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Integrated Care Systems: design framework

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Introduction and summary

Everyone across the health and care system in England, in the NHS, local authorities and voluntary organisations, has made extraordinary efforts to manage the COVID-19 pandemic and deliver the vaccination programme while continuing to provide essential services.

We still face major operational challenges: tackling backlogs; meeting deferred demand, new care needs, changing public expectations; tackling longstanding health inequalities; enabling respite and recovery for those who have been at the frontline of our response; and re-adjusting to a post-pandemic financial regime. The intensity of the incident may have abated, but we are still managing exceptional pressure and uncertainty, with differential impacts across the country.

As we respond, Integrated Care Systems (ICSs) will play a critical role in aligning action between partners to achieve their shared purpose: to improve outcomes and tackle inequalities, to enhance productivity and make best use of resources and to strengthen local communities.

Throughout the pandemic our people told us time and time again that collaboration allowed faster decisions and better outcomes. Co-operation created resilience. Teamwork across organisations, sectors and professions enabled us to manage the pressures facing the NHS and our partners.

As we re-focus on the ambitions set out in the NHS Long Term Plan, it is imperative we maintain our commitment to collaborative action, along with the agility and pace in decision-making that has characterised our response to the pandemic.

We want to do everything we can to support this nationally and give you the best chance of making effective and enduring change for the people you serve.

This means seizing the opportunities presented by legislative reform to remove barriers to integrated care and create the conditions for local partnerships to thrive. And it means asking NHS leaders, working with partners in local government and beyond, to continue developing Integrated Care Systems during 2021/22, and preparing for new statutory arrangements from next year.

We know this is a significant ask. This document sets out the next steps. It builds on previous publications¹ to capture the headline ambitions for how we will expect NHS leaders and organisations to operate with their partners in ICSs from April 2022. It aims to support you as you continue to deliver against the core purpose of ICSs and put in place the practical steps to prepare for their new arrangements that we expect to be enabled by legislation in this Parliamentary session.

The ambition for ICSs is significant and the challenge for all leaders within systems is an exciting one. Successful systems will align action and maintain momentum during transition, with systems continuing to make progress in improving outcomes and supporting recovery while embedding new arrangements for strategic planning and collective accountability across partners. The collective leadership of ICSs and the organisations they include will bring teams with them on that journey and will command the confidence of NHS and other public sector leaders across their system as they deliver for their communities. The level of ambition and expectation is shared across all ICSs – and there will be consistent expectations set through the oversight framework, financial framework national standards and LTP commitment – with ICSs adjusting their arrangements to be most effective in their local context.

It is important that this next year of developing ICSs and implementing statutory changes, if approved by Parliament and once finalised, builds on progress to date and the great work that has already taken place across the country. Effective transition will see high performing systems taking their existing ways of working and creatively adapting these to the new statutory arrangements. It is an acceleration, in the current direction.

This document begins to describe future ambitions for:

- the **functions of the ICS Partnership** to align the ambitions, purpose and strategies of partners across each system²
- the **functions of the ICS NHS body**, including planning to meet population health needs, allocating resources, ensuring that services

¹[Integrating care: next steps to building strong and effective integrated care systems](#) and [Integration and innovation: working together to improve health and social care for all NHS Operational Planning and Contracting Guidance](#)

² Guidance on the Partnership will be developed by DHSC with local government, NHS and other stakeholders. Expectations described here are based on the proposals set out in the Government's White Paper and initial discussions with local government partners.

are in place to deliver against ambitions, facilitating the transformation of services, co-ordinating and improving people and culture development, and overseeing delivery of improved outcomes for their population

- the **governance and management arrangements** that each ICS NHS body will need to establish to carry out those functions including the flexibility to operate in a way that reflects the local context through place-based partnerships and provider collaboratives
- the opportunity for **partner organisations** to work together as part of ICSs to agree and jointly deliver shared ambitions
- **key elements of good practice** that will be essential to the success of ICSs, including strong clinical and professional leadership, deep and embedded engagement with people and communities, and streamlined arrangements for maintaining accountability and oversight
- the key features of the **financial framework** that will underpin the future ambitions of systems, including the freedom and mechanisms to use resource flexibly to better meet identified needs and to manage financial resources at system level
- the roadmap to **implement new arrangements** for ICS NHS bodies by April 2022 to establish new organisations, appoint leadership teams to new statutory organisations and to ensure that people affected by change are offered a smooth transition that allows them to maintain focus on their critical role in supporting recovery from the pandemic.

Further information or guidance, developed through engagement with systems and stakeholders, will be made available to support detailed planning. Where relevant, this will follow the presentation of proposed legislation to Parliament.

We have heard a clear message from systems that they are looking for specificity about the consistent elements of how we will ask them to operate, alongside a high degree of flexibility to design their ways of working to best reflect local circumstances. This document aims to achieve both: to be clear and specific on the consistent requirements for systems and to define the parameters for the tailoring to local circumstances which is key to success. It goes beyond likely minimum statutory requirements and sets out the ambition from NHS England and NHS

Improvement³ on what will be necessary for systems to be successful as they lead our recovery from the pandemic and the wider delivery of the Long Term Plan.

The Framework does not attempt to describe the full breadth of future ICS arrangements or role of all constituent partners but focuses on how we expect the NHS to contribute. For non-NHS organisations, we hope this document will provide helpful framing on how the NHS will be approaching the proposed establishment of ICS NHS bodies, and inform broader discussions on the creation of system-wide and place-based partnership arrangements.

From the outset, our ambition for ICSs has been co-developed with system leaders, people who use services and many other stakeholders. We will continue this approach as we develop guidance and implementation support, based on feedback and ongoing learning from what works best.

The Framework is based on the objectives articulated in Integrating Care: next steps, which were reflected in the Government’s White Paper.⁴ But content referring to new statutory arrangements and duties, and/or which is dependent on the implementation of such arrangements and duties, is subject to legislation and its parliamentary process. Systems may make reasonable preparatory steps in advance of legislation but should not act as though the legislation is in place or inevitable.

³ In this document we use ‘NHS England and NHS Improvement’ when referring to the functions and activities of both NHS England and NHS Improvement prior to April 2022, and NHS England only from April 2022 (subject to legislation).

⁴ This document uses the terminology of the White Paper (ICS Partnership and ICS NHS Body). The final legal terms to be adopted for the new statutory components of each ICS will be determined by the legislation.

Context

In November 2020 NHS England and NHS Improvement published [*Integrating care: Next steps to building strong and effective integrated care systems across England*](#).

It described the core purpose of an ICS being to:

- **improve outcomes** in population health and healthcare
- **tackle inequalities** in outcomes, experience and access
- **enhance productivity** and value for money
- help the NHS support broader **social and economic development**.

It emphasised that the next phase of ICS development should be rooted in underlying principles of subsidiarity and collaboration. It described common features that every system is expected to have and develop, as the foundations for integrating care, with local flexibility in how best to design these to achieve consistent national standards and reduce inequalities, as:

- decisions taken closer to, and in consultation with, the communities they affect are likely to lead to better outcomes
- collaboration between partners, both within a place and at scale, is essential to address health inequalities, sustain joined-up, efficient and effective services and enhance productivity
- local flexibility, enabled by common digital capabilities and coordinated flows of data, will allow systems to identify the best way to improve the health and wellbeing of their populations.

Reflecting insight drawn from local systems, the document outlined the key components to enable ICSs to deliver their core purpose, including:

- **strong place-based partnerships** between the NHS, local councils and voluntary organisations, local residents, people who access service their carers and families, leading the detailed design and delivery of integrated services within specific localities (in many places, long-established local authority boundaries), incorporating a number of neighbourhoods
- **provider collaboratives**, bringing NHS providers together across one or more ICSs, working with clinical networks and alliances and other partners, to secure the benefits of working at scale.

In February 2021 NHS England and NHS Improvement made [recommendations to Government](#) to establish ICSs on a statutory basis, with strengthened provisions to ensure that local government could play a full part in ICS decision-making. These proposals were adopted in the Government's White Paper [Integration and Innovation: working together to improve health and social care for all](#), and we expect legislation to be presented to Parliament shortly. This document is based on our expectations as to the content of that legislation, describing how new arrangements would look if the proposals were implemented, while recognising that the legislation is subject to Parliament's amendment and approval.

Subject to the passage of legislation, the statutory⁵ ICS arrangements will comprise:

- an ICS Partnership, the broad alliance of organisations and representatives concerned with improving the care, health and wellbeing of the population, jointly convened by local authorities and the NHS
- an ICS NHS body, bringing the NHS together locally to improve population health and care.

This ICS Design Framework sets out in more detail how we expect NHS organisations to respond in the next phase of system development, including the anticipated establishment of statutory ICS NHS bodies from April 2022. It describes the 'core' arrangements we will expect to see in each system and those we expect local partners to determine in their local context; depending on their variation in scale, geography, population health need and maturity of system arrangements.

Its purpose is to provide some 'guide rails' for NHS organisations as they develop their plans - reflecting the best ways of serving communities and patients in their specific local context - to give them the best chance of delivering on the four core purposes, in the urgent context of COVID recovery.

⁵ ICSs will comprise a much wider set of partnership arrangements supported by this statutory framework.

The ICS Partnership

Each ICS will have a Partnership at system level established by the NHS and local government as equal partners. The Partnership will operate as a forum⁶ to bring partners – local government, NHS and others – together across the ICS area to align purpose and ambitions with plans to integrate care and improve health and wellbeing outcomes for their population.

