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NIHR POLICY RESEARCH UNIT IN HEALTH AND
SOCIAL CARE SYSTEMS AND COMMISSIONING

The Developing Architecture of System Management: Integrated Care Systems and Sustainability and Transformation Partnerships

Interim report

February 2021

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Executive Summary

Background

Since the introduction of Sustainability and Transformation Plans in 2015, there has been an increasing emphasis in the English NHS on developing geographically based partnerships across the NHS and local government, where commissioners and providers take a co-ordinated approach to services, agree system-wide priorities, and plan collectively how to improve population health. This policy is a continuation of the long term direction of travel which seeks to improve inter-organisational collaboration in the planning and provision of NHS services. However, achieving system-wide collaboration through Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs) is also a fundamental shift away from the architecture of the internal NHS market, most specifically organisational autonomy designed to facilitate competition and the separation of commissioners and providers, albeit without (as yet) any change to legislation.

As STPs and ICSs are not currently statutory bodies, their success is determined by the willingness of actual statutory bodies to work together to agree strategies which may be against their own direct interest, within a wider framework which continues to hold individual organisations to account for their own performance. Successful system working also depends on securing the commitment of key system partners from outside the NHS, such as local government, who are subject to separate institutional contexts regarding priorities, ways of working and financial rules.

In order to understand how effective these new forms of collaboration are in achieving their goals, there was a need to investigate how STPs and ICSs are developing locally, including the development of leadership and co-operative arrangements, the way system partners are reconciling individual and system roles and the way local priorities are being reconciled with system priorities. This interim report presents findings from the first stage of this research.

Aims

The objectives of the study are to find out:

- 1) How the local leadership and cooperative arrangements with stakeholders (statutory, independent and community-based, including local authorities) are governed in the light of the ICS governance recommendations in the LTP. How statutory commissioning organisations including local authorities are facilitating local strategic decisions and their

implementation; and whether different types of commissioning function are evolving at different system levels.

- 2) Whether ICSs are able to allocate resources more efficiently across sectoral boundaries and bring their local health economies into financial balance.
- 3) How individual organisations are reconciling their role in an ICS with their individual roles, accountabilities and statutory responsibilities.
- 4) How national regulators are responding to the changes in modes of planning and commissioning and actual service configurations, in the light of the changed priorities for these regulators set out in the LTP.
- 5) Which mechanisms are used to commission services in ICSs. In particular, how is competition used to improve quality and/or value for money of services; and are more complex forms of contract (such as alliancing) being used? How are local organisations reconciling new service configurations with current/evolving pricing structures, and thus how are financial incentives being used?
- 6) How locality priorities, including those of local authorities, are reconciled with the wider priorities embodied in STPs and ICSs. In particular, how is co-ordination achieved between STP and ICS plans, local priorities and existing programmes of work such as any local new models of care?

Design and methods

The study consists of three in-depth case studies to investigate the development of STPs and ICSs. Each case study consists of a system and its partners. During the first stage of fieldwork one of the case study sites was an ICS and two were STPs.

This report is based on findings from the first phase of fieldwork which was undertaken between December 2019 and March 2020. Fieldwork was halted prematurely in March 2020 before the first phase was complete due to the emergency response to the COVID-19 pandemic.

The main form of data was interviews with the Director level staff and/or senior managers who were responsible for representing each member in the system, and with the system leaders. The interviews explored interviewees' experience of decision making in systems, the reconciliation of individual roles, accountabilities and statutory responsibilities with system roles, the impact of financial mechanisms on system working, reconciliation of local and system priorities, co-ordination between place and system, and system impact on resource allocation across sectoral

boundaries and the achievement of financial balance. Twenty eight interviews were conducted in this phase of the research.

We analysed local documents to understand governance structures, decisions being made in systems and strategic plans. We observed eight meetings during the first phase of the research (three in Case Study 1, three in Case Study 2 and two in Case Study 3). All meetings were system level meetings, of the Partnership Board or significant system forums. The purpose of observing a variety of meetings was to supplement the information we obtained from interviews with the system partners.

Results

The first phase of our research suggests that systems are still developing relationships and refining the governance arrangements to allow system partners to work effectively together to achieve their aims using the system form. Overall, systems are a challenging environment in which to make binding decisions, particularly those of a contentious nature. System partners are seeking to reconcile potentially competing interests in their governance arrangements: balancing representation, inclusivity and consensus with the need to act; the accommodation of both cross cutting pieces of work and issues specific to certain groups of organisations; and of the principle of subsidiarity and the need for system oversight. Measures being introduced include proposals to streamline membership of governance forums, the incorporation of existing governance architecture into system structures, and the recruitment of system leaders who hold positions of authority in statutory bodies within the system.

The development of system governance which ‘goes with the grain’ of the local context appears an important way of enabling the full engagement of local government in systems and places, and facilitating governance arrangements which are clear and functional. Interviewees acknowledged that it remains challenging to get the division of responsibilities “right” between systems and places. Not all commissioning could be carried out at ICS level, and it was necessary to make commissioning decisions at place level too. It was anticipated the progression towards a single CCG per system would lead to the delegation of some commissioning decisions to place level. At place level, agreements to formalise co-operative working and agreements to share risk, such as Alliance agreements, are under discussion but not yet widely implemented.

We found a broad acceptance among partners of the need to work collaboratively together, and to take decisions in the best interest of the system. However, some interviewees still doubted

that, given the current legislative environment, partners would prioritise the interests of the system above individual roles, accountabilities and statutory responsibilities when faced with decisions significantly against organisational interests. It appears that a shift from competition to a collaborative ethos in the NHS is underway, but this is a long-term undertaking. Local government bodies were concerned about their potential exposure to financial risk, and loss of control over limited council resources.

The question of how systems were accountable, to whom and for what was far from settled. The developing landscape has made things unclear on the ground for NHS partners, with the potential for confusion in the way responsibilities flow between the system, the regulator, providers and places.

Systems were starting to make use of opportunities to agree the allocation of central resources between partners, to develop shared resources in ways that had not been possible before, and to explore novel and unique initiatives based on system partnerships, but these types of initiatives were not yet common practice. At the time of the fieldwork, action to achieve long term financial sustainability in the case studies had not been agreed or implemented.

Conclusions

The governance structures of STPs and ICSs are complex and making decisions through these structures can be difficult. System partners are keen to embrace collaboration, and systems are starting to make use of opportunities to agree the allocation of resources and to develop shared resources in ways that had not been possible before. It is not clear how however, ICSs and STPs, in their current form, are addressing contentious issues such as the need to achieve financial sustainability. System working is not aided by accountability relationships that are unclear to some. It is important that system governance structures ‘go with the grain’ of the local context, in order to facilitate meaningful engagement of local government, and to improve the clarity and functionality of decision making processes. The division of functions between systems and places is not straightforward. As CCGs merge to become coterminous with systems, there is a need for clear arrangements for the necessary commissioning functions at both system and place level.

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Glossary

Alliance agreement - An NHS Alliance agreement overlays but does not replace existing service contracts. It brings providers together around a common aspiration for joint working across the system, setting out shared objectives and principles, and a set of shared governance rules allowing providers to come together to take decisions

Better Care Fund - A single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities

Blended payments - A holistic blended payment model comprising a fixed element with a quality/outcomes based element, a risk sharing element and/or a variable payment to encourage providers and commissioners to adopt cost effective, joined up approaches

Block contract - The NHS payment system under which a healthcare provider receives a lump sum payment to provide a service irrespective of the number of patients treated

Care Quality Commission (CQC) - The independent regulator of quality of all health and social care services in England

Commissioner Sustainability Fund (CSF)- System of cash rewards for CCGs in return for meeting financial targets

Committee in common – an approach to co-ordinated decision making across organisations, by which multiple organisations establish their own committee with delegated authority to make certain decisions, which meet at the same time, with the same remit, and where possible identical membership to co-ordinate decisions. Each committee remains accountable to its own board.

Devolution Agreement – An agreement involving the transfer, concurrent exercise, or joint exercise of functional responsibilities from a public authority (which could include a Government department or NHS England) to a local party

GP Federation - a group of general practices or surgeries forming an organisational entity and working together within the local area

Health and Wellbeing Board - a formal committee of a Local Authority, which has a statutory duty, with CCGs, to produce a joint strategic needs assessment and a joint health and wellbeing strategy for the local population

Individual Control Total – Annual financial target that NHS organisations must achieve to unlock access to national funding and other financial benefits

Lead contracting – a contractual configuration where one provider organisation holds a service contract with NHS commissioners and sub contracts part of its performance to other organisations

Memorandum of Understanding (MoU)- A document that records the common intent and agreement between two or more parties. It defines the working relationships and guidelines between collaborating groups or parties.

NHS England/NHS E - An executive non-departmental public body responsible for directly commissioning primary care and specialist services and overseeing the commissioning arrangements created by the HSCA 2012. From 1 April 2019, NHS England and NHS Improvement are working together as a new single organisation (NHSEI)

NHS Improvement/NHS I - An executive non-departmental public body responsible for overseeing NHS foundation trusts, NHS trusts and independent providers, helping them give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable. From 1 April 2019, NHS England and NHS Improvement are working together as a new single organisation (NHSEI)

NHSEI - From 1 April 2019, NHS England and NHS Improvement are working together as a new single organisation (NHSEI)

PbR - Payment by Results: the payment system relying on national tariffs for certain HRGs

Overview and Scrutiny Committee - a Local Authority Committee, required by the Local Government Act 2000, for the scrutiny of the provision of local health services

Provider Sustainability Fund (PSF)- System of cash rewards in return for meeting financial targets

System control total - annual NHS financial target for an STP or ICS area, based on the sum of individual organisation control totals

1. Introduction

1.1 Policy Background

Since the introduction of Sustainability and Transformation Plans in 2015, there has been an increasing emphasis in the English NHS on developing geographically based partnerships across NHS and local government, take a co-ordinated approach to services, agree system-wide priorities, and plan collectively how to improve population health. This interim report relates to the findings from the first stage of a research study to investigate the developing architecture of system management through Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs) in order to find out how effective these new forms of collaboration are in achieving their goals, and what factors influence this.

The establishment of NHS structures at a regional level and a reliance on collaboration are not novel approaches. Firstly, an ‘intermediate tier’, which is shaped by central policy-making decisions whilst overseeing the organisation of local health services, has been a feature for nearly the entire history of the NHS (Lorne et al., 2019). Spatial ‘regions’ have also been a near constant – if constantly changing – feature within the organisation of healthcare. Such intermediate bodies may be statutory or non-statutory, and may at times have greater autonomy (decentralist) or may operate merely as administrative layers (de-concentration) (ibid.). Secondly, alongside the use of market mechanisms to promote competition in the NHS since the late 1980s, there has been an ongoing reliance on collaboration. Co-operation between organisations is acknowledged as an ‘essential behaviour’ in the provision of ‘seamless and sustainable care’ to patients (Department of Health, 2010e, p12). The need for co-operation is enshrined in *The Health and Social Care Act 2012* (HSCA 2012) in the requirement that the economic regulator is responsible for promoting co-operation, and that NHS commissioners should ensure that the appropriate levels of both competition and cooperation exist in their local health economies

However, the development of STPs and ICSs has marked a fundamental shift in emphasis in NHS policy, moving away from the architecture of the internal NHS market, where organisational autonomy was designed to promote competition and the separation of commissioners and providers, albeit without (as yet) any change to legislation. System working in STPs and ICSs elevates partnership working alongside the interests of individual organisations, prioritises collaboration over competition and market mechanisms, and facilitates greater collaboration across all partners involved in population health. Early

guidance relating to Sustainability and Transformation Plans (which would later become Sustainability and Transformation Partnerships) emphasised the involvement of all *'local leaders coming together as a team, developing a shared vision with the local community, which also involves local government as appropriate; [and] programming a coherent set of activities to make it happen'* (NHS England et al., 2015). ICSs later emerged out of a series of policy documents and announcements as more advanced local partnerships which *'bring together local organisations in a pragmatic and practical way to deliver the 'triple integration' of primary and specialist care, physical and mental health services, and health with social care'* (NHS, 2019a, p. 29). There are currently 42 local systems in place. As of December 2020, 29 of these systems were ICSs, and it was expected the remaining 13 STPs would mature to become ICSs by April 2021.

The establishment of STPs and ICSs takes place within a wider context which is not necessarily supportive of the partnership approach. Collaboration across NHS bodies is situated in the residual wider institutional context in the NHS of hierarchical control and market incentives. As STPs and ICSs are not currently statutory bodies their success is determined by the willingness of NHS bodies within the system to work together to agree strategies for resource utilisation which may be against their own direct interest, within a wider framework which continues to hold individual organisations to account for their own performance. A further important element of system working is securing the commitment of system partners from outside the NHS, such as local government, who are subject to separate institutional contexts regarding priorities, ways of working and financial rules. STPs and ICSs are voluntary partnerships (although in effect mandated by NHS policy for NHS organisations), with no formal powers or accountabilities, in which decision making is consensual. There have been no relevant legislative changes, so the HSCA 2012 provisions concerning the respective roles of NHS commissioning organisations and the regulatory framework in respect of competition remain in force (Sanderson et al., 2017).

In order to understand how effective these new forms of collaboration are in achieving their goals, it is important to investigate how STPs and ICSs are developing locally, including the development of leadership and co-operative arrangements, the way system partners are reconciling individual and system roles and the way local priorities are being reconciled with system priorities.

1.2 Governance and regulation of ICSs and STPs

ICSs and STPs are focused on shared decision-making regarding the allocation of resources, service design and improving population health (although under existing legislation, any procurement or awarding of contracts must be undertaken by NHS commissioners). Guidance published by NHS England (NHS, 2019b, p. 3) sets out the functions of ICSs as follows: to develop system strategy and planning; to develop system-wide governance and accountability arrangements; to lead the implementation of strategic change; to manage performance and collective financial resources; and to identify and spread best practices across the system to reduce unwarranted variation in care and outcomes. Underlying these overarching aims are more detailed expectations of the outcomes that systems will be instrumental in delivering alongside statutory organisations. For example, ICSs and STPs are tasked with driving forward five key NHS priorities set out in *The Long Term Plan (LTP)* (NHS England, 2019) (including boosting out of hospital care, reducing pressure on emergency hospital services, developing personalised care, implementing digitally enabled care, and focusing on population health and local partnerships), and *The 20/21 Operational Planning and Contracting Guidance* outlines clear expectation that systems, alongside statutory organisations, will oversee the delivery of operational targets (NHS England and NHS Improvement, 2020f).

The policy context regarding the development of STPs and ICSs can be characterised as permissive. STPs and ICSs are ‘bottom-up’ partnership arrangements, rather than following a single national blueprint and there are currently few governance requirements to which all systems must adhere. All systems are organised according to a three tier spatially based model, with the implicit expectation that the levels will nest within one another: broadly speaking, the ‘system’ area covered by the STP or ICS (population size of 1-3 million) contains ‘places’ and ‘neighbourhoods’ within it, and ‘regional’ and ‘national’ oversight through the regional arms and national presence of NHS England and Improvement (NHSEI) (see *Figure 1* below). In practice STPs and ICSs (and ‘places’ and ‘neighbourhoods’) vary considerably in terms of population size and organisational complexity, reflecting local factors such as demography and existing networks of collaboration, and may elude neat containment within coherent territorial geographies (Hammond et al., 2017). NHS policy guidance sets out ‘places’ (population size of 250, 000 – 500,000) as operating typically at borough/local authority level ‘*served by a set of health and care providers in a town or district, connecting primary care networks to broader services including those provided by local councils, community hospitals or voluntary organisations*’ (NHS, 2019b). Local authorities have a key role in working in ‘places’ through

ICS structures whereby ‘commissioners will make shared decisions with providers on population health, service redesign and Long Term Plan implementation’ (NHS, 2019a, p. 10).

Figure 1: Overview of integrated care systems and their priorities from the NHS Long-Term (from (NHS England and NHS Improvement, 2019b))

Level	Function	Priorities
Neighbourhood (c. 30,000 to 50,000 people)	<ul style="list-style-type: none"> Integrated multi-disciplinary teams Strengthened primary care through primary care networks – working across practices and health and social care Proactive role in population health and prevention Services (e.g. social prescribing) drawing on resource across community, voluntary and independent sector, as well as other public services (e.g. housing teams). 	<ul style="list-style-type: none"> Integrate primary and community services Implement integrated care models Embed and use population health management approaches Roll out primary care networks with expanded neighbourhood teams Embed primary care network contract and shared savings scheme Appoint named accountable clinical director of each network
Place (c. 250,000 – 500,000 people)	<ul style="list-style-type: none"> Typically council/borough level Integration of hospital, council and primary care teams / services Develop new provider models for ‘anticipatory’ care Models for out-of-hospital care around specialties and for hospital discharge and admission avoidance 	<ul style="list-style-type: none"> Closer working with local government and voluntary sector partners on prevention and health inequalities Primary care network leadership to form part of provider alliances or other collaborative arrangements Implement integrated care models Embed population health management approaches Deliver Long-Term Plan commitments on care delivery and redesign Implement Enhanced Health in Care Homes (EHCH) model
System (c. 1 million to 3 million people)	<ul style="list-style-type: none"> System strategy and planning Develop governance and accountability arrangements across system Implement strategic change Manage performance and collective financial resources Identify and share best practice across the system, to reduce unwarranted variation in care and outcomes 	<ul style="list-style-type: none"> Streamline commissioning arrangements, with CCGs to become leaner, more strategic organisations (typically one CCG for each system) Collaboration between acute providers and the development of group models Appoint partnership board and independent chair Develop sufficient clinical and managerial capacity
NHS England and NHS Improvement (regional)	<ul style="list-style-type: none"> Agree system objectives Hold systems to account Support system development Improvement and, where required, intervention 	<ul style="list-style-type: none"> Increased autonomy to systems Revised oversight and assurance model Regional directors to agree system-wide objectives with systems Bespoke development plan for each STP to support achievement of ICS status
NHS England and NHS Improvement (national)	<ul style="list-style-type: none"> Continue to provide policy position and national strategy Develop and deliver practical support to systems, through regional teams Continue to drive national programmes e.g. Getting It Right First Time (GIRFT) Provide support to regions as they develop system transformation teams 	

Important changes are occurring to create ‘neighbourhoods’ (population size of 35,000-50,000) through the formation of Primary Care Networks (PCNs). Introduced in the *NHS Long Term Plan* (NHS, 2019a), but building on an aspiration for greater ‘at scale’ working in primary care established in the *Five Year Forward View* (NHS, 2014), PCNs involve groups of GP practices (typically covering patient populations of 30,000-50,000) agreeing to work more closely with each other, as well as attempting to integrate better with community health care services and other local health and care organisations.

