Written evidence submitted by NHS Confederation (ICS0051)

About us

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

Our Integrated Care Systems (ICS) Network is the only independent national network which supports ICS leaders to exchange ideas, share experiences and challenges, and influence the national agenda. We are delighted to have all 42 ICSs in membership.

Summary

- **Recognise variation** – These is huge variation between integrated care systems (ICSs) in their size, maturity of integrated working and the demography of their local populations. A permissive framework which allows local flexibility to make decisions and measure progress is needed for ICSs to deliver against their four statutory objectives and continue to make a difference to communities.
- **Streamline and localise regulation** – The regulatory landscape is complex and needs to be joined-up. Regulators need to operate in a way that reflects both the integrated care board (ICB)'s role as an accountable NHS body and the role of the integrated care partnership (ICP)' as a partnership of equals between the NHS, local government and other partners who all shape health outcomes, while at the same time respecting local governments' independent mandate to their electorates. Locally determined measures will help to achieve this; primarily nationally driven performance targets risk crowding out local priorities and inhibiting ICSs' ability to improve care and services for their local populations.
- **Don't let today's challenges crowd out tomorrow's vision** – The need to meet performance targets (particularly reducing waiting times and the elective care backlog) and balance budgets in the short-term risks undermining investment of time and effort in the transformation ICSs need to deliver to improve patient care and make the health and care system sustainable in the long-term. Accountability should consider both and system leaders should be empowered with autonomy to deliver longer-term change.
- **Let local leaders lead** – Given constraints on NHS and social care funding, difficult choices need to be made about where to prioritise investment. These choices are best made as close to local populations as possible – by local leaders – and they need greater flexibility to decide how to use their resources and measure success against local priorities. NHS England's operating model will need to adapt to the establishment of ICSs and enable them to respond more directly to the needs of their varying populations.
- **Address external risks** – Workforce supply, capital investment and flexibility, social care capacity and their level of autonomy are factors largely outside of ICS leaders' control, but determined by central government, which will determine ICSs' success of and shape patients' care and experience.

  We have answered the questions contained in the terms of reference throughout the submission and have indicated where specific questions are addressed in detail. Our response is ordered thematically for ease of reading.

1. Purpose and role of ICSs

Addressing questions:

- What can be learned from examples of existing good practice in established ICSs?
- How can a focus on prevention within ICSs be ensured and maintained alongside wider pressures, such as workforce challenges and the electives backlog?

1. The Health and Care Act 2022 puts ICSs on a statutory footing, codifying and strengthening collaborative practices which were already evolving on the ground.[1] ICSs have a range of legal duties to their populations and four common statutory purposes:
    1) improving outcomes in population health and healthcare.
    2) tackling inequalities in outcomes, experience and access.
    3) enhancing productivity and value for money.
    4) helping the NHS support broader social and economic development.

    Our members, leaders from all 42 integrated care boards (ICBs) and integrated care partnerships (ICPs), are united behind these four aims and the broad direction of the reforms.

2. The demographics, geographies and population health needs of each ICS vary significantly – as do the local organisations and their arrangements for joint working. Formal commencement of statutory ICSs began on 1 July, but systems have been forming relationships and partnerships for years. They are all at different stages of development.

3. The health and care system faces long-term challenges: demand for care is rising, largely driven by an aging population and rising multi-morbidities, which is increasing waiting times to receive care and financial pressures on the public purse. Against this pressure, to improve health outcomes and patient experience, we need to make smarter use of our resources: preventing ill-health in the first place on the demand side and improving the efficiency of services on the supply side by delivering the right care in the optimal setting through a more integrated approach to planning and delivery. This is the role of ICSs. While ICSs will not be a panacea, they are well-placed to do this as they bring all the relevant partners together to make decisions collectively.

4. Firstly, ICSs will help to manage increasing demand for care by facilitating population health and preventative models of care, which will reduce the acute pressures in urgent and emergency care and reduce health inequalities both in the short- and longer-term. In practice, this means improved analysis to identify those most at risk and greater investment in non-clinical social determinants of health as well as primary and community care.

