Integrated Care Systems Network
NHS Confederation

The state of integrated care systems 2021/22

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About

This report assesses integrated care systems' progress. It sets out areas where system leaders feel they have progressed well and where improvements are needed.

The NHS Confederation is the membership organisation that brings together, supports and speaks for the whole healthcare system in England, Wales and Northern Ireland. The members we represent employ 1.5 million staff, care for more than 1 million patients a day and control £150 billion of public expenditure. We promote collaboration and partnership working as the key to improving population health, delivering high-quality care and reducing health inequalities.

The Integrated Care Systems Network is part of the NHS Confederation. As the only national network bringing together the leaders of health and care systems, it supports ICS leaders to exchange ideas, share experiences and challenges, and influence the national agenda.

Contents

Key points

- This is the first annual report by the NHS Confederation's ICS Network to assess the progress of integrated care systems (ICSs). It is based on the views of system leaders, gathered through a national survey and interviews with a range of stakeholders. This report sets out areas where leaders feel they have progressed well and where improvements are needed.

- There is a risk that if ICS leaders are not given sufficient time and space they will not be able to deliver the radical changes to health and care services that the pandemic has demonstrated are needed. We encourage the Department of Health and Social Care, NHS England and the Care Quality Commission to ensure regulation, oversight and performance management are proportionate, encourage innovation and drive improvement. A distributive leadership model is encouraged, both within ICSs and from the centre. ICSs should continue to work on the basis of subsidiarity – making decisions at the most local level possible – and be empowered to define what metrics they will be assessed on based on local priorities.

- One of the biggest strengths of ICSs so far has been improving joint working between partner organisations. 90 per cent of system leaders believe they have been able to improve joint working quite or very effectively. Much progress in joint working was catalysed by the pandemic, which necessitated quick adoption of innovative ways of working to adapt and respond to COVID-19 alongside increasing demand for care.

- System leaders are committed to the principle of subsidiarity and 9 out of 10 stated that this principle already applies to their system to either a moderate or great extent.

- System leaders feel another strength of ICSs has been their local workforce. ICS leaders feel they are making significant contributions to system-wide efforts to mitigate workforce pressures and improve working culture. Almost 80 per cent have indicated they are quite or very confident about delivering a 'one workforce' approach by July 2022.

- On areas to improve, further support is needed to help systems achieve against the ambition of systems contributing to local social and economic development. Fewer than 1 in 20 of those surveyed stated that they had been very effective in delivering progress. NHS England should provide a suite of support for systems in this area, which should be co-developed with cross-sector leaders in a way that recognises and empowers local nuance and partnerships.

- Similarly, interviews with primary care leaders have highlighted that in many areas there is uncertainty about how the experiences and insights of those leading primary care services at neighbourhood level inform system-level planning and strategy. Clear requirements for primary care governance and engagement at 'place' are needed to ensure this voice is not lost with the disbandment of clinical commissioning groups.

- Looking ahead, system leaders feel the biggest obstacle preventing further progress is national workforce shortages. This was given as the top priority by 3 in 4 respondents. While ICS leaders report making progress on workforce issues, the national strategic framework needs to enable them by addressing long-term shortages. The NHS Confederation is seeking amendments to the health and care bill to strengthen

the duties on the Secretary of State for workforce planning. Furthermore, to provide the long-term planning and ambition that is urgently required, we have called on the government to develop and publish a health and care workforce strategy as a priority.

- With ICS implementation recently delayed to July 2022, system leaders will need logistical, administrative and legal support to effectively manage the period between April and July. We look forward to working closely with NHS England and the government on ensuring the right support is provided through this period, and more broadly to ensuring that the recommendations of this report are taken forward over the coming months.

Introduction

Though they have been in operation for several years in many parts of the country, integrated care systems (ICSs) across England are set to become new statutory bodies from July 2022. This will represent a significant shift in how health and care services are planned and delivered – away from the model of fragmentation and competition followed in previous decades (and reinforced through the Health and Social Care Act 2012), and towards one of collaboration between services.

There is broad support across the health and care sector for ICSs. Prior to the introduction of the health and care bill, the NHS Confederation was the first organisation to note the growing appetite across the health service for systems to be given more formal powers to deliver integration.[1] In the ICS Network's verbal evidence to the Health and Care Bill Committee, we welcomed the inclusive manner in which the reforms have been developed. NHS England consulted widely across the health and care sector on its original proposals for integrated care, many of which are now included in the bill. This helps to explain why the legislation has largely been welcomed by health leaders.

However, there is a need for realism on the challenges ahead. Despite the broad support for moves towards more integrated care, analysis of integration reforms internationally shows a mixed picture in terms of outcomes.[2] Within England, the new care model vanguards (which paved the way for sustainability and transformation partnerships (STPs) and subsequently ICSs) have delivered limited success in areas such as reducing emergency hospital admissions, but results have only been observed after several (five to six) years.[3]

ICSs will not, therefore, be a silver bullet for tackling the significant challenges facing the health and care system. The new legal framework will act as an enabler for local health and care leaders, encouraging rather than obstructing flexible integration models in future. However, ultimately the success of systems (as with many healthcare reforms) will rely most on the kind of culture that develops between partners in each ICS. While in many areas of the country fostering a culture of collaboration – incorporating leadership, shared values and trusting relationships – will take time, good progress has been made across ICSs so far.

> "ICSs are a revolution in the mindset, not just a reorganisation of services."
>
> **A system leader**

As we look ahead to July, this report seeks to assess this progress. It presents the views of system leaders in autumn 2021, both on where they feel they have progressed well and where improvements are needed. It also assesses the prospect of further progression over the coming years, outlining where system leaders believe there are opportunities and identifying key barriers to the success of systems in future.

Recommendations are made throughout the report. While some are directed to national decision makers (NHS England and the Department of Health and Social Care), others are directed to system leaders themselves. For many integrated care board chairs and designate chief executives, and integrated care partnership chairs now in place – some of whom are taking on system-level positions for the first time – the following sections will be useful reading for understanding the challenges ICSs have faced so far and informing future planning. We look forward to engagements with all system leaders to support them in establishing their systems and addressing short-, medium- and long-term priorities.

Methodology

This report is based on data and analysis gathered in three ways:

1. Quantitative research

We invited all 42 ICSs across England to respond to a survey on various aspects relating to system progress so far and challenges ahead. The survey was open to independent chairs, executive leads and programme directors and was undertaken through September 2021. We received 50 responses in total, with 35 of the 42 systems represented in the resulting data set.

There are some limitations to the dataset due to the small sample size. However, the results of the survey are nevertheless useful for highlighting where there are shared views or broad concerns across ICSs. The survey results are used to support points throughout the report.

