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

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Note

This research was conducted as part of PRUComm's study investigating the further development of ICS's in order to find out how effective these new forms of collaboration are in achieving their goals, and what factors influence this.

An early output from this study was a review of literature on previous intermediate tiers in the NHS. This review was issued as an earlier separate document and has already been peer reviewed.

Literature review:

Lorne, C., Allen, P., Checkland, K., Osipovic, D., Sanderson, M., Hammond, J., Peckham, S. (2019). *Integrated Care Systems: What can current reforms learn from past research on regional co-ordination of health and care in England? A literature review*

Link: https://prucomm.ac.uk/assets/uploads/PRUComm_-_Integrated_Care_Systems_-_Literature_Review.pdf

Executive Summary

Policy background

The introduction of Sustainability and Transformation Partnerships (STPs) and their successors Integrated Care Systems (ICSs) since 2015, signified a change in emphasis in the English NHS from competitive to more collaborative methods of working. Specifically, commissioners and providers of health and social care were asked to form geographically-based collaborations which take a co-ordinated approach to services, agree system-wide priorities, and plan collectively how to improve population health.

ICSs cover a population of 1-3 million and are organised according to a three tier spatially-based model, including 'places' which are partnerships of NHS and other care provider organisations operating typically at local authority scale. ICSs are voluntary partnerships in which decision making is consensual, and system collaboration takes place in the wider context of organisational sovereignty, pre-existing partnerships such as Health and Wellbeing Boards (HWBs), and networks of provider organisations focusing on particular specialties or care groups.

At the time of our research ICSs were non-statutory. Towards the end of the research the Health and Care Bill 2021 (HCB) was published (at the time of writing in February 2022 it is making its way through parliament), in which the intention to put ICSs on a statutory footing was confirmed. Two types of statutory body are proposed for each ICS: Integrated Care Boards (ICBs) are to be responsible for the day to day running of the ICS and will take over the commissioning function of CCGs (which are to be abolished), and Integrated Care Partnerships (ICPs) will be statutory committees which bring together all system partners including local authorities and independent providers of care.

Under the HCB, statutory ICSs will delegate significant amounts of resources and decision making to place-based partnerships. NHS England has also mandated the formation of 'provider collaboratives', which are non-statutory partnerships involving two or more healthcare providers which may form at supra-ICS level, may partially cover multiple ICSs, or may cover multiple places.

The legislative changes proposed in the HCB intend to strengthen collaboration between NHS and other care providers while increasing accountability for system performance. Organisational sovereignty of separate statutory bodies constituting ICSs remains unaffected

Our study aims, design and methods

The aim of our research was to understand how effective the ICS form of collaboration is in achieving its goals, by investigating how ICSs were developing locally, the way system partners were reconciling organisational and system roles, how collaborations and providers could be held to account and the way local priorities were being reconciled with system priorities.

The study was conducted in two phases and used qualitative methods with a small quantitative component. Primarily, we used a case study research design, consisting of three in-depth case studies, each consisting of a system and its partners. The first phase of fieldwork was undertaken between December 2019 and March 2020 and focused on studying ICSs (and their predecessor STPs). Fieldwork was interrupted in March 2020 by the COVID-19 pandemic. The second phase of fieldwork took place between January 2021 and September 2021 and focused on a more detailed examination of one place within each of our case studies. We conducted a total of 64 in-depth, semi-structured interviews and observed eight system level meetings (three in Case Study 1, three in Case Study 2 and two in Case Study 3). The purpose of observing a variety of meetings was to supplement the information we obtained from interviews with the parties. In addition, we gathered documentation from all three case study sites which included strategic plans, meeting papers and details of governance structures. These sources were used to add detail to the interview accounts. In relation to the small quantitative component of the research, we analysed routine data about health and care activity and used non-experimental programme evaluation methods to estimate the impacts of ICSs on distribution of spending across sectors, indicators of integration and care quality, and health outcomes.

Summary of findings

Our research suggests that the move to a more collaborative ethos was welcomed, and system partners widely supported the development of system working, and the opportunities for improved planning and provision of services which they offered.

System and place leadership and collaborative arrangements were developing within a complex landscape of pre-existing governance arrangements, structural tensions between the NHS and

local government, and a regulatory and legislative structure in the NHS which focused on individual organisations' performance. Considerable effort was made to set up appropriate formal governance arrangements in our case study ICSs and 'places' although system leaders and partners voiced scepticism about the added value of continuing refinement of governance arrangements, stressing that informal relationships between partners were more important to the achievement of collaboration. Where local agreement regarding the configuration of spatial scales did not exist, it was very difficult for partners to move forward and agree governance arrangements due to the lack of any blue-print to be followed, and the need to reach consensus.

There was uncertainty about emerging vertical and horizontal accountabilities. Although the vertical lines of accountability between regional branches of NHSEI and ICSs were clearer, horizontal accountabilities within systems and places were less clear, characterised by 'softer' mechanisms of holding to account through trust, rather than in a formal or codified way. Processes of accountability to the public were even less developed.

During the research period, NHS capital allocations became increasingly arranged around systems, easing the co-ordination of system and place priorities. The reconciliation of system priorities with those of partners outside the NHS appeared more challenging. The co-ordination of plans across health and local councils was not easy, due to differences in business and planning cycles between the two sectors, the wider remit of local councils (of which social care was only a part) and differing approaches to procurement. In cases where system and local authority footprints were not aligned, local authorities were more reluctant to engage in strategic commissioning and planning discussions.

Commissioning mechanisms, pricing structures and financial incentives were also subject to change. All our case studies agreed that competition and the use of competitive tendering were things of the past. Collaboration was becoming the dominant approach to commissioning. At the same time, there was an acknowledgement of the danger that ICSs might become 'slightly too cosy', and the need to put in place other mechanisms to ensure value and quality. Changes were also occurring in the allocation of money to providers. The payment system for acute care, the 'national tariff', was being replaced by 'block contracts' and 'blended payments' which were more likely to incentivise collaboration, as they were not based on payment per case. The notion of sharing financial risk between providers was being discussed at system and place level. This process was encouraged by the fact that several targets (e.g. system control totals and elective recovery targets) were being set for whole systems instead of individual

providers, although there was some scepticism about the effectiveness of these system-wide incentives. Interviewees also reported subtler forms of incentivisation of collaborative working, including the increase in transparency of financial reporting and decision-making regarding system-wide resource allocation.

It was anticipated that in the future, systems would be responsible for more 'strategic' commissioning decisions, while place-based partnerships, or provider collaboratives, would assume more responsibility for making local planning decisions, although systems were struggling to specify exactly which decisions would be made by which fora. At the time of the research, there was uncertainty regarding formal delegations to place-based partnerships, or the mechanisms through which this delegation would be achieved. A crucial consideration was the feasibility of disaggregating budgets to reflect places without destabilising partner organisations which spanned several places

Taking collaborative decisions was not always easy, mainly due to individual providers giving priority to their organisational rather than collective obligations. It was believed that this would inhibit the ability of systems to confront difficult issues. Some organisations, however, were quite sanguine about the prospect of dropping some of their organisational priorities in favour of shared priorities, if they led to an improvement of services in the locality. It was acknowledged that conflicts of interest were inherent in this partnership mode of commissioning, but interviewees took the view that the benefits of collaborative decision making outweighed the risks of conflicting interests.

Our research was conducted during the early days in the development of system working, and due to the disruption caused by the COVID-19 pandemic, it is difficult to assess the extent to which ICSs are achieving their aims concerning the allocation of resources more efficiently across sectoral boundaries and the achievement of financial balance within the system. Our quantitative analysis did not establish any significant link between ICSs' existence and indicators of integration, which can be regarded as their goals. While we gathered multiple examples of work being carried out at system and place scale to share resources, change resource allocation and improve partnership working, the impact of these initiatives in terms of efficiencies and quality markers is difficult to quantify.

Discussion and policy implications

The shift to collaborative working was in general welcomed with enthusiasm for the opportunities it offered to achieve significant improvements in the planning and delivery of

health and care services to local populations, and our findings suggest competition is no longer being used as an organising principle. Local actors felt that collaboration in systems led to improvements in ways that did not occur previously, and our research found many examples of changes to service delivery that had been achieved through place-based partnerships. There were, however, a number of challenges.

Our findings confirm the significance of local context in relation to the ease with which collaboration can be achieved. We found that the existence of shared understandings between health and local government of the 'best' spatial configurations were of particular importance to ensuring clarity of governance arrangements and 'buy-in' to strategic commissioning and planning discussions.

There is a balance to be struck between retaining flexibility at local level regarding governance arrangements, and being able to draw on support and guidance. There are many matters, such as governance arrangements in place-based partnerships and the division of functions between spatial scales, which systems are trying to address in parallel. It may be that national or regional guidance can be increased to obviate individual systems spending too much time on these common issues while retaining scope for local flexibility.

A further issue relates to the potential conflict between organisational and system-wide interests. Organisational sovereignty has the potential to significantly disrupt collaboration. Making ICSs statutory bodies does not overcome this problem and it is not clear how the proposed changes of HCB such as increased authority of ICSs and use of shared financial targets for systems will enable individual partner organisations to address difficult issues which they consider will adversely affect their statutory obligations. An independent arbiter may be required and it seems likely that the regional directors of NHSEI could undertake this role in practice.

Furthermore, conflicts of interest between organisations tasked with making collective decisions in systems must be acknowledged and mitigated. Proposals regarding the management of conflicts of interest are framed from an individual person's perspective. These do not address the forms of conflict of interest in relation to ICSs, which exist at an organisational level. This issue goes to the heart of how ICBs will be able to operate in the interests of the local population as opposed to prioritising those of powerful organisations. It is not clear how ICSs will be able to plan and commission services which best meet the needs of local populations when there is no organisation (such as a CCG or other commissioner) whose

sole role it is to achieve these results without having undue regard to the effects on the finances of individual local organisations. It is not clear that consensus will always be achieved, nor that it will be the optimum consensus for population health.

A further issue relates to accountability. Our research found that aspects of vertical and horizontal accountabilities were underdeveloped, and public accountability was almost completely lacking. The Design Framework issued by NHS England makes clear that the involvement of patients, unpaid carers and the public is expected in the future at place and system levels, with requirements for public meetings and published minutes by both ICBs and ICPs. However, it is not specified how other forums such as 'provider collaboratives', where significant decisions regarding the planning and provision of services may be made, will be publicly accountable. At the very least, the requirements for public transparency of provider collaboratives should be strengthened. More fundamentally, the role of provider collaboratives in relation to ICS decision making needs clarification, and the extent to which ICBs may delegate powers and decisions to these non-statutory groupings should be clarified.

Assessing the extent to which system working is achieving its ends is a long-term endeavour, and any judgement that could be made in a shorter-time frame, such as regarding the effect of system working on the attainment of financial balance, has been impaired by the impact of the pandemic. It is clearly important to continue to study the development of system working in the future to see how these issues are tackled as the effect of the pandemic diminishes and systems have longer experience of working together.

Further research

Given the likely commencement of legislative changes from July 2022, and the ongoing introduction of provider collaboratives mandated by NHSEI, it is important to understand how governance, accountability and decision making arrangements are developing to support the interplay of these layers of bodies and partnerships in order to ensure collaboration achieves system and national goals. PRUComm is due to continue its research in this area with a study investigating how the developing forms of statutory and non-statutory collaboration, together with the existing landscape of statutory organisations and forums, interact to support the achievement of system and national goals.

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

CCG - Clinical Commissioning Group: the statutory bodies responsible for planning, organising and buying health and care services for their population

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

ERF – Elective Recovery Fund - is a fund made available by the UK government to help hospitals recover their levels of elective activity, post COVID-19 pandemic.

FT – Foundation Trust - NHS trusts which were created in April 2004 and were given more autonomy over capital borrowing, selling of assets, retaining annual surpluses, and developing their own systems for managing and rewarding their staff.

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

ICB – Integrated Care Board - according to the Health and Care Bill 2021, each ICS would be led by an NHS Integrated Care Board (ICB), a statutory body with responsibility for NHS functions and budgets. When ICBs are legally established, clinical commissioning groups (CCGs) will be abolished.

ICP - Integrated Care Partnership - according to the Health and Care Bill 2021, each ICS will have to have a statutory committee bringing together all ICS partners to produce a health and care strategy.

ICSs – Integrated Care Systems - non-statutory partnerships bringing together providers and commissioners of NHS services across a geographical area with local authorities and other local partners to collectively plan health and care services to meet the needs of their population. They grew out of sustainability and transformation partnerships (STPs) and are expected to be put on a statutory footing in 2022.

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)

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

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

PCNs - Primary Care Networks- Introduced in the NHS long-term plan (2019), and bring together a number of GP practices to work collaboratively in a geographical area covering a population of 30,000 – 50,000 patients. They are non-statutory primary care collaboratives.

PTL – Patient Tracking List- an established, forward-looking, management tool that can be used by the NHS to help achieve and sustain short Referral to Treatment and diagnostic waits.

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

Scheme of Reservation and Delegation (SoRD)- a reference document showing what authority a board has delegated to committees, other volunteers or staff under the powers of the Constitution

Social enterprise – a business-like entrepreneurial organisation with primarily social objectives

STPs – Sustainability and Transformation Partnerships: local partnerships formed in 2016 to develop long-term plans for the future of health and care services in their area

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

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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, which take a co-ordinated approach to services, agree system-wide priorities, and plan collectively how to improve population health. This report contains findings from research to investigate the developing architecture of system management through the former Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs)[1]. In order to understand how effective these new forms of collaboration are in achieving their goals, it is important to investigate how 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.

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). 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 1990s, there has been an ongoing reliance on collaboration of some kind. There is a long history of partners developing collaborative approaches to jointly plan and deliver health, social care and public health services alongside other services. Co-operation between organisations is acknowledged as an 'essential behaviour' in the provision of 'seamless and sustainable care' to patients (Department of Health, 2010). The need for co-operation alongside competition is enshrined in *The Health and Social Care Act 2012* (HSCA 2012). Since 2014 and the publication of the Five Year Forward View (NHS England, 2014), collaboration has been intrinsically linked to the drive to improve the integration of services: broadly speaking, co-

[1] STPs were in existence until April 2021 when the last remaining STPs in England gained ICS status.

ordinating care to overcome the divides between health and social care, primary and secondary care, and mental and physical health.

While co-operation was always a feature of NHS policy and legislation, the development of ICSs has accompanied a fundamental shift away from the architecture of the internal NHS market. This is culminating in the proposed legislative changes of the Health and Care Bill 2021 (at the time of writing making its way through parliament) which will formally remove competition as a co-ordinating force in the NHS by changing the following key aspects of NHS systems: how competition law applies to the NHS; procurement requirements; and how the payment system operates. In addition the Bill seeks to enable collaboration through increased flexibilities for joint working and by putting ICSs on a statutory footing.

System working at ICS and lower levels elevates partnership working alongside the interests of individual organisations 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 England, 2019). As of April 2021, all 42 local systems in England had gained ICS status.

ICSs are voluntary partnerships (although in effect mandated by NHS policy for NHS organisations) in which decision making is consensual. The success of ICSs is determined by the willingness of system partners 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.

The recent White Paper and Health and Care Bill propose important changes in the ICS landscape. Key in these is the creation of statutory bodies: Integrated Care Boards, which will be responsible for the day to day running of the ICS and will take over the commissioning function of CCGs, and Integrated Care Partnerships (ICPs) which will be statutory committees which bring together system partners to support integration and develop a plan to address health, public health, and social care needs. The legislative changes proposed in the Health and Care Bill 2021 give ICSs stronger decision-making authority, and increase accountability for system performance. However, organisational sovereignty and the functions and duties of separate statutory bodies remain unaffected.

1.2 Spatial scales within systems

ICSs 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 ICS (population size of 1-3 million) contains 'places' and 'neighbourhoods' within it. 'Regional' and 'national' oversight will be provided through the regional arms and national presence of NHS England and Improvement (NHSEI) (see *Figure 1* below). In practice 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 England, 2019). Place-based partnerships are considered 'foundations' of ICSs, and the White Paper and Health and Care Bill anticipate that statutory ICSs will delegate significantly to place-based committees (DHSC, 2021).