The configuration of PCNs is not straightforward: while policy suggests that multiple contiguous PCNs make up ‘neighbourhoods’ and nest ‘within places’, in reality PCN boundaries are much less clear cut and include significant overlap (Checkland et al., 2020). PCN policy and guidance suggests that other community-based services – such as community nursing – will realign themselves around neighbourhood footprints. Research into PCNs is currently underway, led by other members of the Policy Research Unit in Health and Social Care Systems and Commissioning (PRUComm) (Checkland et al., 2020). Therefore, whilst links are noted here, their development is analysed in depth elsewhere.

The document ‘*Next Steps on the NHS Five Year Forward View*’ (NHS England, 2017) (*NHS England and NHS Improvement, 2020f*) sets out the governance requirements of STPs and ICSs (later updated in *The Long Term Plan* (NHS, 2019a, p. 30) and expanded upon in the *20/21 Operational Planning Guidance* (*NHS England and NHS Improvement, 2020f*)), namely that they should include: system wide governance which includes a partnership board, drawn from commissioners, trusts, primary care networks, local authorities, the voluntary and community sector and other partners; a clear leadership model including a system leader and a non-executive chair; sufficient clinical and management capacity drawn from across their constituent organisations to enable them to implement agreed system-wide changes; system capabilities to fulfil the core role of an ICS and a sustainable model for resourcing these; agree ways of working across the system in respect of financial governance and collaboration; and capital and estates plans at system level. It is also expected that ICSs should engage fully with primary care and PCNs.

Although there have been no changes to the wider institutional context to date there are expectations in *The Long Term Plan* that local organisations, professionals and national regulatory bodies should align to system working where possible. Specifically, it is expected that clinical leadership should be aligned around the ICS to ensure clear accountability to the ICS, that the CQC’s regulatory approach should emphasise partnership working and system wide quality; NHS providers are required to contribute to ICS goals and performance; and ICSs are expected to work with Health and Wellbeing Boards (HWBs) (NHS England, 2019, p30). Most recently, NHSEI has put forward plans for changes to regulation and oversight to support system working which include issuing guidance under the NHS provider licence that good governance for NHS providers includes a duty to collaborate; and ensuring foundation trust directors’ and governors’ duties to the public support system working (NHS England and NHS Improvement, 2020b).

The Care Quality Commission (CQC) which has a remit across health and adult social care delivery is, to a degree, focusing on the performance of individual organisations through the system lens. The CQC's powers in regard of system review are somewhat limited as *The Health and Social Care Act 2008* gives the CQC the power to regulate individual providers, with no equivalent set of mechanisms to drive improvement at system level. However, in July 2017 the CQC commenced 20 system wide reviews (later extended to 23 reviews) conducted across local authority areas, triggered by a ministerial request for targeted reviews of local health and social care systems (CQC, 2019), and in July 2020 announced a series of Provider Collaboration Reviews, which look at how health and social care providers are working together in local areas (Trenholm, 2020). The aim of these Provider Collaboration reviews is to help providers learn from each other's experience of responding to COVID-19, by looking at provider collaboration across all ICSs and STPs. Reflecting the jurisdiction of the CQC in relation to individual organisations only, participation in these latter reviews is not mandatory, and findings do not affect ratings. The recent proposals from NHSEI regarding legislative reform suggests it is working with the CQC to embed a requirement for strong participation in ICS collaborative arrangements in its provider assessment (NHS England and NHS Improvement, 2020b).

While quality regulation through the CQC has a focus across adult health and social care delivery, NHSEI is responsible for the performance regulation and support of commissioners and providers of NHS services only. Local Authorities are outside this framework, and have separate accountabilities for finance and performance, to communities for how they spend their money, and local politicians and officers operate within local governance frameworks of checks and balances, overseen by the Ministry of Housing, Communities and Local Government (National Audit Office, 2019a).

The new regional NHSEI teams led by regional directors are tasked with supporting the development and identity formation of the ICSs and STPs (NHS England, 2019). The oversight arrangements for regional teams include shifting from a focus on the NHS individual organisations to working through systems where possible, specifically: taking a system perspective with greater emphasis on system performance, and the contribution of individual healthcare providers and commissioners to system goals; working with and through system leaders, wherever possible, to tackle problems; matching accountability for results with

improvement support as appropriate; allowing greater autonomy to systems with evidenced capability for collective working and track record of successful delivery of NHS priorities (NHS England and NHS Improvement, 2019d).

The ‘System Maturity Matrix’ outlines the core capabilities expected of emerging ICSs, developing ICSs, maturing ICSs and thriving ICSs (NHS England and NHS Improvement, 2019b). For a system to be formally named an ICS, they will need to broadly meet the attributes of a maturing ICS across domains consisting of system leadership, partnerships and change capability, system architecture and financial management and planning, integrated care models, track record on delivery and coherent and defined population. The matrix uses a ‘progression model’ rather than a checklist approach, recognising that systems will not develop all domains at the same pace and will therefore have varying levels of maturity across each domain. As systems progress across the matrix they are given increased freedoms and flexibilities according to a principle of earned autonomy, including a greater shared responsibility for the overall quality of care and use of resources across their population (NHS England and NHS Improvement, 2019d, Annex 1). Assurance functions are expected to develop as systems progress through the Matrix. At Level 4, Thriving ICS’s are expected to lead the assurance of individual organisations, agree and co-ordinate any Trust or CCG intervention carried out by NHSEI. At this level NHSEI will undertake the least number of formal assurance meetings possible with individual organisations, and will operate a light touch regarding the assurance of organisational plans.

NHS providers and commissioners are subject to various financial mechanisms to incentivise partnership working. The most significant of these is the System Control Total which provides incentives to NHS providers and commissioners. In 2019/20 all STPs/ICSs were required by NHSEI to produce a system operating plan for 2019/20 comprising a system overview and system data aggregation, containing shared capacity and activity assumptions to provide a single, system-wide framework for the organisational activity plans (NHS England and NHS Improvement, 2019c). NHSEI also set a System Control Total for each STP/ICS (based on the sum of individual organisation control totals). Providers within ICSs were expected to link a proportion of their Provider Sustainability Fund (PSF) and any applicable Commissioner Sustainability Fund (CSF) (systems of cash rewards in return for meeting financial targets) to delivery of their system control total (*ibid.*).

1.3 Research Questions

System integration is a key goal of NHS policy and will continue to be salient for the next few years as the details of the relevant structures and governance arrangements develop. Understanding system management and oversight and exploring the role of commissioning and incentives in such systems will be important for supporting policy development and practice. The aim of this PRUComm study is to investigate the further development of STPs and ICSs in order to find out how effective these new forms of collaboration are in achieving their goals, and what factors influence this. Building on extensive previous PRUComm research in this area (Allen et al., 2017, Moran et al., 2018, Lorne et al., 2019) the objectives of the study are to find out:

- 1) How the local leadership and cooperative arrangements with stakeholders (statutory, independent and community-based, including local authorities) are governed in the light of the ICS governance recommendations in the LTP. How statutory commissioning organisations including local authorities are facilitating local strategic decisions and their implementation; and whether different types of commissioning function are evolving at different system levels.
- 2) Whether ICSs are able to allocate resources more efficiently across sectoral boundaries and bring their local health economies into financial balance.
- 3) How individual organisations are reconciling their role in an ICS with their individual roles, accountabilities and statutory responsibilities.
- 4) How national regulators are responding to the changes in modes of planning and commissioning and actual service configurations, in the light of the changed priorities for these regulators set out in the LTP.
- 5) Which mechanisms are used to commission services in ICSs. In particular, how is competition used to improve quality and/or value for money of services; and are more complex forms of contract (such as alliancing) being used? How are local organisations reconciling new service configurations with current/evolving pricing structures, and thus how are financial incentives being used?
- 6) How locality priorities, including those of local authorities, are reconciled with the wider priorities embodied in STPs and ICSs. In particular, how is co-ordination achieved between STP and ICS plans, local priorities and existing programmes of work such as any local new models of care?

This interim report is based on the first phase of fieldwork, which consisted of interviews with system members, meeting observation and the analysis of documents. The fieldwork was curtailed due to the impact of the COVID-19 pandemic response on the availability of system partners for interviews. Consequently, we did not complete all our planned interviews with system partners. We are intending to complete a further round of fieldwork, including interviews with system partners, partners at place level and representatives of regional NHSEI, which will form the basis of the final report.

2. Theoretical framework

The study is underpinned by a number of relevant theories broadly relating to network governance which have informed the development of research questions and will inform the analysis of the findings for the interim and final reports for the study.

STPs and ICSs are forms of networks. Definitions of networks vary, but they can be characterised as informal modes of co-ordination (Thompson, 2003) between organisations (6 et al., 2006, Thompson, 2003), or between organisations and individuals (6 et al., 2006). Members typically have complementary strengths and share interdependencies, a combination which motivates them to make plans together in advance to co-ordinate their activities in light of long-term reciprocal relationships. Networks can be conceptualised as a third mode of governance, with co-operation mechanisms which differ from the mechanisms of the market (price, transactions, exit) and those of the hierarchy (rules, commands, authority). Relational norms are valuable enablers of collaboration in networks, where there is a lack of unifying external control and sanctions, and where there is a high level of uncertainty about the future (Williamson, 1993). Norms such as openness, reciprocity and fairness are acknowledged to generate trust and discourage ‘malfeasance’, and can take a ‘smoothing’ role in relations between organisations and within organisations, effectively allowing parties to co-ordinate their behaviour without vertical integration (Granovetter, 1985). The wider environment in which networks are situated is of importance to the establishment and endurance of these attributes and is therefore of particular significance to network scholarship and understanding the operation of networks in practice. For example, it is thought that trust is produced and strengthened by action (Sydow, 1998), and is more likely to exist where there is familiarity through repeated interactions, when it is not considered to be in the interest of the other party to act opportunistically, and where there are coinciding values and norms (Gambetta, 1988).

A further relevant field of scholarship is economic theories of cooperation, which can inform understanding of the circumstances in which organisations and individuals are willing and able to cooperate with each other. The significant policy turn in the English NHS emphasises the collective nature of the delivery of health services calling on local commissioners and providers to put self-interest aside and work collectively make best use of the available collective resources (National Audit Office, 2019b, NHS England, 2017). However, this is somewhat at odds with the residual institutional context of the English NHS (as explained in Section 1)

which is predominantly state led, with some elements of market institutions. Economic theory refers to the paradox of achieving co-operation between self-interested parties through the concept of ‘social dilemmas’. Social dilemmas arise when a group has shared usage of a common output, and each individual in the group can decide their own strategy regarding the use of the resource. Such collective action problems are characterised by a conflict between the immediate self-interest of the individual and longer term collective interests. A well-known social dilemma, ‘The Tragedy of the Commons’ (Hardin, 1968), suggests collective action problems must always lead to overgrazing and resource degradation.

The work of Elinor Ostrom (1990, 1994) disputes that collective action problems regarding usage of common pools must always lead to overgrazing and resource degradation, and contends that communities can agree rules governing the ‘appropriation’ (withdrawal) of such limited common pool resources in a way that benefits all community members and leads to the sustainability of the resource. The resonance of the notion of the ‘health commons’ with the development of place based systems of care within the NHS to address issues of organisational fragmentation and scarcity of resources has been acknowledged (Ham and Alderwick, 2015, Sanderson et al., 2020), and this research will consider her framework in relation to the ongoing development of STPs and ICSs. Through multiple case studies of long-enduring, self-governed common pool resources, Ostrom developed principles which describe the environment in which ‘appropriators’ (those who withdraw resources) are willing to devise and commit to shared operational rules and to monitor each other's conformance (Ostrom, 1990). These principles address the need for ‘communities’ (those with a shared dependence on the common pool) to set up clear boundaries and membership around the common pool, agree for themselves rules regarding appropriation and provision of resources, and agree the process for monitoring of behaviour and sanctions. Rules can help or hinder levels of co-operation, the development of trustworthiness and the achievement of ‘effective, equitable and sustainable outcomes’ (Ostrom, 2010). This research will draw on these principles in order to understand the ways in which ICSs/STPs and the wider institutional context in which they are situated may support the development of successful self-governance of common resources.

Alongside economic theories regarding co-operation, the report draws on relevant theories regarding governance. These theories are important as they relate to the development of STPs’ and ICSs’ capacity to make decisions about the allocation of resources, and the type of

accountabilities which are developing between system partners, and between the system and regulators.

Bossert's (1998) theorisation of 'decision space' proposes an analytical framework to describe the decentralisation of health systems in terms of the set of functions and degrees of 'choice' (discretion) that are transferred to local officials from central authorities. It has been used to explore the extent to which local autonomy is available in areas of relevance to health and social care systems, such as finances, service organisation, human resources and rules of governance. 'Decision space' refers to how much autonomy decentralised bodies have to develop policy, allocate resources, and define programs and services. Decentralised bodies act within decision space which is defined both formally, by laws and regulations, and informally by the enactment of the rules in practice. Decision space is therefore iterative, and subject to negotiation, challenge and friction. Whether decentralized institutions obtain the decision space allotted to them in formal frameworks depends on norms as well as the broader institutional context. Decision space is an important analytic concept which can be applied to the developing relationships and division of functions between STPs/ICSs and other actors, such as regulators, and between systems and places, in order to understand the decentralisation of functions that is occurring and the degree of discretion in place.

Accountability is a central concept to be considered when examining the potential of these new forms of collaboration to achieve their goals. The development of accountabilities within systems is central to the development of co-operation between system partners (Moran et al., 2018). The development of accountabilities affecting the function of STPs and ICSs will be considered in the light of Bovens' conceptualisation of accountability. Accountability can be described as *'a relationship between an actor and a forum, in which the actor has an obligation to explain and to justify his or her conduct, the forum can pose questions and pass judgement, and the actor may face consequences'* (Bovens, 2007). This definition can be interrogated to identify different types of accountability based on the nature of the actor, forum, conduct and obligation. Vertical accountability refers to a hierarchical relationship between the actor and the forum, which allows the latter to formally wield power over the former. In contrast, with horizontal accountability, a hierarchical relationship and formal accountability obligations are absent, and the concern is with accountability between stakeholders in a network (Bovens, 2007; Bovens et al., 2014).

An aim of this research is to investigate the development of leadership and co-operative arrangements in the light of STP and ICSs' status as horizontal cooperative working arrangements without legal sanction. A further key question to be addressed by the research is how system partners balance system accountabilities with their own pre-existing accountabilities as sovereign organisations, for example vertical accountabilities to regulators such as the CQC and NHSEI. There is a number of potential accountability relationships in systems. These can be categorised as firstly vertical (and formal): holding to account of the system, system leaders and (NHS) system partners for system performance by NHSEI, but secondly also informal and horizontal within systems: the holding to account of system partners by the system. STP and ICSs also have an informal accountability relationship with the public which should be considered alongside system partners' own accountabilities to the public. NHS bodies have public accountabilities, which have been characterised as a relatively weak notion of transparency with no associated sanctions (Peckham, 2014). Local Authorities however have direct local accountability to their electorate who vote for council members in local elections (alongside other complex accountability relationships) (National Audit Office, 2019a).

Using the definitions of Bovens regarding accountability to better understand system partners' experience and understandings of accountability relationships forms an important element of the conceptual framework of this research.

3. *Empirical studies of STPs and ICSs*

This section reviews the existing evidence relating to STPs and ICSs relevant to the perspective taken by this research, namely how these new forms of collaboration are developing to address their goals, including the development of leadership and co-operative arrangements, the way system partners are reconciling individual and system roles and the way local priorities are being reconciled with system priorities.

Collaboration has always been an important behaviour in the English NHS, as illustrated by many empirical studies which describe the persistence of collaborative behaviour amongst commissioners and providers of NHS services since the establishment of the internal market (e.g. Bennett and Ferlie, 1996, Flynn et al., 1996, Allen, 2002, Ferlie et al., 2010, Ferlie et al., 2011, Frosini et al., 2012, Porter et al., 2013). The interplay of competition and co-operation was the subject of PRUComm research which investigated the way in which local health systems were managed to ensure that cooperative behaviour was appropriately coexisting with competition in the period following the HSCA 2012. This research found that commissioners and providers used a judicious mixture of competition and cooperation in their dealings with each other, and that CCGs played an important role in co-ordination at a local level (Allen et al., 2015).

More recently, a small number of empirical studies have been published which are concerned with the development of STPs and ICSs. These studies focus on the challenges and opportunities of system working (Timmins, 2019), the development of systems in different parts of the UK, including in the light of the move to ICS status (Charles et al., 2018, NHS Providers and NHS Clinical Commissioners, 2018, Pett, 2020a), the funding and resourcing of ‘engine room’ staff (Pett, 2019), and the role of CCGs in the current commissioning landscape, including STPs. Additionally, the NHS Confederation has published reports which reflect the views of senior leaders from NHS and local government on various aspects of the development of systems (NHS Confederation, 2020, Das-Thompson et al., 2020, Pett, 2020b). The work of Walshe et al concerning the ‘devolved control’ of the budget for health and social care for the population of Greater Manchester is also highly relevant to the development of system working (Walshe et al., 2018).

The research suggests that, in order to be effective in achieving their aims, STPs and ICSs need to undertake substantial ground work to establish robust governance arrangements, clear lines of accountability and to build relationships, and furthermore that such ground work may be the overriding concern in the early stages of collaborative working, preceding any collaborative decision making to achieve system aims. Indeed, Charles et al (2018) found, in a study based on interviews across 8 ICSs, that much of the work of those systems had focused on such preliminary activities. This is supported by the research relating to the devolution of the health and social care budget in Greater Manchester (Walshe et al., 2018) where it was reported that, in the first two years of the arrangement, effort had been expended on the establishment of governance arrangements, relationship and agreeing strategies, with only a recent shift in focus to implementation. It is not always the case that system working will develop strong relationships. A recent management consultancy review of one of the first wave ICSs discovered poor relationships and a lack of trust between partners (Health Service Journal, 2021). However, research also suggests that these forms of collaboration do have the capacity to effect change, finding that collaboration within ICSs and STPs is resulting in tangible improvement in relationships (Timmins, 2019) and collaborative working is taking place to manage finances and performance across the system in ways that did not occur previously (Charles et al., 2018).