5. As only 10-20 per cent of health outcomes are determined by NHS care,[2] greater collaboration between the NHS, local authorities, Voluntary Community and Social Enterprise (VCSE) organisations to improve people's health and wellbeing will be essential. ICSs bring all these organisations into their governance on both the ICB and ICP to help achieve this. Collaboration should also make the delivery of care more seamless, improving patients' experiences and outcomes.

6. Secondly, ICSs can improve services (the supply of care) by redesigning care pathways, so patients receive the right care, from the right people, in the best setting. This requires use of

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[1] The ICS is a collective term for the Integrated Care Board (ICB), a statutory organisation, and Integrated Care Partnership (ICP), a statutory committee.

[2] Hood, C. M., Gennuso, K. P., Swain, G. R., Catlin, B. B., 2015. 'County Health Rankings: Relationships Between Determinant Factors and Health' Outcomes *American Journal of Preventive Medicine:* https://www.ajpmonline.org/article/S0749-3797(15)00514-0/fulltext

multidisciplinary teams from different organisations to review and revise whole patient pathways together, determining what care and treatments they get from different care providers at difference stages. In practice, this will see organisational and professional siloes being broken down, more streamlined delivery of care by sharing resources and risk across the system – notable through shared workforce planning. This will feel very different for patients, especially those with long-term conditions and multi-morbidities, whose care should be delivered more seamlessly and without the need to repeat their story as they interact with different parts of the system.

7. There are already examples of the impact of partnership working through ICSs in both improving patients' experiences and making the NHS more sustainable:

8. Police, social care, the NHS and other partners within Devon ICS worked together to form One Northern Devon, which developed a programme to help regular users of accident and emergency (A&E) and other emergency services. Caseworkers worked with individuals with complex needs to develop plans to co-ordinate support from various services to tackle issues such as housing and finance, preventing them from reaching crisis point. The scheme simultaneously improved the lives of their service users and helped to reduce A&E visits by 60 per cent, saving the taxpayer £200,000.

9. Leicester, Leicestershire and Rutland ICS piloted a scheme during the pandemic to provide people with significant frailty/complex comorbidity with the choice to receive care within the community as an alternative to hospital admission where this could improve their safety, experience and outcomes. The initial pilot led to the appropriate avoidance of 577 hospital admissions and 2,885 bed days, the saving of 730 ambulance journeys, and financial savings of at least £395,245.

10. West Yorkshire ICS is supporting its learning disability population and families by harnessing the scope of the NHS's Transforming Care Programme to ensure early intervention support is readily available to these individuals and their families. Partnership working with the VCSE sector through the care (education) and treatment reviews means that fewer young people with learning disabilities are being admitted into assessment and treatment hospitals.

11. In Lincolnshire, senior clinical leaders are pilotting an entirely different model of care for patients, a model without external referrals, hand offs, waiting lists, discharges and re-referrals. A model in which primary and secondary care were not operating in separate domains, but as one clinical network, working together to provide patients with seamless care – primary care led integration into secondary care. In July 2020, they formed the Connected Health Network (CHN), which worked with a local Primary Care Network, the Meridian Health Group, to pilot this new model in cardiology. Within the CHN model follow-up appointments are vastly reduced and the average waiting time for new patients to be reviewed by a specialist is under 2 weeks, compared with a 16-week wait for routine cardiology referrals into the Trust previously. They plan to expand this model to other specialties in medicine, surgery and women and children's services.

12. ICSs will be developing strategies and delivery plans through 2022/23 which should provide milestones for the process of integrating care going forward.

2. Measuring integration

Addressing questions:

- To what extent is there a risk that ICBs become an additional layer of bureaucracy if central targets are not reduced as ICBs are set up?
- How can it be ensured that quality and safety of care are at the heart of ICB priorities?