Since September, chair designates and subsequently designate chief executives have been appointed across the country. While in many cases these positions have been filled by those previously holding the roles, there has also been a significant number of new appointments. It is hoped that the report will be useful reading for those taking on system leadership positions for the first time. The next edition will include the views of the 'new intake' of system leaders.

2. Qualitative research

We conducted a series of group and individual interviews with a range of stakeholders from across health and care to test the findings of the survey. We sought to critically question the following issues:

- Do the results align with your experiences of working within your ICS?
- What factors help to explain the results of individual questions?
- What conclusions and recommendations can we draw from the survey results?

Interviews were held through autumn and winter 2021 and participants included system leaders, primary care network clinical directors, council leaders, directors of public health and trust chief executives.

As you will read, there are some topics relating to system working on which there are differences of opinion between system leaders and other stakeholders.

3. Desk research

This report is also supplemented and informed by the analysis of existing work in the public domain that has sought to assess the progress of ICSs so far. We have, however, observed a relative dearth of material assessing ICS progress and performance. We hope that this paper will add to the literature. However, we are aware that evaluation of system and stakeholder views on ICS progress is no substitute for objective assessment against clear integration metrics. The NHS Confederation continues to work with NHS England and other organisations to develop such an assessment framework.

This report is the first in an annual series assessing ICS progress. The ICS Network, which is part of the NHS Confederation, intends to ask the same (or similar) questions of ICS leaders next year, allowing us to identify trends over time on levels of confidence or concern in different areas relating to system development. This year therefore represents the 'baseline' for future assessments.

From next year, and over time, we hope to expand the scope of this research so that other stakeholders are included in the survey, for example those in primary and community care. This would allow us to identify where there is consensus and divergence between partners within systems.

Where are ICSs progressing well?

Strengthened relationships and improved levels of joint working

In response to our survey, system leaders were confident that their system has so far been able to improve joint working between health services and other system partners, including local authorities. Nine in 10 said they were able to do this quite or very effectively; only 2 per cent said this was not being done effectively.

9 in 10 were able to improve joint working quite or very effectively

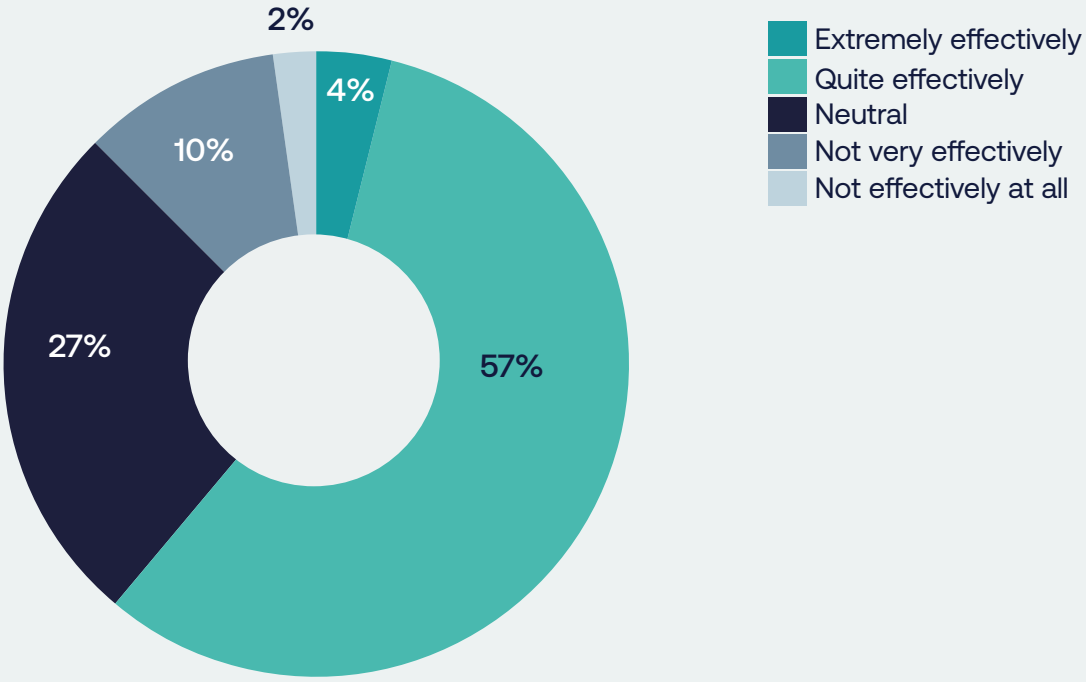
Much progress in joint working was catalysed by the pandemic, which necessitated quick adoption of innovative ways of working to adapt and respond to COVID-19 alongside increasing demand for care.

Staff across the health and care system have worked tirelessly over the past two years to deliver innovation in digital technology and ways of working which enhance collaboration across organisations, sectors and professional boundaries. Details on how the NHS and local government have improved cooperation on 'continuing healthcare', for example, will be set out in a forthcoming report by NHS Clinical Commissioners.

System leaders were similarly positive about how effectively their place-based partnerships – which will be crucial for addressing

the wider determinants of health – are currently operating within their ICS. Over 60 per cent said place-based partnerships were operating extremely effectively or quite effectively in their ICS.

How effectively are the place-based partnerships currently operating within your ICS?



Strong place-based partnerships will be crucial to the success of ICSs. As one ICS leader responded to our survey:

> "Place-based planning in the medium term is the only answer to the issues of multi-morbidity and inequality."

Another commented:

> "The best way of delivering on health outcomes, on inequalities, on successful lives in successful places, and sustainable health and care, is through integrated, place-based approaches and working differently with communities."