The Partnership will facilitate joint action to improve health and care services and to influence the wider determinants of health and broader social and economic development. This joined-up, inclusive working is central to ensuring that ICS partners are targeting their collective action and resources at the areas which will have the greatest impact on outcomes and inequalities as we recover from the pandemic.

We expect the ICS Partnership will have a specific responsibility to develop an 'integrated care strategy' for its whole population using best available evidence and data, covering health and social care (both children's and adult's social care), and addressing the wider determinants of health and wellbeing. This should be built bottom-up from local assessments of needs and assets identified at place level, based on Joint Strategic Needs Assessments. We expect these plans to be focused on improving health and care outcomes, reducing inequalities and addressing the consequences of the pandemic for communities. We expect each Partnership to champion inclusion and transparency and to challenge all partners to demonstrate progress in reducing inequalities and improving outcomes. It should support place- and neighbourhood-level engagement, ensuring the system is connected to the needs of every community it includes.

The Government has indicated that it does not intend to bring forward detailed or prescriptive legislation on how these Partnerships should operate. Rather the intention is to set a high-level legislative framework within which systems can develop the partnership arrangements that work best for them, based on the core principles of equal partnership across health and Local Government, subsidiarity, collaboration and flexibility.

⁶ The ICS Partnership will be a committee, rather than a corporate body.

To support this process, formal guidance on ICS Partnerships will be developed jointly by the Department of Health and Social Care (DHSC), NHS England and NHS Improvement, and the Local Government Association (LGA), and consulted on ahead of implementation, including on the role and accountabilities of the chair of the Integrated Care Partnership. This document gives an overview of the type of information that we expect to be included in that guidance.

Establishment and membership

The Partnership will be established locally and jointly by the relevant local authorities and the ICS NHS body, evolving from existing arrangements and with mutual agreement on its terms of reference, membership, ways of operating and administration. Appropriate arrangements will vary considerably, depending on the size and scale of each system.

Members must include local authorities that are responsible for social care services in the ICS area, as well as the local NHS (represented at least by the ICS NHS body). Beyond this, members may be from health and wellbeing boards, other statutory organisations, voluntary, community and social enterprise (VCSE) sector partners, social care providers and organisations with a relevant wider interest, such as employers, housing and education providers and the criminal justice system. They should draw on experience and expertise from across the wide range of partners working to improve health and care in their communities, including ensuring that the views and needs of patients, carers and the social care sector are built into their ways of working. The membership may change as the priorities of the partnership evolve.

To facilitate broad membership and stakeholder participation, Partnerships may use a range of sub-groups, networks and other methods to convene parties to agree and deliver the priorities set out in the shared strategy.

Leadership and accountability

The ICS NHS body and local authorities will need to jointly select a Partnership chair and define their role, term of office and accountabilities.

Some systems will prefer the Partnership and ICS NHS body to have separate chairs. This may, for instance, provide greater scope for democratic representation. Others may select the appointed NHS ICS body chair as the chair for both the NHS

Board and the Partnership to help ensure co-ordination. This will be a matter for local determination.

We expect public health experts to play a significant role in these partnerships, specifically including local authority directors of public health and their teams who can support, inform and guide approaches to population health management and improvement.

Partnerships will need clear and transparent mechanisms for ensuring strategies are developed with people with lived experience of health and care services and communities, for example including patients, service users, unpaid carers and traditionally under-represented groups. These mechanisms should draw on best engagement practice; for example, by using citizens' panels and co-production approaches, including insights from place and neighbourhood engagement. Partnerships should build on the expertise, relationships and engagement forums that already exist across local areas, building priorities from the bottom up, to ensure the priorities in the strategy resonate with people across the ICS.

As a key forum for convening and influencing and engaging the public, the Partnership will need to be transparent with formal sessions held in public. Its work must be communicated to stakeholders in clear and inclusive language.

Partnership principles

The ICS Partnership will play a key role in nurturing the culture and behaviours of a system. We invite systems to consider these 10 principles:

1. Come together under a distributed leadership model and commit to working together equally.
2. Use a collective model of decision-making that seeks to find consensus between system partners and make decisions based on unanimity as the norm, including working through difficult issues where appropriate.
3. Operate a collective model of accountability, where partners hold each other mutually accountable for their shared and individual organisational contributions to shared objectives.
4. Agree arrangements for transparency and local accountability, including meeting in public with minutes and papers available online.

5. Focus on improving outcomes for people, including improved health and wellbeing, supporting people to live more independent lives, and reduced health inequalities.
6. Champion co-production and inclusiveness throughout the ICS.
7. Support the triple aim (better health for everyone, better care for all and efficient use of NHS resources), the legal duties on statutory bodies to co-operate and the principle of subsidiarity (that decision-making should happen at the most local appropriate level).
8. Ensure place-based partnership arrangements are respected and supported, and have appropriate resource, capacity and autonomy to address community priorities, in line with the principle of subsidiarity.
9. Draw on the experience and expertise of professional, clinical, political and community leaders and promote strong clinical and professional system leadership.
10. Create a learning system, sharing evidence and insight across and beyond the ICS, crossing organisational and professional boundaries.

The ICS NHS body

ICS NHS bodies will be established as new organisations that bind partner organisations together in a new way with common purpose. They will lead integration within the NHS, bringing together all those involved in planning and providing NHS services to take a collaborative approach to agreeing and delivering ambitions for the health of their population. They will ensure that dynamic joint working arrangements, as demonstrated through the response to COVID-19, become the norm. They will establish shared strategic priorities within the NHS and provide seamless connections to wider partnership arrangements at a system level to tackle population health challenges and enhance services at the interface of health and social care.

Functions of the ICS NHS body

The ICS NHS body will be a statutory organisation responsible for specific functions that enable it to deliver against the four core purposes:

- **Developing a plan** to meet the health needs of the population within their area, having regard to the Partnership's strategy. This will include ensuring NHS services and performance are restored following the pandemic, in line with national operational planning requirements, and Long Term Plan commitments are met.
- **Allocating resources** to deliver the plan across the system, including determining what resources should be available to meet the needs of the population in each place and setting principles for how they should be allocated across services and providers (both revenue and capital). This will require striking the right balance between enabling local decision-making to meet specific needs and securing the benefits of standardisation and scale across larger footprints, especially for more specialist or acute services.
- **Establishing joint working arrangements** with partners that embed collaboration as the basis for delivery of joint priorities within the plan. The ICS NHS body may choose to commission jointly with local authorities, including the use of powers to make partnership arrangements under section 75 of the 2006 Act and supported through the integrated care strategy, across the whole system; this may happen at place where that is the relevant local authority footprint.

- **Establishing governance arrangements** to support collective accountability between partner organisations for whole-system delivery and performance, underpinned by the statutory and contractual accountabilities of individual organisations, to ensure the plan is implemented effectively within a system financial envelope set by NHS England and NHS Improvement.
- **Arranging for the provision of health services** in line with the allocated resources across the ICS through a range of activities including:
 - Putting contracts and agreements in place to secure delivery of its plan by providers. These may be contracts and agreements with individual providers or lead providers within a place-based partnership or provider collaborative. They will reflect the resource allocations, priorities and specifications developed across the whole system and at place level. We expect contracts and agreements to be strategic, long-term and based on outcomes, with providers responsible for designing services and interventions to meet agreed system objectives.
 - Convening and supporting providers (working both at scale and at place) to lead⁷ major service transformation programmes to achieve agreed outcomes, including through joining-up health, care and wider support. In addition to ensuring that plans and contracts are designed to enable this, the ICS NHS body will facilitate partners in the health and care system to work together, combining their expertise and resources to deliver improvements, fostering and deploying research and innovations.
 - Working with local authority and VCSE partners to put in place personalised care for people, including assessment and provision of continuing healthcare and funded nursing care, and agreeing personal health budgets and direct payments for care. This may be delegated to individual place partnerships and delivered through integrated teams working in neighbourhoods or across local places, further supporting the integration of planning and provision with adult social care and VCSE organisations.
- **Leading system implementation of the People Plan** by aligning partners across each ICS to develop and support the ‘one workforce’, including through closer collaboration across the health and care

⁷ It is expected that the ICS NHS body will be able to delegate functions to statutory providers to enable this.

sector, and with local government, the voluntary and community sector and volunteers (See 'People and culture' section below).

- **Leading system-wide action on data and digital:** ICS NHS bodies will work with partners across the NHS and with local authorities to put in place smart digital and data foundations to connect health and care services and ultimately transform care to put the citizen at the centre of their care (see 'Data and digital' section below);
- Using joined-up data and digital capabilities to **understand local priorities, track delivery of plans, monitor and address variation and drive continuous improvement** in performance and outcomes.
- Working alongside councils to **invest in local community organisations and infrastructure** and, through joint working between health, social care and other partners including police, education, housing, safeguarding partnerships, employment and welfare services, **ensuring that the NHS plays a full part in social and economic development and environmental sustainability.**
- **Driving joint work on estates, procurement, supply chain and commercial strategies** to maximise value for money across the system and support these wider goals of development and sustainability
- **Planning for, responding to and leading recovery from incidents** (EPRR), to ensure NHS and partner organisations are joined up at times of greatest need, including taking on incident coordination responsibilities as delegated by NHS England and NHS Improvement.
- **Functions NHS England and NHS Improvement will be delegating** including commissioning of primary care and appropriate specialised services.

We expect that all clinical commissioning group (CCG) functions and duties will transfer to an ICS NHS body when they are established, along with all CCG assets and liabilities including their commissioning responsibilities and contracts.