13. As they develop strategies and plans and decide how to evaluate their impact, ICB and ICP leaders are considering how to measure integration. This will be important both in terms of formal reporting processes and in their own assurance role in measuring integration within and across systems. There has been a tendency within the NHS, driven by a targets-oriented centre, to measure what is measurable, rather than what will drive improvement in the longer-term. There is therefore a risk of defaulting to existing performance metrics such as waiting lists and finances, especially as integrated care can be hard to define and measure. Measures will require collective endorsement and accountability across partners, including the NHS and local government. In the words of one ICB chief executive: "We need to quantify the right things to look at, but which are nebulous, such as culture and values."

14. Given the huge challenges facing the healthcare system and central ministerial accountability for the NHS, there will be some centrally driven performance metrics. But there will need to be realism that the wider determinants of health, outcomes and behaviours move much more slowly, and ICSs transcend local government (with its own local democratic accountability) and other partners. Many of the things ICBs aspire to do may not be measurable in the short-term with the metrics that currently exist. There is a balance to be drawn between how ICSs measure themselves and how they are measured through formal performance management processes, although these metrics should be as aligned as possible.

15. Improving outcomes in population health and healthcare is the first statutory objective for ICBs, and quality and safety is crucial to achieving this. ICB quality committees will assure safety and day-to-day performance on behalf of the Board. They will inherit CCGs' quality assurance function, ensuring a focus on outcomes first by considering the public's experience of services. The committees have been guided by the national quality board (NQB), which in time will help with standardisation in approach and outcomes, and will carry forward the NQBs requirements for 'Managing Risks and Improving Quality through Integrated Care Systems'.[3] ICB quality committees will be able to go further than CCG or trust quality committees by drawing on data and input from system partners, such as Healthwatch and VCSE partners sitting on the ICP, allowing them to focus on population health, outcomes and inequalities. As providers are part of the ICS and will be part of quality committees, there should be a more improvement-based culture, grounded in a peer review approach. The CQC has a new remit to conduct independent reviews of systems – these will play an important role in helping systems to ensure that the quality and safety of patient care is not impacted by patients falling between different providers and that they get effective, joined-up care. Given that ICBs have only been operating as statutory organisations since 1 July, including the appointment of new non-executive directors who chair ICB quality committees, we are still working with our members on their plans to ensure quality and safety is thoroughly embedded within systems. We would be happy to provide further evidence on and examples of how ICBs are taking this forward at a later date when they have had more time to make progress.

16. Various organisations have developed models for measuring levels of integration which may be useful tools for ICB leaders. IPPR and Carnell Farrar have produced a hybrid metric of existing outcome data that is tailored towards the various goals of integration, called the Insights and Collaboration Engine (ICE). The ICE is comprised of 40 metrics[4] and can be used to identify health

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[3] National Quality Board, 'Position Statement: Managing Risks and Improving Quality through Integrated Care Systems' (April 2021).

inequalities by illustrating the link between an ICS's average deprivation (IMD) score and the platform's integration score index.[5] Usefully, this shows that it is harder to demonstrate integration in outcomes with ICSs with high levels of deprivation.

17. The Office for National Statistics (ONS) has developed a Health Index, which seeks to track progress over the long-term and includes health outcome measures, modifiable risk factors and the social determinants of health, helpfully grouped according to healthy people, healthy lives and healthy places.[6] The index's simple design could be useful for leaders at various levels of the ICS to compare to similar areas to identify improvement opportunities, although a lag in the data will make comparison more difficult.

18. NHSE is working jointly with patients' groups and the voluntary sector to develop an Integration Index. It measures, from the point of view of patients, carers and the public, the extent to which the local health service and its partners are genuinely providing joined up, personalised and anticipatory care. They are working with ICSs to implement a new survey to specifically measure integrated care and understand how organisations work together, with a focus on people and carers who rely on multiple services, providing a unique perspective on how well care is being joined up.

19. These models are helpful and are broadly aligned in their focus on the wider determinants, behaviours, services, resources - including funding and workforce - and outcomes. However, ultimately it will be for ICB and ICP leaders to determine the metrics they use for measuring partnership working and long-term health improvement and integration according to the health needs of their area. They still need time and flexibility to develop and agree these with their local partners and communities.