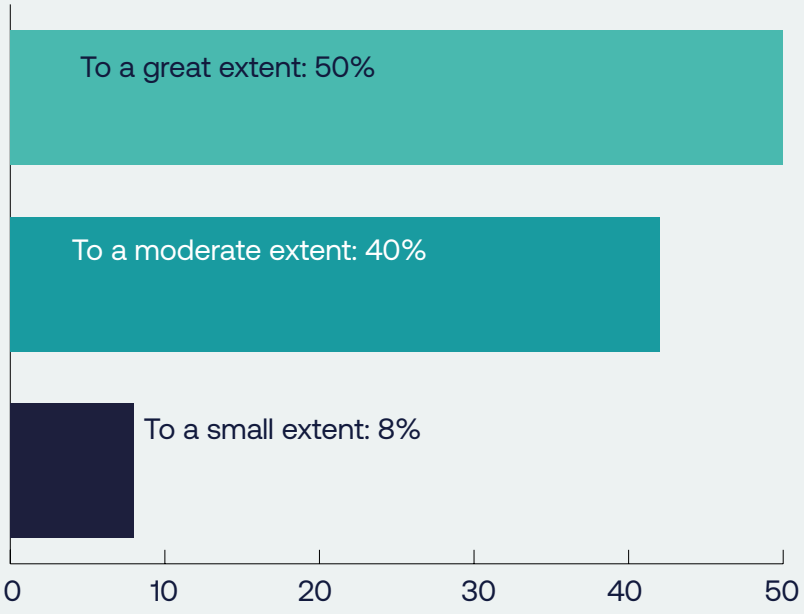
We have heard from systems that primary, secondary and community services are coming together and working in tandem with social care and the voluntary sector in exciting new ways. Crucially, this has already led to improved outcomes for groups of patients and residents. In Leicester, Leicestershire and Rutland ICS, for example, a pilot pre-transfer clinical discussion and assessment (PTCDA) scheme has protected elderly residents' health during the pandemic and significantly reduced hospital admissions. Read more about this case study and others on our website.

Local decision-making

The NHS Confederation, along with partners such as the Local Government Association, has long advocated the benefit of taking decisions as close to the communities they impact as possible.[4] System leaders consider this to be a strength.

When asked to what extent the principle of subsidiarity – making decisions at the most local level – applied to their system, 50 per cent said to a great extent and 42 per cent said to a moderate extent.

To what extent do you think the principle of subsidiarity applies to your ICS?



The West Yorkshire Health and Care Partnership, for example, is lauded as a system which works locally unless an issue passes one of its three subsidiarity tests:

- working at scale is necessary to achieve a critical mass to get the best outcomes
- where variation in outcomes is unacceptably high and working together will help to reduce variation and share best practices
- or where working at scale offers opportunities to solve complex, intractable problems.[5]

In the words of its chief executive, Rob Webster:

> "This means we only work together at a West Yorkshire and Harrogate level where it makes sense to do so – where there are economies of scale, where good practice can be shared and where wicked issues can be solved together."

However, our survey suggests that medium-sized as well as the largest ICSs are committed to local decision-making and practicing subsidiarity. Leaders of smaller ICSs will need to find ways of operating within a subsidiarity-based model, although they may be doing this in a different way with different partners. All systems will need to look 'beyond' place and to how they can best structure collaborative working at locality (or 'neighbourhood') level.

System leaders hope that the health and care bill will facilitate local flexibility and collaboration. If successful, it could ensure local changes and decisions are made at the most appropriate level by local leaders who understand their local populations best. However, if the laudable visions set by the bill and integration white paper are to be achieved, we need to learn lessons from experience. The bill contains provisions that grant the Secretary of State significant and largely unchecked new powers of direction over local service

reconfigurations. We are concerned that this could undermine subsidiarity. Local clinicians and leaders, rather than ministers, are best placed to make decisions about issues pertaining to the safety and outcomes of their local communities.

Mitigating workforce pressures and improving working culture

ICS leaders feel they are making significant contributions to system-wide efforts to mitigate workforce pressures and improve working culture.

Almost 8 in 10 respondents were quite or very confident about delivering a 'one workforce' approach by July 2022, while only 4 per cent were not at all confident.

Numerous examples of progress in workforce issues have resulted from the pandemic.

Almost 8 in 10 respondents were quite or very confident about delivering a 'one workforce' approach by July 2022

Case study: Humber Coast and Vale ICS

Humber, Coast and Vale ICS has a Health and Social Care Workforce Consortium, an alliance of health and social care partners and educators focused on the recruitment and retention of support staff across the ICS area.8

The Workforce Consortium Programme team is working with North East Lincolnshire Council to deliver seminars to promote emotional resilience for registered managers and deputies, and stress awareness for registered managers and deputies. Along with other local partners including two trusts, the Humber, Coast and Vale Staff Resilience Hub was established to support health and care staff in the area who are struggling with the impact of COVID-19.

Case study: Black Country ICS

Black Country ICS has taken a system-wide, collective approach to addressing issues and delivering solutions in the area of people and workforce planning by establishing the Black Country and West Birmingham People Board. Five delivery groups within the board are tasked with delivering on improving workforce supply, education and training and access, leadership and culture (including equality, diversity and inclusion), workforce support, health and wellbeing, and improving flexibility and consistency. Importantly, this work has developed a common understanding of workforce issues facing partners within the system. Find out more.

Despite the huge pressures that systems are facing, it is encouraging that ICS leaders are reporting good progress on improving working culture. A national workforce strategy will be important, but it cannot provide all the answers. Workforce strategies at system level will be essential to ensuring that levels of retention are improved across health and care.

Where may improvements be needed?

Driving social and economic development

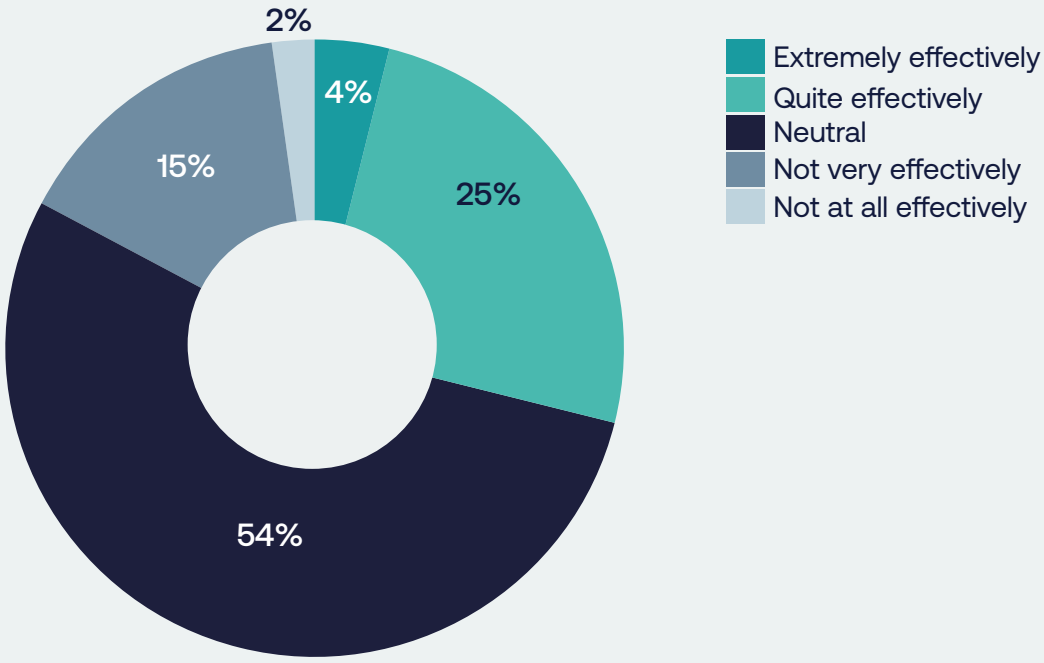
As NHS England has made clear in several policy documents, including Integrating Care: Next Steps to Building Strong and Effective ICSs across England, ICSs were introduced to achieve four ambitions:

- improving population health and healthcare
- tackling unequal outcomes and access
- enhancing productivity and value for money
- helping the NHS to support broader social and economic development.