An area of commonality across much of the research which has been conducted to date is the significance of local context as a factor which impacts the evolution of system working (Charles et al., 2018, Moran et al., 2018), such as the relative levels of influence between trusts, CCGs and local government (Pett, 2020a), and the degree of fit between shared understandings of ‘places’ and system boundaries (Charles et al., 2018). It is suggested, for example that where there are strong local relationships these will benefit most from the permissive policy context (NHS Providers and NHS Clinical Commissioners, 2018). One recommendation arising is to support local ways of working, and allow local relationships to develop (NHS Confederation, 2020).

Alongside findings related to the establishment of necessary governance arrangements, are findings relating to the lack of clarity in system governance and accountabilities, and difficulties arising from the lack of formal status of systems. Studies suggest that system leaders may have variations in perceptions of accountabilities, that governance is subject to ongoing flux (Timmins, 2019), that systems may be treated as accountable by NHSEI (Moran

et al., 2018) and that there may be a lack of understanding over the existence of functions at regional, place and neighbourhood level (Pett, 2019). In relation to the development of partnership arrangements in Manchester, it was found that the formal status of partnership governance forums was perceived to be ambiguous, and that the partnership had few formal levers to use over NHS organisations, and even fewer in relation to local authorities, with individual organisations continuing to guard their autonomy carefully and act to serve organisational self-interest (Walshe et al., 2018). Additionally, it has been noted that there is a continuing tension between the statutory framework and the emphasis on systems and partnership working (Charles et al., 2018, Moran et al., 2018). The most recent research on the operation of systems in the COVID-19 and post COVID-19 world suggests that there is an increasing appetite for the strengthening of system working, and the formalisation of working arrangements (Pett, 2020b).

4. Study Design and Methods

The study consists of three in-depth case studies to investigate the development of STPs and ICSs. Each case study consists of a system and its partners.

The research questions and the research instruments were derived from relevant scholarship including economic theories of co-operation and the relevant NHS policy context, and address the aspects of these partnership models of decision making which are likely to relate to important issues concerning the operation and impact of these arrangements.

4.1 Selection of the case study sites

The use of case studies was thought to be the most appropriate research design for this study as interviews and documentary analysis were informed by the contextual information we were able to gather by concentrating on three specific systems. An initial literature review of NHS systems governance (Lorne et al., 2019) examined research into previous intermediate tiers in the NHS and this was also drawn on to inform strategy when selecting case study sites. The literature review highlighted the importance of boundaries in relation to system working, in particular suggesting that coterminosity of boundaries may help co-ordination between health and social care, but would not necessarily lead to ‘integrated care’ for patients. Additionally, the report highlighted uncertainty regarding the degree to which voluntary and private sector organisations were embedded in systems. Consequently, we identified local authority configuration, system boundaries, private sector and/or social enterprise partners and concentration of providers as characteristics of interest to the study, and we sought to recruit case study sites which demonstrated variance across these characteristics. Additionally, as we were also interested in the role of the regional NHSI function, we sought to identify case study sites from a variety of NHSEI regions. We identified possible case study sites after reviewing our own database of all STPs and ICSs in England, which contained information drawn from publicly available sources. We shortlisted a number of possible sites after considering the STPs and ICSs in relation to the characteristics of interest and then gathered more information about these sites from publicly available information (most commonly Board papers).

An overview of the systems which were selected can be found in Section 5. The three case study sites (one ICS and two STPs) are located in different parts of England. Case Study 1 covers an urban population, has complicated boundaries and includes 5 unitary authorities. Case Study 2 system shares near coterminosity with the county council, and system partners

include social enterprises. Case Study 3 system has a large geographical footprint, and a complex, multi-layered governance structure spanning seven CCGs and eight Local Authorities.

4.2 Securing access to case study sites

Potential research sites were initially approached by email to the leader of the STP or ICS. If this approach was successful we then liaised with this person or a nominated representative about the best way to secure system permission to conduct the research. In two case studies this involved attending a system governance forum to gain permission of all partners, and in one case it involved a detailed discussion with representatives of system leaders, who then presented the case to system partners. Once permission was granted we then liaised with the main contact to establish the key contacts in each member organisation or body. Each contact was approached separately to request their participation in the research. The interviewees consisted of Director level staff and/or senior managers who were responsible for representing their organisation in the system.

4.3 Ethical approval

Ethical approval for the study was granted by the London School of Hygiene and Tropical Medicine internal ethics committee on 23 August 2019 (Ref:17711). NHS research governance approval from the HRA was granted on the 6th August 2019 (266175/REC ref 19/HRA/3261). We participated in a streamlined NHS research governance approval process piloted by the Health Research Authority (HRA). Due to the low burden nature of this study and the seniority of the research participants, we were not expected to separately notify this project to the Research and Development office of each NHS organisation from which we sought participation. The seniority of the research participants meant that the research participants were themselves the most appropriate parties to confirm whether they were willing to participate. We also received endorsement from the Association of Director of Adult Social Services Executive Council for the research on 19 November 2019.

4.4 Summary of methods

This interim report is based on findings from the first phase of fieldwork which was undertaken between December 2019 and March 2020. Fieldwork was halted prematurely in March 2020 before the first phase was complete due to the emergency response to the COVID-19 pandemic.

Interviews

During Phase 1 of the fieldwork we interviewed 28 people across the three case study sites (see Table 1). MS, DO, CL and OB conducted the interviews. The interviews explored interviewees' experience of decision making in systems, the reconciliation of individual roles, accountabilities and statutory responsibilities with system roles, the impact of financial mechanisms on system working, reconciliation of local and system priorities, co-ordination between place and system, and system impact on resource allocation across sectoral boundaries and the achievement of financial balance.

Findings from three interviews (with four interviewees) from the start of Phase 2 of the fieldwork (see Table 2) have also been included in this interim report as they contained information about the system role in relation to the COVID 19 response. Fieldwork in respect of Phase 2 continues and will be written up in our final report.

Table 1: Phase 1 interviewees by case study site and organisational type

	<i>Case Study 1</i>		<i>Case Study 2</i>		<i>Case Study 3</i>		<i>Total interviews</i>
	<i>No of partners</i>	<i>Interviews</i>	<i>No of partners</i>	<i>Interviews</i>	<i>No of partners</i>	<i>Interviews</i>	
<i>STP leadership</i>	--	2	--	4	---	2	8
<i>CCG</i>	4	0	4	1 (lead of all CCGS)	7	1	2
<i>NHS Providers</i>	5	3	6 (inc Amb Trust)	3	5	4	10
<i>Local Authorities</i>	5	1	1	1	8	4	6
<i>Primary Care</i>	0	0	0	0	0	0	0
<i>Other Providers</i>	0	0	2	2	0	0	2
<i>Total interviews</i>	--	6	--	11	--	11	28

Table 2: Early Phase 2 interviewees by case study site and organisational type

	<i>Case Study 1</i>	<i>Case Study 2</i>	<i>Case Study 3</i>	<i>Total</i>
<i>STP leadership</i>	0	1	1	2
<i>CCG</i>	0	0	2	2
<i>Total</i>	0	1	3	4

Use of documentation

We gathered documentation, from all three case study sites. This included strategic plans, meeting papers and details of governance structures. These sources were used to add detail to the interview accounts.

Meeting observation

We observed eight meetings during the first phase of the research (three in Case Study 1, three in Case Study 2 and two in Case Study 3). All meetings were system level meetings, of the Partnership Board or significant system forums. The purpose of observing a variety of meetings was to supplement the information we obtained from interviews with the parties. Notes were taken during each of these meetings, and were subsequently used to confirm our understandings of the governance processes in place.

Analysis of data

PA, MS, DO and CL agreed the theoretical framework, and the main themes derived from the research questions. MS and DO agreed additional themes emerging from the data. These themes were used to analyse the data, and structure the report. MS, DO, CL and OB conducted the thematic analysis. The findings are presented in a way as to highlight similarities between three cases; where there is a difference/variation it is further emphasised.

5. Overview of case studies

The section gives an overview of each case study area in terms of the size of the system, some information about the area and population it covers, an overview of system partners, and their configuration. Table 3 summarises the characteristics of each case study site, as they are described in the narrative. Figure 2 (overleaf) depicts the spatial organisation of each case study system and its constituent partners.

Table 3: Characteristics of case study sites (as at December 2019)

	Case Study 1	Case Study 2	Case Study 3
Population	<i>1.5 million</i>	<i>1 million</i>	<i>1.9 million</i>
CCGs	<i>4</i>	<i>4</i>	<i>7</i>
NHS providers*	<i>5</i>	<i>6</i>	<i>5</i>
Other healthcare providers*	<i>0</i>	<i>2</i>	<i>0</i>
Single tier local government*	<i>5 Unitary Authorities</i>	<i>0</i>	<i>8 Local Authorities</i>
Upper tier of local government*	<i>0</i>	<i>1 County Council</i>	<i>0</i>
Lower tier of local government*	<i>0</i>	<i>10+ Borough Councils</i>	<i>0</i>
No of ‘places’ within system*	<i>5</i>	<i>5 (one non spatial)</i>	<i>3 sub systems</i>

* a fuller description of these categories is given below in the narrative descriptions of each case study system

Case Study 1

Case Study 1 is an STP covering a population of approximately 1.5 million people. At the time of the fieldwork it consisted of four constitutive CCGs and five NHS providers (see Table 2 above). The STP area includes five unitary authorities. Due to complicated boundaries, changing leadership and the evolving vision for the STP, membership of the STP was characterised by certain fluidity with some providers being added as partners of STP during the fieldwork.

The STP has formed into five places which correspond with the five unitary authorities. Each place has a distinct and strong local identity, with different local priorities, governance and service delivery models.

There are multiple complications around boundaries and membership. CCG and local authority boundaries are largely coterminous, with the exception of one CCG which stretches into two LA areas. However the five authorities are part of a Combined Authority with strategic powers, including over transport, and economic development, which is larger than the STP area. At the time of the fieldwork there appeared to be a tension between the desire to retain local identity and distinction at place/local authority level and a move to create more uniformity across the system. At the time of the fieldwork GPs were opposing the plans to merge the CCGs by April 2021 into one CCG coterminous with the STP.

Case Study 2

The Case Study 2 system has ICS status (Stage 3 ‘thriving’ ICS). The ICS serves a population of around one million people. Formal system membership at the time of the fieldwork included four CCGs, five NHS provider organisations, two social enterprises, an NHS Ambulance Trust, general practice (represented as a single provider), and the County Council.

Additionally, a devolution agreement is in place locally between the CCGs, the County Council, NHS England and NHS Improvement focusing on the development of local control of health and care commissioning decisions and increasing alignment between NHS and local government commissioning responsibilities.

In terms of its boundaries and coterminosity, the system is in many ways straightforward. At the time of fieldwork, there was near coterminosity between the ICS and Council, with the ICS encompassing the vast majority of the Council population, and this was reflected in strong Council leadership of the system. A merger to form a single CCG covering the ICS was anticipated to take place in April 2020. However, within the system issues of boundaries and coterminosity were more complex. The lower tier of local government consisted of more than ten Districts and Boroughs, which largely did not share boundaries with the CCGs. One of the providers is a member of two systems, which are in two different NHS England regions.

The ICS has formed four spatially configured places (a fifth non-spatial place has a remit concerning services that need to be planned, prioritised and delivered at scale, such as children’s and family services, learning disability and autism, mental health and continuing health care). The four geographically configured places are based around the population flows into an acute hospital, reflect former CCG boundaries, and are largely not coterminous with District or Borough Council boundaries.

Case Study 3

Case Study 3 is an STP in a large urban area. It has a large geographical footprint, and covers a population of 1.9 million, making it the largest of the case studies. The STP is projecting a considerable population growth over the next ten years. The system has a complex, multi-layered governance structure spanning seven CCGs and eight Local Authorities.

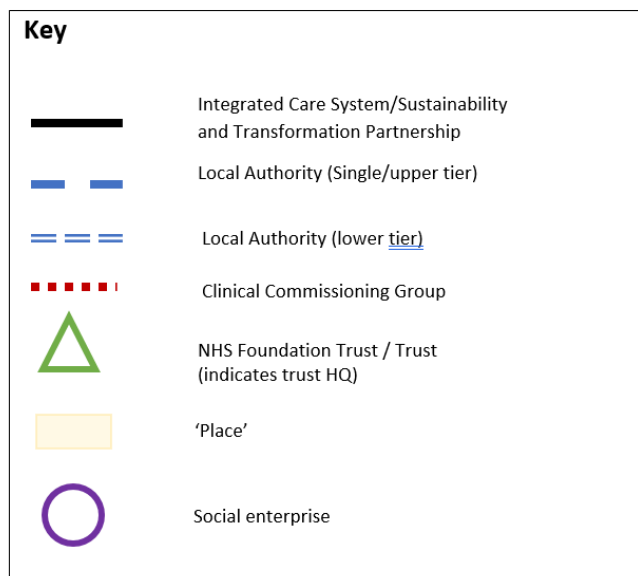
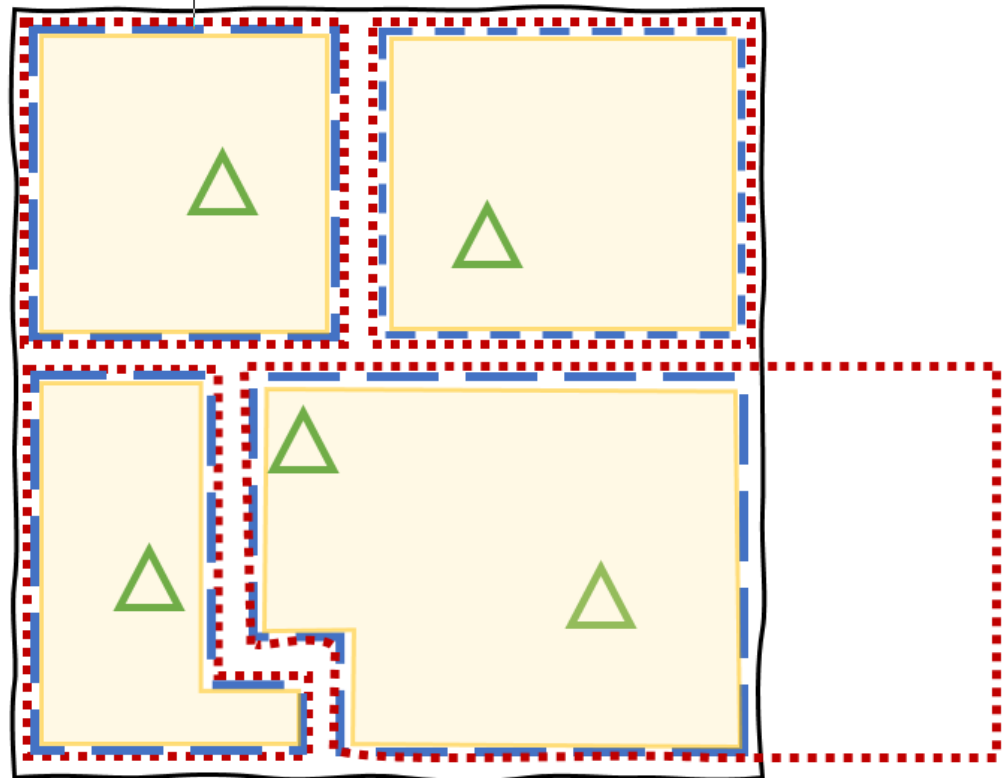
At the time of fieldwork, the system was particularly notable for the formation of a two-tier place level. The STP was organised on the basis of three places each corresponding with a main acute provider footprint and anchored in the historical host commissioner arrangements. These places were referred to as ‘systems’ or ‘partnerships’ in the STP documents, however, in order to avoid confusion with the STP system level in this report we refer to them as ‘subsystems’. The three subsystems were of unequal size in terms of population and geographical area and were at different stages of partnership development. Each subsystem/place was in turn divided into borough-based partnerships corresponding with local authority boundaries. Thus, this case study had an additional layer of network cooperation nested between the STP and the borough place level envisaged by policy – i.e. the larger places/subsystems.

The STP has not decided how to involve GP Federations and PCNs in system governance, but GP Federations are (and PCNs may be) involved at sub-system/place level.

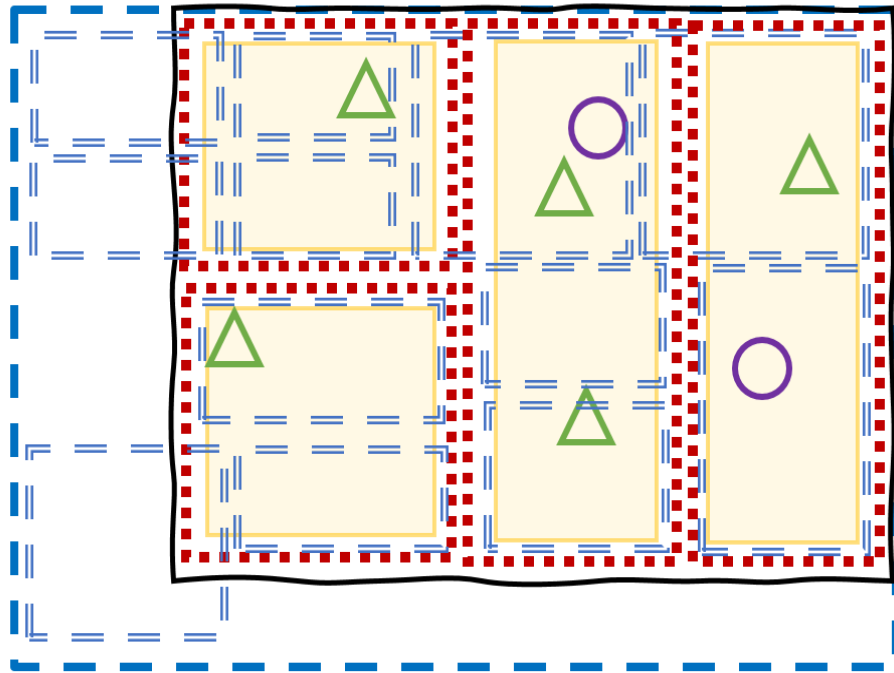
Notwithstanding internal complexity, the Case Study 3 STP has relatively straightforward external boundaries. The three acute providers are mostly internally facing, although some serve as major tertiary care centres and receive some patients from neighbouring STPs. In contrast, the two community and mental health providers have to engage more closely with the work of other STPs where they provide services.