3. Autonomy

Addressing questions:

- How best can a balance be struck between allowing ICSs the flexibility and autonomy they need to achieve their statutory duties, and holding them to account for doing so?
- What does a permissive framework for ICSs look like in practice?
- Are central targets consistent with local autonomy in this context?
- To what extent is there a risk that ICBs become an additional layer of bureaucracy if central targets are not reduced as ICBs are set up?
- What scope is there for variation between ICSs, to enable them to improve the overall health of the populations they serve and tackle inequalities?

20. We commissioned Sir Chris Ham to write a landmark report on the relationship the health system has with the centre, setting out a vision for reforming accountability and autonomy in the health and care system. A central message of the report was that: "leaders in the NHS spend much of their time looking up at the expense of looking out to the communities they serve."[7] Refreshing the NHSE operating model will be an important development for clarifying how NHSE will work differently with ICSs at various levels and how its culture will develop so it is consistent with the behaviours they wish to incentivise within the system. As Sir Chris emphasised in his report, this model should be underpinned by autonomy, an adult-to-adult relationship between

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[4] https://www.carnallfarrar.com/services-and-products/health-systems/data-innovation/our-insights-collaboration-engine-ice/
[5] https://icstl.cfdata.io/
[6] https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandwellbeing/bulletins/healthinengland/2015to2019

[7] https://www.nhsconfed.org/publications/governing-health-and-care-system-england

ICS and the centre, a move away from a blame culture towards better communication, coordination and cohesion between different NHSE regions and programme teams. One of the recommendations of the report was to slim down the number of staff at the centre – something which has been taken on board by NHSE[8] - but this should be accompanied by increasing improvement capacity within the ICS structures themselves. This also includes reviewing the role of NHSE's regional teams, particularly when ICSs have demonstrated their ability to act as system leaders, with a view to streamlining the organisation of the NHS and empowering local leaders to lead.

21. As one system leader opined: "The centre has a legitimate set of interests in the operation of the NHS, not least that it is a taxpayer funded system out of general taxation. The service has an accountability to Parliament and to Government. However, excessive direction and control from the centre – by NHSE or by DHSC – is likely to stifle initiative and neglect local context."

22. There is a perceptible tension between ministers, on the one hand, wanting to assure patients and the public that there are clear lines of accountability running between them and NHS leaders, and the NHS, on the other, wanting to ensure sufficient autonomy and space for leaders to make decisions about how to prioritise care and manage demand. In the words of one ICB chief executive: "There will always be a tension between local decision making and national targets." Our members regularly share concerns that policy overload weakens their ability to respond to a large number of national targets – the most recent NHS planning guidance contained over 100 priorities for systems to deliver, diluting their ability to prioritise delivery and consider particular local needs.[9]

23. Leaders at various levels within the new ICS structure will have far-reaching duties to their communities. These leaders have detailed knowledge of their own communities and the interests of their patients and are ultimately accountable to parliament and the taxpayer – in the case of local government leaders they are democratically accountable and guardians of public interest. ICSs need autonomy from the centre to formalise structures, partnerships and ways of working that will allow them to innovate and prioritise the needs of their populations. ICSs, such as West Yorkshire and Surrey Heartlands, which formed earlier (on a non-statutory basis) benefitted from a permissive policy framework and were able to find ways of working successfully in partnership that befitted their local context.

24. Given that the task facing ICSs is not equal (including varying levels of deprivation and other population health factors), the pressure on their health and care services vary, as do the resources at their disposal. Variation between ICSs should be permitted to enable them to improve the overall health of the populations they serve and tackle inequalities. Given their different starting points, the rate of improvement, rather than absolute outcomes, will give a better indication of how ICSs are performing. We support the requirement in the government's integration white paper for local leaders to develop a local outcomes framework that will sit alongside a smaller set of national priorities and believe local leaders, who are closest to the needs of the populations they serve, should be given as much autonomy as possible in developing their local outcomes frameworks. Local outcomes frameworks can reflect the priorities of residents in each area, facilitated through public engagement, local government and organisations such as Healthwatch.