Relevant statutory duties of CCGs regarding safeguarding, children in care and special educational needs and disabilities (SEND) will apply to ICS NHS bodies. We will clarify in guidance how these statutory duties will transition to ICS NHS bodies. ICSs should support joint working around responsibilities such as safeguarding through new and existing partnership arrangements; and health and

care strategies and governance should account for the needs of children and young people.

The board of the ICS NHS body will be responsible for ensuring that the body meets its statutory duties. We expect these duties will include supporting achievement of the triple aim, improving quality of services, reducing inequalities, ensuring public involvement, obtaining clinical and public health advice, promoting innovation and research, and other duties that may be defined in law.

We are reviewing our own operating model - including how our functions and activities will be carried out in future and how associated resources will be deployed -in the context of the expected creation of statutory ICS NHS bodies. We are committed to ensuring that the principle of subsidiarity is applied in considering our own functions, that resources are devolved accordingly, and that the creation of ICS NHS bodies does not lead to duplication or create additional bureaucracy within the NHS. We will co-design our new arrangements with the sector and our partners.

People and culture

Better care and outcomes will be achieved by people – local residents, service users, carers, professionals and leaders – working together in different ways. Successful ICSs will develop a culture that attracts people to work in and for their community and supports them to achieve their full potential.

The [NHS People Plan](#) sets out the ambition of having ‘more people, working differently, in a compassionate and inclusive culture’. Although individual employers remain the building blocks for delivering the People Plan, ICSs have an important role in leading and overseeing progress on this agenda – including strengthening collaboration among health and care partners – and have already developed their own local People Plans setting out how they will achieve this ambition in their area. These plans should be aligned with the ICS Partnership’s Strategy as it is developed and be refreshed annually, taking account of national priorities.

From April 2022, ICS NHS bodies are expected to have specific responsibilities for delivering against the themes and actions set out in the NHS People Plan and the people priorities in operational planning guidance. ICS NHS bodies will play a critical role in shaping the approach to growing, developing, retaining and supporting the entire local health and care workforce. While the People Plan sets out specific objectives and responsibilities for NHS organisations, we expect ICS NHS bodies to adopt a ‘one workforce’ approach and develop shared principles and ambitions for people and culture with local authorities, the VCSE sector and other partners.

Those planning and delivering health and care services are employed by a range of different organisations (including the ICS NHS body in future). Each will have strategies for attracting, retaining and developing the people they need to deliver the services and functions they are responsible for. To deliver against the ICS’s four core purposes and to make the local area a great place to work and live, the ICS NHS body – working with the ICS Partnership – will help bring these partners together to develop and support the ‘one workforce’ which contributes to providing care across the system. This includes supporting the expansion of primary care and integrated teams in the community and closer collaboration on workforce development across the health and care sector, and with local government, the third sector and volunteers.

The ICS NHS body will be expected to establish the appropriate people and workforce capability to discharge their responsibilities, including strong local leadership. In particular, the ICS NHS body will need to:

- have clear leadership and accountability for the organisation's role in delivering agreed local and national people priorities, with a named SRO with the appropriate expertise (registered people professional (CIPD accredited) or with equivalent experience)
- demonstrate how it is driving equality, diversity and inclusion. It should foster a culture of civility and respect, and develop a workforce and leadership that are representative of the population they serve.

To support local and national people priorities for the one workforce in the system, the ICS NHS body should work with organisations across the ICS to:

- Establish clear and effective governance arrangements for agreeing and delivering local strategic and operational people priorities. This will include ensuring there are clear lines of accountability and streamlined ways of working between individual organisations within the system, with other ICSs and with regional workforce teams
- Support the delivery of standardised, high-quality transactional HR services (eg payroll) across the ICS, supported by digital technology. These services should be delivered at the most effective level within the ICS footprint, based on the principle of subsidiarity, but proactively taking opportunities for collaboration and securing the benefits of delivering at scale. Local arrangements for delivering these services should be agreed by relevant employers across the system, facilitated by the NHS ICS Body, to support standardisation and remove duplication to allow for the reallocation resources to deliver on the strategic people agenda across the ICS
- Ensure action is taken to protect the health and wellbeing of people working within the ICS footprint, delivering the priorities set out in the 2021/22 planning guidance and in the People Promise, to improve the experience of working in the health and care system for all
- Establish leadership structures and processes (including leadership development, talent management and succession planning approaches) to drive the culture, behaviours and outcomes needed for

people working in the system and the local population, in line with the Leadership Compact⁸

- Undertake integrated and dynamic workforce, activity and finance planning based on population need, transformation of care models and changes in skills and ways of working – reflected in the system people plan and in the ICS Partnership’s Strategy
- Plan the development – and where required, growth – of the one workforce to meet future need. This should include agreeing collaborative recruitment and retention approaches where relevant, planning local educational capacity and opportunities, and attracting local people into health and care employment and careers (including creating long-term volunteering opportunities)
- Develop new ways of working and delivering care that optimise staff skills, technology and wider innovation to meet population health needs and to create flexible and rewarding career pathways for those working in the system. This should be enabled by inclusive employment models, workforce sharing arrangements and passporting or accreditation systems
- Contribute to wider local social and economic growth and a vibrant local labour market, through collaboration with partner organisations, including the care home sector and education and skills providers.

To support ICS NHS bodies to discharge these responsibilities and deliver national and local people and workforce priorities, we will work with Health Education England to publish supplementary guidance and implementation support resources for ICSs on developing their strategic People capabilities, including a People operating model.

⁸ The NHS Leadership Compact will set out the compassionate and inclusive behaviour we want all our leaders to show towards people. It will require every leader, at every level, to recognise, reflect and bring to life every day six core principles focused on: equality and diversity; continuous improvement; kindness, compassion and respect; trust; supporting people and celebrating success; and collaboration and partnership. The Compact will be published in due course.

Governance and management arrangements

Strong and effective governance and management arrangements are essential to enable ICSs to deliver their functions effectively. The pandemic has shown the success of partnership approaches that allow joined-up, agile and timely decision-making underpinned by common objectives. ICSs will build from this to establish robust governance and management arrangements that are flexibly designed to fit local circumstances and that bind partners together in collective endeavour.

This guidance provides an overview of our expectations for ICS governance and management arrangements. We will provide further resources throughout the year that share learning on the different approaches ICSs are developing.

The ICS NHS board

The statutory governance requirements for the NHS ICS body will be set out in legislation and NHS England and NHS Improvement will provide further guidance on the constitution of the board and process for this being agreed prior to establishment. This section provides an overview of our current expectations which will be developed, through engagement. As a new type of organisation, the governance arrangements for ICS NHS bodies will be different to those of existing commissioner and provider organisations in the NHS. They will need to reflect the different ways of working that will be required for ICS NHS bodies to effectively deliver their functions - as independent statutory NHS bodies, that bring together parties from across the NHS. The minimum requirements we set out are designed to provide a common framework for effective leadership and governance in this context.

The ICS NHS body will have a unitary board. The board will be responsible for ensuring the body plays its role in achieving the four purposes of the wider ICS and should be constituted in a way that ensures this focus on improving outcomes in population health and healthcare; tackling inequalities in outcomes, experience and access; enhancing productivity and value for money; and contributing to broader social and economic development.

All members of the ICS NHS board (referred to below as “the board”) will have shared corporate accountability for delivery of the functions and duties of the ICS

and the performance of the organisation. This includes ensuring that the interests of the public and people who use health and care services remain central to what the organisation does. The board will be the senior decision-making structure for the ICS NHS body.

The statutory minimum membership of the board of each ICS NHS body will be confirmed in legislation. To carry out its functions effectively we will expect every ICS NHS body to establish board roles above this minimum level, so in most cases they will include the following roles:

- Independent non-executives: chair plus a minimum of two other independent non-executive directors (as a minimum required to chair the audit and remuneration committees). These individuals will normally not hold positions or offices in other health and care organisations within the ICS footprint.
- Executive roles (employed by the body): chief executive (who will be the accountable officer for the funding allocated to the ICS NHS body), director of finance, director of nursing and medical director.
- Partner members: a minimum of three additional board members, including at least:
 - one member drawn from NHS trusts and foundation trusts who provide services within the ICS's area
 - one member drawn from the primary medical services (general practice) providers within the area of the ICS NHS body
 - one member drawn from the local authority, or authorities, with statutory social care responsibility whose area falls wholly or partly within the area of the ICS NHS body.

We expect all three partner members will be full members of the unitary board, bringing knowledge and a perspective from their sectors, but not acting as delegates of those sectors.

We expect the partner members from NHS trusts/foundation trusts and local authorities will often be the chief executive of their organisation or in a relevant executive-level local authority role.

The process of appointing the partner members, and the rules for qualification to be a member, will be set out in the constitution of the body.

The final composition of the board and the process of appointment of partner members will need to be consistent with any requirements set out in primary legislation and is therefore subject to Parliamentary process.

ICS NHS bodies will be able to supplement these minimum board positions as they develop their own ICS NHS body constitution, which will be subject to agreement with NHS England and NHS Improvement.

We expect all members of the board will be required to comply with the Nolan Principles of Public Life and meet the Fit & Proper Persons test, and boards must have clear governance and board level accountability for discharging the associated regulations.

Boards of ICS NHS bodies will need to be of an appropriate size to allow effective decision making to take place. Through a combination of their membership, and the ways in which members engage partners, the board and its committees should ensure they take into account the perspectives and expertise of all relevant partners. These should include all parts of the local health and care system across physical and mental health, primary care, community and acute services, patient and carer representatives, social care and public health, with directors of public health having an official role in the ICS NHS bodies and the Partnership.