Figure 2: Representation of the spatial organisation of case study systems and partners

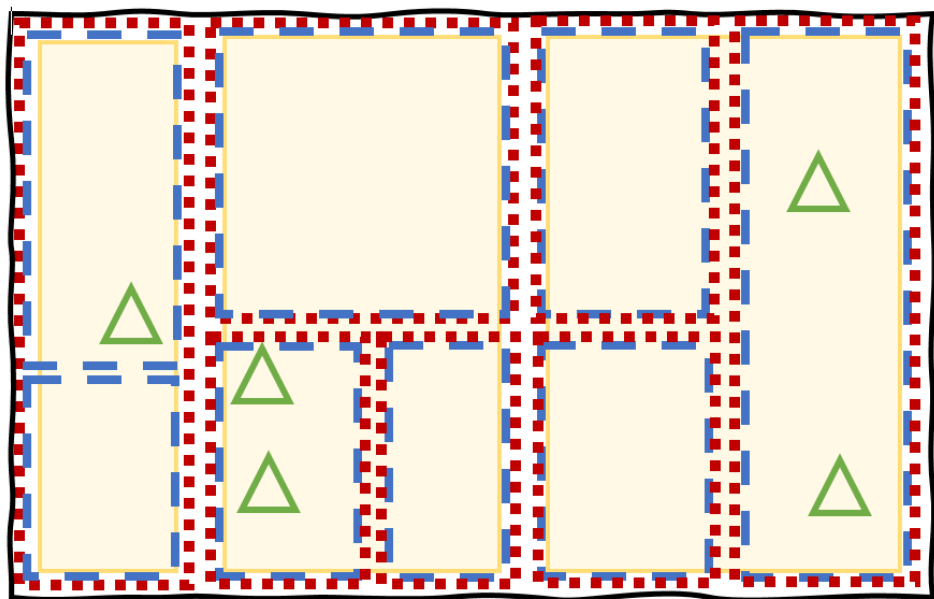
Case Study 1



Case Study 2



Case Study 3



Findings

6. *The configuration of systems and system membership*

This section discusses interviewees' views regarding the configuration of systems and system membership, and the implications of this for the achievement of co-ordination within systems. We found system partners' capacity to co-operate was subject to structural tensions reflecting the differences in accountability and focus between NHS and local government. Additionally, the degree of fit between system partners' delineations, such as flows of a provider's patients or local authority boundaries, and STP or ICS footprints had the capacity to differ greatly. In this respect local context led to complexity of governance arrangements where organisational functions did not align with the spatial configurations at system and place level, and weakened incentives for collaboration where organisations were spread across more than one system. In terms of NHS partners, it appeared that a shift from competition to a collaborative ethos was underway, but this was acknowledged to be a long-term undertaking.

6.1 Membership of systems

Policy expectation as laid out in the *Long Term Plan (NHS England, 2019)* is that the core membership of systems should include '*commissioners, trusts, primary care networks, and – with the clear expectation that they will wish to participate – local authorities, the voluntary and community sector and other partners*' (ibid.). In the case studies, membership at system level was largely confined to 'core' providers drawn from the NHS and local government, with other partners such as voluntary sector organisations, independent sector providers, and wider agencies such as police and education engaged at place or neighbourhood level, in particular system forums or through specific engagement activities. System membership was experienced differently by organisations inside and outside the NHS, reflecting differences in institutional contexts and the NHS-led nature of ICS and STPs.

Although the relationships between system partners in all case studies were said to be developing constructively, interviewees identified a number of structural tensions which could negatively impact system working, and which systems were engaged with mitigating. The inherent differences between the governance of local government and of the NHS complicated collaboration within systems, highlighting tensions aligning *national* health with *local* government which have been in existence since the NHS was created (Lorne et al., 2019).

Structural tensions exist around different institutional frameworks and ways of working between NHS and local government, across areas of difference such as degree of local independence, accountability of local government to local politicians and the public, differing financial rules and regulations, the use in local government of competitive tendering to procure services and a reliance on private sector providers. The locally derived, political mandate of Local Authorities (LAs) led to a focus on immediate, locally circumscribed strategic interests and less uniformity in their actions than NHS organisations:

All local authorities probably work in a slightly different way. We all have different agendas, we all have different political ambitions, we all have different priorities. From the health system point of view, because it's very much a top down driven organisation, you know, there is one way of doing things (Local Authority Director 4, Case Study 3, March 2020)

Given the NHS genesis of the STP and ICS agenda, some LA interviewees felt it could be perceived that system working had been imposed on them. System development was viewed as both an opportunity and with a dose of scepticism by the LAs. The emphasis on achieving financial balance in the NHS, for instance, was seen by some as an NHS-centric focus. LAs were keen to be involved in arrangements as an equal partner, and not the “*last thing that you come to*” (Local Authority Director 4, Case Study 3, March 2020) in a health focused system. In some significant aspects membership and participation was different for local government than from NHS partners, for example LA partners were not included in the system control totals.

The nature of LA participation differed across the case studies, illustrating the importance of local context in driving partnership between NHS and local government in ICSs/STPs. In Case Study 2 significant benefit was derived from the near coterminosity between the system and the County Council, with joint system leadership and use made of Council structures such as the Health and Wellbeing Board (HWB) in system governance structures (see section 8 below). However, such arrangements are necessarily difficult to establish where local government arrangements do not coincide with system footprints, such as in Case Study 1 (where the system contained five unitary authorities) and Case Study 3 (which contained eight unitary authorities), where system leadership is brokered across multiple principal councils. In these instances, place was suggested as the important forum for meaningful LA and NHS co-ordination.

Although it was less common for organisations outside NHS and local government to be partners of systems, this did occur. In Case Study 2, social enterprises were considered ‘full’ partners of the ICS, however they did not contribute to the control total, and were also subject to different financial rules, for instance around spending and the implications of financial deficit.

Systems are expected to engage with wider bodies from the voluntary and community sector (NHS England, 2019). Such bodies had not been designated formal system partners of the case study systems, but were reported to be engaged at both system and place level, for example in specific working groups or through engagement events.

6.2 System boundaries

NHSEI guidance suggests that system boundaries should be meaningful in the local context particularly regarding patient flows, where possible should be contiguous with LA boundaries and should cover a sufficient scale (NHS England and NHS Improvement, 2019b), and that place should typically operate at borough/council level ‘*served by a set of health and care providers in a town or district*’ (*ibid*). In practice, NHS commissioners, Trusts, and LAs operate across different geographies, and examples of complexity where organisational functions did not align with the spatial configurations at system and place level were common in the three case studies. In the case of local government in particular, it appeared that it was often the case that spatial configurations recommended for systems and places did not align with existing configurations and ways of working. In two of our case studies (Case Studies 1 and 3), the system was not a natural footprint for multiple LAs keen to preserve distinct local identities and democratic mandates. In Case Study 2, where there was near coterminosity with the County Council at system level, borough and district councils were not always coterminous with place footprints (see *Figure 2*).

Beyond local government, it was also not unusual for NHS organisations to encounter complexities of organisational boundaries or interests. This occurred for instance when the partner operated on a pan-system scale (e.g. Ambulance Trusts), or spanned system boundaries (e.g. a Trust with multiple sites). In a few instances, NHS provider partners had a stake in the neighbouring systems due to considerable patient flows from those areas, or even, in one instance, was a partner in more than one system.

These difficulties were largely met with pragmatism by system partners, acknowledged as inherent in the challenge of imposing spatial footprints on complex configurations of organisations across health and social care, including some which did not operate on population basis. Despite accepting the complexity of boundaries and spatial scales as inevitable, in some instances this lack of alignment had the potential to inhibit collaboration. The impact of non-coterminosity with system boundaries experienced in systems included duplication of effort, complexity of financial arrangements, reduced access to performance information, weakened incentives for co-operation and engagement, and communication difficulties.

Systems sought to mitigate such challenges where they could be addressed, for instance by putting in place bespoke governance arrangements. In some cases, the remedy was more fundamental. In Case Study 3, where local government configurations were perceived to be a particularly awkward fit at the system level due to the sheer volume of organisations involved, and where it was recognised that deciding on an appropriate footprint for the STP had not been obvious or straightforward, the local actors had deviated from the system/place division in favour of a two tier structure at place level, described by one interviewee as “*systems within systems within systems*” (Local Authority Director 1, Case Study 3, January 2020). This arrangement was thought to reflect more accurately local configurations and arrangements, particularly those of local government. However, it was also acknowledged these arrangements, due in part to the lack of uniformity, remained complex and risked confusion and lack of clarity in governance arrangements.

6.3 *System identity*

An important aspect of systems, particularly given their lack of formal status, is the formation of a strong identity, ethos, vision and objectives (NHS England and NHS Improvement, 2019b). The strength of system identity varied across our case studies.

In Case Study 2 (the ICS), system identity and its associated concepts seemed most clearly established with system partners. This is not surprising given the expectations of system progression to ICS status in this regard. It was not clear whether the strong identity led to the ICS status, or whether it was the ICS status itself which conferred a strong identity. Certainly, the ICS status was perceived by the ICS partners to bring greater opportunities for “*freedom and liberation*” (ICS Director 1, Case Study 2, January 2020), a responsibility for innovation and trail blazing, and a clear mindset that partners will work together to solve problems. For

example, as will be described in Section 7, the ICS was exploring novel opportunities to capitalise on the close collaborative relationship between NHS and local government. However, as will be explored in Section 12, the nature of the increased *'freedom and liberation'* of the ICS was less clear during this first stage of the fieldwork.

In contrast in the STP case studies, system identity was under development. In Case Study 1, the STP is seen by one interviewee as a mix of independently functioning individual organisations focussing on their own performances, and there was also a view that apart from board meetings that coordinate the STP activities, not much delineates the system. In Case Study 3, despite growing awareness amongst LA partners of what the STP does, and that it increasingly plays an important role in decision-making and strategic planning, some LA interviewees still struggled with defining what the STP is:

'It's still quite difficult to describe what the STP is, partly as it already has about four different names ... is it a commissioning body, is it a strategic body, does it exist? I mean, you know, glibly someone said to me, well, the STP only exists on a presentation slide, you know.... so I think it's still forming.' (Local Authority Director 1, Case Study 3, January 2020)

Uniting behind a system vision was acknowledged as a long term task, particularly so in the case of system level collaboration, which was at a scale where relationships may not have a prior existence. Conversely, there were notably strong relationships at place level where strong local place level identities were aided by factors such as coterminosity between acute trusts and LA at place level, and pre-existing alliances between providers. Place was more commonly seen as the level at which relationships and a common outlook were more likely to pre-exist:

'You can have as much governance and as much legislation as you like but unless you build relationships you won't improve things. The only way you'll build relationships is by people having a common core vision, uniting behind that and having enough time to spend together. So at the moment they haven't spent enough time together to develop the relationships, it's still quite early days, I think. They've spent more time in their places obviously.' (STP Director 2, Case Study 1, December 2019).

6.4 Attitudes towards collaboration

It appeared a shift from a competitive to a collaborative ethos was underway and making steady progress, but this was acknowledged to be a long-term undertaking. Competitive culture and behaviour in the NHS were perceived to be deeply ingrained, with one interviewee likening a move to system thinking *“like turning an oil tanker”* (STP Director 2, Case Study 1, December 2019).

System leaders were generally enthusiastic about the value of and opportunities for increased collaboration, with a widespread recognition that collaboration was the best way to achieve better use of resources and health improvement across health and social care, and the only way to address the joint challenges shared across health and social care. Relationships between leaders within the systems were reported to be improving, and previous relationships which had been fractured by competition were becoming collaborative. For example, it was reported that CEOs of providers communicated regularly with each other and had begun to take up some opportunities to share and collaborate.

On the other hand, system partners were less certain about the embeddedness of this system ethos. There was some mistrust of the intentions of others, particularly whether NHS Trusts and Foundation Trusts fully intended to abandon the behaviours associated with competitive attitudes. Contextual factors were acknowledged to hinder rather than assist the development of collaboration within systems. Firstly, it was acknowledged that meaningful collaboration depended on the growth of trusting inter-organisational relationships which necessarily develop over time. Secondly, it was not certain that the system ethos had permeated beyond leadership to those within member organisations, reflecting the entrenched attitudes and behaviours of managers who had spent their careers navigating the NHS purchaser/provider split, and the concentration of involvement of the most senior leaders of organisations (*‘you’ve got to retrain a whole, massive layer of NHS management to work collaboratively. And that is really, really hard’* (Acute Trust 1, CEO, Case Study 2, December 2019)). Thirdly, the residual formal rules relating to competition in the NHS, the accompanying financial incentives and the lack of statutory footing for collaboration within system footprints still incentivised competitive behaviour:

‘Until we change the constitution and the targets and the way the money flows and actually the legality behind the construct of a foundation trust, and the construct of an

ICS, it's going to be a more and more difficult conversation to have.' (Acute Trust 1, CEO, Case Study 2, December 2019)

'So they're going to get plaudits if their hospital gets outstanding or good with the CQC, they're going to get plaudits if they deliver their targets. They're not going to get any particular plaudits for working together.' (STP Director 2, Case Study 1, December 2019)

Consequently, the attitudes of providers to the residual opportunities for competition appeared to vary across systems. There was both a perception that NHS Trusts and Foundation Trusts in particular were incentivised to remain inward looking, concerned with their own performance and behaviour, with some providers reported to still be embracing opportunities to compete. However, some NHS providers interviewed were keen to see the full dismantling of the architecture of competition. It was not clear at the time of the fieldwork how these attitudes to system working were translating into behaviour in practice. A view was expressed in both Case Studies 1 and 2 that, in practice, until the architecture was dismantled, there were limits to the loyalty of providers to the system above their own organisation, if this were to be tested.

7. System action to achieve financial sustainability

Interviewees were hopeful that system working offered an opportunity to achieve a fairer and more effective allocation of resources. There was not a high degree of confidence at the time of the research (before the COVID -9 pandemic) that current NHS financial targets for systems were attainable, or that their attainment was supported by the wider regulatory context. Alternative approaches to payments such as blended payments¹ were being introduced in some places, and were perceived to aid collaboration. Systems were making use of opportunities to agree the allocation of central resources between partners, and to develop shared resources. At the time of the fieldwork, action to achieve long term financial sustainability in the case studies had not been agreed or implemented. This was related to the need to build constructive relationships and clear working arrangements between system partners, and was also related to wider factors such as an unsupportive wider regulatory and legislative context, a perceived lack of power for system leaders to drive through unpopular decisions, and little scope for local flexibility due to the number of NHS national mandatory actions.

7.1 System control totals

System and individual control totals were viewed as unrealistic by system partners, and the notion that systems were able to achieve financial balance was disputed. More detailed objections were that individual control total allocations did not consider local circumstances and imposed stringent efficiency targets on already struggling and historically underfunded providers. Agreeing projections of performance against control totals was described as a process of negotiation with NHSEI.

In spite of the incentives for a system approach to financial performance contained in the system control totals, NHS partners' view was that the current policy and regulatory regime did not support the adoption a system-wide view at the expense of the financial well-being of their individual organisation. Some providers were being asked to take on additional cost improvement programmes to compensate for large deficits elsewhere in the system, and this was felt to be untenable in light of the contradictions in the policy and regulatory context, and the non-statutory nature of systems:

¹ A holistic blended payment model comprising a fixed element with a quality/outcomes based element, a risk sharing element and/or a variable payment to encourage providers and commissioners to adopt cost effective, joined up approaches (NHS ENGLAND AND NHS IMPROVEMENT 2019a. 2020/21 National Tariff Payment System - a consultation notice. London: NHS England and NHS Improvement.)

At the end of the day you've got organisations with governing bodies and boards, which are tasked with making sure that they're in financial balance, so they're hardly going to say, oh yes give all my money for [Trust x] – it just isn't going to happen, is it? (STP Director 2, Case Study 1, December 2019)

Avoiding the imposition of financial penalties for missing the control total required a lot of skilful negotiation, clever accounting (*'herding of the finance cats'* (STP Director 1, Case Study 3, February 2020)) and discussions. Rather than identifying, agreeing and implementing a raft of savings to be made, use was made of system-wide accounting and use of non-recurrent savings. Examples of measures to achieve system control targets included: asking well performing providers to subsidise those in financial difficulty; focusing on the resolution of 'income anomalies'; and the use of land sales. It was also noted that policy at the time (the Provider Sustainability Fund)² created incentives for providers to remain in financial balance at all costs, rather than commissioners, *'it's advantageous for commissioners to hold the deficit rather than providers...so we work together to manipulate the system frankly'* (ICS Director 2, Case Study 2, March 2020).

As yet, systems had not reached agreement regarding the detailed actions necessary to achieve long term financial sustainability. In part this was because time had been spent building the necessary relationships to weather difficult decisions. There was agreement of the broad strategic direction (for example to spend more in primary/community services, increase digital interventions, reduce duplication of functions across organisations, and limit ineffective procedures), but this had not yet translated into specific agreements in practice about the nature of the action to be taken. In Case Study 2 forthcoming work was commencing to both analyse what functions can be shared across acute hospitals, and reduce the number of face to face outpatient appointments, but this was expected to be a *'really difficult and painful'* process (ICS Director 3, Case Study 2, January 2020).

7.2 *Use of financial mechanisms to aid collaboration*

The national tariff³ was perceived to be incompatible with collaboration and integrated working, and moving away from the national tariff to longer term block contracts (a payment

² Provider Sustainability Fund was a £2.5bn fund held by NHS England and NHS Improvement, which NHS providers could access if they hit certain financial and performance targets (ANANDACIVA, S. & WARD, D. 2019. July 2019 quarterly monitoring report. The King's Fund.)