25. While we understand the need for some national priorities, these should be kept to a minimum. Too much emphasis on centrally defined NHS priorities determined by the centre risks excluding

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[8] https://www.hsj.co.uk/workforce/6000-plus-jobs-to-be-cut-at-new-nhs-england/7032760.article
[9] https://www.england.nhs.uk/publication/2022-23-priorities-and-operational-planning-guidance/

key partners such as local authorities. Over time, as systems develop deeper insights into their populations and make measurable progress with health inequalities, we hope there will be less need for national 'must-do's'.

26. One system leader commented on the risk that national targets could lead to ICBs being seen as an additional layer of bureaucracy: "We need to be outcome focussed and so if targets are set with that in mind at all levels and not, as so often happens, with targets that are set addressing "the how", then there is a greater chance of ICBs adding much greater value that is not seen as bureaucracy but a collective of our stakeholders in an integrated approach that adds capacity, capability and intelligence into the system. This will enable autonomy but with direction that is co-owned and meaningful enabling a common purpose and the delivery of high quality safe innovative care."

27. ICB leaders have already raised concerns that there are strings attached to funding from the Treasury, which could slow progress on short- and longer-term priorities. For example, ring-fenced capital funding is restricting ICSs' scope to deliver programmes such as community diagnostics. While difficult choices need to be made given constrained funding, these are best made as close to local populations as possible.

28. Guidance, directives and communications from the centre can often be seen as unhelpful and add to bureaucratic burden on system leaders. As one system leader commented: "Direction from the centre should be light touch but already we have seen additional and often duplicative requests for information and updates. Where it works well is when NHSE core roles are embedded in the ICB teams and relationships are regular and strong." Citing the example of NHSE retaining detailed control over changes to ICB constitutions, another described the past six months of transitioning to ICBs as "asphyxiating, with high levels of micro-management." During a transitional year, ICS leaders have multiple priorities, including developing their integrated care strategy, in addition to winter plans and their five-year joint forward plan setting out how they will exercise their functions.

29. In the words of a system leader: "In my view the balance between the centre and local autonomy can best be described as 'The solutions are in the system', meaning that the centre cannot develop and maintain the relationships, innovate and move the money around in ways that deliver the short- and longer-term objectives. However, ICBs have to earn autonomy by managing an awfully tough winter, taking bites out of waiting lists and making solid progress on the immediate challenges we face post pandemic, as well as developing a coherent medium- and longer-term plan that is SMART."

30. Another has described a permissive framework as: "There is flexibility to enable ICS to operate, plan and deliver services that are right across health and care through the local place-based arrangements. Recognising that we need to ensure decisions are made as close to the individual as possible but also recognising that ideally there should be some agreed or negotiated flexibility… We need "broad but focused" national direction that are focused on outcomes that enable (permissive) regions and ICSs to further focus on what that means for the region/ICS. So that ICSs will deliver on those outcomes but the "how" will be through the local based arrangements across region and in ISCs – they will facilitate and deliver the high-level outcomes that are meaningful for their citizens and people and their communities."

4. Regulation

Addressing questions:

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

31. The UK has a complex regulatory architecture, with NHSE national and regional offices, ICBs, the Care Quality Commission (CQC), new patient safety commissioner, Parliamentary and Health Service Ombudsman (PHSO), Healthcare Safety Investigations Branch (HSIB), the Office of Health Disparities (OHID) and the UK Health Security Agency (UKHSA) and around ten professional regulators working with multiple system regulators across the four nations. While each of these has a definable role, there is a risk of duplication and confusing the public. Regulators will need to work together to clearly define and explain their roles and how they work together to prevent duplication and acting at cross purposes. ICB leaders are clear that they are not simply another layer of oversight and do not wish to reinforce old models of performance management, which would undermine the shift from processes to outcomes.