'Neighbourhoods' (population size of 35,000-50,000) are based around Primary Care Networks (PCNs). PCNs are non-statutory and 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). Research into PCNs is currently underway, led by other members of PRUComm *(ibid.)*. Therefore, whilst links are noted here, their development is analysed in depth elsewhere.

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)	• Integrated multi-disciplinary teams • Strengthened primary care through primary care networks – working across practices and health and social care • Proactive role in population heath 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).	• 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)	• 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	• 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)	• 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	• 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)	• Agree system objectives • Hold systems to account • Support system development • Improvement and, where required, intervention	• 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)	• 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	

Alongside this three tier spatially-based model are pre-existing partnership arrangements and planning footprints such as Health and Wellbeing Boards (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), and networks of provider organisations reflecting planning footprints for particular specialities. Additionally, a further development in this landscape are provider collaboratives. These are non-statutory partnership arrangements involving two or more trusts which may form at supra-ICS level, may partially cover multiple ICSs, or may cover multiple places. In addition to a role in improvement of quality, efficiency and outcomes, it is anticipated that in the future provider collaboratives will deliver systems' strategic priorities, and that the statutory ICS could to delegate significantly to both place level and to provider collaboratives (NHS England and NHS Improvement, 2021c). It is not clear, however, how the configuration of provider collaboratives will dovetail with those of ICS and places within them (Sanderson et al., 2021).

1.3 Governance and regulation

ICSs are focused on shared decision-making regarding the allocation of resources, service design and improving population health (although under current legislation, any procurement or awarding of contracts must be undertaken by NHS commissioners). Guidance published by NHS England (NHS England and NHS Improvement, 2019b) 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. System working has become the central mechanism through which the achievement of NHS goals will be co-ordinated, with the development of system-based approaches to funding and planning (NHS England and NHS Improvement, 2021a).

ICSs are 'bottom-up' partnership arrangements, rather than following a single national blueprint. The long-standing approach to ICS governance is permissive. Current guidance states that system wide governance should include 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; system capabilities to fulfil the core role of an ICS and a sustainable model for resourcing these; agreed ways of working across the system in respect of financial governance and collaboration; and capital and estates plans at system level (NHS England, 2019, NHS England and NHS Improvement, 2020e). This permissive approach remains the same under the proposed legislation where, beyond some minimal stipulations for the

membership of the ICB, governance arrangements are largely a matter for local specification in the local constitution.

Governance arrangements within systems are equally permissive, and recent guidance makes clear that this will remain the case in the future. Guidance is clear that while system governance should be aligned, NHSEI will not prescribe the membership of individual provider collaboratives or place-based partnerships and it will be up to providers and their system partners to decide together which arrangements, including membership, create the best opportunities to deliver the full range of expected benefits (NHS England and NHS Improvement and Local Government Association, 2021, NHS England and Improvement, 2021).

Regulatory approaches are being tailored to reflect the primacy of system working. 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. Although providers' relationships with CQC will remain unchanged under the proposals of the Health and Care Bill, an amendment proposes a new clause imposes a duty on the Care Quality Commission to carry out reviews and assessments into the overall functioning of the system for the provision of NHS care and adult social care services within the area of each integrated care board (House of Commons, 2021).

NHSEI is responsible for the performance regulation and support of commissioners and providers of NHS services. 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). While the existing statutory roles and responsibilities of NHSEI in relation to trusts and commissioners and the accountabilities of individual NHS organisations remain unchanged, the oversight arrangements shift from a focus on the NHS individual organisations to working through systems where possible. Thus the approach is additive rather than substitutive. The principles outlined in the System Oversight Framework include working with and through ICSs, wherever possible, to tackle problems, a greater emphasis on system performance and quality of care outcomes, and a greater autonomy for ICSs and NHS organisations with evidence of collective working and a track record of successful delivery of NHS priorities, including tackling inequality, health outcomes and access (NHS England and NHS Improvement, 2021d).

The 'System Maturity Matrix' produced by NHSEI outlines the core capabilities expected of emerging ICSs, developing ICSs, maturing ICSs and thriving ICSs (NHS England and NHS Improvement, 2019b). 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). 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.

Most recently, the Health and Care Bill includes further support system working including the introduction of the 'Triple Aim', a duty on NHS organisations to consider the effects of their decisions on the better health and wellbeing of everyone, the quality of care for all patients, and the sustainable use of NHS resources and the ability for NHS England to modify licence conditions to enable co-operation.

NHS providers and commissioners have been subject to various financial mechanisms to incentivise partnership working, and develop a system-based approach to funding and planning. In 2019/20 all STPs/ICSs were required by NHSEI to produce a system operating plan 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.)*. From 2021, systems were given fixed funding envelopes to fund local elective and non-elective activity (NHS England and NHS Improvement, 2021b), with the expectation that systems would break-even within these allocations, although individual organisations can deliver surpluses or deficits by mutual agreement with the other bodies in the system.

1.4 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 was to investigate the development of 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 were 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?

Additionally we focused on the development of place-based partnerships, and the developing role of the regional NHSEI function. The research questions of the second phase of the research were:

1. How the local leadership and cooperative arrangements with stakeholders (statutory, independent and community-based, including local authorities) are governed in place-based partnerships, and how arrangements are developing to facilitate co-ordination between the the ICS and place-based partnerships.
2. How functions and responsibilities are evolving in place-based partnerships, and whether different types of commissioning functions are evolving at different system levels.
3. What decisions are being made in place-based partnerships, and how disagreement between members and conflicts of interest are being addressed.
4. How individual organisations are reconciling their role in place-based partnerships with system responsibilities, individual accountabilities and statutory responsibilities
5. How regional NHSEI is responding to the changes in modes of planning and commissioning and actual service configurations.
6. How accountability relationships are developing (between place members, between place and system scales and with national regulators), and creating clear accountability for and facilitating the achievement of, system and place-based partnership aims.
7. How system leaders view the future development of collaboration in the light of the proposals of the Health and Care Bill.

The following sections of the report will now summarise the relevant theoretical and empirical literature, and the methods used in the research before addressing the research findings themselves. There are three elements to the research findings: phase 1 findings and phase 2

findings (reflecting the two distinct phases of the research as described above in relation to the research questions), and a final findings section describing the quantitative analysis which established if ICS status could be linked to an improvement in outcomes. The report concludes with a discussion section which considers all findings, limitations of the research and outlines the implications of the research for policy and practice, together with suggestions for future research.

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.

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 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 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 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 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 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 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).

A small number of empirical studies have been published which are concerned with the development of collaborative arrangements within ICSs (Charles et al., 2018, NHS Providers and NHS Clinical Commissioners, 2018, Pett, 2019, Pett, 2020a, Timmins, 2019), and the development of commissioning in the light of system collaboration (Moran et al., 2018, NHS Providers and NHS Clinical Commissioners, 2018). 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 (Das-Thompson et al., 2020, NHS Confederation, 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).

Research suggests that ground work (such as establishing robust governance arrangements, clear lines of accountability and building relationships) was the overriding concern in the early stages of collaborative working, preceding any collaborative decision making to achieve

system aims (Charles et al., 2018, Walshe et al., 2018). It is also suggested that these forms of collaboration do have the capacity to effect change, with collaboration within systems resulting in tangible improvement in relationships (Timmins, 2019) and the management of 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). It is hoped that by adopting a case study approach incorporating all partners in a system our research will provide a nuanced analysis of the interaction between local context and system collaboration.

4. Study Design and Methods

The study consists of three in-depth case studies to investigate the development of ICSs, and their predecessors STPs. 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[2] 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 NHSEI function, we sought to identify case study sites from a variety of 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).

In Phase 2 of the research we focused our interviews on one place in each of our case studies. Places were shortlisted based on characteristics of interest emerging from the Phase 1 fieldwork

[2] A social enterprise can take any legal form, including being a limited company, community interest company, co-operative, partnership, or charity. Social enterprises have primarily social objectives, which should be underpinned by investment, although this does not necessarily imply that profits will not be distributed to owners or shareholders.

such as place boundaries, private sector and/or social enterprise partners and concentration of providers, and bearing in mind illustrating variance across these characteristics across the three case studies. Places were selected in consultation with case study representatives.

An overview of the systems which participated can be found in Section 5. The three case study sites (which consisted of one ICS and two STPs at the time of recruitment) 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 Directors of Adult Social Services Executive Council for the research on 19 November 2019.

4.4 Timeframe of the research

There were two phases of data collection. The first phase was conducted between December 2019 and March 2020, when fieldwork was halted prematurely due to the emergency response to the COVID-19 pandemic. The second phase was conducted between January 2021 and September 2021. The period during which the fieldwork was conducted was a period of great national policy change, local organisational change in the case study areas and disruption caused by the COVID-19 pandemic. The White Paper was issued during the second phase of the research, followed by the Health and Care Bill. These events may have impacted on the views of people at ICS level, but we did not re-interview people in phase 2 of the field work, as it concentrated on place level interactions. However we did ask interviewees about the system role in response to COVID-19 and in the later interviews to reflect on the implications of the Health and Care Bill.

For purposes of clarity the findings sections of this report are divided between phase 1 findings relating to the period of December 2019 to March 2020, and phase 2 findings relating to the period of January – September 2021.

4.5 Summary of methods

Our main method of data collection consisted of interviews with senior management representatives of system partners. We also examined locally produced documents, such as local strategic plans, and attended some meetings. The meeting observations provided context and prompts for more detailed interview questions. The documents we gathered gave us more information regarding governance arrangements in each of our case studies. We used this information as prompts for more detailed interview questions, particularly in relation to understanding governance arrangements in the case studies.

Additionally we carried out a quantitative analysis of routine data about health and care activity to estimate the impacts of ICSs on distribution of spending across sectors, indicators of integration and care quality, and health outcomes.

Interviews

In both phases of the research we identified potential interviewees based on their role as the individuals who represented system partners on the principal system and place governance forums. The vast majority of interviewees were Director level managers, or Chief Executives, in their organisations. During Phase 1 of the fieldwork we interviewed 28 people across the three case study sites (see Table 1). CL, DO, MS and OB conducted the interviews. The interviews explored the development of leadership and co-operative arrangements, decision making in systems including the allocation of resources, the reconciliation of individual roles, accountabilities and statutory responsibilities with system roles, the impact of financial mechanisms on system working, mechanisms used to commission services, reconciliation of local and system priorities, system impact on resource allocation across sectoral boundaries and the achievement of financial balance.

During Phase 2 of the fieldwork we interviewed 36 people across three 'places', one in each case study site, together with system leaders and representatives of the regional NHSEI (see Table 2). CP, DO, MS and OB conducted the interviews. Some findings from interviews from the start of Phase 2 of the fieldwork relating to system responses to COVID-19 were included in Phase 1 findings.

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

	Case Study 1	**Case Study 2**	**Case Study 3**	**Total interviews**
ICS leadership	**2**	**4**	**2**	**8**
CCG	**0**	**1**	**1**	**2**
NHS Providers	**3**	**3**	**4**	**10**
Local Authorities	**1**	**1**	**4**	**6**
Primary Care	**0**	**0**	**0**	**0**
Other Providers	**0**	**2**	**0**	**2**
Total interviews	**6**	**11**	**11**	**28**

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

	Case Study 1	**Case Study 2**	**Case Study 3**	**Total interviewees**
ICS leadership*	**2**	**2**	**3**	**7**
Regional NHSEI	**1**	**1**	**1**	**3**
CCG	**3**		**5**	**8**
NHS Providers	**2**	**2**	**3**	**7**
Local Government	**1**	**2**	**3**	**6**
Primary Care	**1**	**1**	**1**	**3**
Other Providers		**1**		**1**
Other		**1**		**1**
Total interviews	**10**	**10**	**16**	**36**

*Where an interviewee held a joint ICS/CCG role, this is recorded as an ICS leadership interviewee

The Phase 2 interviews explored decision-making in place-based partnerships, the allocation of functions and responsibilities across systems and places, the reconciliation of individual roles, accountabilities and statutory responsibilities with place and system roles, developing accountabilities and thought about the proposals of the Health and Care Bill. We asked regional NHSEI interviewees how regional NHSEI is responding to the changes in modes of planning and commissioning and actual service configurations. Included in the protocol for the study was the intention to interview the CQC as well as NHSEI. However in light of the limited function of the CQC in relation to system working, as described in Section 1 (Introduction), we decided not to interview a CQC representative. Additionally, the study protocol referred to conducting a small number of interviews with representatives of local community groups in each case study to find out about those not included in ICSs. Unfortunately it was not possible to conduct this strand of interviews due to the disruption to the research caused by COVID-19, and subsequent time restraints.

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 of system decision-making forums during the first phase of the research (three in Case Study 1, three in Case Study 2 and two in Case Study 3). 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, DO and CP agreed additional themes emerging from the data. These themes were used to analyse the data, and structure the report. MS, DO, CP, CL and OB conducted the thematic analysis. The findings are presented to highlight similarities between three cases; where there is a difference/variation it is further emphasised.

Quantitative methods

The methods for the quantitative analysis are detailed with the results of the analysis for ease of reference (see section 22).

5. Overview of case studies

The section gives an overview of each case study area in terms of the 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	1.5 million	1 million	1.9 million
CCGs	4	4	7
NHS providers*	5	6	5
Other healthcare providers*	0	2	0
Single tier local government*	5 Unitary Authorities	0	8 Local Authorities
Upper tier of local government*	0	1 County Council	0
Lower tier of local government*	0	10+ Borough Councils	0
No of 'places' within system*	5	5 (one non-spatial)	3 sub-systems

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

5.1 Phase 1: System descriptions

Case Study 1

When the research commenced in Case Study 1 in December 2019, the system had STP status. The system gained ICS status in 2021. Covering a population of approximately 1.5 million people, it consisted of four constitutive CCGs (merging into one from 2021), five NHS providers and five unitary authorities (see Table 3 above). Due to complicated boundaries, changing leadership and the evolving vision for the system, membership was characterised by certain fluidity with some providers being added as system partners during the fieldwork.

The system formed into five places which corresponded with the five unitary authorities. Each place had a distinct and strong local identity, with different local priorities, governance and service delivery models. However the five authorities were part of a Combined Authority with

strategic powers, including over transport, and economic development, which was larger than the system area.

Case Study 2

The Case Study 2 system had ICS status throughout the fieldwork. The ICS served a population of around one million people. Formal system membership included four CCGs (merging to one from 2020), five NHS provider organisations, two social enterprises (both providing community health services), an NHS Ambulance Trust, general practice (represented as a single provider), and the County Council. There was a devolution agreement 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 was in many ways straightforward. There was near coterminosity between the ICS and Council, with the ICS encompassing the vast majority of the Council population. 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 was a member of two systems, which were in two different NHSEI regions.

The ICS formed four spatially configured places (a fifth non- spatial place had 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 were based around the population flows into an acute hospital, reflected former CCG boundaries, and were largely not coterminous with District or Borough Council boundaries.

Case Study 3

Case Study 3 was an STP in a large urban area, which became an ICS in 2020. It had a large geographical footprint, and covered a population of 1.9 million, making it the largest of the case studies. The system had a complex, multi-layered governance structure spanning seven CCGs (merging to a single CCG in 2021) and eight Local Authorities.