It will be important that boards have strong leadership on issues that impact upon organisations and staff across the ICS, including the people agenda and digital transformation.

The ICS NHS body will be expected to promote open and transparent decision-making processes that facilitate finding consensus, drawing on agreed decision-making processes to manage areas of disagreement to ensure that the statutory duties of the ICS NHS body continue to be met. The board and its committees will have to make decisions transparently, holding meetings in public and publishing the papers.

NHS England and NHS Improvement will publish further guidance on the composition and operation of the board, including a draft model constitution. We will also provide guidance on the management of conflicting roles and interests,

ensuring partners can work together effectively and that the public can have confidence decisions are being made in their best interests as taxpayers and service users (see below for new provider selection regime).

Committees and decision-making

All ICS NHS bodies will need to put arrangements in place to ensure they can effectively discharge their full range of duties and functions. This is likely to include arrangements for committees and groups to advise and feed into the board, and to exercise functions delegated by the board. Boards may be supported by an executive group including, for example, other professional and functional leads, to manage the day-to-day running of the organisation.

These arrangements should address the cross-cutting functional responsibilities of the body including finance and resources, people, quality, digital and data performance and oversight. They should enable full involvement of clinical and professional leaders, leaders of place-based partnerships and providers, including relevant provider collaboratives. We expect the ICS NHS body will have arrangements that bring all relevant partners together to participate in decision-making.

We expect that each board will be required to establish an audit committee and a remuneration committee. The board may establish other decision-making committees, in accordance with its scheme of delegation. The board may also establish advisory committees to advise it on discharging certain duties, such as public and patient engagement.

The legislation is expected to give ICS NHS bodies flexibility in how they establish and deploy such committees. In particular, they will have the power to:

- appoint individuals who are not board members or staff of the ICS NHS body to be members of any committee it has established
- establish joint committees with NHS Trusts/FTs to which they may delegate responsibilities (decision making) in accordance with those bodies' schemes of delegation.

As ICSs will have significant flexibility in how and where decisions and functions are undertaken, every ICS NHS body should maintain a 'functions and decision map' showing its arrangements with ICS partners to support good governance and

dialogue with internal and external stakeholders. This should include arrangements for any commissioning functions delegated or transferred by NHS England and NHS Improvement.

The boards of ICS NHS bodies, and their committees, should conduct their business in a way that builds consensus, and should seek to achieve consensus on decisions. They should foster constructive challenge, debate and the expression of different views, reflecting the scope of their remit and their constituencies. They should have agreed processes for resolving differences in the first instance, if consensus cannot be reached; for example, through referencing the principles and behaviours set out in the ICS NHS body's constitution and by assessing the decision for consistency with overarching objectives (including the triple aim) and plans already agreed. The chair may make decisions on behalf of the board where there is disagreement. Where necessary boards may draw on third party support such as peer review or mediation by NHS England and NHS Improvement.

The ICS NHS body's constitution may provide for a vote to be taken where consensus cannot be reached and to set out how the vote will be conducted (for example, the chair having the casting vote). However, voting should be considered a last resort rather than a routine mechanism for board decision-making.

Place-based partnerships

Partnerships between organisations to collectively plan, deliver and monitor services within a locally defined 'place' have a long history. These place-based partnerships have typically been established by local agreement according to their context and this bottom-up approach has been an important enabler to meaningful collaboration. However, as part of the development of ICSs, we now expect that place-based partnerships are consistently recognised as key to the coordination and improvement of service planning and delivery, and as a forum to allow partners to collectively address wider determinants of health.

We have asked each system to define its place-based partnership arrangements, covering all parts of its geography, agreed collaboratively between the NHS, local government and other system partners working together in a particular locality or community.

There is no single way of defining place or determining a fixed set of responsibilities that a place-based partnership should hold. All systems should establish and

support place-based partnerships with configuration and catchment areas reflecting meaningful communities and geographies that local people recognise. In the smallest ICSs, the whole system may operate as a single place-based partnership. The arrangements for joint working at place should enable joined-up decision-making and delivery across the range of services meeting immediate care and support needs in those local places but should be designed flexibly to reflect what works in that area.

The ICS NHS body will want to agree with local partners the membership and form of governance that place-based partnerships adopt, building on or complementing existing local configurations and arrangements such as Health and Wellbeing Boards. At a minimum, these partnerships should involve primary care provider leadership, local authorities, including directors of public health, providers of acute, community and mental health services and representatives of people who access care and support.

The ICS NHS body will remain accountable for NHS resources deployed at place-level. Governance and leadership arrangements for place-based partnerships should support safe and effective delivery of the body's functions and responsibilities alongside wider functions of the partnership. Each ICS NHS body should clearly set out the role of place-based leaders within the governance arrangements for the body.

An NHS ICS body could establish any of the following place-based governance arrangements with local authorities and other partners, to jointly drive and oversee local integration:

- consultative forum, **informing** decisions by the ICS NHS body, local authorities and other partners
- committee of the ICS NHS body with delegated authority to take decisions about the use of ICS NHS body resources⁹
- joint committee of the ICS NHS body and one or more statutory provider(s), where the relevant statutory bodies delegate decision making on specific functions/services/populations to the joint committee in accordance with their schemes of delegation

⁹ Contracts would be awarded and held, and payments made, by the ICS NHS body as the legal entity.

- individual directors of the ICS NHS body having delegated authority, which they may choose to exercise through a committee. This individual director could be a joint appointment with the local authority or with an NHS statutory provider and could also have delegated authority from those bodies
- lead provider managing resources and delivery at place-level under a contract with the ICS NHS body, having lead responsibility for delivering the agreed outcomes for the place.

Effective leadership at place level is critical to effective system working, but the specific approach is to be determined locally. The roles of place-based leaders will include convening the place-based partnership, representing the partnership in the wider structures and governance of the ICS and (potentially) taking on executive responsibility for functions delegated by the ICS NHS body CEO or relevant local authority.

Supra-ICS arrangements

There are some functions where ICS NHS bodies will need to work together; for example, commissioning more specialised services, emergency ambulance services and other services where relatively small numbers of providers serve large populations, and when working with providers that span multiple ICSs or operate through clinical networks. In many areas, multiple providers and ICS NHS bodies will need to work together to develop a shared plan for cancer services, with existing Cancer Alliances¹⁰ continuing to use their expertise to lead whole-system planning and delivery of cancer care on behalf of their constituent ICSs, as well as providing clinical leadership and advice on commissioning. Similarly, provider collaboratives, including those providing specialised mental health, learning disability and autism services, will span multiple ICS footprints where this is right for the clinical pathway for patients.

The governance arrangements to support this will need to be co-designed between the relevant providers, NHS ICS bodies clinical networks or alliances and, where relevant, NHS England and NHS Improvement regional teams. In smaller ICSs it will be particularly important to establish joint working arrangements at the appropriate scale for the task, joining up planning for services across a wider

¹⁰ Service Development Funding for cancer will continue to be provided to Cancer Alliances to enable them to continue to deliver their existing functions on behalf of their constituent ICS(s).

footprint where that makes sense to establish provider collaboratives at the appropriate scale to support service transformation across wider clinical networks.

ICSs and ambulance providers, which typically provide services to a population across multiple ICSs, should agree their working relationships carefully to ensure that, where appropriate, there is a joined-up dialogue between ICSs and their relevant ambulance provider, avoiding unnecessary variation in practice or duplication of communication. Alongside this, ambulance providers should consider how they can play their role effectively as part of individual systems, provider collaboratives and place partnerships, for example supporting the implementation of an effective integrated urgent care offer.

Quality governance

Quality is at the heart of all that we do. Each NHS organisation has individual responsibilities to ensure the delivery of high quality care. ICS NHS bodies will also have statutory duties to act with a view to securing continuous improvement in quality. We expect them to have arrangements for ensuring the fundamental standards of quality are delivered including to manage quality and safety risks and to address inequalities and variation; and to promote continual improvement in the quality of services, in a way that makes a real difference to the people using them.

ICSs are expected to build on existing quality oversight arrangements, with collaborative working across system partners, to maintain and improve the quality of care. ICS NHS bodies will need to resource quality governance arrangements appropriately, including leading System Quality Groups (previously Quality Surveillance Groups) and ensuring that clinical and care professional leads have capacity to participate in quality oversight and improvement. Operational support will also be provided through NHS England and NHS Improvement regional and national teams in line with National Quality Board's guidance, namely the refreshed [Shared Commitment to Quality and the Position Statement](#). These key documents set out the core principles and consistent operational requirements for quality oversight that ICS NHS bodies are expected to embed during the transition period (2021/22) and beyond.

The role of providers

Organisations providing health and care services are the frontline of each ICS. They will continue to lead the delivery and transformation of care and support, working alongside those who access their services and the wider communities they serve. As ICSs have developed, providers have increasingly embraced wider system leadership roles, working with partners to join up care pathways, embed population health management, reduce unwarranted variation and tackle health inequalities.

The arrangements put in place by each ICS Partnership and ICS NHS body must harness the expertise, energy and ambition of the organisations directly responsible for delivering integrated care.

As constituent members of the ICS Partnership, the ICS NHS body and place-based partnerships, providers of NHS services will play a central role in establishing the priorities for change and improvement across their healthcare systems and delivering the solutions to achieving better outcomes.

We expect the contracts health service providers hold (NHS Standard, or national primary care¹¹ supplemented locally) to evolve to support longer term, outcomes-based agreements, with less transactional monitoring and greater dialogue on how shared objectives are achieved.