³ The national tariff sets the prices and rules that commissioners use to pay providers for NHS services; in many cases, this is a price paid for each patient a provider sees or treats but the tariff also supports different payment

made to a provider to deliver a specific, usually broadly-defined, service) was seen as a major enabler of the collaborative working in the system. Some, but not all providers, had moved to block contract at the time of the research. It was also acknowledged that for block payments to incentivise collaboration required attitudinal changes, and the establishment of trusting relationships between providers, in order to reach agreement regarding the sharing of financial resources.

The development of approaches to achieving break even position with respect of system control totals was taking place at both system and place level, with places commonly organised around main acute provider footprint and ‘tasked’ with keeping the provider within financial means, and system intervention across places. Place was seen as a logical footprint for sharing financial risk rather than the larger system footprint. There were some examples of the agreement of financial mechanisms at place level to facilitate the sharing of financial risk. In Case Study 3, one subsystem had put in place a contract with the main acute provider based on blended tariff as opposed to the national tariff, and a further subsystem was working towards agreeing a similar approach with their acute provider. In one place relying on pre-existing risk share arrangements agreed between CCGs and a struggling acute provider based on blended tariff approach was thought to have provided some helpful levers to achieve the required breakeven position. The use of Alliance agreements⁴ was also under discussion in a number of places as a possible mechanism to secure co-operation and the sharing of financial risk at place (see section 8).

7.3 Local Authority involvement in action to achieve system financial sustainability

It was acknowledged that the finances of local government and the NHS were intertwined (for example that the poor financial position of a LA would impact efforts to integrate health and social care services provision), and that LAs were important partners in achieving system financial sustainability. Experiences of partnering with LAs to achieve financial sustainability varied across the case studies. The different financial regimes across the NHS and local government impacted the way the two sectors could work together in systems to address their collective financial position. The lack of requirement for NHS organisations to break even

approaches (NHS ENGLAND AND NHS IMPROVEMENT 2020h. Understanding and using the national tariff. London: NHS England and NHS Improvement.)

⁴ An NHS Alliance agreement overlays but does not replace existing service contracts. It brings providers together around a common aspiration for joint working across the system, setting out shared objectives and principles, and a set of shared governance rules allowing providers to come together to take decisions

(while LAs were required to balance their budgets) was a source of frustration for some LA partners. This interviewee, for example, viewed the NHS financial rules as lacking discipline and rigour, and also limiting their ability to invest in shared services:

'There's this constant tension of 'Can you invest in this, can you do this, will you pay for that?'. And as a partner, in principle I want to be able to say yes, that makes sense, but as a local authority corporate director, sometimes that becomes quite difficult because I don't have that money.' (Local Authority Director 2, Case Study 3, February 2020)

Other further potential areas of tension in relation to the risks which local government was exposed to related to system initiatives aimed at achieving financial sustainability. These included the risk that moving acute activity out of hospital might increase the demand for social care services, concerns that savings would be directed solely to the NHS, a lack of enabling legislation that supported and promoted collaborative work, and the complexity of the mechanics of pooling budgets between LAs and NHS. Many of these tensions could be overcome through detailed specification and agreement of risk share arrangements, however the financial conditions within which LAs operate heightened the anxieties about how the limited council resources are being spent and who has control over it.

While these tensions existed in all case studies, in Case Study 2 (the ICS), where the coterminous County Council held a system leadership position, novel opportunities to maximise the benefit of Council/ NHS partnership in innovative ways were being explored. The Council was viewed as having expertise in relation to service transformation and the achievement of financial sustainability which could be of value to the ICS. Also under discussion were a number of area wide strategies, encompassing health and local government concerning functions such as workforce, programme management, digital and technology and estates. For example, in relation to estates, a proposal under discussion with all key decision-makers (e.g. NHS Property Services at a national level; Districts and Boroughs etc) was the development of a unified Estates and Assets Strategy for the area with all partners. The aim of such an arrangement was to rationalise estates, for example by moving some health services into other public buildings, thereby delivering significant savings to be reinvested into frontline services. Such arrangements were facilitated by the fact that the Council encompassed the ICS, and thus cannot be easily replicated in other contexts.

7.4 *Resource allocation decisions within systems*

There was an emerging role for systems as a ‘funnel’ (STP Director 1, Case Study 3) both top-down for dispersal of central funding allocations and bottom-up for funding applications to the centre. This was accompanied by an assumption that the system will have more say in the way central resources are allocated between the system partners, even if such resources have been pre-assigned centrally (such as for primary, community or mental health).

There were examples of systems deciding the allocation of pots of national funding for particular services, rather than this being imposed on them. The Case Study 2 system had made a commitment to put more money into Child and Adolescent Mental Health Services (CAMHS) despite the deficit position of a number of organisations. The Case Study 3 system had reached local agreement regarding the allocation of funding for hospices, despite some initial opposition from the largest provider likely to lose out most on the scale of the funding:

‘But what we did is we got all the hospices in the room, we got all the end of life commissioners in the room and said how do you want to do this? It was great. We planned it jointly. So it was a complete new world. It was like we didn’t do some ghastly contract discussion, we said, so, we know there’s problems, we know there’s workforce...how best should we do this? And they loved it. They were so pleased. They didn’t get what they’d have got, each of them. Some got less than they would have got on a capitation basis, but they were much happier because they’d helped design it.’
(STP Director 2, Case Study 3, February 2020)

However, the difficulty of making such decisions was acknowledged. There was the perception of limited freedoms in systems in the light of NHS ‘must do’s’, and the challenge of securing agreement of system partners where some were being financially disadvantaged.

A significant tranche of top-down allocations related to ‘transformation funding’. In relation to Case Study 2 (the ICS) in particular this funding had been substantial, and while half the money had been pre-allocated to national programmes, the ICS had complete autonomy over the remainder. System decisions regarding spend had been made through a structured process which had been agreed with NHSEI:

‘So we had broad themes and then we asked for detailed bids against it and we had a whole investment framework agreed with a national team around business case approval and evaluation approaches’ (ICS Director 2, Case Study 2, March 2020)

This process resulted in the dedication of some funds to ‘support the bottom line’, and the remainder on transformation activities (the development of inter-organisational relationships , support for ‘place’ creation, service initiatives). It was acknowledged that this approach was rather ‘piecemeal’ and unsatisfactory in terms of impact.

7.5 Sharing of resources between system partners

Systems had agreed a number of initiatives to share resources in order to make best use of economies of scale, and to support each other.

These included sharing staff (both managerial and clinical) between different providers and between providers and commissioners, with a view to helping to improve performance, sharing best practice and expertise where providers were struggling with service provision. Other significant shared resources were being put in place on a long term basis, such as a proposed joint staff bank. In Case Study 2 the most significant of these shared resources was a virtual academy, conceptualised as an ‘incubation space’, established with the support of the Academic Health Science network. This was a resource shared across all system partners, which encouraged the adoption of shared approaches and learning across the system. The primary benefit of this initiative was to support and explore innovative approaches to networked learning across the system, places and neighbourhoods relating for example to the reduction of unwarranted variation across the system, and introduction of new national learning and best practice, such as developing population health management. The academy also developed leadership skills in key individuals particularly in relation to how to lead in systems and places without hierarchical power.

8. *Development of system governance*

Systems were developing local leadership and co-operative arrangements within a complex landscape of pre-existing organisational accountabilities. Where system governance appeared most developed this was characterised by the development of system authority and accountability through making use of the existing organisational architecture with the assimilation of powers of statutory bodies into the system governance functions, and through the increasing formalisation of governance and accountability arrangements. This had the effect of ‘lending’ authority to the system, allowing system forums to make binding decisions without reference to other governance forums and also, through utilising existing governance actors and forums, mitigating the additional burden of the system in the existing governance landscape.

8.1 *Leadership of systems*

An important source of authority within the system for system leaders was the amalgamation of system leadership with leadership of statutory organisations. In both Case Studies 2 and 3 CCG and system leadership was amalgamated, with the CCG Chief Officer also fulfilling a system leadership role. In Case Study 1, the outgoing STP lead saw the amalgamation of system and CCG roles an important source of influence over system partners:

If I was to be an executive lead on my own, like without an organisation to back me up, I have no influence of any sort apart from purely trying to persuade people, because I've got no people and no money (...) I think to be without an organisation behind me makes it, well, nigh impossible, to be honest, especially if you were to come into conflict with the accountable officer at the CCG and have a different view on how you think things should develop. (STP Director 2, Case Study 1, December 2019)

This approach was also evident elsewhere, with examples of CCG employed Directors appointed to dual system and place leadership roles. Duality of system/CCG roles was acknowledged to invoke potential conflict of interests, and could be seen to elide CCG and system differences, and increase the opacity of decision making. However, for interviewees the benefits were thought to outweigh such potential complications.

In Case Study 2, where the County Council had near coterminosity with the system, the Council was an important further source of system authority. Significantly, a senior Council leader also held leadership posts in the system. Council partnership and leadership of the system was described as fulfilling an important outward facing function:

'So I think for an ICS to be successful, we need to be accountable to the population, and that's why, the Council leader as a democratically elected politician brings that, and that's why linking our strategy to the Health and Wellbeing Board, with elected members and all the rest of it...so that's really important to me.' (ICS Director 1, Case Study 2, January 2020)

8.2 Alignment of system governance with partners' statutory responsibilities

A further instance of 'lending' of statutory authority from existing statutory bodies and functions was the alignment of system decision making with governance forums in which statutory responsibilities were discharged. This facilitated decision making in system forums which did not require approval elsewhere. This mechanism also mitigated the volume of forums member organisations were required to attend by 'piggy backing' system governance on existing forums where possible. For example, a CCG forum could be expanded to include a wider system membership, and retain CCG statutory decision making powers. This approach was most widespread in Case Study 2, the ICS, where a number of system governance forums were amalgamated with existing CCG forums and provided assurance to the CCGs' Governing Bodies for the discharge of CCG statutory duties. In other instances, ICS partners delegated powers and authority to ICS governance forums, for example giving authorisation to the ICS system to investigate activities, and seek information from partners, officers and/or employees.

Health and Wellbeing Boards (HWBs) and Overview and Scrutiny Committees are relevant to the work of STPs and ICSs as they have statutory duties concerning the planning and delivery of services to address the health and wellbeing of the local population across the NHS, public health and local government. HWBs are a formal committee of LAs, which have a statutory duty, with CCGs, to produce a joint strategic needs assessment and a joint health and wellbeing strategy for the local population. Additionally, LAs are required by the Local Government Act 2000 to scrutinize the provision of local health services (Local Government Act 2000) through Overview and Scrutiny Committees.

There was variability in the way our case study systems linked with these statutory forums. In Case Study 2, the HWB had a formal position in the ICS governance structure as the highest approval giving forum, and was recognised as the overall strategy setting body for the area. In the other two case studies, due to the local geography in respect of local government configuration, HWBs were situated at place rather than system level. These did not appear to be prominent bodies in relation to ‘place’ governance, and it was noted in relation to Case Study 3 that the role of HWB at place was underdeveloped and unclear. It is also the case that the function of HWBs as a decision-making body will always be tempered by the need for representatives to return to their own organisations for approval before decisions can be made. The role of the Overview and Scrutiny Committee in relation to the case study systems appeared less prominent at the time of the research

8.3 Formalisation of system governance

Systems had adopted formal commitments from partners to collaborative behaviour. In Case Studies 1 and 2 system partners had signed a Memorandum of Understanding. Memorandums of Understanding are not legally binding, and do not affect signatories’ accountability as individual organisations. The purpose of their adoption was to formalise the commitment of all partners of systems to work collaboratively, and the governance arrangements, including how decisions would be made, and principles which would be adhered to. Additionally, in Case Study 2 a Devolution Agreement was in place locally between the CCGs, the County Council, NHS England and NHS Improvement, focusing on the development of local control of health and care commissioning decisions and increasing alignment between NHS and local government commissioning responsibilities.

A number of place based partnerships within the systems were developing various forms of formal contractual arrangements, such as Alliance agreements, as mechanisms to anchor their partnership arrangements. The agreement of these arrangements was a matter for place level decision making, with the acceptance that each place would adopt whatever particular mechanism was most suited to the local context. These alliances were at the early stages of development at the time of the first stage of research.

9 System level governance structures

Governance structures in the case study systems were in flux and subject to ongoing refinement. This fluidity reflected both the lack of prescription regarding governance arrangements and the developing system agenda, particularly refinement of governance structures in preparation for application for ICS status. The governance structures of systems were acknowledged as inherently complex, balancing potentially competing interests: that of representation/inclusivity and operational decision making; of accommodating both cross cutting pieces of work and issues specific to certain groups of organisations; and of the principle of subsidiarity and the need for oversight.

9.1 System governance structures

In response to the horizontal and informal nature of governance in systems, system leaders in both Case Study 2 and Case Study 3 wanted governance structures to reflect the difference of network led governance from hierarchical model of governance, and to recognise the sovereignty of partners:

‘I’m trying to think about our communities being the leaves of the tree and the top and the roots being the, you know, NHS England sort of stuff but I think what we’ve been looking for is borough-based partnerships ... very much linked in to community and actually even further down to that because... whether you call it a neighbourhood or network or local area partnership, actually... [...] the local lead ward councillor is very much part of that structure.’ (STP Director 1, Case Study 3, February 2020)

Important principles for decision making in systems were the use of consensus decision making and the principle of subsidiarity (decision taken closest to those it affects). Despite the recognition of the differences of network governance from vertical governance, system governance structures mirrored vertical governance structures as systems sought to achieve oversight of activities, for instance with approvals required at system level for some decisions made at place level. The formalisation of a hierarchical relationship between place and system formed part of systems’ work to progress arrangements and responsibility for ‘oversight’ in line with the System Maturity Matrix (NHS England and NHS Improvement, 2019b).

Within the three case study systems there was a proliferation of governance forums, which were multi-layered at various spatial scales. In the two STPs (Case Studies 1 and 3), the governance structures were formally under review in anticipation of application for ICS status.

In Case Study 2, the ICS, the governance structure had already undergone significant refinement, with input from a governance specialist as part of the process of gaining ICS status.

The following outlines the key structures in place in the three case studies at the time of the research. *Figure 3* (below) summarises the key governance structures at system level in the case study sites. Section 10 presents the experiences of system partners of decision making within these structures.

9.2 Partnership Boards

The NHS Long Term Plan specified that each system should establish a Partnership Board with participants *'drawn from and representing' commissioners, trusts, primary care networks, and local authorities, the voluntary and community sector and other partners'* (NHS England, 2019). In the case study systems, decision making remained the remit of a smaller group of commissioners and providers of health and social care services, with a wider group of organisations engaged in other ways.

In Case Study 1, the STP Partnership Board membership consisted solely of the statutory providers and commissioners of health and care services, with remit to also proactively engage organisations within the wider local health and social care system. In Case Study 2, the Health and Wellbeing Board (HWB), which had an existing wide membership including those with influence over the wider causes of health inequalities, such as employment, transport and housing, was designated as the system Partnership Board. A further system-specific Board with a smaller membership drawn from the commissioners and main providers of health and social care services reported into the HWB. In Case Study 3, the Partnership Board was defunct at the time of the fieldwork. There were varying rationales for this including sheer size of membership, but also lack of clarity about the function of the Board and around how to achieve representation.

Where formal Terms of Reference for these Boards were obtained (Case Studies 1 and 2), these reflected the permissive policy context in relation to governance, differing for example in the degree of specificity regarding processes of decision making and conflict resolution, such as whether decisions could be only reached by consensus or by simple majority. The Terms of Reference reflected the sovereignty of member organisations and the informal status of decision making. Case Study 2 had increased the formality of decision making to a degree through the designation of the statutory HWB as the Partnership Board. However, while having a statutory duty, HWBs themselves have very limited formal powers, and are constituted as

partnership forums. It was also the case that before being presented to the HWB for ratification all matters were first discussed and agreed (or vetoed) at the system specific Board. However, the designation of the HWB as the Partnership Board also ensured that the work of the system had a degree of public transparency.

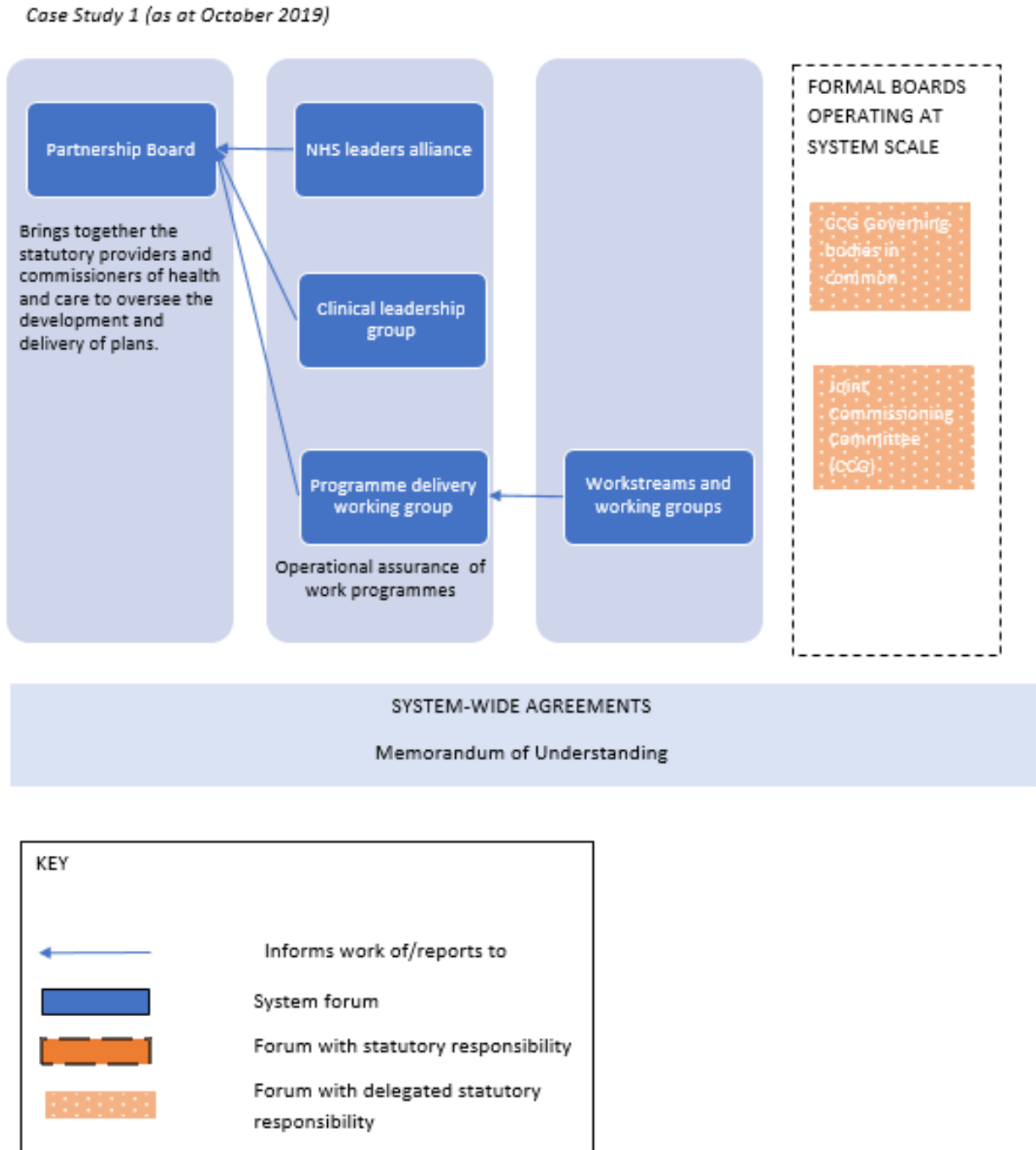
9.3 *Other system level governance forums*

Reflecting the permissive policy context around system governance, each case study had a different approach to the structure of system level governance outside the Partnership Board. Notwithstanding local differentiation, several consistent factors can be noted.

