a way that best takes account of local circumstances. Formal accountability for spending and performance (and meeting statutory duties) would flow from the ICS AO (the Chief Executive) to NHSE AO to Parliament. The NHS ICS Chair appointment process should be locally driven, with an appointment formally made by NHSE.

Legislative recommendation 4: There should be maximum local flexibility as to how the health and care partnership is constituted, for example using existing arrangements such as existing ICS partnership boards or health and wellbeing boards where these work well.

The composition of the board of the NHS ICS body must be sufficiently streamlined to support effective decision-making. It must be able to take account of local circumstances as well as statutory national guidance. Legislation should be broadly permissive, mandating only that the members of the Board must include a chair and CEO and as a minimum also draw representation from (i) NHS trusts and Foundation Trusts, (ii) general practice, and (iii) a local authority. As with CCGs now, NHSE/I should approve all ICS constitutions in line with national statutory guidance. Explicit provision should also be made for requirements about transparency.

Should ICSs take on some NHSE direct commissioning functions?

60. The proposal set out in our engagement document questioned whether – where appropriate – the direct commissioning functions of NHSE should be transferred to ICSs or delegated at an appropriate point. As there would no longer be a conflict of interests with the current GP-led CCG model (created by the 2012 Act), many commissioning functions for which NHSE is currently responsible could, for the most part, be transferred or delegated to ICS bodies – although safeguards such as national contracts and service specifications would remain. It would also be possible to allocate combined population-level primary care, community health services and specialised services population budgets to ICS bodies, enabling greater integration in the way services are arranged and delivered.

| | |
|------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Survey proposal | 1,738 responses (5,142 KONP responses) |
| 4 | Do you agree, subject to appropriate safeguards and where appropriate, that services currently commissioned by NHSE should be either transferred or delegated to ICS bodies? |

61. Of the unique and clearly identifiable responses received 42.5% agreed or strongly agreed with our proposals, with 43.7% disagreeing or strongly disagreeing. 13.9% of respondents were neutral towards the proposal. Although a range of commissioning bodies, providers and representative bodies across the range of directly commissioned services responded, the majority of responses to this question referenced specialised services and/or primary medical services, with a smaller number outlining the impacts on the other directly commissioned services. Many of the reservations here related to concerns about general practice contracts.

62. Whilst many respondents recognised the potential opportunities around integrating commissioning responsibilities currently sitting across NHSE and CCGs through transferring or delegating NHSE’s commissioning of primary care services (i.e. primary medical, dental, ophthalmology and pharmaceutical services) to ICSs, they raised a number of issues that will need to be addressed as part of any transition and implementation.

- *Commissioning decisions should be made as locally, as possible. In principle commissioning of services by ICS rather than by NHSE is preferable in areas such as primary care where integration between, for example, pharmacy, dentistry and general practice may be very valuable. (Healthwatch Richmond Upon Thames)*
- *Whether transfer or delegation is appropriate or safe depends largely on the service in question. Some services are most efficiently and equitably commissioned at a national level (especially rare or standardised services). In others, the additional costs of more local commissioning are outweighed by local ‘fit’ and sensitivity to local circumstances. (FODO, The Association for Eye Care Providers)*
- *The LDC Confederation considers that commissioning dental services at a more local level would bring many benefits, providing that adequate funding and contract management experience is also devolved. (LDC Confederation)*

63. There were a number of specific comments on specialised services, the majority of which were supportive of the principles behind our proposals. Nearly all respondents recognised that some (mainly high-volume and low-cost services) would be suitable to be transferred or delegated to ICS bodies, with other services commissioned on a multi-ICS footprint, depending on the population and geography. There was also clear recognition that some services, including highly specialised, should continue to be commissioned at a national level. Over three quarters of responses highlighted a need for resources and funding to follow the function.

- *With regards to specialised commissioning, some services lend themselves well to devolution to system level or clusters of systems*

regionally (such as kidney dialysis). Devolving such services makes sense if it allows systems to plan around the entire continuum of care (improved preventative care can lead to less need for high end/cost interventions further down the line). However, there is good reason for certain aspects of specialised commissioning being held at national level, not least to ensure national consistency in service quality for the most difficult and most expensive conditions to treat. Some services are so specific and high cost that they would be better retained at national level. Such services include those relating to rare diseases. (NHS Confederation)

64. Of the few responses relating to health and justice services, one was supportive and the other supportive in principle. The Ministry of Justice and Prisons and Probation Service both believed transferring Health and Justice services would reduce gaps in support for continuity of care and would improve the delivery and availability of services for offenders in other parts of the criminal justice system, by collaboratively working across the prison and probation pathway. It flagged a concern that for offender health personality disorder, current arrangements should be maintained for several years. In considerable potential delegation or transfers, it will be important to protect the existing national focus that has developed in recent years.