Primary care in Integrated Care Systems

All primary care professionals have a fundamental role to play in ensuring that ICSs achieve their objectives. The success of efforts to integrate care will depend on primary care and other local leaders working together to deliver change across health and care systems.

Primary care should be represented and involved in decision-making at all levels of the ICS, including strategic decision-making forums at place and system level. It should be recognised that there is no single voice for primary care in the health and care system, and so ICSs should explore different and flexible ways for seeking primary care professional involvement in decision-making. In particular, primary care should have an important role in the development of shared plans at place and

¹¹ Primary care contracts will continue to be negotiated nationally

system, ensuring they represent the needs of their local populations at the neighbourhood level of the ICS, including with regards to health inequalities and inequality in access to services.

ICSs should explore approaches that enable plans to be built up from population needs at neighbourhood and place level, ensuring primary care professionals are involved throughout this process.

The role of primary care networks

Primary care networks (PCNs), serving the patients of the constituent general practices, play a fundamental role improving health outcomes and joining up services. They have a close link to local communities, enabling them to identify priorities and address health inequalities. PCNs will develop integrated multi-disciplinary teams that include staff from community services and other NHS providers, local authorities and the voluntary, community and social enterprise (VCSE) sector to support effective care delivery. Joint working between PCNs and secondary care will be crucial to ensure effective patient care in and out of hospital.

PCNs in a place will want to consider how they could work together to drive improvement through peer support, lead on one another's behalf on place-based service transformation programmes and represent primary care in the place-based partnership. This work is in addition to their core function and will need to be resourced by the place-based partnership.

ICSs and place-based partnerships should also consider the support PCN clinical directors, as well as the wider primary care profession, may need to develop primary care and play their role in transforming community-based services. Place-based partnerships may also wish to consider how to leverage targeted operational support to their PCNs, for example with regard to data and analytics for population health management approaches, HR support or project management.

Voluntary, community and social enterprise partners

The VCSE sector is a vital cornerstone of a progressive health and care system. ICSs should ensure their governance and decision-making arrangements support close working with the sector as a strategic partner in shaping, improving and delivering services and developing and delivering plans to tackle the wider determinants of health. VCSE partnership should be embedded as an essential part

of how the system operates at all levels. This will include involving the sector in governance structures and system workforce, population health management and service redesign work, leadership and organisational development plans.

We expect that by April 2022 Integrated Care Partnerships and the ICS NHS body will develop a formal agreement for engaging and embedding the VCSE sector in system level governance and decision-making arrangements, ideally by working through a VCSE alliance to reflect the diversity of the sector. These arrangements should build on the involvement of VCSE partners in relevant forums at place and neighbourhood level. A national development programme is in place to facilitate this in all areas.

Independent sector providers

All providers, including independent providers to the NHS and local authorities, will need to be engaged with other relevant partners in the ICS, through existing or newly formed arrangements, to ensure care meets the needs of the population and is well co-ordinated.

NHS trusts and foundation trusts

NHS trusts and foundation trusts will play a critical role in the transformation of services and outcomes within places and across and beyond systems.

As now, they will work alongside primary care, social care, public health and other colleagues in each of the places or localities they serve, to tailor their services to local needs and ensure they are integrated in local care pathways. They will also be more involved in collectively agreeing with partners how services and outcomes can be improved for that community, how resources should be used to achieve this and how they can best contribute to population health improvement as both service providers and as local 'anchor institutions'. The most efficient and appropriate ways of doing this will vary for different types of providers and in different local contexts. ICS NHS bodies will need to work with providers that span multiple ICSs and cross ICS boundaries, including ambulance and community trusts, to agree arrangements that ensure they are fully engaged.

In future, we expect the ICS NHS body could ask NHS trusts and foundation trusts to take on what have been 'commissioning' functions for a certain population,

building on the model that NHS-led provider collaboratives for specialised mental health, learning disability and autism services have been developing.

The success of individual trusts and foundation trusts will increasingly be judged against their contribution to the objectives of the ICS, in addition to their existing duties to deliver safe and effective care. This will include delivering their agreed contribution to system financial balance, improving quality and outcomes and reducing unwarranted variation and inequalities across the system as a whole, in the context of the new ‘triple aim’ duty to promote better health for everyone, better care for all and efficient use of NHS resources.

The new provider selection regime

NHS England and NHS Improvement has recommended that Parliament legislates to remove the current rules governing NHS procurement of healthcare services; and these are replaced by a new regime specifically created for the NHS.

This regime would give decision-makers greater discretion in how they decide to arrange services, with competition and tendering a tool to use where appropriate, rather than the default expectation. We want to make it straightforward for local organisations to continue with existing service provision where the arrangements are working well and there is no value in seeking an alternative provider. Where the system wants or needs to consider making changes to service provision, we want there to be a flexible, sensible, transparent and proportionate process for decision-making that allows shared responsibility to flow through it, rather than forcing the NHS into pointless tendering and competition.

The central requirement of the proposed new regime is that decisions about who provides NHS services must be made in a transparent way, in the best interests of patients, taxpayers and the population. The regime would need to be applied by NHS bodies (NHS England and NHS Improvement, ICS NHS bodies, NHS trusts and foundation trusts) and local authorities when making decisions about who provides healthcare services (the new regime will not apply to other local authority services).

The regime sets out the steps that decision-making bodies should take when seeking to justify continuing existing arrangements with an existing provider; how to select the most suitable provider when a service is new or changing substantially, but a competitive procurement is not appropriate; and how to run a competitive

procurement where this is considered appropriate. The regime sets out some key criteria decision-makers need to consider when arranging services, as well as requirements around transparency and scrutiny of decisions. Further details can be found at www.england.nhs.uk/publication/nhs-provider-selection-regime-consultation-on-proposals/

Provider collaboratives

Provider collaboratives are partnership arrangements involving two or more trusts (foundation trusts or NHS trusts) working across multiple places to realise the benefits of mutual aid and working at scale. The response to COVID-19 has demonstrated both the need for and potential of this type of provider collaboration. During 2021/22 the dynamic management of capacity and resources, greater transparency and collective accountability seen during the pandemic must be continued and developed. Specifically, providers are expected to work together to agree and deliver plans to achieve inclusive service recovery, restoration and transformation across systems, and to ensure services are arranged in a way that is sustainable and in the best interests of the population.

From April 2022 trusts providing acute and/or mental health services are expected to be part of one or more provider collaboratives. Community trusts, ambulance trusts and non-NHS providers (eg community interest companies) should participate in provider collaboratives where this is beneficial for patients and makes sense for the providers and systems involved.¹²

The purpose of provider collaboratives is to better enable their members to work together to continuously improve quality, efficiency and outcomes, including proactively addressing unwarranted variation and inequalities in access and experience across different providers. They are expected to be important vehicles for trusts to collaboratively lead the transformation of services and the recovery from the pandemic, ensuring shared ownership of objectives and plans across all parties.

¹² Community trusts, ambulance trusts and other providers may need to maintain relationships with multiple provider collaboratives, and/or focus on relationships within place-based partnerships, in ways they should determine with partners.

Provider collaboratives will agree specific objectives with one or more ICS, to contribute to the delivery of that system's strategic priorities. The members of the collaborative will agree together how this contribution will be achieved.

Provider collaboratives will help facilitate the work of alliances and clinical networks, enabling specialty-level plans and decisions to be made and implemented in a more coordinated and systematic way in the context of whole system objectives. For example, Cancer Alliances already work with the providers in their local systems to lead a whole system approach to operational delivery and transformation, and in future Alliances will work with their relevant Provider Collaboratives.

It will be up to providers, working with partners, to decide on the specific model and best governance arrangements for their collaboratives.

ICS NHS bodies will contract with NHS trusts and foundation trusts for the delivery of services, using the NHS Standard Contract. For services delivered through collaborative arrangements, ICS NHS bodies could:

- contract with and pay providers within a collaborative individually. The providers would then agree as a provider collaborative how to use their respective resources to achieve their agreed shared objectives
- contract with and pay a lead provider acting on behalf of a provider collaborative (whole budget for in-scope services). The lead provider would agree sub-contracting and payment arrangements across the collaborative. The existing mental health provider collaboratives have been successfully based on lead provider arrangements.

The ICS NHS body and provider collaboratives should define their working relationship, including participation in committees via partner members and any supporting local arrangements, to facilitate the contribution of the provider collaborative to agreed ICS objectives.

Further guidance on provider collaboratives will be published in due course.

Clinical and professional leadership

All ICSs should develop a model of distributed clinical and care professional leadership, and a culture which actively encourages and supports such leadership to thrive. This includes ensuring professional and clinical leaders have protected time and resource to carry out system roles, and are fully involved as key decision-makers, with a central role in setting and implementing ICS strategy.

These arrangements should support and enhance those of the organisations within the ICS footprint, which are responsible for the professional and clinical leadership of their people and services.

They should reflect the learning and experience gained from CCG clinical leadership, building out from this to reflect the rich diversity of clinical and care professions across the wider ICS partnership, including health, social care and the VCSE sectors, embedding an inclusive model of leadership at every level of the system.

Specific models for clinical and care professional leadership will be for ICSs to determine locally and we recognise that ICSs are at different stages of development in this regard. We will provide further resources describing the features of an effective model, informed by more than 2,000 clinical and care professionals and illustrating case studies from systems with more advanced approaches. These features include:

- effective structures and communication mechanisms to connect clinical and care professional leaders at each level of the system
- a culture which systematically embraces shared learning, supporting its clinical and care professional leaders to collaborate and innovate with a wide range of partners, including patients and local communities
- protected time, support and infrastructure for clinical and care professional leaders to carry out their system leadership roles
- clearly defined and visible support for clinical and care profession leaders, including support to develop the leadership skills required to work effectively across organisational and professional boundaries
- transparent approaches to identifying and recruiting leaders, which promote equity of opportunity and a professionally and demographically diverse talent pipeline which reflects that community it serves.