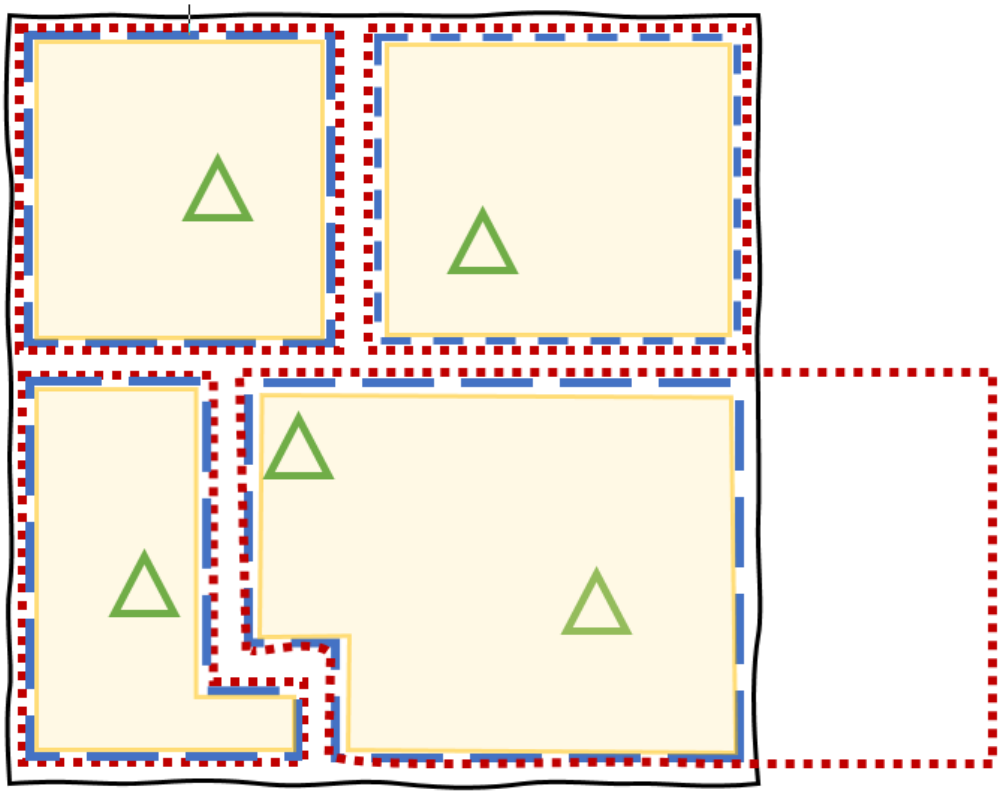
The system was particularly notable for the formation of a two-tier place level. The system was organised on the basis of three places each corresponding with a main acute provider footprint and anchored in the historical host commissioner arrangements. These places were referred to

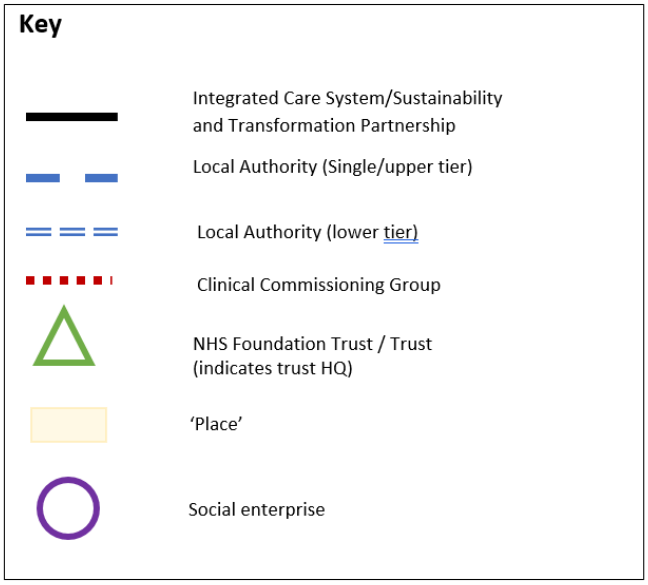
as ‘systems’ or ‘partnerships’ in system documents, however, in order to avoid confusion with the STP/ICS system level in this report we refer to them as intermediate ‘subsystems’. The three intermediate subsystems were of unequal size in terms of population and geographical area and were at different stages of partnership development. Each subsystem 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/ICS and the borough place level envisaged by policy – i.e. the larger intermediate subsystems.

Notwithstanding internal complexity, the Case Study 3 system had relatively straightforward external boundaries. The three acute providers were mostly internally facing, although some served as major tertiary care centres and received some patients from neighbouring systems. In contrast, the two community and mental health providers had to engage more closely with the work of other systems where they provided services.

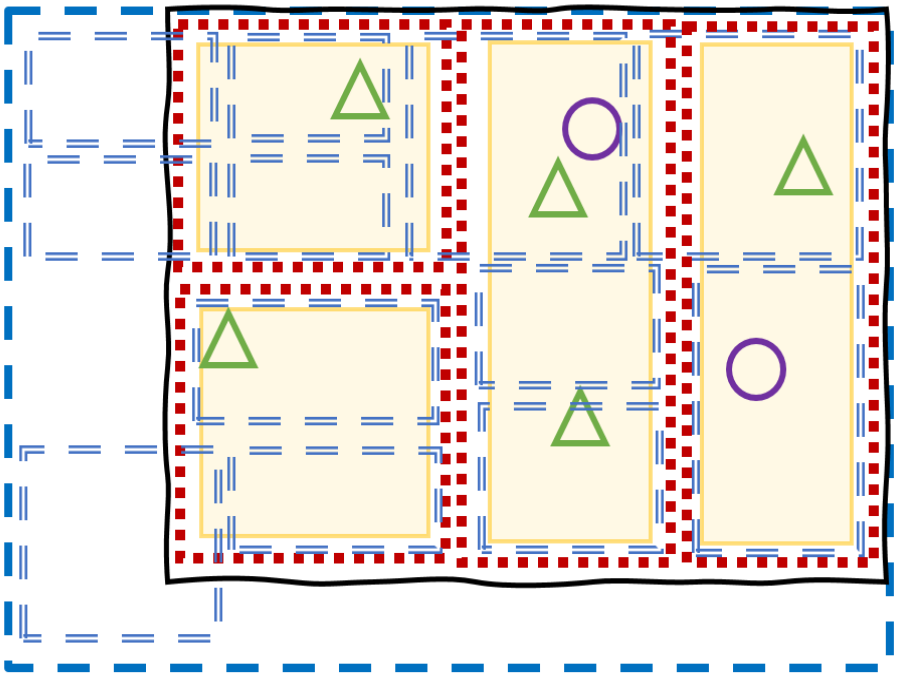
Figure 2: Representation of the spatial organisation of case study systems and partners (as at February 2020)

Case Study 1

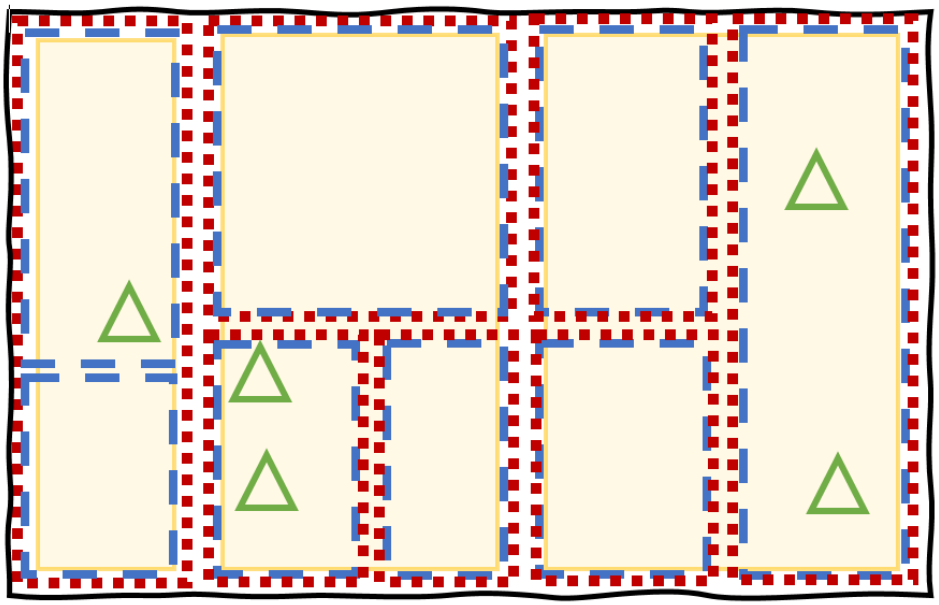




Case Study 2



Case Study 3



5.2 Phase 2: place descriptions

In phase 2 of our study, we selected one place in each of the three case studies and conducted a detailed analysis of their configuration, their governance structures, their degree of decision-making powers and financial autonomy, relationships among partners within each place, and their relationship with the overall system to which they belonged. A brief description of each place follows.

Case Study 1

The 'place-based partnership' (known locally during the research period as an Integrated Care Partnership (ICP)) in Case Study 1 covered a population of approximately 250,000. It was one of five 'places' in the ICS and its board had the following core membership: one CCG, one integrated care NHS FT (combined acute and community care), one local authority, one mental health trust, and six PCNs. The clinical director of each PCN was the PCN's representative on the ICP board. In addition to that, there were executives from other organisations feeding into the work of the ICP as needed (in a consulting, non-voting capacity) about operational decision-making (examples of such organisations were the local hospice, a private provider of musculo-skeletal services, or the local housing association). The place in this case study was coterminous with the local authority. In addition, the vertically integrated NHS Trust contained some practices which belonged to a different place, and this was seen as posing challenges in the future.

Case Study 2

The place in Case Study 2 was one of four place-based collaborations, and was considered 'the epitome of a tidy health economy' (Place Director) and 'self-contained' (GP Federation). It was based on a former CCG footprint and covered a population of approximately 350,000. Members of the place Board were: an acute NHS Foundation Trust, one area director for social care, four borough councils (lower tier authorities), an NHS Foundation Trust providing services for adult and children with mental health and learning disabilities, a social enterprise providing community services for adults and children, a GP Federation, 3 clinical directors drawn from 9 PCNs and a hospice.

A number of members had footprints which spanned more than one place. This was the case for the mental health NHS FT which spanned two systems, and the social enterprise which provided community services across two 'places' (and sat on the Boards of both 'places'), and was also the majority provider for a system scale children's contract, which was managed by a

third place. Other members broadly shared coterminosity with the place. The majority of the Acute NHS Foundation Trust patient flows were within the area, and the GP Federation encompassed all the practices within the place.

The place had been a surplus health economy, however, the financial position had been made uncertain by the changing financial regime of the Covid-19 response, changing patterns of spending and the need to invest in additional equipment to aid the elective recovery. During the fieldwork, members of the place signed an Alliance Agreement.

Case Study 3

In Case Study 3, the fieldwork for our study coincided with the ongoing negotiations around the purpose, meaning and composition of the place configuration within Case Study 3. The definition of place was complicated by the 'double-layer' set up which consisted of two tiers of place, exemplified by the presence of an intermediate subsystem level (i.e. the upper tier or 'subsystem' partnership) which lay between the ICS and the three lower tier 'borough-based place partnerships'. The three intermediate subsystems were of unequal size in terms of population and geographical area and were at different stages of partnership development. Each subsystem was in turn divided into borough-based partnerships corresponding with local authority boundaries. Local negotiations resulted in a consensus which emerged towards the end of our fieldwork to move away from the 'double-layer' place configuration to a 'single-layer', based around the local authority boundaries.

The Case Study 3 'double-layer' place selected for our study, was an urban area comprising three local authorities covering a population of nearly 1m, considerably larger than the other two places we studied. Until the system CCGs merged to form a single CCG in 2021, three CCGs operated jointly across the area. There was no statutory boundary that mirrored the subsystem footprint. The membership of the sub-system tier was also imprecise and open-ended. According to one document its membership comprised 3 local authorities, one acute trust, two community and mental health trusts, 3 GP federations, over 20 PCNs, one (by then merged) CCG which covered the whole system as well as other 'voluntary and community partners' and an ad hoc input from other organisations and services. The NHS providers and commissioners had relationships stretching beyond the footprint of the subsystem. The main acute trust was a large, multi-hospital provider with extensive and varied patient flows. It was also a tertiary care provider. The community services were provided by two standalone community and mental health trusts, one trust serving two local authorities and another trust

serving the third local authority area. The two community and mental health trusts operated also in areas outside of this place and system. The one merged CCG covered the footprint of the whole system. On the other hand, some organisations such as local authorities, GP federations and PCNs operated at the lower tier borough-based place partnerships level.

The aim of the intermediate sub-system tier was often referred to as enabling teams, programmes and forums to work at scale, in particular with regards to the transformation of acute services and joint management and leadership across three CCGs. The CCG financial allocations, support and assurance functions were also managed at this footprint. However, by the end of the fieldwork a consensus emerged to scale down the prominence of this footprint in the system governance architecture and move towards a 'single-layer' of three lower tier borough-based place partnerships based on local authority boundaries.

6. Phase 1 - 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. It is based on interviews, meeting observations and documentary analysis conducted in the first phase of the research, December 2019 and March 2020.

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'*. 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.

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 between NHS and local authorities, across areas of difference such as degree of local independence, accountability of local authorities to local politicians and the public, differing financial rules and regulations, the use in local authorities of competitive tendering to procure services and a reliance on private sector providers. The locally derived, political mandate of local authorities 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)

Given the NHS genesis of the STP and ICS agenda, some local authority 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 local authorities. The emphasis on achieving financial balance in the NHS, for instance, was seen by some as an NHS-centric focus. Local authorities 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) in a health focused system. In some significant aspects membership and participation was different for local authorities than from NHS partners, for example local authorities were not included in the system control totals.

The nature of local authorities' 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 9 'System governance structures'). 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 local authority 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 scales, 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 local authority boundaries and should cover a sufficient scale (NHS England and NHS Improvement, 2019b), and that place should typically operate at borough/council scale '*served by a set of health and care providers in a town or district'(ibid).* In practice, NHS commissioners, Trusts, and local authorities 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 authorities 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 local authorities 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. 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 'double-layer' place set up, exemplified by the presence of an intermediate subsystem level (i.e. the upper tier place-based partnership) which lay between lower tier borough-based place partnerships and the ICS, described by one interviewee as "*systems within systems within systems"* (Local Authority Director 1, Case Study 3). 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 at the time of the Phase 1 research (December 2019 and March 2020).

In Case Study 2, system identity and its associated concepts seemed most clearly established with system partners. ICS status in this case study was perceived by the ICS partners to bring greater opportunities for '*freedom and liberation*' (ICS Director 1, Case Study 2), 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 (System action to achieve financial sustainability), the ICS was exploring novel opportunities to capitalise on the close collaborative relationship between NHS and local government.

In contrast in the other case studies, which had yet to gain ICS status at this point, system identity was seen as under development. In Case Study 1, the STP was 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 delineated the system. In Case Study 3, despite growing awareness amongst local authority partners that the system increasingly played an important role in decision-making and strategic planning, some local authority interviewees struggled with defining what the STP was:

'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)

Uniting behind a system vision was acknowledged as a long-term task, particularly so in the case of system scale collaboration, which was at a scale where relationships may not have a prior existence. Conversely, relationships at place scale tended to be seen as stronger, aided by factors such as coterminosity between acute trusts and local authorities 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).

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).

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 embededdness 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 partner 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'* (Director, Acute Trust 1, Case Study 2)). 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.'* (Director, Acute Trust 1, Case Study 2)

> *'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)

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 this Phase 1 fieldwork (December 2019 and March 2020) 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.

6.5 Conclusion

In relation to the configuration of systems and system membership in late 2019/early 2020, we found 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. Where organisational footprints did not align with the spatial configurations of systems and places, this led to complexity of governance arrangements, and weakened incentives for collaboration. In relation to co-ordination within systems, it appeared that a shift from competition to a collaborative ethos was underway in the NHS, but this was acknowledged to be a long-term undertaking. 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.

7. Phase 1 - System action to achieve financial sustainability

This section, based on interviews conducted between December 2019 and March 2020, discusses actions that were being taken in the case study systems to achieve financial sustainability. It addresses partners experience of financial incentives to aid collaboration, specifically system control totals and payment mechanisms. Moving the focus away from the NHS, we also explore local authorities involvement in action to achieve financial sustainability in systems. The section concludes with an analysis of the way resources were being allocated within systems, firstly how systems were making decisions regarding the allocation of resources and secondly, the development of shared resources between system partners.