While there is strong support for this fourth ambition, evidence from our survey suggests that system leaders feel least confident about it, with most respondents responding neutrally on whether they had been effective in delivering progress on supporting broader social and economic development. Fewer than 1 in 20 stated that they had been very effective in delivering progress.

Fewer than 1 in 20 stated that they had been very effective in delivering progress

How effectively do you believe your system has so far been able to deliver progress on helping the NHS to support broader social and economic development?



There appears to be several reasons for this. For some, it seems to be an issue of incentivisation and prioritisation. In our conversations with ICS leaders, we heard that while they are likely to be judged (by regulators, partners and the public alike) on issues such as performance, access to services and tackling health inequalities, they are unlikely to be criticised for neglecting their duties on supporting social and economic development. This ambition was therefore seen as something to get to once the system has matured and the more pressing clinical priorities are being addressed.

> "I think supporting broader social and economic development has the least focus at present but should grow in profile as place/health and wellbeing board and place-based partnerships tackle the wider determinants of health."

For others, supporting economic development still represents unfamiliar territory (especially those with a background in the NHS). It is not an area in which many feel they have experience and/or expertise, and relationships between ICSs and organisations such as businesses and universities remain in their infancy in many areas. This was reflected in some of the comments received through the survey:

> "Little dialogue exists between different players and local employers. Far more needs to be done to build relationships and identify opportunities for mutual support and improvement."

> "Engagement in the wider economic development agenda is proving challenging as this is not an area where NHS approaches traditionally align well with wider processes. There is much to learn, especially linked to long-term structural planning."

There are, however, significant benefits to be reaped when support for local social and economic development is put at the heart of ICS planning and delivery, and some systems have been able to do so. Cheshire and Merseyside Health and Care Partnership, for example, has placed a strong emphasis on social value. This has led to a shared approach across partners to improving population health and boosting local employment:

Case study: Cheshire and Merseyside Health and Care Partnership

Cheshire and Merseyside (C&M) Health and Care Partnership runs the C&M Social Value Partnership. This acts as a forum,

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bringing together health services, patients, residents, local authorities, the voluntary sector, local businesses and others.

Embedding social value across C&M is part of the system's strategic approach and co-production is key to this. The approach aims to build connections for a shared ambition to improving population health across the public, voluntary and community sectors, as well business and industry.

One aspect has been the system's Social Value Award, which is given to public sector organisations within the ICS which demonstrate they have taken steps towards becoming 'anchor institutions'. This has been awarded to several councils and NHS bodies already, with such organisations being rewarded for providing hundreds of local jobs, taking on apprentices, increasing procurement from local businesses and other measures.

The NHS Confederation is working with NHS England, ICSs and other stakeholders to support this process. A series of roundtable events and interviews will help to develop an agreed narrative for the ICS principle around the NHS's role in supporting broader economic and social development.

We will publish a report following the roundtable series that outlines how NHS England can successfully embed this 'health and wealth' thinking in the future governance and frameworks of statutory ICSs.

Recommendations

- A suite of support should be co-developed (involving ICSs, local authorities, local enterprise partnerships, government and NHS England) for systems to play a more significant role in driving social and economic development. This should recognise and empower local nuance and partnerships. Future policy should

reiterate the wider role systems can play in economic and social development.

- ICS leaders, government and NHS England should continue to champion the NHS as an anchor concept, ensuring that progress in addressing this ICS priority builds on and further develops emerging work in this area.

Defining the role of health and wellbeing boards

Many systems have so far had mixed success in engaging health and wellbeing boards (HWBs), with most – just over 50 per cent – stating HWBs are involved to a moderate extent in the delivery of strategy, but only 1 in 10 saying to a great extent.

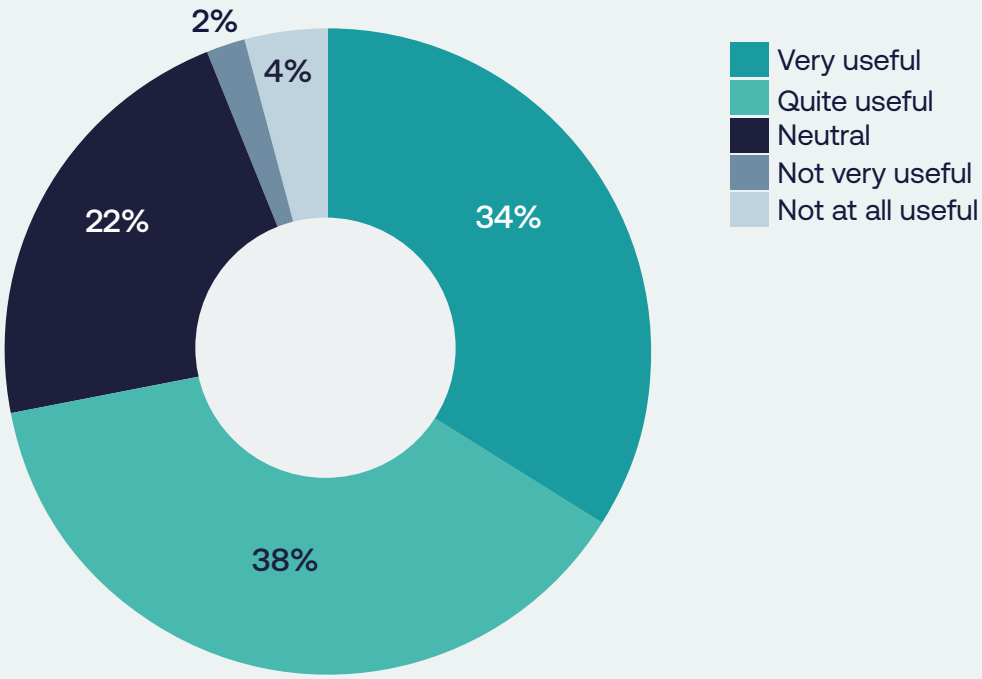
HWB engagement has been a long-standing issue, dating back to the development of sustainability and transformation partnerships (STPs). As research from the King's Fund has shown, HWB involvement in systems has been variable over recent years.[6] Our survey results also confirm this.