We will expect ICSs to use the resources to support self-assessment of their clinical and professional leadership model and implement mechanisms to measure their progress and performance. We encourage systems to consider how they could use a peer review approach to support their development in this area, buddying with other systems to undertake their assessment and develop subsequent plans.

For the NHS ICS body, the clinical roles on the Board, described in the 'Governance and management arrangements' section, are a minimum expectation, ensuring executive-level professional leadership of the organisation. Individuals in these roles are expected to ensure leaders from across clinical and care professions are involved and invested in the purpose and work of the ICS.

The ICS NHS board will be expected to sign off a model and improvement plan for clinical and care professional leadership that demonstrates how this will be achieved, and to ensure that the five guiding principles described above are reflected in its governance and leadership arrangements.

Working with people and communities

The parties in an ICS, including those of the ICS Partnership, the NHS ICS body and place-based partnerships will be expected to agree how to listen consistently to, and collectively act on, the experience and aspirations of local people and communities. This includes supporting people to sustain and improve their health and wellbeing, as well as involving people and communities in developing plans and priorities, and continually improving services.

As part of the ICS-wide arrangements, we expect each ICS NHS body to build a range of engagement approaches into their activities at every level and to prioritise engaging with groups affected by inequalities. The solutions to reducing inequalities will often be found by engaging with communities through relational and strengths-based approaches drawing on the experience of local authority, VCSE and other partners with experience and expertise in this regard.

We expect that this will be supported by a legal duty for ICS NHS bodies to make arrangements to involve patients, unpaid carers and the public in planning and commissioning arrangements, and by the continuation of the existing NHS trust and foundation trust duties in relation to patient and public involvement, including the role of foundation trusts governors.

Working with a range of partners such as Healthwatch, the VCSE sector and experts by experience, the ICS NHS body should assess and where necessary strengthen public, patient and carers' voice at place and system levels. Places are an important component, as they typically cover the area and services with which most residents identify. We are working with ICSs, Healthwatch England and others to identify and disseminate some of the most effective place-based approaches, for example through place-level citizens' panel work.

Arrangements in a system or place should not just provide a mechanism for commentary on services but should be a source of genuine co-production and a key tool for supporting accountability and transparency of the system. Where decision-making affects communities, groups or specific services, these arrangements (including any formal consultation) should fully engage those affected, including populations, patients and carers across health and social care.

We have previously set out seven principles for how ICSs should work with people and communities. These are:

1. Use public engagement and insight to inform decision-making
2. Redesign models of care and tackle system priorities in partnership with staff, people who use care and support and unpaid carers
3. Work with Healthwatch and the voluntary, community and social enterprise sector as key transformation partners
4. Understand your community's experience and aspirations for health and care
5. Reach out to excluded groups, especially those affected by inequalities
6. Provide clear and accessible public information about vision, plans and progress to build understanding and trust
7. Use community development approaches that empower people and communities, making connections to social action.

Each ICS NHS body should use these principles as a basis for developing a system-wide strategy for engaging with people and communities, building on the existing relationships, good practice and networks across system partners.

As part of this strategy, the body should work with its partners across the ICS to develop arrangements for:

- ensuring the ICS Partnership and place-based partnerships have representation from local people and communities in priority setting and decision-making forums
- gathering intelligence about the experience and aspirations of people who use care and support, together with clear approaches to using these insights to inform decision making and quality governance.

More detailed information will be made available to systems in guidance on membership and governance of ICS NHS bodies and in the implementation support for how ICSs work with people and communities.

Accountability and oversight

The ICS NHS body will be a statutory organisation. The members of its unitary board will have collective and corporate accountability for the performance of this organisation and will be responsible for ensuring its functions are discharged. NHS England and NHS Improvement through its regional teams, will agree the constitutions and plans of ICS NHS bodies and hold them to account for delivery through the chair and chief executive.

ICSs more broadly bring together NHS, local government and other partners, who each retain formal accountability for the statutory functions they are responsible for. Building on the relationships and ways of working they have developed to date, these partners will need to maintain a working principle of mutual accountability, where, irrespective of their formal accountability relationships, all partners consider themselves collectively accountable to the population and communities they serve, and to each other for their contribution to the ICS's objectives.

Providers of NHS services will continue to be accountable:

- for quality, safety, use of resources and compliance with standards through the provider licence (or equivalent conditions in the case of NHS trusts) and CQC registration requirements
- for delivery of any services or functions commissioned from or delegated to them, including by an NHS ICS body, under the terms of an agreed contract and/or scheme of delegation.

Executives of provider organisations will remain accountable to their boards for the performance of functions for which their organisation is responsible. Where an executive of an NHS provider organisation sits on the board of an NHS ICS body, they will in their capacity as a member of that board also be accountable – collectively with other board members – for the performance of the ICS body and ensuring its functions are discharged. And when acting as an ICS body board member, they must act in the interests of the ICS body and the wider system, not those of their employing provider. NHS England and NHS Improvement will provide guidance to support ICS NHS bodies to manage conflicting roles and interests of board members.

Approach to NHS oversight within ICSs

The oversight arrangements for 2022/23 will build on the final 2021/22 System Oversight Framework (SOF) reflecting the statutory status of ICS NHS bodies from April 2022. We expect these arrangements to confirm ICSs' formal role in oversight including:

- bringing system partners together to identify risks, issues and support needs and facilitate collective action to tackle performance challenges
- leading oversight and support of individual organisations and partnership arrangements within their system.

While ICS NHS bodies will, by default, lead local oversight and assurance, NHS England and NHS Improvement's future statutory regulatory responsibilities will be similar to its existing ones. This means that any formal regulatory action with providers will, when required, be taken by NHS England and NHS Improvement.

We will work with each ICS NHS body to ensure effective and proportionate oversight of organisations within the ICS area, with arrangements that reflect local delivery and governance arrangements and avoid duplication. In particular, where additional assurance or intervention is required, NHS England and NHS Improvement will work with the ICS partners to ensure such action is informed by the perspective of system stakeholders, and that any recovery plans agreed align with system objectives and plans.

NHS England and NHS Improvement and ICS NHS bodies may, over time, decide to take the role of provider collaboratives and place-based partnerships into account when determining how to address issues identified through system oversight. This may, for instance, include looking to these arrangements (and the partners involved) for support where poor performance is identified; or considering the effectiveness of collaborative working arrangements when considering whether systems/providers have an effective plan for improvement/recovery.

Systems will also benefit from existing local authority health overview and scrutiny committees reviewing and scrutinising their work. Scrutiny provides a mechanism for local democratic accountability through local government elected members. It enables valuable connections to be made between the experience and aspirations of residents and ICS governance, via the relationships that local councillors have with their constituents.

Accountability and transparency in ICSs will also be supported via:

- clearly agreed and articulated arrangements for how the system works with people and communities
- public meetings, published minutes, and regular and accessible updates on the ICSs' vision, plans and progress against priorities.

We are working with colleagues from the Care Quality Commission (CQC) and DHSC to agree the process and roles for reviewing and assessing systems. The aim is that this would complement the role of NHS England and NHS Improvement, avoiding duplication and overlap, and support the delivery of integrated care across system partners.

The proposed principles for NHS system oversight are:

- working with and through ICSs, wherever possible, to provide support and tackle problems
- a greater emphasis on local priorities and on system performance and quality of care outcomes alongside the contributions of individual organisations to system goals
- matching accountability for results with improvement support, as appropriate
- greater autonomy for ICSs and organisations with evidence of collective working and a track record of successful delivery of NHS priorities, including tackling inequality, health outcomes and access
- compassionate leadership behaviours that underpin all oversight interactions.

Financial allocations and funding flows

Systems are currently funded under the COVID financial regime through a system funding envelope for each ICS, which includes system top-up and COVID fixed allocation arrangements. In due course, system funding allocations will move back towards the population-based distribution and funding quantum allocated as part of the Long Term Plan funding settlement, taking account of subsequent funding allocations and the outcome of the Spending Review.

ICS allocations

NHS England and NHS Improvement will make financial allocations to each ICS NHS body for the performance of its functions. Decisions about spending will be devolved to ICS NHS bodies.

This will include the budgets for:

- acute, community and mental health¹³ services (currently CCG commissioned)
- primary medical care (general practice) services (currently delegated to CCGs)
- running cost allowances for the ICS NHS body.

This may also include the allocations for a range of functions currently held by NHS England and NHS Improvement, including:

- other primary care budgets
- relevant specialised commissioning services suitable for commissioning at ICS level (for example, excluding highly specialised services)
- the allocations for certain other directly commissioned services
- a significant proportion of nationally held transformation funding and service development funding
- the Financial Recovery Fund
- funding for digital and data services.

¹³ Every ICS will be required to continue to meet the mental health investment standard and as such a minimum level of mental health funding remains ringfenced (ICSs are free to invest above this level).

Funding will continue to be linked to population need. Allocations will be based on longstanding principles of supporting equal opportunity of access for equal needs and contributing to the reduction of health inequalities. NHS England and NHS Improvement's approach will continue to be informed by the independent Advisory Committee on Resource Allocation (ACRA).¹⁴ Allocations will be set in a way that avoids large swings in funding that would risk destabilising local health economies.