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 of a system-wide view when this might be at the expense of the financial well-being of their individual organisation. Some providers reported 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 wider policy and regulatory context, and the non-statutory nature of systems:

> *'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)*

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*) 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)[3] 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).*

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).

7.2 Use of financial mechanisms to aid collaboration

The national tariff[4] was perceived to be incompatible with collaboration and integrated working, and moving away from the national tariff to longer term block contracts (a 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 Phase 1 research (December 2019 and March 2020). 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.

[3] 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.)

[4] 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 approaches (NHS ENGLAND AND NHS IMPROVEMENT 2020g. Understanding and using the national tariff. London: NHS England and NHS Improvement.)

The development of approaches to achieving break even position with respect of system control totals was taking place at both system and place scale, with places commonly organised around main acute provider footprint, 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, a contract with a main acute provider was based on blended tariff[5] as opposed to the national tariff, and in a further example, risk share arrangements agreed between CCGs and a struggling acute provider based on blended tariff approach were thought to have provided some helpful levers to achieve the required breakeven position. The use of Alliance agreements[6] was also under discussion in a number of places across the case studies as a possible mechanism to secure co-operation and the sharing of financial risk at place (see section 8 'Development of system governance').

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 local authority would impact efforts to integrate health and social care services provision), and that local authorities were important partners in achieving system financial sustainability. Experiences of partnering with local authorities 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 (while local authorities were required to balance their budgets) was a source of frustration for some local authority 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,*

[5] 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.)

[6] 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

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)

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 local authorities and the NHS. Many of these tensions could be overcome through detailed specification and agreement of risk share arrangements, however the financial conditions within which local authorities operated heightened the anxieties about how the limited council resources were being spent and who had control over it.

While these tensions existed in all case studies, in Case Study 2, where the coterminous County Council held an ICS 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)

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, where the system had ICS status, 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)

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.

7.6 Conclusion

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 Phase 1 research (December 2019 and March 2020) 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 payments 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 Phase 1 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.

8. Phase 1 - Development of system governance

This section describes how system governance was developing in late 2019/early 2020. It describes the arrangements which were being established regarding the leadership of systems, and the co-ordination of system governance with the existing governance landscape. The section also describes the increasing formalisation of system governance structures at this early state in 2020.

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)

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)

8.2 Alignment of system governance with partners' statutory responsibilities

A further instance of making use of statutory authority from existing statutory bodies and functions observed during the Phase 1 research 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 systems 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 local authorities, 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, local authorities 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 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 were adopting formal commitments 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, and NHSEI, 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 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-based 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.

8.4 Conclusion

At this early stage in 2020, 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.

9. Phase 1 - System governance structures

This section describes the main system governance structures which were in place in the three case study systems in early 2020. It details the principles which were underlying the establishment of system governance structures, the development of system partnership boards and the development of other system governance forums to help systems deliver their aims.

9.1 Principles underlying 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)

Important principles for decision making in systems were the use of consensus approaches to decision making and the principle of subsidiarity (where the decision is taken closest to those it affects). While recognising the differences from vertical governance, system governance structures sought to achieve oversight of activities, for instance with approvals required at system level for some decisions made at place level. The formalisation of an oversight 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, which was already an 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 (System governance in practice) 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.

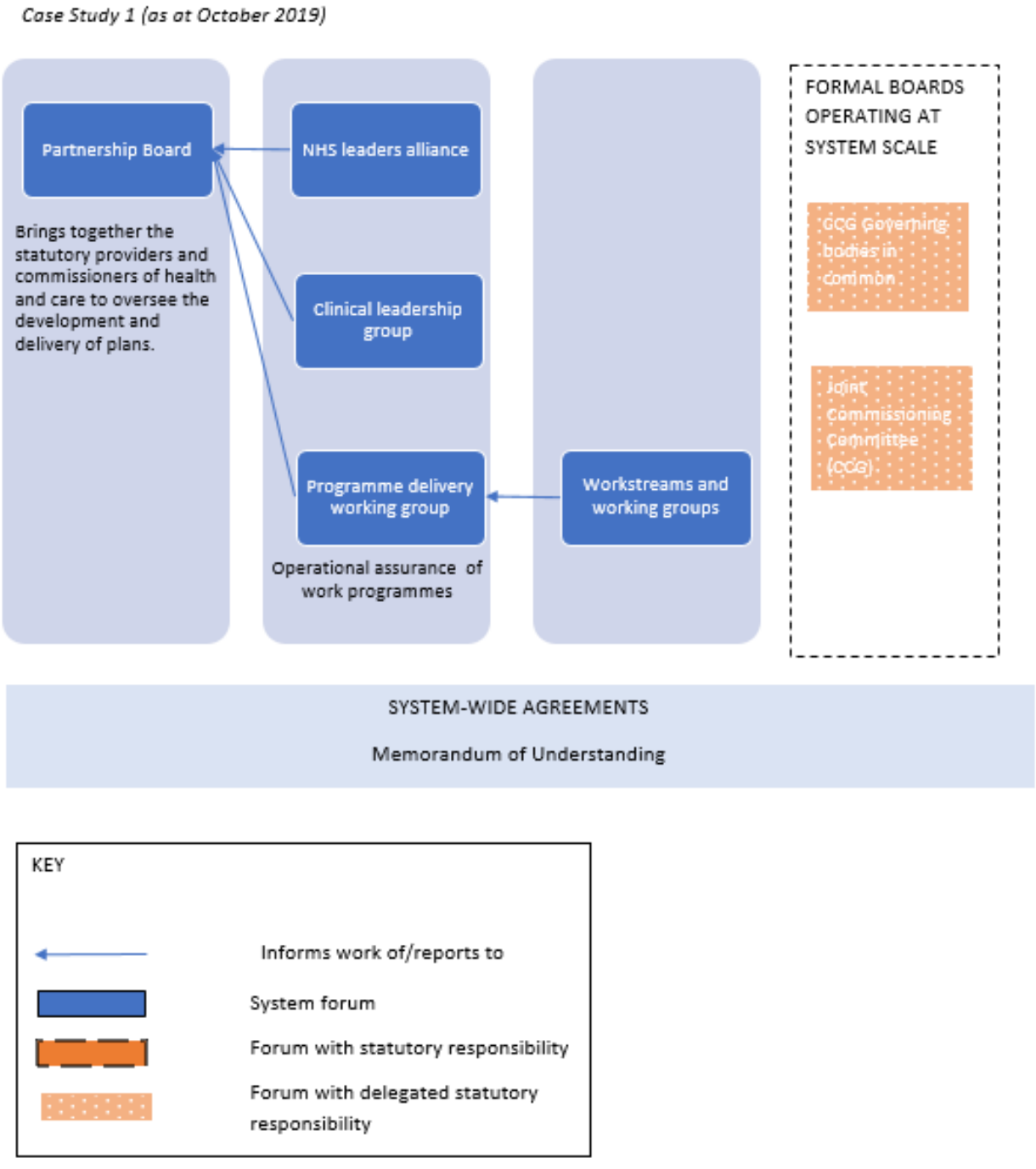
9.3 Other system level governance forums

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

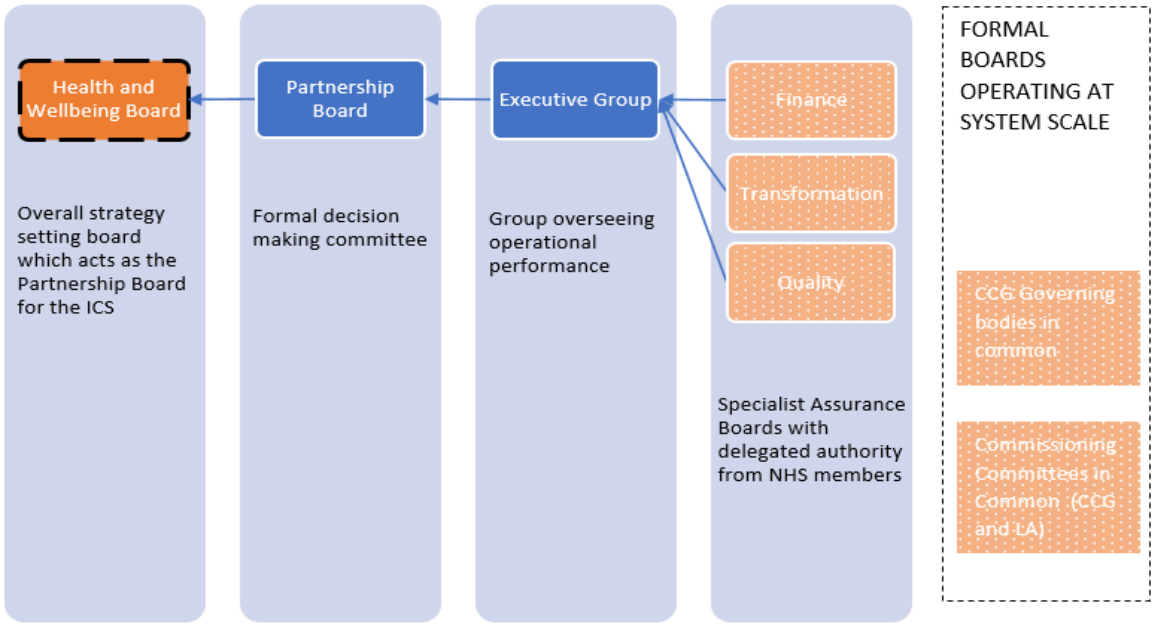
In all our case studies, an executive group existed at system level. These were important forums, in two case studies (Case Studies 2 and 3) they were arguably the main decision-making forum. These executive groups held other system forums to account and reported to the partnership board (where it existed).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

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)

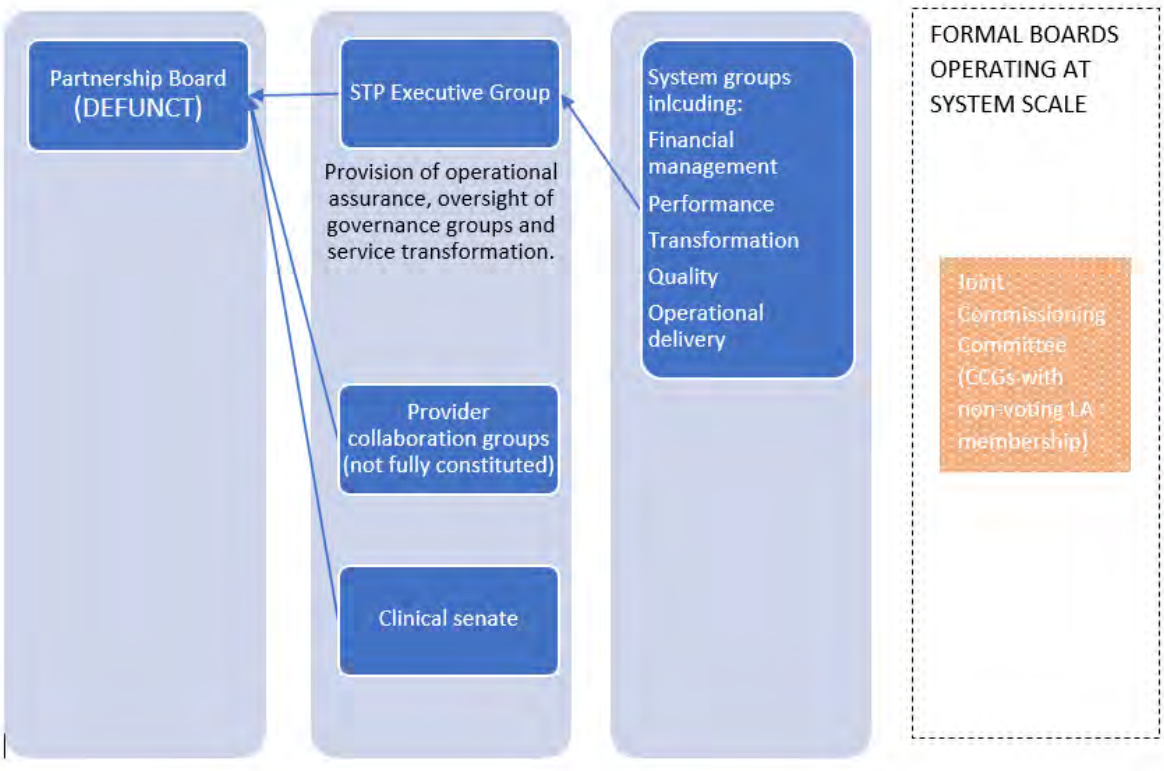


ADDITIONAL SYSTEM-WIDE AGREEMENTS

Memorandum of Understanding

Devolution Agreement

Case Study 3 as at February 2020



8.4 Conclusion

When the Phase 1 research was conducted between December 2019 and March 2020, 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, at this point in time, the 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.

10. Phase 1 - System governance in practice

This section discusses system partners' experiences of making decisions through system governance structures in early 2020. It details the developing co-ordination between system-decision making and decision-making in statutory organisations, the clarity of system decision making processes, and how governance arrangements were evolving in light of the underlying principles of inclusivity and consensus.

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'* (Mulderrig, 2011). It was recognised that power lay in the ability of the system leader or partners to influence the decisions of others. System leaders were reported to spend 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)*.

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.' (Director, Acute Trust 1, Case Study 2)

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, at the time of the Phase 1 fieldwork in early 2020, the lack of a statutory basis for systems was seen to be 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*" (Director, Acute Trust 1, Case Study 3).

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 in place-based partnerships, 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)

One consequence of this cycle of refinement was that written governance documentation became 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 Inclusivity and consensus in decision making

Systems prioritised inclusivity 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.' (Director, Acute Trust 1, Case Study 2)

It was feared that, in large systems, having many people round the table may stifle decision making and make the meetings unmanageable (Director, Acute Trust 1, Case Study 3). 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 (System governance structures), 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.'* (Director, Acute Trust 1, Case Study 2)

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 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.

10.4 Conclusion

In early 2020, 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. Some interviewees still doubted that, given the legislative environment of early 2020, 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.

11. Phase 1 - The division of functions between systems and places

This section, based on research conducted from December 2019 to March 2020, describes the way systems were developing the relationship between system and place to reflect the principle of subsidiarity, and the reconciliation of local priorities with the wider priorities embodied in STPs and ICSs. The division of functions between system and place was a focus of the second phase of this research, and our findings in this regard are reported on in more detail in section 17 (Apportioning functions and decisions between system and place scales).

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 scales, Case Study 3 had departed significantly from these spatial scales, and governance structures existed at system and a 'double-layer' place, exemplified by the presence of the intermediate subsystem level (i.e. the upper tier place-based partnership) which lay between lower tier borough-based place partnerships. 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 scale, each place-based partnership 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 intermediate 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 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 remained challenging to get the division of responsibilities "right" between levels *(Director, Acute Trust 3, 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 local authorities 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. In Case Study 3, where the double layer subsystem/borough footprint existed, subsystems were seen as focused on the acute hospital agenda, and place was the focus of engagement with local authorities.

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 up to March 2020, 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. The place role in relation to population health was seen having access to data to support the development of targeted action where there is the need in the local population. 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 co-ordinate commissioning decisions across CCGs and local authorities were being developed. For example, Case Study 2 had established a Joint Commissioning Committee of the system CCGs and the County Council, 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. 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.

Table 4: Actual or postulated division of functions between system and place (from Phase 1 interviews)

Function	***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)

In scope areas included mental health, learning disabilities, continuing health care, children (including mental health) and the Better Care Fund. In a further example, in Case Study 3, local authorities were non-voting members of the system wide Joint Commissioning Committee, and integrated commissioning with local authorities was situated at the borough scale through pooled funding through Section 75 agreements such as the Better Care Fund.

Commissioning at various spatial scales was under development. At the time of the phase 1 research, CCGs were in the process of merging to form larger scale organisations. 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 scale.