There will be several reasons for this but it may, in part, be explained by the variability in HWB effectiveness nationally. The Care Quality Commission carried out a review of 20 local health and care systems in 2017 and 2018 and concluded that HWBs varied in their effectiveness as forums for exercising wider oversight of the system and for promoting transformational change.[7] The current configurations of HWBs are varied, with different levels of operational involvement in health and care oversight.

That said, system leaders are clear that joint strategic needs assessments (JSNAs) – produced by HWBs – are useful for informing system planning, with 7 out of 10 stating that they are quite or very useful.

System leaders are clear that joint strategic needs assessments are useful for informing system planning

How useful are joint strategic needs assessments in informing system planning and strategy?



Interestingly, our data showed that larger systems tended to find JSNAs more useful than smaller ones. This may be because, with a greater 'distance' between place and system levels, JSNAs reveal local issues that system leaders of larger systems may not have been so aware of.

In future, larger systems are likely to find JSNAs helpful as place-based strategies to inform the broader ICP strategy. However, in smaller systems it remains unclear how JSNAs and the ICP strategies will differ (there would appear to be significant overlap between both).

It has been welcome that the centre has broadly left systems to develop their relationships with HWBs as they see fit. The relationships between HWBs, place-based partnerships and ICPs will look different depending on local circumstances and relationships. However, systems should continue to be seen as equal partnerships between the NHS and local government. It will therefore be important that HWBs, which play an important role in ensuring local democratic accountability, are used in a meaningful way.

Recommendations

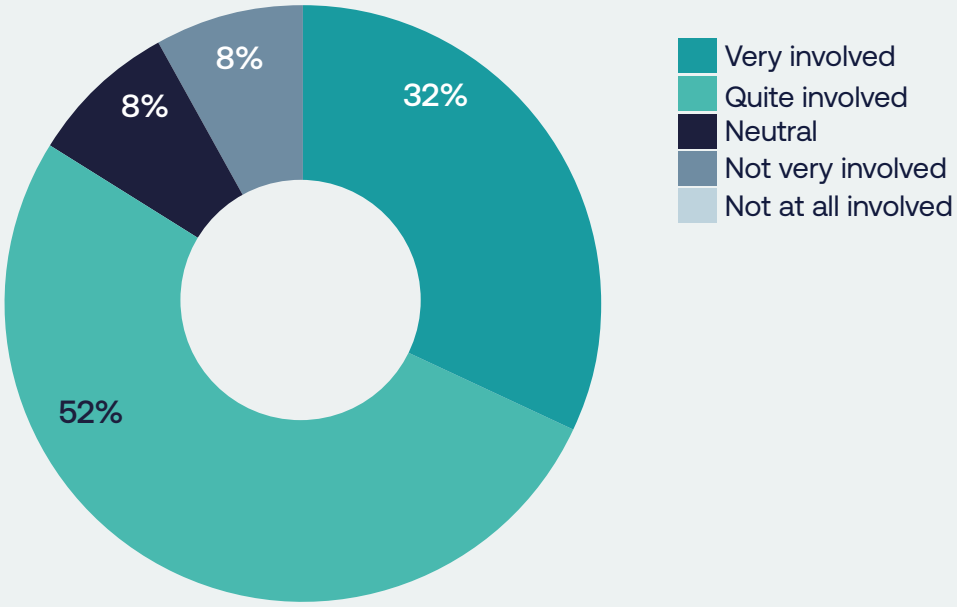
- Over the coming months systems should be given freedom and support to develop clear relationships between HWBs, place-based partnerships and integrated care partnerships (ICPs). The ICS Network will continue to engage with ICSs to support this process over the coming months.

- Flexibility from the centre on the role HWBs should play within ICSs from July has been welcomed and should continue.

Engagement of primary care in planning and strategy

Through our survey we sought to assess how well ICS leaders feel primary care providers are engaged in system planning and delivery. The response was positive, with more than 8 in 10 stating that primary care partners are quite or very involved.

To what extent are primary care partners within your system involved in ICS planning and delivery?



However, after presenting the results to a subsequent roundtable of primary care leaders it became clear that the positive picture suggested by ICS leaders did not reflect their own experiences. Those in attendance felt distant from their ICS and uninvolved in planning or delivery of system ambitions – especially in larger systems. This can be because of the complexity of the primary care landscape and understanding how to engage, as well as primary care leaders not having the time to effectively engage.

> "We are in a big ICS and they are so far removed. How do we know how our ICS is doing? In our area, nobody does."

This appears to be less of an issue in smaller systems, where there is little or no distinction between system and place. Indeed, even in larger systems many primary care leaders have told us that while the 'system' feels distant, their place-level relationships are broadly positive.

> "There are good relationships at place – but at ICS level they are non-existent."

For some, it is simply not clear how their concerns and local experience is used to inform system planning. This stems from a sense that, even where there is a primary care leader on a system board, this one individual has no means of understanding what is happening across the broader primary care landscape.

> "What frustrates is that there is no one clear voice for primary care. There are no federations in our area. In [our area] we have created an organisation that practices buy into, but this hasn't worked."

Our engagement with both ICS and primary care members suggests that those leading systems may have positive relationships with a small number of primary care leaders, hence their view they are effectively involving primary care. Yet there may be a 'silent majority' of primary leaders across systems who currently feel unrepresented and frustrated. More support is needed to help facilitate wider primary care 'buy in' to system planning and engagement as a 'true' partner.

We are reassured that NHS England has appointed Dr Claire Fuller to lead a stocktake into how ICSs and primary care partners can work together most effectively to improve out-of-hospital care. Embedding meaningful primary care input in all levels of ICS decision-making is a key recommendation of a forthcoming report that NHS Clinical Commissioners will be publishing shortly on the legacy of CCGs.

Recommendations

- NHS England's regional teams should work with ICSs and primary care leaders to develop and support fora that allow all primary care leaders across a system to feed views into those representing primary care on the ICB.

- Clear requirements for primary care governance and engagement at 'place' to replace, and build on, those lost with the disbandment of CCGs. As recommended in The Role of Primary Care in Integrated Care Systems, these include infrastructure support for primary care to enable links into the wider NHS, and those that facilitate partnership working.

- With PCNs set to be the 'building blocks of ICSs', NHS England and the government should provide sufficient funding and support to ensure they can fulfil their contracts, while contributing to wider partnership working and integration at both place and system level.