NHS England and NHS Improvement will allocate funding to ICSs, continuing to take into account both the need of their population ('the target allocation') and how quickly ICSs move towards their target allocations (known as pace-of-change). We would not make a centrally set allocation to 'place' within the ICS. Existing allocations tools can be adapted to support ICS NHS bodies in making decisions about how to deploy resource to places.

An open book relationship between providers of NHS services, supported by improved cost data (PLICS), will give further transparency for stakeholders that the NHS is meeting its commitment to deploy resource according to need and tackle inequalities.

Full capital allocations will be made to the ICS NHS body, based on:

- the outcome of the 2022/23 capital settlement for operational capital, building on the arrangements initially implemented in 2020/21
- capital budgets being a combination of system-level allocations (operational capital), nationally allocated funds (for large strategic projects) and other national programmes
- the methodology being kept under review to ensure available capital is best allocated against need. We hope future allocations can be set over a multi-year, subject to the outcome of the next Spending Review.

Distribution of funds by the ICS NHS body

The ICS NHS body will agree how the allocation will be used to perform its functions, in line with health and care priorities set at a local level.

¹⁴ An independent committee of academics, public health experts, GPs and NHS managers that makes recommendations on the preferred, relative, geographical distribution of resources for health services.

Money will flow from the ICS NHS body to providers largely through contracts¹⁵ for services/outcomes, which may be managed by place-based partnerships or provider collaboratives.

The existing provider collaboratives for specialised mental health, learning disability and autism services have paved the way in taking on budgets through lead provider arrangements. In conjunction with ICS leaders, we will consider supporting provider collaboratives to take on further responsibility for use of resources to deliver population health outcomes.

The ICS NHS body will be able to commission jointly with local authorities under a section 75 joint commissioning arrangement, as CCGs can.

Spending will be part of a plan to deliver financial balance within a system's financial envelope, which would also be set by NHS England and NHS Improvement. This envelope covers expenditure across the whole system, including spending by NHS trusts/foundation trusts for services delivered for commissioners from outside the system.

Each ICS will have an agreed framework for collectively managing and distributing financial resources to address the greatest need and tackle inequalities in line with the NHS system plan, having regard to the strategies of the Partnership and the Health and Wellbeing Board/s. This is in line with the duty we expect to remain for the system to have regard for reducing health inequalities.

Financial rules will apply to ensure delivery of key national commitments, such as the Mental Health Investment Standard and the primary medical and community health services funding guarantee.

Based on these local priorities and national rules (including the National Tariff Payment System), the ICS NHS body will agree:

- priorities and outcomes to be achieved in plan against NHS budget (with clinical advice and with regard to ICS Partnership plan)
- the distribution of the NHS revenue allocation (both total financial value and service lines) to:

¹⁵ The ICS NHS body will also be able to make grants to VCSE organisations and to NHS Trusts/FTs. In future, the ICS NHS body may wish to use its expected power to delegate its functions to statutory providers.

- each place-based partnership as appropriate
- each NHS provider (individually contracted or via a lead provider contract, including where operating as part of a provider collaborative)
- contracts with other service providers
- other collaboratives partnerships.
 - A capital plan including how capital spend should be prioritised locally (developed through collective decision making across NHS providers, and with ability to co-ordinate with the estates and assets managed by local authorities).

The ICS NHS board and chief executive (AO) will be ultimately responsible for services under delegation arrangements with place-based partnerships or through lead provider contracts. They will need to put in place proportionate mechanisms to provide assurance on the spending of public money.

Setting budgets for places

The ICS NHS body will have the freedom to set a delegated budget for place-based partnerships to support local financial decisions to spend ICS NHS resources. However, it must adopt the principle of equal access for equal need and the requirements to reduce health inequalities. The ICS NHS body should engage local authority partners on the ICS NHS resources for the NHS services to be commissioned at place and support transparency on the spending made at place level. It should explain any variation from previous CCG budgets and enable the shared planning or pooling of NHS and local authority budgets, including stated minimum NHS contributions to Better Care Fund arrangements.

Budget allocated to and managed within a place (under the agreed schemes of delegation) might include:

- primary medical care
- other primary care as delegated/transferred from NHS England and NHS Improvement – dental, pharmaceutical, ophthalmology services
- community services
- community mental health including IAPT
- community diagnostics
- intermediate care

- any services subject to Section 75 agreement with local authority
- any acute or secondary care services that is has been agreed should be commissioned at place-level.

Financial and regulatory mechanisms to support collaboration

ICS NHS bodies will have a duty to co-operate with other NHS bodies, including NHS trusts and foundation trusts, and local authorities. They also have a duty to promote integration. These duties, combined with the new triple aim duty, should be a key driver for ensuring NHS ICS partners work together to meet the four purposes of the ICS with the resources available.

Collaboration in the NHS has accelerated in recent years and this is already supported by a wide range of enablers to ensure a shared investment in system objectives and plans.

Enablers already established, or expected to be established, through NHS England and NHS Improvement's system-by-default approach include:

- Setting system financial envelopes, which describe the funding available to spend in an ICS, including CCG allocations and national sustainability funding. These budgets will be based on population need and will support systems to work together to free up resources, which can be spent elsewhere in the system
- Proposals to establish an aligned payment and incentive (API) approach, in which fixed payments are set for an agreed level of planned activity; variable payments would also be agreed for activity above or below these plans. This should give the ICS NSH body, NHS trusts and foundation trusts greater certainty over payments and the agreed level of activity these payments will cover
- Inclusion of a System Collaboration and Financial Management Agreement in the NHS standard contract, which is a collaborative document aimed to ensuring NHS system partners work together to deliver shared financial objectives. The ICB, NHS trusts and foundation trusts will agree in advance ways of working and the risk management approach to dealing with unplanned pressures

- Change in oversight focus in the System Oversight Framework (SOF) which works with and through the system to tackle problems with an emphasis on system performance and greater autonomy for organisations with evidence of effective joint working.
- Guidance to be issued on provider governance to support providers to work collaboratively as part of ICSs to deliver system objectives. This will include an updated Code of Governance for NHS provider trusts, updated guidance on the duties of foundation trust governors, and updated memorandums for accounting officers of foundation trusts and NHS trusts. New guidance will be issued under the NHS Provider Licence that good governance for NHS providers includes a requirement to collaborate.

In addition to these policy developments, further enablers to support system collaboration are expected from the proposed legislation and policy, including:

- A common duty for ICS NHS bodies, NHS trusts and foundation trusts in relation to the triple aim, which requires them to have regard to the wider effect of their decisions in each of the three strands of the triple aim improving population health, quality of care and the use of resources
- Imposition of duties on the ICS NHS body to act with a view to ensuring system financial balance and to meet other financial requirement and objectives set by NHS England and NHS Improvement. This would also apply to NHS trusts and foundation trusts. This should mean that ICS NHS bodies, NHS trusts and foundation trusts have shared investment in the delivery of system financial balance and strong reason to collaborate to agree a system plan for meeting this; supported by a review of the NHS provider licence
- Powers to ensure organisational capital spending is in line with system capital plans. A review of the NHS provider licence in light of the new legislation and policy developments and specifically to support providers to work effectively as part of ICSs to deliver system objectives.

Services currently commissioned by NHS England and NHS Improvement

The legislation will enable the direct commissioning functions of NHS England and NHS Improvement to be jointly commissioned, delegated or transferred at an appropriate time to ICS NHS bodies.

NHS England and NHS Improvement is considering how it might shift some of its direct commissioning functions to ICS NHS bodies. Subject to discussions with systems and our Regions and further work on HR, our intention is to enable ICS NHS bodies to take on responsibility as soon as they are ready to do so after the enactment of legislation.

Commissioning of primary medical services is currently delegated to CCGs and will transition immediately into ICS NHS bodies when they are established. ICS NHS bodies might also take on primary dental services, general ophthalmic and pharmaceutical services commissioning.

Further work is taking place at national and regional levels to explore how the commissioning model for specialised services could evolve , in line with the safeguards and four principles set out in [*Integrating Care: Next steps to building strong and effective integrated care systems across England.*](#)

NHS England and NHS Improvement has a range of other direct commissioning functions including health and justice, armed forces and aspects of public health. Engagement with ICSs will continue to establish how they could take on greater responsibility for these services in future.

Data and digital standards and requirements

The standards and requirements for digital and data will be centred around the What Good Looks Like framework, which will set out a common vision to support ICS leaders to accelerate digital and data transformation in their systems with partner organisations. Based on consultation with a wide range of NHS and care stakeholders, the framework identifies seven success measures and will be published in the first quarter of 21/22.

We expect digital and data experts to have a pivotal role in ICSs, supporting transformation and ensuring health and care partners provide a modern operating environment to support their workforce, citizens and populations.

From April 2022, systems will need to have smart digital and data foundations in place. The way that these capabilities are developed and delivered will vary from system to system. Systems will locally determine the right way to develop these capabilities and to ensure they are available at system and place level, and across provider collaboratives.

Specifically, ICS NHS bodies are expected to:

- Have a renewed digital and data transformation plan that is embedded within the ICS NHS body plan and details the roadmap to achieve 'What Good Looks Like'; and enables a cross system approach to transformation, so that changes to models of care and service redesign involve digital and data experts working with partners from all relevant sectors.
- Have clear accountability for digital and data, with a named SRO with the appropriate expertise, (registered professional or with equivalent experience), underpinned by governance arrangements that have clear oversight and responsibility for digital and data standards and requirements for the ICS and enabling partner organisation programmes and services.
- Invest in levelling-up and consolidation of infrastructure, linked to the future ICS reference target architecture and data model, adopting a simplified cloud-first infrastructure that provides agility and frictionless cross-site working experience for the workforce.