11.4 Conclusion

This section described the way, in early 2020, systems were developing the relationship between system and place to reflect the principle of subsidiarity, and the reconciliation of local priorities with the wider priorities embodied in STPs and ICSs. At this point in our case studies, governance structures were multi-layered with decision-making structures at different spatial scales. At place scale we found varying degrees of formality and uniformity of governance, and some unease at the potential for diversity in governance at place. The drive to establish partnership working at the location closest to delivery, 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. The division of functions between system and place was a focus of the second phase of this research, and our findings in this regard are reported on in more detail in section 17 (Apportioning functions and decisions between system and place scales). Commissioning at various spatial scales was under development.

12. Phase 1 - 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 as at early 2020.

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 at this point in early 2020 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.' (Director, CCG 1, Case Study 3)

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). 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…' (Director, Acute Trust 1, Case Study 2)

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 phase 1 fieldwork) the CQC announced a series of Provider Collaboration Reviews, focused on partnership working in response to COVID-19.

12.2 Horizontal accountabilities – holding system partners to account

During the phase 1 fieldwork in early 2020, 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'(Director Acute Trust 1, Case Study 3)*. Interviewees reported a shift from bilateral performance management meetings between provider and regulator to trilateral 'assurance' meetings involving systems. Horizontal accountabilities were developing at place scale, with the notion firstly, that places partners could hold each other to account for performance, and secondly that places (rather than individual providers) could be held to account by systems. 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 said to be 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, ICSs 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). The Case Study 2 system 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.

12.4 Conclusion

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.

13. Phase 1 - The system role in the COVID-19 response

The fieldwork reported in relation to phase 1 of the research ceased in March 2020 due to the disruption caused by the pandemic. However, it is valuable to consider the way organisational collaboration necessitated by the health and social care response to COVID-19 has influenced system working, and this can add to our understanding of system working. A small number of interviews were conducted in Case Studies 2 and 3 in August 2020 which focused on the system role in the COVID-19 responses. A brief summary of the findings in this regard are detailed here. In Case Study 1 we were not able to obtain an interview to explore the role of the system in relation to the COVID-19 response.

Due to the non-statutory nature of systems there were very few roles in relation to the response to COVID-19 which were allocated formally to ICS and STPs by NHSEI. The NHSEI letter *'Reducing burden and releasing capacity at NHS providers and commissioners'* (NHS England and NHS Improvement, 2020b) 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 would 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 would 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, 2020c); and that ICS/STPs were 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, 2020f).

In our case studies, system involvement as a co-ordinating force of the COVID-19 response varied. In Case Studies 2 and 3 we found that the system played a co-ordination role in relation to the COVID-19 response. 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. Interviewees suggested the NHSEI region wanted the ICS to be the first point of contact. Board papers suggest that this was because scale of the Local Resilience Forum (LRF)[7] 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.

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

> *'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)

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

[7] *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

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). For example, there was a need operationally for Intensive Care teams 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, 2020d) which had in effect 'completely rewritten the rulebook for this year' (ICS Director 2, Case Study 2).

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) and was described as *'liberating'*. New forums based on the COVID-19 response replaced system forums and ways of working. 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)

Some system wide sharing of resources was necessitated by the COVID-19 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. Phase 2 – Place governance structures

The second phase of our research took place from January 2021 to September 2021, and focused on arrangements in place-based partnerships which are the collaborative arrangements formed by the organisations responsible for arranging and delivering health and care services in a locality or community.

This section discusses the formal governance arrangements which were established in 'places'. It links closely with section 15 which discusses how place-based partnerships functioned in practice and section 18 which discusses the decisions which were being taken in place-based partnerships.

Place governance arrangements were not settled and were subject to ongoing refinement. The degree of clarity and coherence of governance arrangements to local actors was affected by both the ongoing refinement of arrangements and the degree of consensus regarding the conceptualisation of place. In terms of membership of place-based partnerships, this was centred on the main providers of health and social care to the local population with less involvement of the voluntary sector and wider partner agencies such as ambulance, education and police. As place-based partnerships matured, there was an emerging focus on the prioritisation of place collective voice and cross cutting interests over representation of individual organisations. Local arrangements regarding decision making and dispute resolution in 'places' reflected the non-statutory nature of place forums, member sovereignty and the primacy of consensus approaches.

14.1 Governance structures in 'places'

The degree of internal alignment between place forums and to which they were viewed as part of a coherent set of arrangements reflected the degree of local consensus regarding the conceptualisation of place.

In Case Studies 1 and 2 interviewees described a single main place forum recognised by place members and by the wider system as the 'place-based partnership' where partners come together to make joint plans and decisions. There was a shared understanding about the membership and role. These governance forums were long-standing, existing under various names as the system approach evolved.

In contrast in Case Study 3 the governance arrangements were far from settled, reflecting the existence of two different spatial configurations as described in section 5: the role and membership of governance forums were differently understood and described, place governance forums existed at two unconnected layers, and the future shape of governance arrangements was contested. Originally it had been thought that arrangements could remain permissive, however it appeared that this proposal was no longer holding. Towards the end of the fieldwork there appeared to be growing consensus about the future governance arrangements and the emergence of a single place governance forum.

14.2 Membership and purpose of place-based partnerships

Place-based partnerships were focused on the co-ordinated delivery of health and care services to the population, and the vast majority of members of place governance partnerships was drawn from the providers delivering statutory NHS health or social care services to the population.

Members of place-based partnerships included NHS Trusts providing acute, community, integrated and mental health services, other providers of NHS services such as social enterprises, and local authorities as providers of adult social care. Primary care was represented either through GP Federations or representatives of PCNs. Additionally, membership included non-NHS hospices (Case Studies 1 and 2), and Healthwatch (Case Study 1), and some interviewees also referred in general terms to voluntary sector membership. In Case Study 2 the place-based partnership included lower tier borough councils (who do not provide statutory health and care services). The lack of wider membership from other statutory bodies such as Ambulance Trusts, education sector, police, or from the voluntary/third sector (beyond hospices) was notable. Interviewees suggested that these bodies were involved for particular projects rather than as core members of the place-based partnership.

The focus of place-based partnerships reflected the concerns of the main providers of health and care. It was not always clear in what way non-statutory members such as hospices or other voluntary sector organisations were involved in the work of place-based partnerships. The common purpose of place co-ordination was to improve the delivery of services, with a focus on service development and transformation, and ensuring financial sustainability. Interviewees felt the focus of place-based partnerships should be on reducing health inequalities, delivering planned, responsive, joined up health and care services, improving population health and engaging the community, although these focuses were at times aspirational. In particular work

relating to improving population health, reducing health inequalities and engaging the community were commonly seen to be part of the future agenda. There was also an operational dimension to place work, particularly where groups were used to co-ordinate the COVID-19 response.

In Case Study 3, membership and purpose of place was less clear, reflecting the nature of governance at two unconnected scales (see sections 5 'Overview of case studies' and 16 'Accountability'). Both scales had a similar focus on services delivery and transformation. Additionally, the upper tier intermediate 'subsystem' was seen by its proponents as fulfilling a support and assurance function, dealing with issues across the smaller units which would otherwise result in duplication.

14.3 Decision-making arrangements in place-based partnerships

Place-based partnerships were increasing the formal specification of governance arrangements, for example using terms of reference and appointing chairs, and these were described as devised by the place members themselves. An additional development was the adoption of formal partnership agreements. Such arrangements had been considered in all three case studies, but only one (Case Study 2) had established a formal agreement through the adoption of an Alliance agreement. This agreement was seen as an enabling device to bring partners around the table in a form which would enable the future devolution of budget from the ICS (or CCG) to place and budgetary decision making at place level.

In Case Study 2, the formalisation of place governance arrangements included an increasing emphasis on cross-organisational portfolios and the assumption of a collective place identity which had prominence over identities of individual organisations. As part of this agenda, cross cutting responsibilities had been assumed for some staff:

> *'We're now saying that there will be some Alliance type roles which actually even, kind of definitely now suggest that we will be working in a more formal joined up fashion, as I said to you, taking some people out of organisations, as part of their day job, but apart from their day job, they will have an Alliance role as well, which we've never had before, you know, it's always been looking at things very much in your particular silos, and what we want to try and do now, is actually almost turn that on its head, and say, how do we start to actually kind of build propositions rather than individual business units.'* (Director, Community provider, Case Study 2)

Decision making in place-based partnerships was described as following a consensus-oriented approach in which partners worked together to try to reach a unanimous agreement. Where such arrangements were not formally described in terms of reference then this consensus approach appeared to be understood by members as the *de facto* approach. A reliance on majority voting tended to be seen as a last resort which was to be avoided as it signalled a failure in the consensus approach:

> *'At the moment like I said it is based on unanimous decision, there is no voting mechanism or a veto in place. It was discussed in great depth but we decided to move away from it, because that had the risk of destroying the collaboration that we were trying to bring in… So we've stuck to a unanimous approach and it's worked clinically, it's yet to be seen how it will work when we start bringing some hardcore decisions in.'* (CCG Chair, Case Study 1)

'Place-based partnerships' had not adopted formal mechanisms to resolve disagreement between place members, and it was noted that so far, in practice, disagreements were scarce and resolved informally (see section 15 'Place governance in practice').

A further significant dimension of formal decision-making was the remit of place-based partnerships regarding decision-making. It was necessarily the case that the decision-making power of place-based partnerships reflected their lack of formal power. Decisions regarding the allocation of resources to organisations could only be made by CCGs as the statutory bodies responsible for planning, organising and buying health and care services for the population (for NHS resources) and councils (in relation to adult social care). Place-based partnerships had no statutory power to direct their members to undertake any course of action. Accordingly, place-based partnership decisions were described as having the status of recommendations to the statutory bodies:

> *'I understand while the decision making might happen at the [place body], statutorily it needs to go back into the CCG, so it will still need to fit into the traditional governing body structures. Financials cannot be moved from one organisation to the other based on what the [place body] decides. It has to stick to the legal statutory ways of making those decisions. It can make a recommendation but not necessarily follow it through and that's a big problem… So legal structures around CCGs should have been*

managed first before this new structure was brought in, but unfortunately that didn't happen.' (CCG Chair, Case Study 1)

Perceptions of the status of 'place-based partnership' recommendations and the subsequent degree of influence on, for instance, commissioning decisions varied across, and within, our case studies. In both Case Study 2 and 3 there were measures to increase the influence and status of decision making in 'place-based partnerships'. One approach was the inclusion of undertakings in terms of reference, such as commitment from partner organisations to delegate authority to the place-based partnership to make decisions that may have resource and activity implications for the partner organisations, and to include this undertaking in the partners' own schemes of delegation.

A further practice was the alignment of 'place-based partnerships' with bodies which had statutory responsibilities. For example, in Case Study 3 the larger scale (subsystem) place partnership met jointly with a CCG joint committee operating at the same scale, which had responsibility for contracting decisions, ensuring oversight of quality and safety and monitoring financial performance:

'So, the [place] group happens every fortnight, area committee meets every two months, but we've made sure that those two-monthly meetings are done in common with the [place] group, because were very keen to get rid of any standalone CCG decision making governance, when everything on those decisions could be made through a much broader discussion, than if it was just a standalone CCG committee.' (ICS Director, Case Study 3).

In Case Study 3, one interviewee suggested that the 'place-based partnership', despite lacking statutory powers, was the main seat of decision making for the footprint with the CCG area committee just '*putting a commissioning frame around decisions that we're making elsewhere'* (Director, Mental Health NHS Trust, Case Study 3).

A number of additional mechanisms were described in Case Study 2, which can be seen as anticipating the sort of arrangements regarding delegation of decision-making to 'places' under the new Health and Care Bill. For example, the Alliance agreement stated that the place director would act as a representative of the commissioner, with appropriate delegated authority from the CCG and a delegated budget. However, this architecture was not operational in the Case Study 2 place-based partnership at the time of the fieldwork. Reasons given for this included the abnormality of the financial regime under COVID-19 (see section 13 'System response to

COVID-19'), and difficulty disaggregating financial flows and the contracting to acute hospitals in order to calculate a place budget:

> *'And because a lot of the activity is not just about the population around that hospital, it makes it really hard to disaggregate now then what sits within a Place based budget or contract. That's just why it needs to be about a contract for services rather than what is the allocation of money that goes to the statutory organisation. And then the statutory organisation then has regulatory and license conditions that it then needs to meet, and the chief executive, as the accounting officer, also has a…that's why it's messy.'* (Director, Acute NHS FT, Case Study 2)

14.4 Representation of place within system scale governance

Across our case studies the representation of place in system-based forums ranged from the use of collective place voice to no formal representation of place voice in system forums. Interviewees suggested that an eventual goal of place-based partnerships was to move away from member organisations representing their own interests to speaking through a place collective voice.

Interviewees saw a shift away from direct representation of all place partners in system forums in favour of the use of an elected place representative as a significant development in governance arrangements. In Case Study 3, for example, place was not represented by 'single voice' in the system governance structures, but some of the place partners sat directly on system-based forums representing their own interests. However, there was an expectation as the partnership development progressed, that place-based partnerships would be represented in the system level structures.

In Case Studies 1 and 2 meanwhile, an agreed individual represented 'place voice' in system forums. Case Study 2 was particularly notable for moving towards a formal representation of place as a collective voice. In the place-based partnership studied in Case Study 2 the appointed Place Director represented the shared perspective of place partners within system level governance forums. Potentially, as a result, not all place partners would have direct representation in the main system-scale forums (an exception being if they sat on a group as the holder of a cross cutting interest). In the place-based partnership studied in Case Study 2, for example, the Acute FT was the only NHS Acute Trust not represented directly on the ICS Executive (as other place-based partnerships in the system had elected their Acute Trust lead

as the Place Director). This lack of direct seat on the ICS Executive was not seen as an issue for the Acute FT:

> *'But that's fine by me, because I completely trust him and I know that he will represent our system and therefore my team well and he'll make…whatever decisions he makes, we will back him up. I think they are held to account there fairly robustly. And we're generally quite good at delivery, so it's not usually too much argy-bargy, and we are also financially pretty good partners in the system.'* (Director, Acute NHS FT, Case Study 2)

Additionally, portfolio responsibilities for system and place members were being developed. Place members were sometimes present in system forums due to cross cutting leadership responsibilities rather than to represent their organisations. For example, the community provider CEO attended some system meetings due to his role as transformation lead across the system.

14.5 Conclusion

Our findings suggest place-based partnerships were becoming increasingly formalised in nature. The direction of travel appeared to be towards the adoption of a collective place identity and voice. However, as Case Study 1 illustrates, the development of clear governance arrangements could be significantly delayed where place was contested as partners needed to work towards reaching consensus.

At the time of the field work (January – September 2021) membership of place-based partnerships focused on the main providers of services to the local population, reflecting the focus of activities on the delivery of health and care services. Perceptions varied regarding the latitude of place-based partnerships to make decisions without reference to partners' own boards. To a degree this reflected variations in practice across our case studies, but also suggested a degree of uncertainty among partners as to the decision-making scope allotted to place-based partnerships.

Place-based partnerships did not appear to have established formal arrangements for resolving disagreements, and addressing conflicts of interest. While these aspects of governance might not have been of great significance in these early days of place development, they are likely to become important if place-based partnerships assume more responsibility for decision-making as anticipated in the proposals of the Health and Care Bill.

15 Phase 2 – Place governance in practice

This section, based on phase 2 of the fieldwork which was conducted from January 2021 – September 2021, discusses how decisions were made in practice in place-based partnerships. Interviewees saw the continuous refinement of formal governance arrangements as potentially yielding little benefit, and contrasted this with the informal relational nature of partnership working in practice. Moreover, it was suggested that place-based partnerships were not appropriate forums for dissent and disagreement due to their non-statutory nature and dependence on good will, and this limited the nature of matters discussed in them. Some interviewees had doubts about the sufficiency of the consensus model to address more difficult or contentious issues, and the lack of arrangements to resolve disagreements. In terms of the leadership of 'places', while all partners were perceived to have equal power when it came to decision-making, it was also the case that some partner organisations seemed to take the lead in driving the changes. Conflicts of interest were seen as inherent and pervasive in place-based decision making. Interviewees generally felt though that the benefits of collaborative decision making outweighed the risks of conflicting interests.