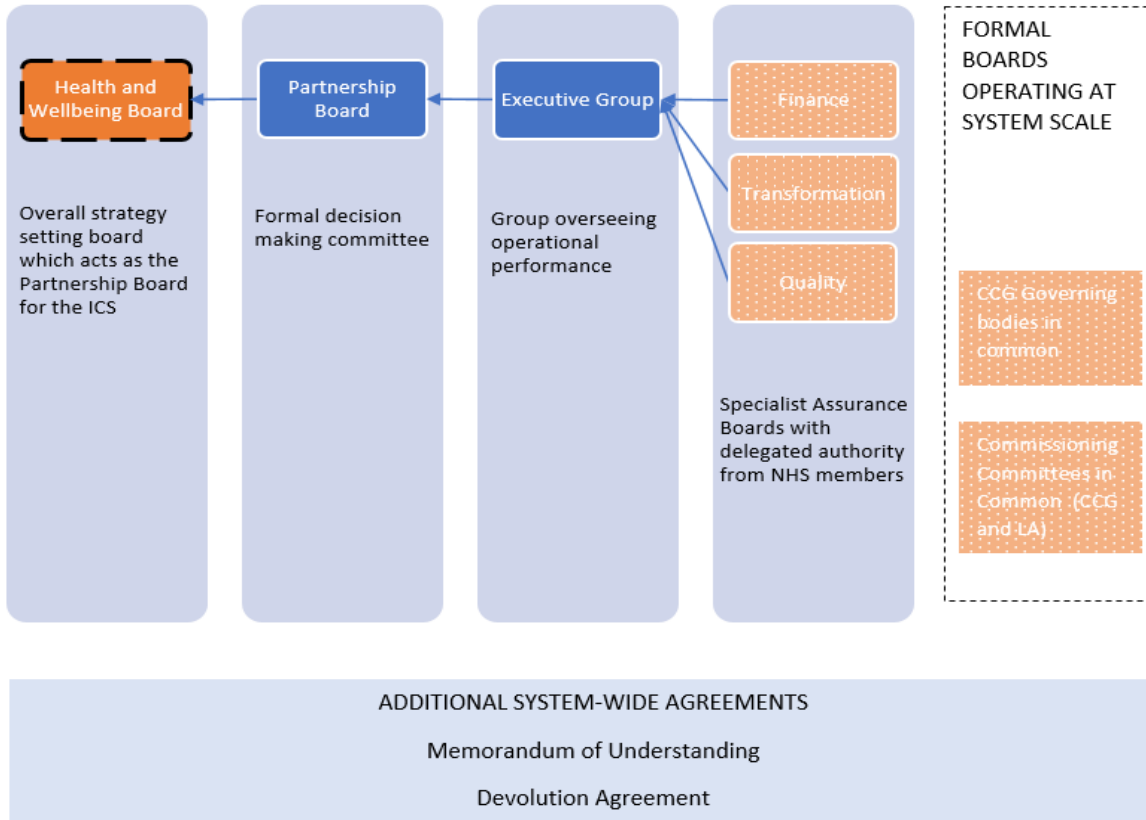
In all our case studies, an Executive Group existed at system level. These were important forums, in two case studies (Case Studies 2 and 3) they were arguably the main decision-making forum. These Executive Groups held other system forums to account and reported to the Partnership Board (where it existed). They were distinguished from the Partnership Boards by a smaller membership, focused on senior Directors of the main provider organisations, the LA, CCG and system leadership. These were operationally focused groups, consisting of *'anybody who can get fired'* (ICS Director 1, Case Study 2, January 2020).

The case study systems structured system activities through a workstream based approach, with system level governance forums across particular functions such as finance, quality and workforce. However, this cross-cutting focus was balanced with the inclusion of special interest groups based on profession or organisational type, indicating the need to balance inclusivity with the acknowledgement of protected fields of interest.

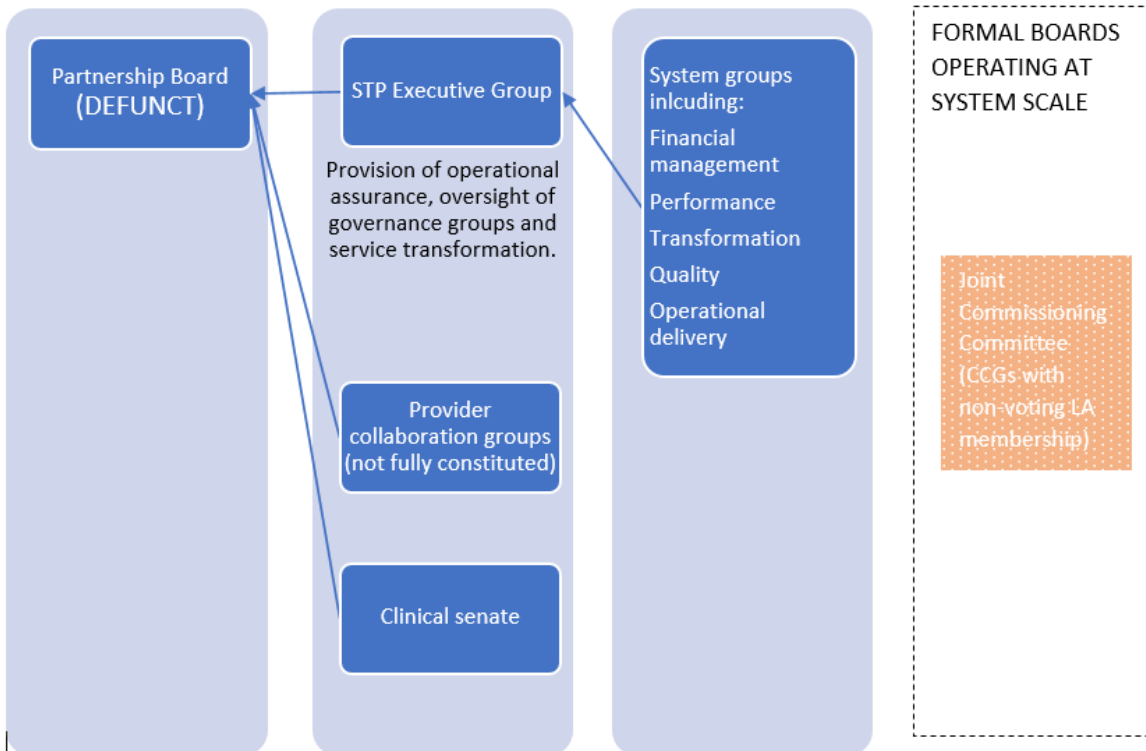
Figure 3: Key governance structures at system level in the case study sites



Case Study 2 (as at February 2020)



Case Study 3 as at February 2020



10. System governance in practice

Systems were working to mitigate weak decision making, complexity of decision making structures, and the burden of participation. Overall the governance structures of systems were a challenging environment in which to make binding decisions, particularly those of a contentious nature. In the current legislative environment, some interviewees still doubted that, given the current legislative environment, partners would prioritise the interests of the system above individual roles, accountabilities and statutory responsibilities when faced with decisions significantly against organisational interests, although it did not appear that this conflict had been significantly tested in practice.

10.1 Decision making and soft power

In practice, decision making in systems relied on the exertion of ‘soft’ power. As described in the preceding sections, systems were putting mechanisms in place to increase the expectation that decisions will be adhered to, both through ‘piggy backing’ on existing authority of member organisations, and through the formalisation of relational norms in documents such as Terms of Reference and Memorandum of Understanding. These mechanisms were supplementary to the operation of ‘soft’ power by system leaders and within systems, a power that ‘*aims to attract rather than coerce*’ (Mulderigg, 2011). It was recognised that power lay in the ability of the system leader or partners to influence the decisions of others. System leaders spent a considerable portion of their time building relationships and trust across system partners, so they exerted personal, informal authority and leadership within the system, and it was recognised that system leaders could not ‘come in cold’ and expect to run a system, as you ‘*have to have some history to build on*’ (ICS Director 1, Case Study 2, January 2020). The consequence of new external leadership would be subjecting systems to volatility when leaders change.

Interviewees described the contrast between the ‘soft power’ of systems and the hard power of existing accountability arrangements as inhibiting system decision making. System partners were largely keen to co-operate within the system and adopt and abide by shared decision making. While acknowledging the expectation that partners will act in good faith, and will not overturn decisions made in meetings, partners were also cognisant that decisions made in system forums were not binding, and could be disputed when representatives returned to their organisations:

‘Because of its legal framework or lack of, you can go into that room and you can agree to anything you like. And you can walk out and no-one’s going to hold you to account for it. And I think quite often, we go in and then you go back to your organisation and the Finance Director probably says – not just in my organisation but the rest of them – ‘Don’t be ridiculous, what have you said that for?’ So I think that the rules are pretty hazy to be honest.’ (Acute Trust 1 CEO, Case Study 2, December 2019)

System partners were aware that accountability lay with the individual organisations for operational and financial performance. It was recognised that there were limits to persuasion as a lever, particularly around difficult conversations such as those concerning acute service reconfiguration. From this perspective the lack of a statutory basis for systems was a significant problem, and there was general agreement that the uncertainty around the proposals for legislative change should be resolved in order to clarify the ‘rules’ to “*avoid it being like treacle*” (Acute Trust 1 CEO, Case Study 3, January 2020).

However, while there was considerable uncertainty regarding the status of system decisions, we did not find examples of system partners defecting from system decisions that had been made, or indeed of making difficult decisions and choosing not to defect. This corresponds with a sense that, as yet, the decision-making structures in the case study systems had not been tested with having to make a serious decision with resource implications, and that the forums were currently a site for discussion and debate.

10.2 Clarity of decision making

There were further challenges to system governance. A significant issue was the lack of clarity about the governance structures themselves: where decisions were to be made and by whom. System governance structures were complex, and were inserted within a pre-existing governance landscape. Furthermore, given the lack of national ‘blueprint’ regarding system governance structures, including at place level, there was the possibility for a great deal of variation in structures. The delegation of decision-making functions from statutory organisations, and the amalgamation of existing committees with system forums, served to streamline arrangements, but also had the potential to increase opacity. Additionally, across our case studies, governance structures were in flux, continually revised as leaders attempted to refine system governance:

‘Achieving clarity over where you make decisions, who makes decisions, and then who enacts them is really difficult, and you often only find out you’ve got it wrong by doing

it...this is bottom up, and it's to take into account statutory body decision making, trying to make use of architecture that was already there, and then linking it all together. And every time we do it, we find other bits that we then add in, because it's just reflective of the size of the remit of an ICS' (ICS Director 1, Case Study 2, January 2020)

A consequence of this cycle of refinement was often that written governance documentation was out of date, and that many iterations existed which did not aid clarity for those on the ground. Examples of this lack of clarity included confusion and disagreement between system partners about the 'seat of power' at system level, and confusion regarding the purpose of certain forums.

10.3 Inklusivity

Systems prioritised inclusivity, subsidiarity and consensus in decision making, and these principles were widely supported, but acknowledged to carry challenges. There were issues inherent in bringing many diverse organisations round a single table. Interviewees warned against systems turning into large, multi-layered, unmanageable structures with many veto players.

Bringing diverse organisations together to make decisions was necessarily complex due to differences of interests. While organisations were keen to collaborate, working together effectively required the development of trusting relationships, and sensitive negotiation over time of various non-aligned interests and power differentials. These dynamics were observed to delay decision making:

I mean, I think the useful thing about that group is having all the partners in the room. The not very useful piece about it is having all the partners in the room....You can probably write on a small piece of paper actually the outcomes from that meeting. And the trouble is that whilst you're getting it set up and while people are bedding in and worried about losing their power they have all got to be there. And the result of that is you don't move forward very far (Acute Trust 1 CEO, Case Study 2, December 2019)

It was feared that, in large systems, having many people round the table may stifle decision making and make the meetings unmanageable (Acute Trust 1 CEO, Case Study 3, January 2020). This dynamic was further exacerbated by the widespread adoption of consensus decision making processes in many system forums. In some instances, as described in Section 9, this dynamic was being managed through a split in system governance between larger forums

aimed at representation (for instance the Partnership Board), and smaller groups which had an operational decision making focus.

A further phenomenon experienced by system partners was the burden of leadership and participation on a finite group of local leaders. In one case study, for example, it was reported they had run out of senior leaders to lead the work streams. A senior leader elsewhere described the significant burden of representation required to embed the system:

' I mean, I could never be in this office to be honest with you. And that's one of the feedbacks. We've just done some of the executive work, and the chap leading it said to me this week, oh, you know, the directors say they wish you were in the Trust more. They understand why you can't be, but they wish you were in the Trust more. And I do...I mean, as I say, I could not be here all the time.' (Acute Trust 1 CEO, Case Study 2, December 2019)

An approach being considered to address both the size of governance forums and the burden of representation was a consolidation of the number of representatives on governance forums. This was being considered variously regarding a proposal of 'one voice for each place' whereby each 'place' would have three seats on the Partnership Board, and one vote per place, and the consolidation of PCN representation through an elected lead clinical director. These arrangements were not in place at the time of the fieldwork, and their success was thought to rest on strength of relationships and unity of voice.

11. The division of functions between systems and places

Governance structures were multi-layered with formal decision making structures at different spatial scales. An important aspect of the development of system governance is the co-ordination of decision making across system and place in line with the principle of subsidiarity, and the reconciliation of local priorities with the wider priorities embodied in STPs and ICSs. This section describes the way systems were developing the relationship between system and place. As this issue is crucial to the effective operation of systems, the relationship between system and place is a focus of the second phase of this research, and will be reported on in more detail in the final report.

11.1 Place level governance structures

There were varying degrees of formality and uniformity of governance at place level. While Case Studies 1 and 2 had adopted governance forums at system and place levels, Case Study 3 had departed significantly from these spatial scales, and governance structures existed at system, sub-system and LA levels. Systems were seeking to balance sensitivity to existing local governance structures and local preferences with the need to ensure clarity of decision-making processes and, increasingly, to be able to provide ‘assurance’. In Case Study 2, which was already an ICS, governance arrangements were formalised at place level, each place had its own Board, with Terms of Reference and clearly defined remits of decision making, including formal rules regarding the delegation of funds, and centralised governance support. In the other two case studies there was markedly less formality and uniformity. Case Study 3 was notable in its attitude towards divergence, with the intent that the three subsystems would be free to determine their internal governance arrangements. In some areas partnership governance structures were more mature at the subsystem level, with the partnership governance structures at the constitutive borough footprints weak or non-existent, and in others vice versa.

The potential for diversity in governance at place level within systems provoked unease in some interviewees regarding the development of new silos and divisions within the wider system, reflected by perceptions of tension between places, a lack of willingness to work together, and concerns that emerging differences between ways of operating and organising at place level created unhelpful differences from a system perspective.

11.2 Division of functions between system and place

Many interviewees acknowledged that it remains challenging to get the division of responsibilities “right” between levels (*Acute Trust 3 CEO, Case Study 3*), and that this was an area where systems had considerable discretion to shape arrangements.

The drive to establish partnership working at the lowest possible level, in line with the principle of subsidiarity, was hampered by a lack of clarity on how to distribute power, resources and responsibilities between different levels of governance. It was therefore difficult to ascertain what subsidiarity meant in practice in terms of the division of functions between spatial scales. There was a move towards increasing formalisation of responsibilities to resolve this lack of clarity. This was particularly the case with the ICS case study (*Case Study 2*), where part of the process of gaining ICS status had been the formalisation of links between places and the system. Even so, the division of functions and responsibilities was described as a “struggle”, with responsibilities bouncing between systems and places.

The division of functions between spatial scales reflected the need to ‘go with the grain’ as far as possible, with layering of system structures over local landscapes, including the size and scale of organisations and diverse historical partnership arrangements, which were far from uniform. In *Case Study 1*, where there were multiple LAs in the system, place was preferred as the focus of engagement with local authorities. In contrast in *Case Study 2*, where the County Council boundary largely reflected the system boundary, place was seen as focused on the acute hospital agenda and configured based on patient flows rather than geographically constituted. In *Case Study 3*, where a two tier sub system/place footprint existed, sub-systems were seen as focused on the acute hospital agenda, and place was the focus of engagement with LAs. Organisational footprints also influenced the division of functions through the location and remit of staff. For example, the organisation of performance monitoring on the basis of CCG footprints reflecting pre-existing arrangements.

In all case studies the division of functions was still an ongoing and challenging task, where the principle of subsidiarity was said to be at times in tension with the need for the achievement of change at scale and a desire for uniformity across the system. An example of this tension in *Case Study 2* was in deciding whether the leadership of service transformation should be through the establishment of a transformation unit at system level, or whether each place or organisation should lead its own transformation activities.