- Implement a shared care record, that allows information to follow the patient and flow across the ICS to ensure that clinical and care decisions are made with the fullest of information.
- Ensure adherence by constituent partners to standards and processes that allow for interoperability across the ICS, and alignment to forthcoming national guidance.
- Enable a single co-ordinated offer of digital channels for citizens across the system and roll out remote monitoring technologies to help citizens manage their care at home.
- Cultivate a cross-system intelligence function to support operational and strategic conversations, as well as building platforms to enable better clinical decisions. This will require ICSs to have linked data, accessible by a shared analytical resource that can work on cross-system priorities.
- Agree a plan for embedding population health management capabilities and ensuring these are supported by the necessary data and digital infrastructure, such as linked data and digital interventions. Online PHM support can also be found at <https://future.nhs.uk/populationhealth/grouphome> and here [Population Health Management - e-Learning for Healthcare \(e-lfh.org.uk\)](https://www.e-lfh.org.uk/).

Arrangements should be co-ordinated across the NHS and local government, as well as between NHS organisations.

Managing the transition to statutory ICSs

We will work in partnership with systems, individual organisations affected, trade unions, voluntary organisations and central and local government to ensure the opportunities for improved outcomes for populations and improvements for our people are realised. We aim to create an environment that enables this change to take place with minimum uncertainty and employment stability for all colleagues who are involved.

The change and transition approach is guided by our Employment Commitment and a set of core principles designed to inform the thinking and actions of all colleagues throughout the process, acknowledging the wide variation in circumstances across systems.

The Employment Commitment

“NHS people within the wider health and care system (below board level) affected directly by these legislative changes, including CCGs, NHS England and NHS Improvement and NHS providers, will receive an employment commitment to continuity of terms and conditions (even if not required by law) to enable all affected colleagues to be treated in a similar way despite a variety of contractual relationships. This commitment is designed to provide stability and remove uncertainty during this transition.”

The Employment Commitment is designed to minimise uncertainty and provide employment stability for people who will transfer directly from their employment or engagement directly into the statutory ICS NHS body. During the transition period the Employment Commitment asks affected organisations not to carry out significant internal organisational change and not to displace people. The commitment does not apply to those people in senior/board level roles who are likely to be affected by the new ICS Board structure and will have to go through organisational change as part of the abolition and establishment process.

Core Principles

People Centred Approach – in line with the People Promise	Compassionate and inclusive	Minimum disruption	Subsidiarity
<ul style="list-style-type: none"> Thinking about the needs of patients and the impact on our people as a first step and amending plans if necessary Taking a supportive talent based approach with colleagues impacted by the changes Seeking to provide stability of employment/ engagement 'One NHS workforce' inclusive change approach supported by the employment commitment Working in partnership with trade union colleagues 	<ul style="list-style-type: none"> Openness and transparency of process and actions Taking action to increase the diversity of the new ICS workforce and particularly the leadership Co-creation at the appropriate level Individual behaviours Supportive change approach 	<ul style="list-style-type: none"> Taking the minimum position to enable the change to happen and setting the direction for future evolution by the new ICS NHS Bodies Keeping policy as simple as possible and testing thinking against these principles Working together to avoid unnecessary duplication of effort and achieve greatest value – based on the principle of subsidiarity Implementing the employment commitment 	<ul style="list-style-type: none"> Functions and accountability move based on the principle of where the work should be carried out to ensure the enablement of continuous improvement and partnership responsibility to the ICS ambitions, through a population health management approach across all functions People follow the function in line with the employment commitment for people below board level Organisation design at national and regional level should mirror the legislative approach and be as minimally prescriptive as possible

Accountability for managing the change process will be with the current ICS and CCG leadership, with increasing involvement of the new leaders (eg chair, chief executive and others at board level) who may be appointed on a shadow or designate basis, pending the legislation.

Each ICS should make initial arrangements to manage the transition and ensure that there is capacity in place ready for implementation of the new ICS body. Plans should be agreed with regional NHS England and NHS Improvement teams.

Each ICS should ensure that planning adequately addresses the implications of organisational development implications as operations evolve from the current into the future configuration. This should be explicitly based in the local context.

It is important to note that any plans are subject to the passage of the legislation. Systems cannot pre-empt the decision of Parliament on whether to approve a bill or how it is to be amended. While plans can be made, systems should not take decisions or enter into arrangements which presume any legislation is already in place or that it is inevitable it will become law, before the Parliamentary process has been completed.

The overarching aim is to ensure and enable:

- the safe transfer of functions into the ICS NHS body (ie existing statutory functions that are to be exercised by the ICS NHS body) and prepare for the ICS body to take on new functions as appropriate
- the smooth transition of our people (ie legally compliant, with minimum disruption).

The indicative outputs expected in every ICS over the course of the transition period in 2021/22 are set out below. This is subject to legislation and other factors (including pending decisions on ICS boundaries in some areas).

<p>By end Q1 Preparation</p>	<ul style="list-style-type: none"> • Update System Development Plans (SDPs) against the key implementation requirements (functions, leadership, capabilities and governance) and identify key support requirements. • Develop plans in preparation for managing organisational and people transition, taking into account the anticipated process and timetable, and any potential changes to ICS boundaries and the need to transform functions to support recovery and delivery across the ICS.
<p>By end Q2 Implementation</p>	<ul style="list-style-type: none"> • Ensure people currently in ICS Chair, ICS lead or AO roles are well supported and consulted with appropriately. • Carry out the agreed national recruitment and selection processes for the ICS NHS body chair and chief executive, in accordance with guidance on competencies and job descriptions issued by NHS England and NHS Improvement. This will reflect the expected new accountabilities and responsibilities of ICS NHS bodies. • Confirm appointments to ICS Chair and chief executive. Subject to the progress of the Bill and after the second reading these roles will be confirmed as designate roles. • Draft proposed new ICS NHS body MoU arrangements for 2022/23, including ICS operating model and governance arrangements, in line with the NHS England and NHS Improvement model constitution and guidance. • Plan for CCG teams to only operate at sub-ICS level where the SDP confirms that the ICS plans to establish a significant place-based function at that footprint. • Begin due diligence planning.
<p>By end Q3 Implementation</p>	<ul style="list-style-type: none"> • Ensure people in impacted roles are well supported and consulted with appropriately.

	<ul style="list-style-type: none"> • Carry out the recruitment and selection processes for designate finance director, medical director, director of nursing and other board level role in the NHS ICS body, using local filling of posts processes. • Confirm designate appointments to ICS NHS body finance director, medical director and director of nursing roles and other board and senior level roles. • ICS NHS bodies and ICS Partnerships to be ready to operate in shadow form. • Engagement on local ICS Constitution and governance arrangements for ICS NHS body and ICS Partnership.
<p>By end Q4 Transition</p>	<ul style="list-style-type: none"> • Ensure people in affected roles are consulted and supported. • Continue the recruitment and selection processes for all other designate ICS NHS body senior roles, including place-level leaders and non-executive roles, using local filling of posts processes. • Confirm designate appointments to any remaining senior ICS roles (in line with our relevant guidance) so that as much of the ICS NHS executive board and other senior leadership is ready (subject to formal decisions on appointments after the legislation is in place/in force). • Complete due diligence and preparations for staff and property (assets and liabilities, including contracts) transfers from CCGs and other NHS staff transfers to new ICS NHS body in line with our guidance. • Commence engagement and consultation on the transfer with trade unions. • Complete preparations to shift our direct commissioning functions to ICS NHS body, where this is agreed from 1 April 2022. • Ensure that revised digital, data and financial systems are in place ready for 'go live'. • Submit the ICS NHS body constitution for approval and agree the 2022/23 ICS MoU with NHS England and NHS Improvement, setting out key elements of how the new ICS NHS body and ICS Partnership will operate in the future, in accordance with guidance to be issued by NHS England and NHS Improvement.

NHS England and NHS Improvement is working with a range of stakeholder groups, including a newly formed ICS Transition Partnership Group, which is a subgroup of the national Social Partnership Forum, to make available a range of resources and guidance to support the transition. The following document will be published in support of this:

- Employment Commitment Guidance – which builds on the commitment made in the FAQs published on 11 February 2021 and sets out what ‘board level’ means in this context. This also sets out the national support and senior level support that is available for colleagues affected by these changes.

After the legislation is introduced, we will publish further resources and guidance to support people transition planning and implementation.

Conclusion

As we move into the next phase of system development, we must capture and build on the spirit and practice of partnership now embedded across the NHS local councils, the VCSE sector and beyond. We continue to face an unprecedented challenge as a health and care system, but ICSs offer a clear way forward.

Strengthening local partnerships through ICSs is one of the most important and exciting missions in the public sector today. We would like to thank colleagues in every part of every system for your continued efforts to pursue it. This is an opportunity to deliver better care and population health; to ensure services treat us all as individuals and respond to our increasingly complex health and care needs. It is also an opportunity to work in partnership with local residents in new ways, removing even more of the traditional barriers to joined-up, personalised care and support.

Building on the achievements of system leaders over several years, the further 'transformation by necessity' prompted by the pandemic provides a platform for ongoing improvement of relationships, services and outcomes. Working together through ICSs will allow us to seize these opportunities, ensure our health and care systems are fit for the future and that we achieve world class health outcomes for our whole population.

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This publication can be made available in a number of other formats on request.

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