15.1 Formalisation of place governance

The analysis of the place governance structures suggested that governance arrangements were becoming increasingly formalised, and subject to a process of ongoing refinement. Interviewees expressed mixed views about the significance of the formalisation of governance.

In both Case Studies 2 and 3, where place governance architecture had been refined to streamline and facilitate the assumption of larger scale decisions in places, interviewees were sceptical about the capacity of such refinement to facilitate co-operation, and saw continuous refinement of governance arrangements as potentially yielding little benefit. Undertakings such as the Alliance agreement in Case Study 2 were described as formal devices overlaying existing collaboration based on relationships, with little significance internally *('it's just a name'* FT Director, Case Study 2). It was noted that the emphasis should be on relationship building through action rather than ongoing refinement of governance (for more on relationships, see section 20):

> *'I can write the most beautiful terms of reference, but if you hate each other, it will make no difference whatsoever. You need to build momentum and partnership by doing stuff, that's what we deliberately focused on in (place), as part of our sort of borough*

development plan, citizen voice, clinical leadership, finance, governance, we know it's on our list to answer …' (NHS Trust Director, Borough-based partnership 2, Case Study 3)

The capacity of governance structures to enable co-operation was understood in light of prior experience of partnership working as an essentially relational undertaking in which formal agreements are non-binding:

'*I think you can easily really get quite led astray on the governance. You can easily spend years and years doing the governance. But I think in reality it's very difficult in governance terms and in NHS contracting terms to force an organisation to do something they don't want to do, and actually in all my years, and I've got many years, actually, in reality I've hardly ever voted on a board, hardly ever had to have a count up of those, and I've hardly ever gone through any sort of legal proceedings on NHS contracts, and actually if the NHS spends loads of money suing each other over contracts again that's not really good practice either. So, you can easily get somebody to try to define a really tidy, perfect binding governance in architectural form, where in reality I think that might be a little bit of a myth. If you try and find a governance form that can strong-arm organisations into doing something, you're probably not going to succeed, and you'll probably waste a lot of time doing it at the moment'* (Place Director, Case Study 2)

On the other hand, however, others experienced governance architecture as significant. Most notably, in Case Study 2 the Mental Health NHS Trust initially declined to sign the Alliance agreement, while remaining a member of the place board itself. There were diverse reasons for this decision including that the Trust felt that its commitment was to the population as a whole on a larger scale than the place footprint, rather than facilitating differentiation of delivery in different places. The implication was that while the Trust was committed to membership of the place, the Alliance agreement would bind the organization to unacceptable commitments which it considered were against its organisational interests and the interests of its patients.

15.2 Nature of decision making in place-based partnerships

As detailed in section 18 'Decisions and activities being undertaken in place-based partnerships', place decisions were somewhat limited in scope by the non-statutory nature of place-based partnerships, with decisions having the status of recommendations to other bodies. In practice, we found that the decisions being made in place-based partnerships were limited.

Some interviewees suggested that places addressed significant issues in an informal and discursive way, rather than approaching them as a decision-making forum. It was observed that in practice, for the kind of issues discussed in place-based partnerships, there were not 'decisions' to be made at a single point in time, but actions were agreed as a result of discussion over extended periods of time, and shaped around the views of organisational members. Additionally, place-based partnerships, due to the informal nature of their working, were not seen as an appropriate place for disagreement and difficult discussions. One interviewee suggested that, instead, these sorts of issues were still resolved bilaterally between the parties directly involved:

> *'When it comes to disagreements, I think the development [place] has got is probably, not that there are a lot of disagreements that we need to design the formal mechanisms to resolve them, but actually it's the willingness of partners to air disagreements in forums that are still informal, collaborative, and not obviously the places where people decide to thrash stuff out. So, disagreements existing is not necessarily something that occurs in those forums I suspect, they're still worked on more bilaterally, to try and prevent them from being aired more.'* (ICS Director, Case Study 3)

A similar chilling effect was also recalled by interviewees in Case Study 2, in relation to reticence to discuss difficult operational issues, particularly at a time when service providers were under a great deal of strain due to the response to COVID-19:

> *'…it's all relationships and trust, you know, and even after all that we've done and all that we've been through together, we're still in a place where if you just don't quite get the tone of your challenge right, then the shutters go up and everybody gets very cross, so…'* (Director, Provider 1, Case Study 2)

An issue in relation to decision making in place-based partnerships was that of organisational sovereignty, meaning that significant decisions or undertakings had to be referred back to the partner organisations' boards. In practice we found that behaviour differed across our case study sites. In Case Study 1, it was reported that many decisions were referred for formal approval from organisational members:

> *'So it's very much been a place to coordinate joint working on programmes of work but then the final decision-making has still needed to go back to the individual organisations.*' (CCG Director, Case Study 1)

Meanwhile in Case Studies 2 and 3 it was reported that very few decisions made by the place-based partnership were referred for formal approval from organisational partners. This difference in the enactment of organisational sovereignty appeared to be attitudinal rather than based in the scale of decisions being made in the place-based partnerships, and reflecting the differing degrees of latitude granted to place-based partnerships by partner organisations. A further view was that place-based partnerships had latitude as long as individual partner organisations were represented at the place-based partnership by senior leaders able to make decisions with budgetary implications on behalf of their organisations:

> *'So it's decision-makers who can make their decisions within their own budget areas, and that's what's important, is that we can asset back our decisions rather than come to a forum where we then don't have the ability to follow them through. And I think that senior representation is important and it's important that each organisation sees the commitment from its senior leaders in the partnership. As soon as everyone starts sending their deputies or the deputy's deputies, it loses traction, it starts to fall apart'*. (CCG Director, Borough-based partnership 2, Case Study 3)

In Case Study 1, the CCG had an important brokering role of mediating to get organisations in places to understand each other's perspectives:

> *'Disagreements, it takes a hell of a lot of work from the CCG to do that at the moment and majority of it is interpersonal relationships about talking to the senior members in each organisation, trying to understand what their problems are, what their worries are around a certain role. Sometimes we've even got to the point of actually getting two different organisations brought into a one to one meeting, mediation in the middle, trying to get them understand each other's perspective. So it's a lot of…it's very intense work that CCGs have to do currently.'* (CCG Chair, Case Study 1)

In the main matters being discussed in place-based partnerships focused on decisions regarding service pathways, with small budgetary implications which could be made by Executives. Examples of matters discussed included the establishment of acute/community outpatient clinics in primary care facilities to provide care closer to patients and the co-ordination of elements of the local COVID-19 response. A detailed analysis of the activities of place-based partnerships is in section 18.

There were doubts about the sufficiency of the consensus model to address more difficult or contentious issues. This was particularly pronounced in Case Study 2 where, due to the local context, there were a number of long-term service provision issues in which organisations' interests were likely to diverge. For example, due to the existence of separate providers of acute and community services, it was likely that the drive to move services into the community would financially disadvantage the acute provider. There were also questions regarding the course of action to be taken when the community services contract, currently provided by a social enterprise who was also a member of the place-based partnership, expired. An interviewee had doubts about the capacity of consensus decision making to sufficiently address issues '*when the difficult decisions come*', and concerns regarding a lack of clarity about how disagreements would be dealt with if/when they did arise. There were some misgivings about the capacity of the Alliance agreement, specifically the consensus model of decision making, to allow difficult decisions to be taken: '*I would have preferred something with a bit more bite in it I suppose*.' (Director, Provider 1, Case Study 2).

However, the consensus model was also popular with members of place-based partnerships who were concerned that otherwise their voice may not be heard, particularly GPs:

> *'So, yes, the ICP board is a partnership, it's not able to impose its will for a sovereign organisation to do something that it doesn't want to do. And I think that was particularly important with having general practice round the table. GPs are sort of smallish independent organisations compared to acute hospital trusts, and therefore they didn't want to feel that by coming into the partnership they were compromising their ability to make their own decisions for their practices. Hence, it's very much a move forward by mutual benefit, not one of, if you come and sit round this table you might have to do things that…you'll be forced to do things that you don't want to do'.* (Director, CCG, Case Study 1)

15.3 Conflicts of interest

Conflicts of interest were seen as inherent and pervasive in place-based partnerships. One view was that conflicts of interest in this environment were inevitable, and individuals needed to be 'grown up' about their role in decision making where they had a conflict. In terms of overcoming conflicts of interest, it was thought that conventional methods of addressing conflicts, most commonly by removing the conflicted party from the decision-making process,

were insufficient as everyone was an interested party with a potential conflict. One interviewee thought that transparency and open working among all partners was the way of dealing with it:

> '*So of course, there are providers who would prefer to provide stuff over the other one, of course there are issues around previous levels of trust and behaviour that we've got to overcome, but I think that's the strength of one of these partnerships, and whether that's an ICS or a borough-based partnership is increasingly having those open conversations. If you're not having those, you're going to struggle'*. (CCG Director, Borough-based partnership 2, Case Study 3)

It was also hoped that the close collaborative environment, peer monitoring of behaviour would guard against abuses of influence, and that the consensus model of decision making would allow objections to be voiced.

15.4 Leadership and power

In all three case studies, interviewees were keen to stress that all partner organisations at place level were of equal power when it came to decision-making. This was evidenced by the preference for unanimous decision-making, as mentioned above. Some partner organisations, however, seemed to take the lead in driving the changes.

One interviewee said that instead of choosing an 'integrated care provider model' they chose an 'integrated care partnership model', which meant that none of the place-based partnership members was 'leader' but they were all working collaboratively. Despite such claims, however, some organisations took the lead in implementing the policy change. In Case Study 1, for example, at least before COVID-19, the place-based partnership formation was led by the CCG:

> *'So from an ICP perspective, it's either an Integrated Care Provider or an Integrated Care Partnership. We are very much going down the partnership route in [place]. I think as time goes by, leaders may well emerge, but I think, like I said, we're very much in our infancy of having a formal ICP structure here. I suppose prior to COVID, I think it's fair to say it's been very much CCG-driven'*. (Director, CCG, Case Study 1)

Another interviewee reported that, during the COVID-19 crisis, the place agenda became 'leaderless' and the acute Trust stepped into the vacuum and became the de facto leader of

place, without any formal process. This may have created some dissatisfaction among some members within place:

> *'Now could I guarantee to you that every stakeholder round the table is happy about that? I don't think so, to be honest. I do detect that particularly some of the PCN leads are a bit kind of who died and made you God kind of thing. But from my organisation's perspective it's like we don't want to step into any of these voids at the moment. So I do understand. I think what you've got in [place] is you've got an acute trust that has got quite a significant power base, a chief executive who is very, very ambitious and bullish and has been there for donkey's years. ...But they are quite a successful organisation, in fairness. So I think there was almost like a sense of some people feeling that they didn't want the acute trust to step in and lead it, but equally who else is going to do that. And I actually think, from what I've observed, they're doing a pretty good job of it, in fairness'*. (Director, Mental Health Trust, Case Study 1)

In Case Study 1, although the place board was formally chaired jointly by the combined acute and community trust and a representative from general practice (i.e. CCG), one interviewee predicted that in future the acute trust (as the main provider of services) would be likely taking the lead.

> *'I think as we move forward, we are anticipating that it will be more of a provider-led partnership and it may be that when we…you know, as we develop, that the sort of lead responsibility is taken more clearly by [the acute] Trust as the main NHS provider in the system. And I think that would probably be accepted by most partners but we've not actually…we've not made that decision yet…*' (Director, CCG, Case Study 1).

Leadership of the place-based partnership in Case Study 2 was formalised through a designated executive lead, who was recruited through an open recruitment process. Equally though it was acknowledged that the backing of the Acute FT had been fundamental to setting the tone for place, and for enabling collaboration. The Director of the FT described a history of trying and failing to merge with or acquire other local organisations when this was the expected behaviour, and where attainment of scale was seen to be the solution to issues of sustainability, in the face of increasing demand and affordability challenges. However, more recently (predating the change of direction in national policy) the Trust adopted collaboration as a formal strategic objective and played a vital role in setting up place.

'We came early to the view that collaboration and working in that way was going to be necessary, and so our sort of place-based journey began …I had a director working for me who was our director of strategy, and essentially I donated her and all of her time to our place to start facilitating and thinking about how we would come together in a different way.' (Director, Acute NHS FT, Case Study 2)

Despite being a key enabler of the collaborative approach in place, the acute FT tried to avoid acting as the leader of place collaboration, including refusing to assume a formal leadership role of place, in the belief that collaboration would be more productive if place explicitly represented the wider partners, and was not seen as synonymous with acute trusts, coupled with the time required to lead a place. However, other interviewees acknowledged that in the future it was expected that a 'lead provider' arrangement would be established at place. The FT Director accepted it would become the lead provider, but did not welcome this due to the possible negative impact it could have on trust and equality among the place members.

The leadership issue was more complicated in Case Study 3 due to the existence of the 'double-layer' place set up, consisting of an intermediate subsystem level (i.e. the upper tier place-based partnership) which lay between the three lower tier borough-based place partnerships and the ICS. At the intermediate subsystem level, it was envisaged that the partnership would have a dispersed leadership with executives of the main partner organisations representing 'a collection of equals' rather than having one designated executive lead of the place. The subsystem partnership was chaired on a rotation basis, with the CEO of the community and mental health trust fulfilling that role during the fieldwork. The chair did not perceive themselves as a leader of the intermediate tier and was keen not to draw attention to the issue of leadership. In addition, there were plans for the intermediate subsystem board to have an independent chair (non-executive, lay member) rooted in public participation: '*We haven't nominated one person as being in charge, except to the extent of chairing the leadership group.'* (Director, Acute Trust, Case Study 3).

On the other hand, in Case Study 3, the borough-based partnerships had different perceptions of leadership. In one borough there was a perception of lack of clear leadership in the current arrangements, as there had been for example when the old CCG was in place. 'I think I was very clear but has become less clear in the last year who the lead of it is probably, as job roles have changed' (NHS Trust Director, Borough-based partnership 1, Case Study 3). Until recently it was clear what the functions of the CCG were, but the new structures had not been

developed at the same rate, and as a result, *'some people are, kind of, scratching around, not being too sure how to be helpful'* (NHS Trust Director, Borough-based partnership 1, Case Study 3).

In other boroughs, leadership was seen as a collective issue: *'Like one of the changes we've tried to make over the last few years is for [the partnership] not to be seen as a kind of something in parallel to everything else that's happening but that it actually is what we're all doing...'* (Borough Director, Borough-based partnership 3, Case Study 3).

At the borough place level, the commissioners were also keen to inject more transparency into the place-based governance structures, for instance by meeting in public and publishing meeting papers, and moving away from 'operational executive-led enterprise model' characterised by a 'fairly small group of executives collaborating and solving problems together', which operated in the intermediate subsystem place partnership.

In general, interviewees were keen to stress the collaborative element and the fact that place-based partnerships were a collection of 'equals' in decision-making power. In reality, the issue was more complicated, with the acute trusts becoming de facto leaders in some places. In other places there was no clear lead organisation and leadership was described as dispersed but also unclear while the new arrangements were being put in place.

15.5 Conclusion

There was a great deal of agreement amongst our interviewees about the experience of decision making in place-based partnerships. At the time of the phase 2 interviews in 2021, place-based partnerships were seen as forums for discussion, and were also not considered the right place to air disagreements. While on one hand there was some scepticism and frustration with the continued refinement of governance arrangements, it was also acknowledged that such arrangements could carry great significance in the future, for instance affecting the capacity of place-based partnerships to address difficult decisions.

Although the consensus approach was valued, the practicality of this approach was questioned by some, in particular in the light of the anticipated future responsibilities of place-based partnerships for decision-making. The consensus approach was perceived to have a chilling effect on the discussion of difficult issues due to concerns about the impact of disagreement on good will. Furthermore, while place-based partnerships were described as a collaboration of

organisations with equal power ('a collection of equals'), some of the partner organisations (usually the acute trusts) were taking on a de facto leading role in the development of the partnership. The acute trusts, however, were reluctant to assume a formal leadership role, because of the time commitment involved but more importantly because they feared the negative impact this would have on maintaining trust and equality among the place members. In one of our case studies, the issue of leadership was more complicated because of the existence of the subsystem partnership. Leadership was described as dispersed, and no designated executive lead had been appointed. The chair of the partnership did not see themselves as 'leader' and were keen not to draw attention to the issue of leadership.