Table 4 provides examples, drawn from interviews, of the division of functions between system and place in the case study sites. This list is not definitive as there was the ongoing work and lack of clarity regarding the division of functions on the ground. Despite the ongoing challenges of finding the ‘right’ division of functions and the differentiation due to local context, there were some cross case study consistencies emerging regarding the allocation of some functions. Place seemed consistently to be the level at which the interaction between social care, primary/community and acute care took place, where integration at service level was driven forward and there was a focus for improving population health. Cross cutting work programmes which would benefit from economies of scale were driven at system level including workforce, IT, finance, maternity and cancer services, and standard setting was also a key function situated solely at system level. The list reveals areas of duplication across place and system, such as workforce strategy and engagement of wider partners. These areas of duplication may contribute to the perception of a lack of clarity, but also may reflect the necessity of ownership at both levels.

11.3 Commissioning across systems and places

Commissioning organisations were exercising their statutory functions in the context of wider system working. The location of commissioning activities varied across case studies reflecting the local organisational landscape.

In the case study systems, CCGs were taking collaborative commissioning decisions on a pan-CCG footprint through the use of ‘committees in common’. The ‘committee in common’ is a mechanism to achieve co-ordinated decision making across organisations by which multiple organisations each establish their own committee with delegated authority to make certain decisions, and those committees meet together at the same time, with the same remit, and where possible identical membership to co-ordinate decisions. Each committee remains accountable to its own board.

Structures to allow co-ordinated commissioning decisions across CCGs and LAs were also being developed. Case Study 2 had established a Joint Commissioning Committee of the system CCGs and the County Council. It was enabled through the establishment in each CCG of a County-wide Commissioning Committee which met in Common with a Commissioning Committee established by the County Council, and underpinned by a variety of Section 75 Agreements such as the Better Care Fund. This arrangement was part of the commitment to progressive devolution in the Devolution Agreement between the system CCGs, the County

Council, NHS England and NHS Improvement. The Committee had jurisdiction over the decision-making of the County Council health-related commissioning functions, and some decision making for CCGs according to a scheme of differential delegation per CCG. Draft Terms of Reference for the Committee-in-Common suggest in scope areas including mental health, learning disabilities, continuing health care, children (including mental health) and the Better Care Fund.

In Case Study 3, LAs were non-voting members of the system wide Joint Commissioning Committee, and, reflecting the local context, integrated commissioning with LAs was situated at the borough/place level through pooled funding through Section 75 agreements such as the Better Care Fund.

Not all commissioning could be carried out at ICS level, and it was necessary to make commissioning decisions at the place level too. Some anticipated the progression towards a single CCG per system would lead to significant changes in commissioning at place level through the delegation of some commissioning budgets and decisions to places, and a concentration of CCG leadership at system rather than place scale. Indeed, in Case Study 2, when a single pan-system CCG was formed at the end of the Phase 1 research period, the CCG Governing Body established a Local Commissioning Committee for each place, which discharged CCG decisions delegated to it and met as part of each 'place' Board meeting. These type of commissioning arrangements were perceived by some to be subject to provider, rather than commissioner, leadership due to the predominance of provider leadership in many places.

The development of commissioning at system and place scales will be addressed further in the second phase of the research.

Table 4: Actual or postulated division of functions between system and place (from interviews)

Function (postulated or in place)	System	Place
Leadership	Uniting partners behind common core vision Facilitating collaborative working Getting all partners onboard for the decisions	Providing leadership of place
Population health		Population health interventions Mapping population needs
Service provision and planning	Leadership of system transformation Delivery of service transformation programmes in partnership with organisations Development of pan system initiatives (e.g. pathology network, digital programmes) Leadership of transformation of acute services provision Engagement with specialist commissioning Planning some specialist services (childrens', mental health)	Leadership and delivery of service transformation programs (including moving services out of hospital, primary, community care) Developing service integration between social, primary, community and acute care Developing integrated services to address wider population needs (e.g. improving access to adequate housing)
Workforce strategy	Creating workforce strategy Workforce recruitment and retention	Workforce development Workforce recruitment and retention
Estates strategy	Development of single estates strategy across NHS and local government	
Financial	Bidding for resources from NHSEI Prioritising capital requests to NHSEI Delivering a balanced and sustainable budget Allocation of central funding to system partners/places Developing approaches to collective sharing of financial risks	Action to achieve place financial recovery plan Taking decisions regarding funding allocated to place by system Developing approaches to collective sharing of financial risks Agreement of financial recovery with acute provider Submission of business cases to system
Governance	Developing focus on place rather than organisation Overseeing CCG mergers Developing system membership Monitoring of performance and holding to account	Developing focus on place rather than organisation Monitoring of performance and holding to account
Involvement of wider partners	Engagement with non-NHS statutory and third sector organisations Improving voluntary sector representation	Involving local people in service redesign Engagement with Local Authorities Engagement/collaboration with other local statutory organisations (police, fire service, schools etc.) and third sector providers (e.g. housing associations)

12 Accountability within systems

Accountability relationships in systems can be categorised as firstly vertical (and formal): holding to account of the system, system leaders and (NHS) system partners for system performance by NHSEI, but secondly also horizontal (and informal) within systems: the holding to account of system partners by each other (Bovens, 2007). The development of horizontal accountability between system partners is an important way of facilitating local strategic decisions and their implementation, and the development of a new emphasis in vertical accountability between systems and regulators is an important mechanism in realising the maturity of ICSs. This section discusses the development of vertical and horizontal accountability in the case study systems.

The question of how systems were accountable, to whom and for what was far from settled, with an increase in actors with accountability relationships, emerging horizontal accountabilities between system partners, and a shift in the performance of vertical accountabilities as systems matured. Level 4, Thriving ICS's are expected to lead the 'assurance' of individual organisations, and agree and co-ordinate any Trust or CCG intervention carried out by NHSEI, with regional teams taking the stance of a 'critical friend' (NHS England and NHS Improvement, 2019b).

This developing landscape made things unclear on the ground, with the potential for confusion about the enactment of accountabilities between the system, the regulator, providers and places. However, the shift in the emphasis in the relationship with NHSEI was welcomed by NHS partners, along with the opportunity for the development of self-assurance arrangements, whereby system partners would undertake peer review with increased responsibility for oversight situated within systems.

12.1 Vertical accountabilities

Interviewees in NHS commissioners and providers welcomed the changing relationship with the regional NHSEI function, characterised as a move away from the 'old' culture of aggressive performance management and its replacement with a more inclusive and supportive culture. System leaders described a high frequency of contact and of an 'alongside' relationship, in which systems and NHSEI worked together. There were many points of contact between NHSEI and systems. NHSEI conducted regular assurance meetings with systems. For example,

in Case Study 1 a process of quarterly system reviews between NHSEI and the system was described, which linked to the performance management of, for example, four hour waiting target or financial performance outcomes, as well as an engagement with systems around the sign off of plans and capital proposals. Additionally, case studies reported weekly and fortnightly scheduled contact between NHSEI and system leadership teams. NHSEI was also a presence in system governance forums. In the ICS case study (Case Study 2) a regional NHSEI representative attended system forums as an observer and was required for the meetings to be quorate. This approach was welcomed by the ICS leadership, as performing an assurance function. NHSEI were also welcomed as an enabler, who could use hierarchical power when ICS 'soft power' was not sufficient.

The emerging 'alongside' relationship between systems and the regional NHSEI made it less clear to some interviewees how systems were held to account. A CCG Director in Case Study 3 expressed confusion regarding accountability for system failure:

'So, I'm slightly less clear about how a failing ICS is held to account. So either at some point NHS England has a cut-off point where they say, we've done all the support we can, we now go back into regulatory mode, ICS, you account to us or at some point they step that back. But they have been part of that joint process so I don't quite see how that works yet and I think this hasn't been thought through, or maybe you end up in front of the national team collectively, region and ICS. I don't know what that is.'
(CCG 1 Director, Case Study 3, January 2020)

An ICS leader's view in Case Study 2 was that the primary vertical accountability for system performance was the formal personal accountability of system leaders through the NHS hierarchy for the transformation of the system and for the delivery of quality, financial and constitutional standards. The sanction in the case of poor performance was understood to be that they could be removed from their posts, and also a wider sanction against the system could be imposed through the roll back of devolved responsibilities.

Interviewees anticipated that, as systems matured, NHSEI would work with and through systems in relation to performance oversight of NHS system partners. Systems described the adoption by NHSEI of a 'system first' approach. One of the functions of this approach was the treatment of system leadership as the first point of contact and as the default focus of co-ordination efforts, rather than individual organisations with whom NHSEI had a vertical accountability relationship. However, system partners found this approach was enacted

unevenly, and that NHSEI approaches via either the system or to member organisations directly appeared relatively arbitrarily distributed, giving system partners few clues as to how the accountability relationships were structured in practice, and causing ‘*confusion and aggravation*’ among system partners (STP Director 2, Case Study 1, December 2019). This dynamic was pronounced in the ICS case study, reflecting the expectation of increased self-assurance associated with ICS status. Indeed, the perception of one Trust leader was that ICS status had exacerbated, rather than diminished, direct contact from NHSEI:

‘The other interesting thing about it is of course the presence of NHSEI and one of the things I would really pull out of this is ever since we have got a bit more devolved...so [the system leader’s] got the responsibility, accountability, I’ve never seen so much of NHSI or E. I’ve never had so many letters telling me what to do. They should be asking [the system leader] for the assurance about me, not asking me to report back to them. And they still can’t...’ (Acute Trust 1 CEO, Case Study 2, December 2019)

A further significant vertical accountability relationship relating to systems was for quality of services between the CQC and system partners. In contrast with the increasing focus on the system by NHSEI, at the time of fieldwork, the CQC focus was reported to be fixed on individual partners. In July 2020 (after the fieldwork) the CQC announced a series of Provider Collaboration Reviews, focused on partnership working in response to COVID-19. These reviews, and the developing accountability relationship between systems and the CQC, will be included in the second stage of fieldwork.

12.2 Horizontal accountabilities – holding system partners to account

Interviewees described a double running of oversight functions between system leaders and the regional function of NHSEI, in which systems were taking an increasing role in system assurance alongside NHSEI. The vertical accountability of NHS bodies to NHSEI for performance was supplemented by a developing system role in relation to the oversight of individual organisations’ performance, and the understanding within systems that they were encouraged wherever possible by NHSEI to ‘*consume our own smoke as regards to performance management*’ (Acute Trust 1 CEO, Case Study 3, January 2020). There was a shift from bilateral performance management meetings between provider and regulator to trilateral ‘assurance’ meetings involving systems. Horizontal accountabilities were developing at place level, with the notion firstly, that places could hold place partners to account for performance, and secondly that places (rather than individual providers) could be held to

account by systems. In the ICS (Case Study 2), places were subject to quarterly performance assurance visits from a system ‘assurance’ team. There were also accounts of places being recognised by NHSEI as actors that could be subject to performance monitoring and held to account.

Instead of the use of direct sanctions for poor performance, the developing system assurance function concerned open information exchange about organisational performance which could serve as an incentive to improve. Systems were developing the information systems necessary to understand performance, quality and finance across the system, and to facilitate open discussion. It was acknowledged to be a difficult task due to the size and scale of the data involved across systems. There were concerns about how efficient and systematic the self-monitoring process could be considering the resources available to systems to carry out this function.

While interviewees were positive about the development of horizontal accountability, this was tempered by acknowledgement of the limits of the ‘soft’ power to hold partners to account. In Case Study 2, there were examples of scrutiny of organisational performance within ‘places’ by place partners, and resultant action being agreed, for example acting to address a provider’s declining A and E performance through increasing support from primary care. However significant examples of holding to account within systems, for instance in relation to poor performance, were lacking in Phase 1 of the research.

12.3 Accountability to the public

Unlike statutory bodies, ICS and STPs have no formal accountability to the population. Formal accountability to the public for system decisions was understood by interviewees to lie with those partners which held a legal duty to involve the public in the exercise of their statutory functions, through, for example, holding board meetings in public. In Case Study 2, the embeddedness of the County Council (whose primary accountability was to the local resident population and elected politicians) in system leadership and governance, specifically through County Council leadership, and the designation of the HWB as the Partnership Board, was thought to be an important mechanism to increase the exposure of the system to public accountability.

An understanding of the needs of local patients and communities underlies the aims of systems, particularly those around population health and the development of local partnerships. The case study systems were developing routes to public engagement of various kinds, seeking to understand the priorities, needs and preferences of the population. Public engagement activities also carried a spatial dimension, and were not necessarily centred on the system. As the analysis of the division of functions between systems and places in Section 11 indicates, the involvement of wider representatives was also situated at place level.

Each case study system had established citizens' panels with varied aims, such as in Case Study 1 to start a public debate about allocation of limited resources (STP Director 2, Case Study 1, December 2019). The ICS (Case Study 2) had established various ongoing initiatives to embed citizen engagement in the development of ICS programmes. These included public engagement research to understand residents' opinions on a range of health and wellbeing issues, and a programme in conjunction with Healthwatch to maximise citizen engagement in service changes.

13 The system role in the COVID-19 response

The fieldwork reported in this report ceased at the time of the first lockdown period due to COVID-19. However, phase two of fieldwork commenced in August 2020, and a small number of initial interviews were conducted which focused on the system role in the COVID response. It is valuable to consider the way organisational collaboration necessitated by the health and social care response to COVID has driven and influenced system working, and can add to our understanding of system working. A brief summary of the findings in this regard are detailed here, and a fuller discussion of the system working in the response to COVID will be included in the final report for this study.

Due to the non-statutory nature of STPs and ICSs there were very few roles in relation to the response to COVID-19 which were allocated formally to ICS and STPs by NHSE/I. The NHSE/I letter *'Reducing burden and releasing capacity at NHS providers and commissioners'* (NHS England and NHS Improvement, 2020c) set out the arrangements for governance, reporting and assurance during the pandemic response in order to free up management capacity. This letter stated that organisations should:

"Put on hold all national System by Default development work (including work on CCG mergers and 20/21 guidance). However, NHSE/I actively encourages system working where it helps manage the response to COVID-19, providing support where possible."

A small number of co-ordination roles were suggested for ICSs and STPs in national documents. These included: that each STP/ICS should have a nominated lead who can make enquiries into (personal protective equipment) stock capacity from local hospitals and other care providers which can be shared as 'mutual aid' (NHS England and NHS Improvement, 2020a); that ICS/STPs may be the lead for co-ordination between Independent Sector providers and other providers in a region, and form an Independent Sector co-ordination network (NHS England and NHS Improvement, 2020d); and that ICS/STPs are part of the major incident escalation procedure in NHS Trusts ('concerns including, but not limited to, workforce, infrastructure, estates or equipment') (NHS England and NHS Improvement, 2020g).

In our case studies, system involvement as a co-ordinating force varied. In Case Studies 2 and 3 we found that the system played a co-ordination role in relation to the COVID-19 response. In Case Study 1, it appeared that the STP had not been a significant co-ordinating force, however we were not able to obtain an interview in Phase 1 of the research to explore the role

of the system, if any, in that regard. Spatial scales and local context shaped the role that systems played in relation to COVID-19. Interestingly, it was suggested that the division between what should occur at system or place level was much less contentious in relation to COVID-19 response than in everyday system business. An interviewee in Case Study 2 suggested that much of the service change to adjust for COVID-19 occurred at place level, and was led by national models so bypassed system planning and decision making.

In Case Study 2, the ICS had a significant role in co-ordination. It was suggested the NHSEI region wanted the ICS to be the first point of contact (gold command). Board papers suggest that this was because scale of the Local Resilience Forum (LRF)⁵ meant that the NHS needed a response on a scale larger than CCGs and smaller than NHSEI regions, and therefore the ICS was asked to represent the local NHS at Strategic Co-ordinating Group meetings. This was not contrary to statutory responsibilities as the CCG and ICS were very closely aligned, and by this time were coterminous. The ICS, with CCG support, set up the Incident Co-ordination Centre, and a Strategic Incident Management Group comprising the ICS Executive Directors and key leads chaired by the ICS SRO / Chief Officer. This structure linked both the LRF Command, control and co-ordination structure and the NHS England national structure through daily regional incident calls with south east systems leaders. From later in the response, a multiagency group, including colleagues from the LRF was set up in CCG offices.

Organisations in Case Studies 2 and 3 worked together at levels most sensible given the function in question, including system level when appropriate. Interestingly, it was reported that partnership working was easier during the crisis, and that the need to work together in the response to COVID-19 improved relationships between system partners:

'I think we've all embraced the response to the crisis, we've all embraced having a different type of decision making in a single focus that we can all get together behind

⁵ *Local resilience forums* (LRFs) are multi-agency partnerships made up of representatives from local public services, including the emergency services, local authorities, the NHS, the Environment Agency and others. The Civil Contingencies Act 2004 and the Contingency Planning Regulations 2005 (Regulations) provide that responders, through the LRF, have a collective responsibility to plan, prepare and communicate in a multi-agency environment

so I think they've all been strengthened in that regard'. (ICS Director 2, Case Study 2, July 2020)

'And effectively we've used our response to COVID as a way of really getting people to work even more close together than they have been before.' (STP Director 2, Case Study 3, August 2020)

The need for organisations to work together in an operational rather than strategic way was thought to have deepened relationships between organisations beyond strategic relationships at Director level, bringing *'the level and multiplicity of relationships between organisations into the system in a way that was a bit theoretical before.'* (CCG Director 2, Case Study 3, August 2020). For example, there was a need operationally for Intensive Care teams to work together, and for PPE leads to work together.

The COVID-19 response had also impacted on collaboration at system level. A significant factor in this regard was the change in the financial regime, specifically the move to block contract payments 'on account' for all NHS trusts and foundation trusts, with suspension of the usual PBR national tariff payment architecture and associated administrative/ transactional processes (NHS England and NHS Improvement, 2020e). which had in effect *'completely rewritten the rulebook for this year'* (ICS Director 2, Case Study 2, July 2020).