32. Regulation can incentivise the right behaviours in relation to integration, population health and equity – this is expanded on in the following section in paragraph 39. However, there is a risk that regulation could encourage less constructive behaviours. We have worked closely with the CQC and NHSE to inform their methodologies for system regulation and oversight and have been encouraged by the 'listening and learning' approaches taken by both organisations, which will allow time to work through accountabilities and ensure the variation between ICSs is reflected in how they assess performance and offer support and improvement resources.

33. The CQC is rightly taking a cautious approach in piloting their new assessment methodology in a small number of systems and not rating ICSs in the first year. If ratings of ICSs are to support improvement, they should be developed in collaboration with ICS leaders who are unequivocal that an Ofsted-style rating system would be too reductive to account for the huge differences in size, partnerships and population health challenges of each ICS. We are supportive of the focus in the CQC's single assessment framework on health inequalities, although the regulator will need to be realistic about the timescales for improvement, which will be in years rather than months. The area of leadership will be particularly challenging for the CQC to assess given that the ICS structures will pave the way to more distributive models of leadership. There cannot be one definition of leadership across the various levels that the CQC will assess, and system leaders' performance should be judged according to whether the ICB and ICP are adding value to their partners.

34. NHSE's new oversight framework provides some clarity on the lines of accountability for oversight by NHSE's national and regional offices and ICBs, and this will rightly be evolved with systems over the coming year. The next model should elaborate on how much autonomy ICBs will have in their assurance role and when NHSE regional teams will step in. In the words of one system leader: "Within every system, there will be trusts in difficult positions, and I would expect the centre to maintain significant oversight of those but the region to work with us to support those trusts on their improvement journey."

35. The focus within the framework on proportionate and effective oversight and an assumption of autonomy will be important to allow system leaders to get on with service improvements and address the huge challenges they face. We are also assured to see the framework attempting to ensure a balance between national and local priorities and clarity around the exit criteria for mandated support. These things should be built on in future iterations of the framework, including some transparency about who has responsibility for monitoring exit criteria for mandated intensive support and how it is applied.[10] We hope the next version of the framework

will be underpinned by the structural, behavioural and cultural changes envisaged by the operating model.

36. Both regulators will need to grapple with the issue of how provider quality will influence ICS assessments. There is a risk that performance management of NHS trusts and foundation trusts increases given that they will continue to be regulated as organisations and will be required to contribute to the wider system and in many cases to hold themselves to account within provider collaboratives. They should work with ICB leaders through the detail on how this works in practice and case studies may be instructive.

37. We are pleased that both regulators are committed to considering the role of peer review as part of their oversight models in future. ICS leadership at all levels should be able to drive self-directed improvement and develop fora for challenge and mutual accountability including peer review and support mechanisms. We hope the peer support offer facilitated and organised by the NHS Confederation, Local Government Association and NHS Providers will become a key tool for driving system improvement over the coming years.[11] Fellow system leaders can provide useful lived experience and can act as critical friends, picking up good practice and sharing their ideas. As ICSs mature, we believe they should become more self-evaluated so that regulation is more targeted. In the longer-term, therefore, ICS peer review may play a more formal role in improvement processes.

38. Regulation should treat ICSs as a partnership of equals by holding to account the NHS, local government and other partners within them, while respecting local government's independent mandate to their electorates. NHSE will need to consider how to do this within the confines of an oversight framework that only has formal oversight of NHS organisations. Regulators will need to navigate the tension between central, managerial NHS accountability to ministers and local government accountability to local voters. Having councils heavily involved in ICSs – including most ICPs being chaired by councillors – is an informal accountability structure to ensure it reflects what communities want. Ultimately, the success of the health and care system depends on the contribution of all partners involved, and accountability should reflect that.

5. Risks

Addressing questions:

- How can it be ensured that quality and safety of care are at the heart of ICB priorities?
- How can a focus on prevention within ICSs be ensured and maintained alongside wider pressures, such as workforce challenges and the electives backlog?