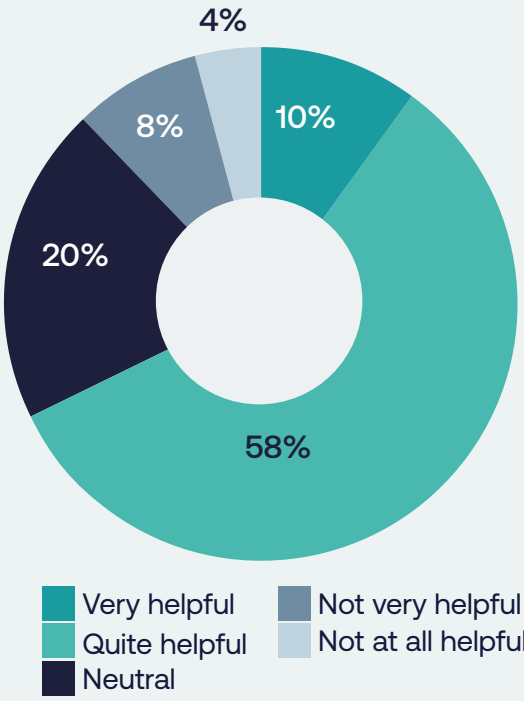
What are the opportunities for systems?

A new relationship between central, regional and local

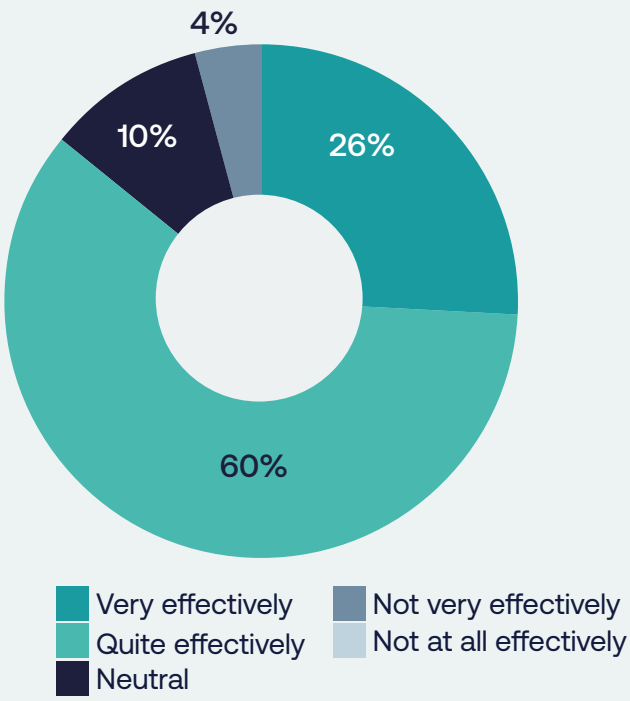
The move towards integration and partnership working provides an opportunity to rethink the relationship that NHS England and its regional teams has with local systems.

Already, system leaders report having made marked progress towards developing a new relationship between central, regional and local. In response to our survey, ICS leaders were pleased with the support offered by NHS England and by the guidance on system working it provided with the Department of Health and Social Care. 86 per cent of respondents felt NHS England had supported the development and progression of their ICS quite or very effectively, while 68 per cent found the guidance on system working quite or very helpful. Respondents remarked that the permissiveness of the guidance was welcome.

Do you feel that guidance on system working that has come through NHSE and DHSC has overall been helpful?



More broadly, how effectively do you feel NHSE has supported the development and progression of your ICS, including through your regional team?



However, it is worth noting that 12 per cent of ICS leaders said the guidance was not very helpful or not at all helpful and 20 per cent were neutral. There was also significant negative qualitative feedback on the guidance, centering around guidance being too little, too late, too detailed and out of touch with the realities of the system.

> "Timeliness is an issue, as is the link between various strands of guidance."[8]

> "The guidance promotes quite a bureaucratic approach and is so lengthy that most partners are not reading it and therefore don't understand the direction of travel."

Such issues could be avoided if NHS England took an approach based on co-production and took more regular feedback from ICS leaders on the amount and quality of guidance.

Similarly, although the feedback was broadly positive, several respondents implied that issues remained with the centre-system relationship. We have long heard from members that performance management, or 'oversight', processes through NHS England's regional teams are unclear and time-consuming, often with duplication in information and reporting requests. As local leaders cautioned in 2018:

> "We need to ensure that regional teams do not become the mechanism by which national clinical teams direct and performance manage the activities of ICS partnerships".

A key development will be NHS England's work on its new operating model, which needs to grapple with how a larger NHSE (merged with Health Education England, NHS Digital and NHSX) will adapt to the new systems-based world. The opportunity here is to move towards a regime of system oversight which reinforces the intention of policy and legislation on collaboration and integration.

The NHS Confederation will shortly be publishing a report by Professor Sir Chris Ham setting out a positive vision for the role of the centre in a systems world.

Recommendations

- National leaders should work with ICS leaders to develop the future NHS England operating model, with co-production of guidance and policy becoming business as usual.

- Systems should continue to focus and build on establishing relationships and trust, in particular at place level, through thriving place-based partnerships and building in engagement mechanisms with local communities at all levels.

- NHS England regional offices should become centred around support and facilitation in future, with a shift away from the 'adult to child' relationship that has evolved in some parts of the country.

Lean, light and agile regulation and the importance of peer review

The health and care bill and the broader shift towards integration offer an inflection point for regulating differently by rewarding partnership working and focusing on whole patient pathways and improving population health. During the height of the pandemic, the CQC halted inspections and our members welcomed a more lean, light and agile approach to regulation.[9] The CQC continues to take a risk-based approach to regulation.[10] It will be imperative that ICS leaders are given sufficient time and space to embed new structures and ways of working. Overly burdensome, bureaucratic regulation and performance management will tie their laces to the starting block, especially when the system remains under immense pressure.

In our conversations with provider and ICS members, national and professional regulators over the past year, there has been a high degree of agreement that a more cohesive approach is needed to avoid creating additional layers of regulation and bureaucracy.

There are positive signs that regulators are being more proportionate

There are positive signs that regulators are being more proportionate, making smarter use of data and embracing co-design. The CQC plans to work closely with ICSs over the next year to test its methodology for reviewing systems – a power conferred by the health and care bill[11] – and NHS England plans to engage with ICSs as it develops its system oversight framework for

2022/23. However, the full opportunity of meaningful co-design will not be met unless ICSs are allowed to define which metrics they are being assessed on based on local priorities. Regulators should also seek to prevent duplication and working at cross purposes by aligning metrics.