In Case Study 3, the COVID-19 response appeared to provide the impetus to streamline decision making, allowing decisions to be made in a clearer way without *'going through five different committees before it got there'* (STP Director 2, Case Study 3, August 2020) and was described as *'liberating'*. New forums based on the COVID-19 response replaced system forums and ways of working. In Case Study 3 it was reported that a fundamental shift was the allocation of pan-organisation responsibilities (according to 'cells') rather than organisation responsibilities, based on areas of expertise. This approach was reported to work particularly well as it increased interdependences between organisations:

'So, for example [Acute Trust], they became the sector lead organisation and chair for the cell around personal protective equipment. We had somebody from within a CCG led on estates and oxygen. And we tried to divvy up those responsibilities across the partnership so that we had different people leading on different things depending on the expertise of their staff but also as a way in which to kind of draw us into being part of a whole. Everyone had some skin the game. Everyone's success was predicated on everyone else

playing and also you playing into whatever was your strength. ' (CCG Director 2, Case Study 3, August 2020)

Some system wide sharing of resources was necessitated by the COVID response. The main examples given concerned the redeployment of clinical staff to cover shortages, and of other staff to support testing, system leadership of the formal mutual aid system for PPE, and sharing of critical care capacity

14 Discussion

This report presents the interim findings from the first stage of research to investigate the further development of STPs and ICSs or their successors in order to find out how effective these new forms of collaboration are in achieving their goals, and what factors influence this. The objectives of the study are to find out:

1. How the local leadership and cooperative arrangements with stakeholders (statutory, independent and community-based, including local authorities) are governed in the light of the ICS governance recommendations in the LTP. How statutory commissioning organisations including local authorities are facilitating local strategic decisions and their implementation; and whether different types of commissioning function are evolving at different system levels.
2. Whether ICSs are able to allocate resources more efficiently across sectoral boundaries and bring their local health economies into financial balance.
3. How individual organisations are reconciling their role in an ICS with their individual roles, accountabilities and statutory responsibilities.
4. How national regulators are responding to the changes in modes of planning and commissioning and actual service configurations, in the light of the changed priorities for these regulators set out in the LTP.
5. Which mechanisms are used to commission services in ICSs. In particular, how is competition used to improve quality and/or value for money of services; and are more complex forms of contract (such as alliancing) being used? How are local organisations reconciling new service configurations with current/evolving pricing structures, and thus how are financial incentives being used?
6. How locality priorities, including those of local authorities, are reconciled with the wider priorities embodied in STPs and ICSs. In particular, how is co-ordination achieved between STP and ICS plans, local priorities and existing programmes of work such as any local new models of care?

This section discusses the research findings, and is structured as follows:

- A summary of the interim findings
- A discussion of interim findings
- Outline of Phase 2 of the research

14.1 Summary of interim research findings

Local leadership and collaborative arrangements are developing within a complex local and national landscape of pre-existing governance arrangements, structural tensions between the NHS and local government, and a regulatory and legislative structure in the NHS which focuses on organisational performance rather than system working. The first phase of our research suggests that systems are concentrating on the development of relationships and governance arrangements to allow them to work effectively together to address their aims using the system form. Earlier studies (Charles et al., 2018, Walshe et al., 2018) found that ground work and preliminary activities had been at the centre of system and partnership working, and our findings suggest that this focus is enduring as STPs and ICSs work to increase their maturity.

Difficulties reconciling existing organisational and service landscapes with system working existed within all case studies. Possible impacts were identified as duplication of effort, complexity of financial arrangements, reduced access to performance information, weakened incentives for co-operation and engagement, and communication difficulties. Our findings confirm those of earlier studies (Charles et al., 2018, Pett, 2020a, Moran et al., 2018) regarding the importance of ongoing efforts of systems to develop system governance which ‘goes with the grain’ of the local context, as a means to enabling meaningful engagement of local government in systems and places, and facilitating local governance arrangements which are clear and functional.

Where there is confusion about decision making processes, partners perceive system governance structures as burdensome, duplicative and unclear. Systems are seeking to reconcile potentially competing interests in their governance arrangements: balancing representation, inclusivity and consensus with the need to act; the accommodation of both cross cutting pieces of work and issues specific to certain groups of organisations; and of the principle of subsidiarity and the need for system oversight. Measures being introduced include formalising governance structures to aid clarity, and proposals to streamline membership of governance forums, through the agreement of lead representative for groups of partners. ‘Soft’ power of network leadership and informal horizontal accountability is increasingly being supplemented by the incorporation of the existing governance architecture into system structures, including the incorporation of statutory decision-making forums into system governance, and the recruitment of system leaders who hold positions of authority in statutory bodies within the system.

An important aspect of the development of system governance is the co-ordination of decision making across system and place, and the reconciliation of local priorities with the wider priorities embodied in STPs and ICSs. Interviewees acknowledged that it remains challenging to get the division of responsibilities “right” between levels. Place appears to be emerging as the scale at which the interaction between social care, primary/community and acute care takes place, where service integration is driven and the focus for improving population health. Standard setting and cross cutting work programmes meanwhile are driven at system scale (including workforce, IT, finance, maternity and cancer services). Commissioning organisations were exercising their statutory functions in the context of wider system working, moving beyond an organisational focus to make collaborative commissioning decisions on a pan-CCG footprint, and within places.

Overall, systems are a challenging environment in which to make binding decisions, particularly those of a contentious nature. System partners are keen to collaborate, and embrace the opportunities for improved planning and provision of services which it is widely believed system working can offer. However the realisation of this is challenging. Local government bodies were concerned about their potential exposure to financial risk, and loss of control over limited council resources. For NHS organisations, it appears that a shift from competition to a collaborative ethos is underway, but this is a long term undertaking. Like Walshe (2018) we found that some interviewees still doubted that, given the current legislative environment, partners would prioritise the interests of the system above individual roles, accountabilities and statutory responsibilities when faced with decisions significantly against organisational interests. Notably however, we found no evidence this conflict had been significantly tested in practice, partly as systems had yet to address contentious issues. At place level, agreements to formalise co-operative working and agreements to share risk, such as Alliance agreements, are under discussion but not yet widely implemented. The limited findings at this stage relating to the COVID-19 response suggest that the operational focus to system activities and the change in the financial regime may have facilitated collaboration and strengthened relationships between system partners.

The question of how systems were accountable, to whom and for what was far from settled, with an increase in the number of actors with accountability relationships, emerging horizontal accountabilities between system partners, and a shift in the management of vertical accountabilities as systems matured. This developing landscape has made things unclear on the ground, with the potential for confusion in the way accountabilities flow between the system,

the regulator, providers and places. This finding is in line with earlier studies which highlight the lack of clarity about accountability arrangements (NHS Confederation, 2020, Moran et al., 2018). A particular factor causing confusion among providers was the extent to which NHSEI contact with individual providers was being replaced by contact through the system. However, the shift in the emphasis in the relationship with NHSEI was welcomed, along with the opportunity for the development of assurance within systems.

At the time of the fieldwork, action to achieve long term financial sustainability in the case studies had not been agreed or implemented. This was related to the need to first build constructive relationships and clear working arrangements between system partners, but was also related to wider factors such as an unsupportive wider regulatory and legislative context, and a perceived lack of power for system leaders to drive through unpopular decisions. Systems were starting to make use of opportunities to agree the allocation of central resources between partners, to develop shared resources in ways that had not been possible before, and to explore novel and unique initiatives based on system partnerships, but these types of initiatives were not yet common practice. As previous studies have suggested (Charles et al., 2018, Pett, 2020a), interviewees wanted the resolution of the questions regarding the future legislative status of ICSs in order to clarify future direction. Current NHS financial targets for systems were viewed as unattainable, and unsupported by the wider regulatory context. Payment structures were altering to support collaboration. The national tariff was no longer a prominent method payment mechanism and blended payments were being introduced in some places.

14.2 Discussion of interim findings

The implications of the findings of this interim report should be considered in the context of the circumstances in which the data was gathered. Phase 1 of the fieldwork (conducted between December 2019 and March 2020), which forms the basis of this interim report, was cut short due to the COVID 19 pandemic. We were not able to interview all partners in our case studies. In particular, we had fewer interviews in Case Study 1 than intended. This restriction may have reduced nuance in the findings of this interim report. Additionally, the context in which ICSs and STPs are operating has changed significantly since Phase 1 of the fieldwork ended due to the changes associated with the COVID-19 response, such as to financial mechanisms. The policy, regulatory and legislative context is also subject to significant proposed change as detailed in *Integrating Care: Next Steps to building strong and effective integrated care systems*

across England (NHS England and NHS Improvement, 2020b), which not only sets out NHSEI's proposals for legislative change, but also announces a series of practical changes anticipated to take place by April 2022, in order to transition to system working focused on further devolution to systems, greater partnership working at place and closer collaboration between providers on a larger footprint. It is important therefore that these interim findings are in due course considered in the light of the findings from the second phase of this research which is currently underway. Nevertheless, these interim findings are useful for both policy development and practice.

The establishment of NHS structures at a regional level, and a reliance on collaboration are not novel approaches. Spatial 'regions' have also been a near constant – if constantly changing – feature within the organisation of healthcare (Lorne et al, 2019). Alongside the use of market mechanisms to promote competition in the NHS since the late 1980s, there has been a continuing reliance on collaboration, and a long history of local organisations working together under the co-ordination of commissioners. Therefore, STPs and ICSs do not mark a novel move towards collaboration. However, the development of STPs and ICSs does mark a significant shift in emphasis in NHS policy. By prioritising spatially-based co-operation over organisational competition, the emergence of ICSs raises questions about the future of the competition orientated *Health and Social Care Act 2012*, and a regulatory landscape focused principally on organisational autonomy, whilst also indicating the necessity for a return in some form to strategic regional or sub-regional oversight. The latter is unsurprising, given its salience in NHS history (Lorne et al, 2019).

The question of how ICSs could be embedded in legislation or guidance is currently under discussion (NHS England and NHS Improvement, 2020b). The outcome of this is subject to considerable uncertainty. NHSEI's initial proposals did not recommend establishing ICSs as formal statutory bodies, instead asking for legislation which would allow commissioners and providers to form decision making committees (a joint committee structure) which would direct the work of ICSs. However it has more recently been suggested that ICSs may be given the status of statutory bodies, possibly leading to the abolition of CCGs (Health Service Journal, 2020). Our interim findings suggest that swift resolution of these questions regarding possible legislative change is needed in order to provide certainty to system members regarding 'the rules of the game'. We found that system partners were keen to collaborate, and embraced the possibilities offered by system working. However, the wider institutional context in the NHS at the time of Phase 1 of the research appeared instrumental in eroding trust between system

partners regarding the likelihood of collaborative behaviour in practice (despite a reported eagerness to embrace collaboration in principle). Likewise the uncertainty regarding the future status of ICSs appeared to threaten partners' commitment to future system plans.

Our interim findings suggest system governance structures are complex and subject to ongoing refinement. The iterative development of governance arrangements and time spent nurturing relationships can develop norms of trust and reciprocity between system partners which underpin increased collaborative working, and encourage fairness and adherence to system rules (Ostrom, 1994, Sydow, 1998, Gambetta, 1988). However, the ongoing refinement of system governance structures was also indicative of the complexity of governance arrangements, as systems sought to ensure representation and inclusivity, to work within the existing governance architecture of member organisations, and to ensure that where possible system decision making had formal status. Interestingly, as the case study systems' governance structures developed as systems matured, they appeared to share characteristics with vertical governance structures, becoming increasingly formalised and hierarchical, for instance with approvals required at system level for some decisions made at place level. This may be a necessary by-product of the need to provide oversight and assurance as the systems take a greater share of responsibility for system performance. Recent NHSEI proposals for the future development of ICS governance formalise this as the required direction of travel, with requirements that all ICSs put in place firmer governance and decision making arrangements for 2021/22 to reflect growing roles and responsibilities (NHS England and NHS Improvement, 2020b). These include the requirement that each 'place' formalises joined up decision-making arrangements for defined functions, and that systems define individual organisation accountability within the system governance framework (*ibid.*).

The approaches being considered by our case study sites to streamline governance arrangements, and confer formality to system decisions should be critically considered as examples of the possibilities of formalising decision making within the current collective model of responsibility and decision-making. Proposals being considered in the case studies to streamline forum membership, such as through establishing 'one voice for each place', are predicated on strong local relationships and the existence of unity of voice amongst partners, both of which may not be realistic. Furthermore, the use of the 'committee in common' mechanism to facilitate pan-organisation decision making is also not a panacea. This is primarily because it does not resolve the issue of organisational sovereignty, as each

represented organisation is making decisions separately and carries the power of veto. A further mechanism to streamline the organisational landscape and increase the status of system decisions was the appointment of CCG leaders to system leadership positions. Arguably, the amalgamation of leadership in this way, whilst increasing the power and responsibility of system leadership, may lead to confusion regarding accountability and decision making processes. It should be noted however, that this effect was not yet reported in our case studies.

Due to the current non-statutory nature of STPs and ICSs, the dependence on goodwill and mutual co-operation, and the non-binding nature of decision making in systems, contentious issues were not being addressed in the case study systems. The continued focus of systems on developing governance arrangements meant that, at the end of the first stage of fieldwork, the case study systems had yet to make significant headway regarding action to achieve long term sustainability, although there were indications that groundwork was being put in place, including the development of local payment mechanisms, formal agreements such as Alliance agreements, the development of approaches for agreeing the allocation of resources, and the development of shared resources. The tracking of further progress in this regard will be an important element of the second stage of the fieldwork for this study. Our fieldwork ceased at the time when the health and local government response to COVID-19 was beginning in earnest, and this response has led to many changes in the context in which systems are operating. Furthermore the changes proposed by NHSEI in *'Integrating care: Next steps to building strong and effective integrated care systems across England'* (NHS England and NHS Improvement, 2020b) suggest significant changes to the financial framework will be forthcoming with the finances of the NHS increasingly organised at ICS level. The second stage of our research will investigate the further development of STPs and ICSs in this greatly changing context.

Our interim findings suggest that local context is very important in relation to system working. It is particularly important, given the aims of STPs/ICSs, that local arrangements are structured in such a way that facilitates the engagement of partners other than health, most significantly local government. Given the layering of system structures over local organisational landscapes, including various sizes and scales of organisations and diverse historical partnership arrangements, these local arrangements will necessarily be far from uniform. In the recent discussion document regarding possible legislative change, NHSEI is seeking to leave room for local discretion and flexibility regarding the way functions are discharged at different levels

(NHS England and NHS Improvement, 2020b). It is possible that in some systems working at system scale will always be limited, for instance where the system level seeks to unite multiple principal councils. In these instances it is expected that 'place' will be the scale at which partnership working between health and local government occurs. Notably however, it does not follow that, given the freedom to organise structures across systems and places, local systems will always establish structures which involve all partners. For example, in some of our case studies important partnership bodies such as Health and Wellbeing Boards and Overview and Scrutiny Committees did not appear to be significant bodies at either system or place level.

The division of functions between systems and places emerged as a difficult process, in which decisions regarding the best scale for functions were not straightforward. Our case study systems were starting to address the need to formalise the division of functions during Phase 1 of our fieldwork. Additionally, our case study systems were moving towards the creation of a single CCG which was coterminous with the system. There is still a role for commissioning at both system and place level, a function which requires that not all decisions are consensual and that a lead organisation is in place for reasons of accountability. The second phase of the research will focus on the relationship between system and place in more detail, including the development of commissioning functions at different system levels.

Accountability is an increasingly important issue as systems mature. At the time of the Phase 1 fieldwork, as NHSEI increasingly worked with and through systems to support improvement across the NHS, the nature of the emerging accountability relationships between system, regulator and system partners remained unclear to some system partners. This lack of clarity may be resolved by the anticipated new System Oversight Framework which will set out expectations of ICSs and the organisations within them (NHS England and NHS Improvement, 2019d). The development of horizontal accountability arrangements is an important factor in the development of successful self-governance of collective resources (Ostrom, 1994). While systems and places were developing the infrastructure for peer review, the capacity of system and place partners to hold each other to account appeared somewhat untested as yet.

While there was an expectation on the ground that NHSEI would step back to a degree to allow primacy to the system, it did not appear in practice that contact between NHS providers and NHSEI had lessened. Indeed without legislative change, although ICSs may be treated as if they are accountable, the vertical accountability relationship lies between sovereign

organisations and NHSEI. At the time of the research, rather than streamlining assurance processes, the current approach appeared duplicative. The presence of NHSEI ‘alongside’ the system in system governance forums did not appear to serve an accountability function (as accountability is inherently retrospective) but could rather be understood as an *ex ante* mechanism of directing behaviour (Bovens, 2007) or, arguably, the development of a shared ‘horizontal’ accountability with system leadership. This ‘alongside’ approach between system leaders and NHSEI also raises questions regarding the ‘decision space’ (Bossert, 1998) available to systems in practice, and the degree of autonomy systems have to autonomously develop plans, allocate resources, and define programs and services.

14.3 Outline of phase two of the research

The second phase of data collection has commenced. We are interviewing partners of a selected ‘place’ within the STP or ICS of each case study to find out how the relationship between place and system is developing. In particular we wish to find out the types of function evolving at different system levels, including commissioning, whether ICSs/STPs are able to allocate resources more efficiently across sectoral boundaries, the development of payment mechanisms and more complex forms of contracting, and the reconciliation of local and system priorities. There will also be a further round of system member interviews at a later date, and we intend to approach representatives of the regional NHSEI function in each case study to request an interview. The second phase of the research will seek to address the following research questions in particular in greater depth:

- 1) How statutory commissioning organisations including local authorities are facilitating local strategic decisions and their implementation; and whether different types of commissioning function are evolving at different system levels.
- 2) Whether ICSs or their successors are able to allocate resources more efficiently across sectoral boundaries and bring their local health economies into financial balance.
- 3) Which mechanisms are used to commission services in ICSs. In particular, how is competition used to improve quality and/or value for money of services; and are more complex forms of contract (such as alliancing) being used? How are local organisations reconciling new service configurations with current/evolving pricing structures, and thus how are financial incentives being used?
- 4) How locality priorities, including those of local authorities, are reconciled with the wider priorities embodied in STPs and ICSs. In particular, how is co-ordination

achieved between STP and ICS plans, local priorities and existing programmes of work such as any local new models of care?

- 5) How national regulators are responding to the changes in modes of planning and commissioning and actual service configurations, in the light of the changed priorities for these regulators set out in the LTP.

We will report our findings in late 2021.

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