65. A limited number of responses directly mentioned section 7A public health services. All were supportive or supportive in principle of the proposal, with a minority seeking further detail. Comments were of a similar nature to those of other directly commissioned services, suggesting that resources should follow the function at the point of transfer or delegation. Some responders identified an opportunity to go further in integrating sexual and reproductive services.

- *Supportive, number of services should transfer. Further delegation to ICPs where appropriate. Resources should follow for direct and specialised teams. Strengthen connections between public health. (Pennine ICP)*
- *The RCOG broadly agrees with this point, but considers that centralisation of commissioning needs to go further than what is outlined in this consultation. The RCOG, the Faculty of Sexual and Reproductive Healthcare (FSRH), the Royal College of General Practitioners (RCGP), the Royal College of Pathologists (RCPATH), the Royal College of Paediatrics and Child Health (RCPCH), and the Academy of Medical Royal Colleges have long called for holistic integrated commissioning of sexual and reproductive healthcare with one body maintaining oversight and holding accountability for all commissioning decisions. (RCOG)*

66. Some respondents sought further clarity on what ‘appropriate safeguards’ would be in place both before the transfer or delegation took place, and how it would be monitored going forward. This was also a common theme across respondents who were supportive or did not state a position.

- *At this stage, without clarity on the ‘appropriate safeguards’ we are not able to fully support this proposal. We have some concerns that delegating or transferring specialised commissioning responsibilities to*

ICS bodies from NHSE could lead to inappropriate variation developing at local or regional level. (RCN)

67. A number of respondents mentioned the need for both the funding of the function and resources (i.e. staff) to move with that function so there isn't a gap in resources or skills to continue to perform that function well.

- *ICSs should also be allocated the resources for primary care, with the expectation that much of this is likely to be delegated in turn to place based partnerships. When transferring or delegating responsibility and budgets to ICSs it will also be important to ensure that they have the staff and access to expertise to undertake these functions. (Kings Fund)*

68. Whilst appreciating the ambition and appetite expressed by many respondents to ensure that commissioning of services should be integrated wherever possible, NHSE/I recognises that this is not a simple process. Consideration needs to be given to how, as much as which, services are transferred or delegated. This is in terms of the timing and transition; the safeguards that must be put in place to ensure consistency of approach; maintaining quality of services for patients; and ensuring financial flows:

- *We agree that specialised services currently commissioned by NHS England should be transferred or delegated to ICS bodies where appropriate. There should be a clear methodology to define which services remain commissioned by NHS England and this methodology is likely to be a mix of the rarity of the condition along with possible complexities in treatment that mean only very limited number of national providers are sustainable. For services transferred to ICSs, ICSs should be allowed to come together to commission services where appropriate and this is likely to vary across the country given the differences in population density and the number of providers. When transferring or delegating responsibility and budgets to ICSs it will also be important to ensure that they have the staff and access to expertise to undertake these functions. (Kings Fund)*

69. NHSEI will undertake a comprehensive primary care commissioning transformation programme, working with contractors, clinicians, NHSE's commissioners, ICSs and others to ensure the safe and effective transfer of any primary care commissioning functions to ICS bodies. At the same time we will maintain a national role in agreeing and maintaining contracts, and managing back office functions (such as transactional payments for eye tests or dental check-ups) and performers lists. For specialised, health and justice, armed forces and s.7A public health services, NHSE/I will work with regional and local teams, and stakeholders, to ensure it takes as flexible approach as legislation allows to transfer or delegation of those directly commissioned services, so that:

- services are commissioned at the most appropriate footprint (population size). Particularly for specialised services, this means that commissioning of certain services will remain the responsibility of NHSE, and others will become the responsibility of ICS bodies either singularly or as groups of ICSs;

- for all services (regardless of who the commissioner is), NHSE/I will continue to have a role in setting national standards and service specifications, and maintaining nationally mandated contracts to ensure continuing national consistency, alongside any other appropriate safeguards NHSE/I and stakeholders identify as essential to preserving the safe and effective commissioning of these services (e.g. an appropriate assurance and oversight framework);
- there can be a phased approach to the implementation of any future operating model to ensure the safe transfer of service commissioning, once safeguards are in place, financial flows and resources are clear, and all systems fully prepared for any new responsibility.

Legislative recommendation 5: Provisions should enable the transfer of appropriate primary medical, dental, ophthalmology and pharmaceutical services by NHS England to the NHS ICS body. Provision should also enable the transfer or delegation by NHS England of appropriate specialised and public health services we currently commission. And at the same time, NHS England should also retain the ability to specify national standards or requirements for NHS ICSs in relation to any of these existing direct commissioning functions.

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