ICS board-level peer review could offer a robust assessment of partnership working. Many of our ICS members advocate for peer-to-peer approaches, which they see as offering credibility and impact to the process of system regulation/oversight and driving improvement. The NHS Confederation works with the Local Government Association and NHS Providers to deliver a menu of peer support tailored to the needs of systems. Further information on this can be found on our website.

During conversations with regulators there is a clear appetite and willingness to consider the role of peer review in system regulation and the next year is seen as a crucial time for exploring and testing this approach. The NHS Confederation will continue to facilitate these conversations and support ICS colleagues in establishing peer review processes.

Recommendations

- ICSs should be involved in steering and leading the peer review process, including the offer facilitated and organised by the NHS Confederation, Local Government Association and NHS Providers. It is hoped that this will become a key tool for driving system improvement over the coming years.

- Regulatory frameworks should be developed on the principles of co-design with local systems, including local determination of the metrics they are assessed on based on local priorities.

- Regulators should actively support ICS peer review by imparting data, skills and understanding of processes, and stripping back layers of regulation where appropriate to prevent duplication.

- A regime of proportionate accountability should be used based on light touch oversight of well-performing systems and rules-based intervention and support of other systems.

Progression towards 'health in all policies'

There is optimism among ICS leaders about their systems becoming a focal point for much broader public sector conversations towards addressing the wider determinants of health. The NHS Confederation and its networks have consistently called for a more coordinated national 'health in all policies' approach and for a recognition that 'health is the new wealth'.[12]

There has not been much progress on this at national level in recent years. It was, however, promising during a keynote session at the 2021 ICS Network conference to hear the Secretary of State argue strongly for a cross-government approach to prevention:

> "These things require a cross-government effort, and we need to bring industry in as well. **Every government department is a health department**. They all have a responsibility to help us with the long-term health of our nation. I'm determined to see that."

Despite limited national progress on this agenda, ICSs hold the potential to demonstrate the value of a 'health in all policies' approach at the local level by bringing together partners in housing, the police and education who hold great influence over the wider determinants of health. Indeed, such work is already happening.[13]

ICSs will facilitate integration between NHS organisations and other partners that determine people's health and wellbeing. Under the health and care bill, each integrated care partnership will be required to develop an integrated care strategy to address

the health and social care needs of its local population, which the integrated care board must have regard to when exercising its functions. As set out in DHSC guidance, the creation of integrated care partnerships provides an enormous opportunity to:

> "...address health challenges that the health and care system cannot address alone, especially those that require a longer timeframe to deliver, such as tackling health inequalities and the underlying social determinants that drive poor health outcomes, including employment, reducing offending, climate change and housing."[14]

A key opportunity for systems is to provide the platform for the 'health in all policies' approach to be achieved in ways that work locally.

New system leadership

Since we undertook our survey of system leaders, many new ICS chief executives and chairs have been appointed.*

With new expertise being brought in by new ICS leaders – including from abroad, the voluntary sector, NHS trusts, industry and local government – these new structures will gain perspectives from different parts of health and care and beyond. There is an opportunity for a departure from more traditional organisational/interest-driven leadership styles and towards more collaborative leadership.

The new system architecture will provide opportunities for distributive leadership, with chief executives devolving power more evenly across the system.

* At the time of writing three ICSs have failed to appoint a chair.

Firstly, integrated care board non-executive directors will have a key role in providing independent scrutiny and building trust and collaborative relationships with key agents of change on the board, in the ICP, at place and beyond. Many boards are appointing five plus non-executive members.

Secondly, as envisaged by the integration white paper, place leaders may also expect to yield influence over the delivery of care.

Thirdly, ICSs represent an important shift towards an equal partnership between the NHS and local government. ICPs – which will also incorporate the expertise of the voluntary, community and social enterprise (VCSE) sector – will play a key role in setting the integrated care strategy for their local population.

Fourth, from July 2022 trusts providing acute and/or mental health services will have to become part of one (although likely more) provider collaboratives, entities which will play a key role in strengthening and supporting local partnership working. We believe this will result in strengthened relationships.

There is, however, a risk that if ICSs do not gain the trust and strength of relationships needed to progress on complex system-wide issues, ICS structures will revert to old, more hierarchical ways of working, in which NHS, local government and VCSE organisations are beholden to the ICS as a top-down arbiter. As former ICS chair Professor Sir Chris Ham has commented:

> "Almost any arrangement can work if the people involved want it to succeed based on a shared vision of what they wish to achieve and a willingness to come together for the good of the population they serve... there must be latitude for ICSs to determine the governance that works best for them... Only in this way will ICSs be able to rely on mutual trust and reciprocity rather than old style oversight and regulation."[15]

The NHS Confederation looks forward to working closely with new ICS chief executives and chairs to develop the leadership styles and cultures that will help them to make progress and achieve the vision of statutory ICSs.

Recommendations

- ICS leaders should work closely with their trust counterparts, local authority and place-based partners to co-produce distributive leadership models for their systems based on the principle of subsidiarity. NHS England and government should accept and encourage variation in these models, reflecting the variation between systems across the country.

- ICS leaders should ensure their governance structures allow mechanisms for input across all the demographic groups they serve, especially including disadvantaged communities, by ensuring meaningful engagement with local authorities and the VCSE sector through the integrated care partnership.

What will be the biggest barriers to success?

In our survey of ICS leaders we asked about the biggest obstacles to ICS progress over the coming years (respondents were able to select up to three options).

The top five results were as follows:

#	Answer	%
1	Workforce	76%
2	Finance	63%
3	Lack of settlement for social care	57%
4	Elective backlog	37%
5	Oversight and regulation	20%

In this section we address each in turn and set out leaders' specific concerns on each of the top three.

Workforce

The NHS went into the COVID-19 pandemic with over 100,000 vacancies, with a similar number in social care. The staffing gaps that have developed and become entrenched across health and care partly explain why recent staff absences due to COVID-19 have been so detrimental to NHS performance.

As research by the Health Foundation has shown, by 2030/31 up to an extra 488,000 healthcare staff will be needed to meet demand

pressures and recover from the pandemic.[16] This is the equivalent of a 40 per cent increase in the workforce – double the growth seen in the last decade.

Earlier in this report, we highlighted that systems broadly feel confident in their ability to deliver a 'one workforce' approach and improve working culture across services. However, we must be realistic on how much culture can be improved if such severe shortages continue.

NHS Confederation work on this issue

- The NHS Confederation, alongside a coalition of nearly 90 other organisations, has pressed for amendments to the health and care bill on workforce planning.[17] Specifically, the coalition wishes to see the bill mandate more regular independent assessments of current and future workforce numbers (every two years), to be published by the Secretary of State before parliament.