39. Improving outcomes in population health and healthcare is the first statutory objective for ICBs, and quality and safety is crucial to achieving this. ICB quality committees will assure safety and day-to-day performance on behalf of the Board. They will inherit CCGs' quality assurance function, ensuring a focus on outcomes first by considering the public's experience of services. The committees have been guided by the national quality board (NQB), which in time will help with standardisation in approach and outcomes, and will carry forward the NQBs requirements for 'Managing Risks and Improving Quality through Integrated Care Systems'.[12] ICB quality committees will be able to go further than CCG or trust quality committees by drawing on data

[10] This includes those ICSs which are clarified in Segment 4 of NHS England's System Oversight Framework (so called SOF4), the regulatory framework which earmarks those systems with the most challenges. See: https://www.england.nhs.uk/system-and-organisational-oversight/nhs-system-oversight-framework-segmentation/
[11] https://www.nhsconfed.org/what-we-do/peer-support

[12] https://www.england.nhs.uk/wp-content/uploads/2021/04/nqb-position-statement.pdf

and input from system partners, such as Healthwatch and VCSE partners sitting on the ICP, allowing them to focus on population health, outcomes and inequalities. As providers are part of the ICS and will be part of quality committees, there should be a more improvement-based culture, grounded in a peer review approach. The CQC has a new remit to conduct independent reviews of systems – these will play an important role in helping systems to ensure that the quality and safety of patient care is not impacted by patients falling between different providers and that they get effective, joined-up care. Given that ICBs have only been operating as statutory organisations since 1 July, including the appointment of new non-executive directors who chair ICB quality committees, we are still working with our members on their plans to ensure quality and safety is thoroughly embedded within systems. We would be happy to provide further evidence on and examples of how ICBs are taking this forward.

40. There are three major risks that may undermine ICSs ability to drive the changes they want to make. The tension between the conflicting challenges of trying to address the backlog and balance budgets in the short-term, and the need to deliver transformation to improve care and make the health and care system more sustainable in the long-term, will require a high degree of "split screen thinking". Given their attachment to the political cycle, the tendency of performance management cultures is to focus on short-term priorities and targets. We believe there is a risk, therefore, that there will be too much emphasis on short-term pressures at the expense of longer-term reform and the difference that ICSs can make in terms of health inequalities and population health. We have heard from our members that short-term funding constraints and the financial planning requirement to balance budgets in-year can prevent investment in projects which will improve long-term sustainability and quality. This risks slowing the pace of integration and improvement.

41. Despite everything health leaders are doing to deliver safe care, there is a risk that when patient safety incidents increase (as they may, given current pressures in urgent and emergency care) regulatory processes are tightened to the degree that they become disenabling. The solutions to the huge challenges the health and care system faces involve working together in new ways to share risk and resources – including staff – across the system. But these ways of working are not always recognised or enabled by regulators. We will continue to work with our members and regulators to ensure care is delivered safely, in a way that is makes sense given existing workforce and capital shortages.

42. ICSs are in the process of implementing what most in the sector believe are the right reforms to reduce waiting times, improve care and make the system financially sustainable over the middle to long-term. This will take some time but as the examples above demonstrate, integrated working is already making a difference by relieving pressures in the acute sector to help reduce waiting times. There are, however, key success factors that are outside of ICSs control, issues which we have engaged the Committee on extensively. Firstly, whether they are given the requisite autonomy and headspace from the centre to make local decisions. Secondly, workforce supply constraints – something they are working hard to overcome in the short- to medium-term but which will require long-term workforce planning, training and funding. Third, they will need access to capital and transformation funding to make urgent changes to infrastructure to improve patient care. Finally, for integration to be successful and to fix the urgent and emergency care pathway, social care investment is sorely needed – something that will not be guaranteed by the social care levy, which replaces private with public investment without increasing net funding to social care provision. To make the health and care system financially sustainable in the long-term and deliver improves in services that patients expect, ICSs need to be given time and front-loaded resources to drive transformation.

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