16. Phase 2 - Accountability

At the time of phase 2 of the research in 2021, a number of vertical and horizontal accountabilities were in the process of developing in the new NHS landscape. The broad lines of vertical accountabilities were: 'places' were accountable to ICSs and ICSs were accountable to NHSEI. Increasingly, the relationship between NHSEI and individual providers was being co-ordinated on a system footprint rather than as a one-to-one relationship. At the same time, ICSs, 'places', PCNs, provider collaboratives, which are themselves partnerships of different organisations, were starting to develop mutual or horizontal accountabilities. The two types of accountability were summarised by one place interviewee: *'...we establish our governance structure overseen by the ICS. They hold a performance monitoring function, as we do at a place level, as well. They hold us to account, but we hold ourselves to account'* (Director, Acute Trust, Case Study 1). This section examines the main issues relating to the network of vertical and horizontal accountabilities which emerged during this phase of the fieldwork in 2021.

16.1 Accountability between NHSEI and systems

Interviewees in all our case studies reported that the main functions of the regional branches of NHSEI were to provide oversight and support and guide the development of the ICSs. NHSEI representatives were not normally involved in the development of 'places', which was a responsibility of the ICSs. Regional offices of NHSEI were involved in providing assurance for the development of the strategy of each ICS but they were not involved directly in the specifics of the design of the place structures. Nevertheless, to understand the accountabilities of places it is necessary to analyse the accountabilities of the ICSs above them

In their role as supporting and overseeing the development of ICSs, the regional branches of NHSEI followed a range of approaches, from 'hands off' to more close monitoring of progress. The oversight and development functions were performed by a range of regular meetings between NHSEI and ICS leads. In Case Study 1, for example, the regional authority had regular (i.e. quarterly) meetings with each of the ICSs. The purpose of these meetings was to track progress related to the development of ICSs. These meetings, however, were not regarded as 'performance management' meetings:

> *'We have a transition stock take once a quarter, so once a quarter we sit down and it's a multidisciplinary team from NHS England and Improvement with the ICS*

development director, transition lead with each system and we run through progress that they have made as a system around their system development in the previous quarter, where they are currently, what support they might need. Certainly from our perspective looking in, any aspects where we think their development might require additional focus and support, but it is certainly not a performance management meeting, it's another mechanism by which we're getting alongside the system but we're doing that across the whole sort of matrix of directorates within the regional team.' (Director, Regional NHSEI, Case Study 1)

In Case Study 2, the NHSEI regional function had also evolved to an approach that went beyond mere support of ICSs to one of co-production. The approach was characterised as a 'one team' approach, in which the regional team worked alongside ICS leaders. The regional NHSEI role was described as looking at the 'how' of national policy developments within systems (the 'what' was set by NHSEI nationally). The ICS leaders were seen as joint decision-making partners, and this was recognised through a formal seat at regional NHSEI governance forums.

'And they now, the ICS leaders, now sit around the regional executive, they have done for about 18 months or so. So, we take decisions that affect the region together and we do our work together.' (Director, Regional NHSEI, Case Study 2)

A key role of regional NHSEI branches was to ensure that national priorities and objectives were delivered consistently across ICSs. In Case Study 2, around 20% of regional NHSEI activities were performed consistently across ICSs. The main activity cited was the national planning process that was regionally enacted, and concerned discharging the same set of national objectives within the resource portfolio of each system. Regional NHSEI Directors and teams were agreeing annually roles, responsibilities, frameworks and priorities for action with ICS leads and chairs. Progress was checked quarterly, trying to tailor support for mature systems and for newly authorised systems.

Apart from their role in providing support for the development of ICSs, regional NHSEI branches had an oversight function, similar to the traditional performance management role within the NHS hierarchy. In addition, therefore, to the quarterly meetings for the developmental work of ICSs, the regional teams held quarterly meetings with each ICS with an oversight focus:

> *'In addition to that, we have with our oversight hat on, we also have a quarterly oversight meeting, an interaction with each system which is executive level, and we in that session look at the delivery, performance, quality, finance of that system and the organisations within that system once a quarter. So that will continue but it will evolve because it'll have to evolve for the new arrangements come April 1'.* (Director, Regional NHSEI, Case Study 1)

A key priority of the regional teams' oversight role was to make sure that systems had in place appropriate mechanisms for resource allocation among the system partners and financial risk management:

> *'As part of our finance development and the finance oversight as it's emerging, it is about us working with systems to ensure that they've got good system financial governance, system financial risk management arrangements, and that there's a mechanism in place by which the system can work together regarding the allocation and best use of resources'.* (Director, Regional NHSEI, Case Study 1)

In Case Study 2 the oversight function was seen as a collaborative process with each ICS. The regional NHSEI was conceptualised as the portfolio holder for performance, quality, finance, system development, service re-configuration, with action-taking jointly with ICS leads to address the objectives.

> *'So, how I'd, kind of, conceptualise is, you know, in the regional executive role we're now a portfolio holder for a specific set of responsibilities that need to be discharged regionally and nationally. You know, performance, quality, finance, system development, service re-configuration. But we discharge those objectives with what I would, kind of, call a geographical director of our regional executive team. And that geographical director is the ICS lead, so all of us as functional directors, you know, with a portfolio of things to do can get along fine, each of the ICS leads make sure that, together, we're doing those things well. So, it's a shared objective around recovery from COVID, it's a shared objective around financial sustainability or operation and performance improving, or quality improvement'.*(Director, Regional NHSEI, Case Study 2)

The Case Study 2 regional NHSEI team adopted a 'hands off' approach to ICSs, which was illustrated by their approach to ICSs governance arrangements. The expectations regarding ICSs governance structures were described as '*de minimus'* (a legal term meaning too small to

be meaningful or taken into consideration; immaterial), and reflected broad guidelines or best practice principles, such as that there should be a lead with enough time for the job and a mandate from the system. Most ICSs undertook an annual refresh of governance to keep it 'contemporary and fit for purpose'. This was not a requirement because it was expected that ICSs would be mature enough to choose to do this of their own accord, and/or it would be a product of the informal co-production relationship between NHSEI and ICS leaders.

The regional NHSEI team in relation to Case Study 3, however, adopted a more rigorous and 'hands on' approach when it came to performance monitoring of ICSs. The performance monitoring and assurance function between the regional NHSEI and ICSs was discharged through bilateral formal monthly meetings, held with each ICS in the region and supported by development sessions with ICSs. The national 'system oversight framework' (which assigned each system and provider a score from one to four, with category four leading to escalation and improvement measures)[8], was supplemented with informal weekly meetings between the leaders of regional NHSEI and chief executives of providers and ICSs/CCGs. The latter meetings were about 'sense making and setting direction' and identifying priorities. As in the other two case studies, the regional authority's relationship with providers was mediated by the ICSs:

> *'Now in terms of the relationship that I have directly with the providers, I'm very clear that the core relationship is between the ICS and its providers, not with me, yeah? (...) So I don't meet with the chief executive of the trust without the ICS SROs being in the room because I think to do so would be undermining'.* (Director, Regional NHSEI, Case Study 3)

The future vertical provider accountabilities will run through the ICSs, which was described as requiring *'a huge cultural shift'* (Director, Regional NHSEI, Case Study 3).

The relationship between regional NHSEI teams and 'places' tended to be mediated by the ICSs to which 'places' belonged. The NHSEI regional approach in Case Study2, for example, was to 'retreat' from place, to allow that space to be filled by the ICS/place relationship. This hands-off approach was an approach taken with the most mature systems in the region through a process of earned autonomy, when systems were judged '*obviously on top of their issues'* and there was a '*high degree of confidence in their leadership and ability to sort issues that*

[8] B0693-nhs-system-oversight-framework-2021-22.pdf (england.nhs.uk)

need to be sorted.' (Director, Regional NHSEI, Case Study 2). For the most mature systems, the approach was described as 'embedded but arm's length'. In these cases, contact was maintained through NHSEI attendance at system 'self-assurance meetings. The NHSEI representative attending system assurance meetings was described as having a 'hybrid' role: not present at meetings in a formal capacity, but not simply an observer either. They would intervene to 'add value' to the conversation, and problem solve:

> *'But the decision is still a local decision, you know what I mean? So, we might provide advice, might just do some intelligence, might share with them an expectation around the regional team's view of it. But, you know, this is very much around trying to get them to take the right decisions'.* (Director, Regional NHSEI, Case Study 2)

However, this approach differed across ICSs, and the regional team had intervened to get some places 'to follow the direction of travel'. Still, any intervention was via the ICSs rather than directly with places. Examples of cases where they had intervened were to support system leaders to get places to adhere to national policy, and where there were performance, delivery or sustainability issues with providers.

> *'But, you know, very much the culture we're trying to foster is, we want the ICSs to be hand in glove with their places and, you know, improving the lot for those individuals within their geography. And, you know, they draw down support from us in order to deal with some of the issues that they need dealt with'.* (Director, Regional NHSEI, Case Study 2)

The approach to individual providers was also through the system architecture rather than direct contact with providers. The approach was summarised as, *'it's there for NHSEI to directly intervene unilaterally with a provider, we're more likely to have the conversation through the established governance forums in a system, where they are participant*', supporting system leaders when they lacked 'tools in the box' due to lack of regulatory relationships. Whilst ICS did not have regulatory tools the view was that they still could bring influence to bear:

> *'No, they can do an awful lot, I think, as the commissioner of the service, you know, so that's why bringing commissioning and ICS together has been an important bit of the journey, because they're the resource allocator with a set of expectations to their providers, albeit, doing it in a collaborate methodology now as opposed to a market based one. But, absolutely, there will still be instances where, you know, whoever phones me up and says, I've got a problem with this provider, can we do that together?*

Because, as you say, the powers will always be reserved in that regard'. (Director, Regional NHSEI, Case Study 2)

In general, the regional NHSEI interviewees reflected that they had a large discretion in their relationships with the ICSs within the confines of the national policies and legal frameworks and described their relationships with ICSs as *'iterative' (Director, Regional NHSEI, Case Study 3).* The end state of these relationships was envisaged as one in which the regional teams would cede more and more functions and responsibilities to ICSs, to the point that they '*become load bearing into statutory entities which have the ability to drive a financially sustainable and self-improving healthcare system*.' (Director, Regional NHSEI, Case Study 3).

In the NHS quasi-market, one of the key mechanisms of holding providers to account was the contractual relationships between commissioners and providers. In the new architecture, the relationship between regional NHSEI and providers was being increasingly co-ordinated on a system footprint rather than as a one-to-one relationship. One NHSEI interviewee indicated that the usual bilateral bargaining which forms part of the contractual process, was suspended and replaced with an expectation that any disputes would be resolved locally within the ICS rather than being escalated up the NHS hierarchy. The interviewee added, however, that it was still there to support ICSs in cases of disputes:

'If somebody came to me to say they can't resolve a contractual dispute I would ask them to go away. Because their jobs are to sort that out. Now of course what we do is of course we end up getting involved in...if you leave the word contractual to one side, do we get involved in disputes? The answer is, of course we do. One of the jobs that we have here is in the nicest possible sense of the word and in a constructive sense is occasionally to knock a few heads together. But by and large people will sort themselves out. I do think it's a little bit disappointing if the region has to get involved'. (Director, Regional NHSEI, Case Study 3)

One of the reasons for which the usual mechanisms of contractual accountability were not applied was COVID-19:

'Normally, there are contractual relationships, accountability of providers to commissioners is through the NHS contract. But during COVID, we've not had the contract in place in the way we previously did between CCGs and the hospital providers. And therefore those usual accountability arrangements from a contractual perspective haven't been in place'. (Director, CCG, Case Study 1)

It was not clear whether and how the contract would continue to be used in the future architecture of systems as a mechanism of holding providers to account.

16.2 Accountability between 'places' and systems

At the time of the phase 2 fieldwork in 2021, work on developing the assurance relationships between place and 'system' was ongoing. 'Places' were developing with support directly from systems and indirectly the regional NHSEI teams. As explained in the previous section, NHSEI regional teams worked with systems to ensure that their 'places' developed appropriate structures which complied with national guidance. According to one interviewee, organisations within place-based partnerships (like in systems) were accountable to each other (horizontal accountability) and, in turn, 'places' were accountable for functions to the system and through the system to the NHSEI regional team (vertical accountability).

> *'Holding to account, I see it as holding to account all the organisations, holding each other to account, so that needs to happen at place as well as at system. Because from the system level it's about holding the whole of [place] to account'. (*CCG Chair, Case Study 1)

In Case Study 3, the issue of vertical accountabilities of place to system were complicated by the 'double-layer' place set up, exemplified by the presence of the intermediate subsystem level (i.e. the upper tier place-based partnership) which lay between the three lower tier borough-based place partnerships and the ICS. There was an acknowledgement that the creation of the subsystem layer extended the hierarchical chains which impacted on decision making, resource allocation and performance monitoring:

> *'Almost the inevitable tension when you form another layer that does hold some accountability and therefore has got a bit of a whip-cracking role, there is inevitably some resentment from those who operate on the smaller footprints.'* (CCG Director, Case Study 3)

A key question for ICS and place members was what mechanisms of performance management and monitoring had to be devised, to ensure that 'places' would be accountable to ICSs for achieving agreed targets and goals. In contrast to ICSs, which from 1 July 2022 were scheduled to become statutory bodies, other collaboratives such as 'places', PCNs, or 'provider collaboratives', were not destined to be statutory bodies. At the time of the research, it was unclear how and by whom these various collaboratives would be held to account. There was

uncertainty, for example, about whether and how ICSs would be able to hold their constituent collaboratives to account, since these collaboratives would not be statutory bodies. One interviewee described the problem in relation to PCNs: '*I'm not sure how [they will be held to account] because PCNs are not an organisation per se, we're not a registered organisation, I don't know how you can hold a collaborative to account'*. (Clinical lead, PCN, Case Study 1).

Another interviewee mentioned that, going forward, discussions at system level were focusing on the possibility of holding place to account by measuring health outcomes rather than performance targets: *'we want to move towards accountability for delivering outcomes, rather than a sort of traditional performance management type approach'. (Director, CCG, Case Study 1)*. In future, mechanisms of holding 'places' to account could be a mixture of performance monitoring of national indicators, and also performance monitoring of a number of locally agreed system and place level outcomes frameworks, although it was not clear whether any financial reward would be attached to achieving the locally agreed outcome priorities:

> *'We do now have a system level outcomes framework that's been agreed. And within that, we have a place level outcomes framework which is aligned to it. Within the workstreams I mentioned that the place-based partnership has, we're currently developing the detail of what the outcome priorities are for each of the workstreams. And so as we go into next year, when I think we'll formalise some of this into contracts...we will also have locally developed outcome priorities, some of which will be owned and delivered through the place-based teams, some of which will sit with the system level…I don't know to what extent we will look to attach financial values to the outcomes, or whether we'll simply make them priorities because they're the things that, as a group of providers, or as a system, we're focusing our efforts on'.* (Director, CCG, Case Study 1).