- There has been no national NHS workforce strategy since 2003. To provide the long-term planning and ambition that is urgently required, we have called on the government to develop and publish a health and care workforce strategy as a priority. We understand the complexities of doing so and remain clear that the ambitions of a national strategy will need to be supported by system-level workforce plans.

Funding for healthcare

As set out in the methodology at the outset of this report, our survey took place in autumn 2021 – before the Comprehensive Spending Review (CSR). In comments received through the survey and in subsequent roundtable and interview discussions, it was clear that system leaders' concerns on finance related primarily to overall levels of healthcare spending being too low.

However, the broad reaction to the increase in health spending through the CSR among system leaders has been positive. It is welcome that core day-to-day spending on the NHS is set to rise by 3.8 per cent between 2021/22 and 2024/25, reaching a total of £152bn (in today's prices) in 2024/25. The government has also provided £8bn to tackle the elective backlog over the Spending Review.

System leaders' secondary concerns lie in how allocations to systems are determined in future and the degree of autonomy they will have to use and direct funding as they see fit. There are, rightly, mechanisms in place in certain areas to direct funding allocation – including the Mental Health Investment Standard – but broadly system leaders feel that delivering population health improvements for their populations will require a high degree of financial autonomy.

NHS Confederation work on this issue

- We pressed strongly for, and welcomed, the increased investment for the NHS through the planned health and social care levy. We will continue to resist calls for a U-turn.

- We have been clear that new powers of direction for the Secretary of State being introduced through the health and care bill should not be used to undermine the integrity of fair share allocations to local systems. For example, government should not be able to unfairly seek to amend allocations to a particular part of the country, contrary to the allocation formula.

- In our engagement with DHSC on the integration white paper, we have argued against placing restrictions on how funding can be used and allocated by system leaders. This includes mandatory pooled health and care budgets, though we would welcome the removal of obstacles to budget pooling.

Lack of settlement for social care

The pandemic has laid bare the interdependencies between the health and care sectors. When one suffers so does the other. In recent months we have seen this, for example, when care homes reach capacity and are unable to take more residents, leading to further delayed discharges in hospitals.

System leaders are innovating to plug gaps in government support. For example, Sir Jim Mackey's trust, Northumbria Healthcare NHS Foundation Trust, is launching itself as a direct provider of domiciliary social care services to meet care costs and improve patient flow.[18] Sajid Javid confirmed at our ICS Network conference that the DHSC will support ICS leaders who want to divert money to the social care sector. However, the problems facing the social care sector will demand long-term funding and support from the government, which the recent white paper on adult social care did not achieve.

System leaders are concerned that continued neglect of the social care sector over the coming years will both restrict the ability of local authorities to engage effectively in ICSs, but also inhibit the NHS in being able to deliver better outcomes for patients and residents.

NHS Confederation work on this issue

- We have been clear in media that the government must build significantly on the commitments of the health and care levy by setting out a long-term sustainable settlement for the social care sector.

- In the immediate term, the NHS Confederation has argued that the government should move fast to stem the haemorrhaging of social care staff. Offering a £1,000 retention bonus to each worker and adding care workers to the Shortage Occupation List would go some way to doing so.

Summary of recommendations

Driving social and economic development

- A suite of support should be co-developed (involving ICSs, local authorities, local enterprise partnerships, government and NHS England) for systems to play a more significant role in driving social and economic development. This should recognise and empower local nuance and partnerships. Future policy should reiterate the wider role systems can play in economic and social development.

- ICS leaders, government and NHSE should continue to champion the NHS as an anchor concept, ensuring that progress in addressing this ICS priority builds on and further develops emerging work in this area.

Defining the role of health and wellbeing boards

- Over the coming months systems should be given freedom and support to develop clear relationships between HWBs, place-based partnerships and integrated care partnerships (ICPs). The ICS Network will continue to engage with ICSs to support this process over the coming months.

- Flexibility from the centre on the role HWBs should play within ICSs from July has been welcomed and should continue.

Engagement of primary care in planning and strategy

- NHS England's regional teams should work with ICSs and primary care leaders to develop and support fora that allow all primary care leaders across a system to feed views into those representing primary care on the ICB.

- Clear requirements for primary care governance and engagement at 'place' to replace, and build on, those lost with the disbandment of CCGs. As recommended in The Role of Primary Care in Integrated Care Systems these include infrastructure support for primary care to enable links into the wider NHS, and those that facilitate partnership working.

- With PCNs set to be the 'building blocks of ICSs', NHSE and government should provide sufficient funding and support to ensure they can fulfil their contracts, while contributing to wider partnership working and integration at both place and system level.

A new relationship between central, regional and local

- National leaders should work with the ICS leaders to develop the future NHSEI operating model, with coproduction of guidance and policy becoming business as usual.

- Systems should continue to focus and build on establishing relationships and trust, in particular at place level, through thriving place-based partnerships and building in engagement mechanisms with local communities at all levels.

- NHSE regional offices should become centred around support and facilitation in future, with a shift away from the 'adult to child' relationship that has evolved in some parts of the country.

Lean, light and agile regulation and the importance of peer review

- ICSs should be involved in steering and leading the peer review process, including the offer facilitated and organised by the NHS Confederation, Local Government Association and NHS Providers. It is hoped that this will become a key tool for driving system improvement over the coming years.

- Regulatory frameworks should be developed on the principles of co-design with local systems, including local determination of the metrics they are assessed on based on local priorities.

- Regulators should actively support ICS peer review by imparting data, skills and understanding of processes, and stripping back layers of regulation where appropriate to prevent duplication.

New system leadership

- ICS leaders should work closely with their trust counterparts, local authority and place-based partners to co-produce distributive leadership models for their systems based on the principle of subsidiarity. NHS England and government should accept and encourage variation in these models, reflecting the variation between systems across the country.

- ICS leaders should ensure their governance structures allow mechanisms for input across all the demographic groups they serve, especially including disadvantaged communities, by ensuring meaningful engagement with local authorities and the VCSE sector through the integrated care partnership.

Conclusion and next steps

The following six months are going to be critical for ICSs as they look to begin operation as statutory organisations from July 2022. The ICS Network and our members remain optimistic about the huge potential system working has across a range of areas. Yet, realising this potential will depend on achieving progress on the issues highlighted in this report. We call on the Department of Health and Social Care, NHS England and the Care Quality Commission to work with us over the coming months to ensure that ICSs are given the support they need to succeed.

As set out in the methodology section, the ICS Network intends to ask the same (or similar) questions of system leaders for 2022/23, allowing us to identify trends over time on levels of confidence or concern in different areas relating to system development.

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