In the quasi-market regime, one mechanism of holding providers to account was for commissioners to impose penalties on providers for non-performance of agreed targets. In light of the new regulatory framework, in which whole systems rather than individual providers will be accountable for spending their annual allocated funds, using financial sanctions for non-performance of agreed goals would not make sense. Instead of imposing financial sanctions, a collaborative decision would need to be taken about how to address the problem:

> *'We'll be needing to manage our finances as a system. So in that sort of context, sort of having old style fines between commissioners and providers doesn't change the system's financial position. So as I say, I think the focus will very much be on making sure that where commitments have been made or where we're not meeting a key target or standard, that the action is being taken to address that, rather than it principally being a financial conversation'.* (Director, CCG, Case Study 1)

The development of monitoring of place performance was viewed with some trepidation by some, and a task that needed system support but also protection from too many 'distracting' targets imposed from higher up in the NHS hierarchy:

> *'So I think it is really important and it's a challenge and I'm not sure entirely how we're going to do it but it's something that we need to look at very carefully. So what is it that we wanted our outcomes to be? And how do we measure that we've got those, to keep the quality right? And that might be different from what we're being asked to do. So I think the system there needs to be able to help with that. So I think there's a two-way thing. We're answerable for what we're doing, and we need to give back the right data and show that what we're doing absolutely is safe and it's got quality and we're improving. But then the system needs to help protect us from potentially getting too much stuff down because NHSE, you get an awful lot of stuff coming down which is distracting, it's not helpful, it doesn't actually lead you to better quality in outcomes. It's just a function that gets done and it becomes a role in its own right. So I think that's where the system needs to help with those balances'.* (Director, GP Federation, Case Study 2)

In Case Study 3, the partner organisations were also acknowledging that an accountability framework between system and borough level 'places' did not exist yet at the time of the fieldwork. The only existing relationships of accountability linked the intermediate subsystem level (i.e. the upper tier place-based partnership) and the system level structures. Plans to establish vertical accountabilities from borough-based partnerships to subsystem and system were disrupted by the COVID-19 pandemic, but later (i.e. Spring 2021) new ideas in terms of the way accountabilities could be set up in the system had resurfaced, for instance foreseeing a role for 'provider collaboratives' to hold some accountability for performance. It was not clear, however, whether such ideas would be supported by the rest of the system or borough partners.

'From a [subsystem] point of view, we would be holding the boroughs accountable for performance, and so on, in the boroughs. And then, I think it would be me being held accountable for what's happening across [the subsystem] as a whole. And then, you know, that goes to ICS, doesn't it, and then that goes upwards to NHSE. I would hope that the end architecture, for the provider collaboratives to hold most of that, to be quite honest with you. And then, I would see us round the ICS table, and then we need to go to NHSE and be accountable for what's happening, I would suggest, I would think, is the simplest way to do it. Whether that's how it turns out or not, I don't know.' (Director, Mental Health Trust, Case Study 3)

The links between the intermediate subsystem-based partnership and the ICS were described as 'agile' and 'relational' rather than based on any formal processes or governance structures (Director, Acute Trust, Case Study 3). The same set of organisations to a large extent worked at different scales of ICS – system, subsystem and borough-based partnerships.

Some interviewees strongly objected to the insinuation that the relationship between ICSs and 'places'/PCNs/provider collaboratives was a hierarchical relationship. Instead, the relationship was articulated more as a 'mutual accountability'. In Case Study 2, an ICS 'architect' had been employed to draw up a full list of lines of delegation and accountability at system level. Work to take this forward had been significant and was ongoing. The vision steering this refinement was to create a governance structure which reflected the situation that the ICS was the sum of its parts (places), rather than suggesting a hierarchical relationship between system and place:

'So we should end up with having hopefully one ICS level decision making forum that probably brings the CCG's governing body and the ICS decision making together in some way. A single forum for the assurance activities around quality and finance and other forms of legal reporting. And then translating that down. So with us as local systems coming up to be part of those things. We're trying to move away from having a separate ICS and separate places, and having the ICS as the sum of its parts, which is what it should be'. (Place director, Case Study 2)

'But 'places' are the system, I mean, that's what I really struggle with is, kind of, this continuing playout narrative of different levels. The ICS is the amalgamation of everybody, you know, the PCNs, and the 'places', and everybody, it is the ICS. So, this real…I still struggle with this and because within the NHS we enjoy hierarchies, we

like to do…right we've got neighbourhood, we've got place, and then we've got system. Actually, everybody is the system'. (ICS Director 2, Case Study 2)

It was reported that a broad view was accepted that place was 'prime', as this *'is where care and communities are and care and therapy and support is delivered'* (Director, Acute NHS FT, Case Study 2). The anticipated direction of travel for the future was that places would make all the operational decisions about the provision of local services: '*Places will make all the decisions about the services, how the services are delivered, how you might want the pathway to work, who might sit where, all the real, sort of, all the real operational bits are going to sit within Place.'* (ICS Director 2, Case Study 2).

In Case Study 3, the system was in the process of designing a 'mutual accountability framework'. Some commissioners were keen to preserve 'grit in the system' to ensure that accountabilities were not blurred between different system members and that there was clarity about who was accountable for what and avoid the situation where *'everyone becomes accountable for everything'* (CCG Director, Case Study 3). The commissioners were designing a framework whereby borough-based partnerships would be accountable to the intermediate subsystem-based partnership for the transformation programmes that the boroughs were leading on, accompanied by milestones and metrics. The newly appointed borough directors would be accountable to the subsystem-based partnership for achievement of these indicators and for the borough's overall performance. At the same time the commissioners were keen to develop a model of 'reverse accountability' or two-way accountability to ensure that the subsystem-based partnership supported the boroughs with adequate resources to achieve their goals and that borough-based partnerships had some mechanisms and frameworks to also hold the subsystem level to account. This mutual accountability principle was meant to also extend upwards to guiding a relationship between the subsystem-based partnership and the system. In this, as in the rest of our case studies, however, it was not clear what levers or mechanisms were available to ensure that the various parts within systems would be accountable for failure to deliver agreed goals.

16.3 Horizontal accountabilities

The new architecture of ICSs contained a range of horizontal accountabilities, which were seen as difficult to achieve. Systems contained a number of independent organisations (e.g. primary and secondary care providers) and collaboratives ('places', PCNs, provider collaboratives). In the quasi-market, statutory organisations were held to account via the traditional channels of

the NHS hierarchy (e.g. NHSEI, the quality regulator, commissioners of care provision). As already mentioned, going forward, non-statutory collaboratives could be difficult to hold to account. Tensions might arise within the complex network of vertical and horizontal accountabilities in each ICS footprint. Since individual providers maintained their independent status, tensions could also arise when their organisational statutory obligations were in conflict with system obligations. In such cases, as described in relation to phase 1 of this research, and in section 15 (Place governance in practice) it was not clear whether internal organisational accountabilities would trump external accountabilities to place or system partners.

In Case Study 2, for example, the acute FT Director reported that system partners were still experiencing tensions between 'best for organisation' and 'best for system' decisions. The Director gave an example of repercussions of national changes to capital development limits, which reduced the allocation to systems mid-year. The solution that potential conflicts between organisational and system obligations were dealt with through documentation of the risks and similar mitigations, was described as highly unsatisfactory.

> *'So then you get into a conversation, well, maybe there's horse trading to be done in the system, which is I expect what the centre thinks, they think, well, they will just have to agree across the system to cut their cloth if you like. So maybe if my, you know, could be an example where my operating theatres are more important than, I don't know…X Hospital needs a new roof which is more important than my theatres because the rain gets in on the patients. Again, so I think this is what the centre thinks will happen, is that we would all get in a room and say, well, you're completely right, we must fix the roof at X Hospital, great, and that probably would be the right thing. However, my Board is still responsible and accountable for delivering health and wellbeing for their staff, all those measures…So this is the difficulty…by not changing I think the basis of the structural arrangements for Trust…so as executive directors we'd all be in danger. Now, you'll be supported I'm sure by documentary evidence of a conversation that the ICS said, we recognise this risk, we've documented the risk, yes, we understand, dah, dah, dah. I don't know, I mean, if a woman in my organisation dies of some hideous infection after she's had her section, I wonder who's going to be in the coroner's court explaining why we let her be operated on in an operating theatre that I knew wasn't meeting the standard. It's really tricky, isn't it?'* (Director, Acute NHS FT, Case Study 2)

Another difficulty was determining at which level in the new architecture the accountabilities lay. There was not always uniform agreement about which level should be responsible for what. An example was the Mental Health Trust in Case Study 2, which as discussed in section 15 (Place governance in practice) above reported that they had not signed the place-based partnership Alliance agreement due to Board accountabilities to the entire population which might run counter to the establishment of the Alliance agreement:

> *'But in principle, the Board considered it and kind of said, this is a really important piece of work, we agree we work better together locally, and we don't want to lose that, but we're not going to sign up to the Alliance, because we want to look at the health of the population, in accordance with the Mental Health Long Term Plan. And that sits more at system, than at place'.*(Director, Mental Health FT, Case Study 2)

For the Mental Health Trust in Case Study 2, accountability for the delivery of the Mental Health Long Term Plan sat with ICSs (for some targets) and the MH Trust itself, and from this perspective place was rather redundant. Given that the Trust operated across multiple 'places' it felt itself unable to commit to making decisions without going back to the Executive Board of the organization itself. However, the Trust also felt that this should not interfere with place-based partnership working. It was just the reality of organisational boundaries against the various levels of health care integration.

Interestingly, in Case Study 3 the main acute provider (an NHS Trust) mentioned that recently they had not been vertically performance managed as an individual organisation by anyone 'other than our own board'. They maintained that as a 'mature' organisation they were able to 'self-govern and self-regulate' by leaving the special measures regime for quality and finances.

> *'We haven't had a consistent oversight or accountability arrangement beyond the Trust for some years, and it hasn't done us a great deal of harm.'* (Director, Acute NHS Trust, Case Study 3)

In at least two of our case studies (Case Studies 2 and 3), towards the end of the fieldwork, whilst the within system performance monitoring and holding to account was formally rooted in the CCG level structures until their planned dissolution in July 2022, the holding to account was beginning to shift from a bilateral basis 'between the CCG and a single provider' to involvement of the place-based structures (ICS Director, Case Study 3).

A variety of views about horizontal accountabilities of place members to each other for the delivery of services were expressed by interviewees. In Case Study 2, horizontal accountabilities were described as '*underdeveloped'* (Director, Provider 1, Case Study 2), *'possibly a bit too polite'* and perhaps lacking in *'challenge'* (Director, Provider 2, Case Study 2). However, it was also felt that horizontal accountability was developing between place members to the point where there was a shared responsibility for key areas, particularly with the development of formal leadership across organisations of particular themes such as quality and governance:

> *'What we're now doing [in place], is actually to kind of then say, actually, how do we come together more effectively? How do we maybe use cross fertilization, how do we challenge why's something done in the acute, when it could be done in the community, and vice versa? A much greater linking in there, with both districts and boroughs and County Council. So, it's more taken a collective responsibility and what we're now trying to do, under [the place Director's] leadership, we're now also then saying that there'll be certain key areas where somebody from one of the providers would take a leadership role on behalf of everybody'.* (Director, Community provider, Case Study 2)

Similarly, in Case Study 3, some interviewees admitted that the frameworks for horizontal accountabilities had not yet been worked out. Clarifying lines of horizontal (and vertical) accountabilities in this case study, would depend on the development of borough-based partnerships and/or provider collaboratives. In particular, the provider collaboratives were posited by some as the vehicles which could potentially hold both vertical accountabilities into the ICS and horizontal accountabilities among different organisations. The considerable overlap in terms of organisational and even individual membership of these different entities was cited as a potential facilitating factor in establishing accountability relationships. There was also a lot of faith expressed that mutual horizontal accountabilities would emerge or were emerging between partners. The importance of the issue of leadership was stressed in this case study too.

> *'I think, in the end, quite a lot of this will come down more to a leadership question, than a governance question. Because even now when I say that, provider collaboratives relating into the ICS, the provider collaboratives are in the ICS. I mean, you know, at*

some level, you're talking to yourself, or your organisation is talking to itself'. (Director, Mental Health Trust, Case Study 3)

Horizontal accountabilities were starting to be built and realised through transparent giving account of one's performance to the other system partners during regular meetings, for instance on achieving the elective recovery plan. Not meeting some of the targets could have consequences for the whole system and lead to escalation to the higher levels of the NHS hierarchy. But the lines between maintaining mutual accountabilities and the need for intervention were still quite blurred:

> *'So in that context we are all getting together to look at each other's elective activity levels, and if someone's not doing what they should be, then that becomes mutual accountability… If someone doesn't do what they should be for months and months and years and years, then I think that's when the system has to say, there's a problem here and it needs intervention beyond us all sitting round as partners and explaining why we haven't achieved it this week. So I think that's what I mean by it…what the system hasn't yet sort of described is how does that relationship between mutual accountability and partnership or formal accountability and intervention work'.* (Director, Acute NHS Trust , Case Study 3)

In all our case studies, at the end of the fieldwork, the collective holding to account both at the place and system level was performed in a 'soft' way 'through trust and belief in a common aim' rather than a formalised or codified way (Director, ICS, Case Study 3):

> *'The place-based partnerships I'm familiar with, they do talk about performance and operational issues, and where things are not going brilliantly, then I suppose it's a form of collective supportive accountability that the place-based partnerships try and solve those problems together(…)*
>
> *And then, I suppose again, the analogy at the system level is the gold command. I mean lots of major issues coming up there, but the mentality that says they are solved collectively and that's solutions and problem solving, but that is a form of accountability, I presume, in some ways*.' (Director, ICS, Case Study 3).

16.4 Public engagement

In all our case studies, accountability of the place partnerships and individual NHS organisations to the public was generally weak and underdeveloped. Some respondents foresaw

an opportunity to strengthen public accountability through the involvement of local authorities in the formation processes of ICSs. The foundation trusts had their own processes for maintaining some accountability to the public through their constitutions and council of governors. Thus the lines of accountability to the public were clearer for local authorities and foundation trusts but very fuzzy for place-based partnerships and provider collaboratives.

At place level, there wasn't yet an established model of public engagement. The main vehicle for public involvement was via having Healthwatch as member (although non-voting) of the place-based partnership board.

> *'We have engaged with the general public when we set up the ICP and actually talked to them about what their requirements are and that this kind of work is happening. We've had positive feedback from most people. We've got Healthwatch on the board at the ICP, who also work very closely with us, nonvoting but they're also part of the [place] governing body on the nonvoting position. They provide us that independent view form patients and public, and I think that's really been helpful in getting that perspective'.* (CCG Chair, Case Study 1)

Another route to public engagement was via existing patient participation groups and also by involving patients in particular programme areas (e.g. cancer, MSK services).

A PCN representative agreed that structures for involving the public in the workings of place were absent, but he expressed the view that public engagement would be more successful if the process of public membership was rationalised:

> *'We have obviously Healthwatch as a representative on the ICP but we're not formally involving the public as yet. I think we're very much in the process of setting the organisation up and agreeing the governance of the organisation and then there will potentially be some public engagement or involvement. We have to be careful because again, the same members of public are already doing practice PPG, Healthwatch, ICS lay representation, ICP lay representation. It's just trying to find the right voices'.* (Clinical lead, PCN, Case Study 1)

In Case Study 2, membership of Healthwatch on the place-based partnership board was under discussion, as was the use of patient stories. Another idea was for place to feed directly into the work of the Borough Council, which had a direct democratic accountability:

> *'In fact we're…just about to start a new Resident Engagement Programme, and I've had an initial conversation with the director of the ICP about how health could be engaged in that conversation. So something that needs work, I think'.* (Director, Borough Council 2, Case Study 2)

Similarly, in Case Study 1, discussions focused on sharing public involvement processes with the local authority:

> *'We're getting to a point now, where we've got shared groups. So, you know, you've got your Healthwatches, and you've got your Patient Participation Groups, and PCNs and things. But, from a local authority point of view, you've got things like PACT, People and Communities Together, everybody's got to have one, and we've started to talk about combining the two, wouldn't that be great?'* (Director, Local Authority, Case Study 1).

There were also suggestions to put in place a 'public engagement group' that would be separate from the formal structures of place but would act in an advisory role to place:

> *'So we are doing a lot of engagement with patients on individual subject areas. But we're looking to put in place a structure whereby we have a patient group that sits alongside the other structures that can support them in ensuring that in the work that we're doing we're effectively engaging patients and the public'.* (Director, CCG, Case Study 1).

The main function of this 'public engagement advisory group' would be to ensure that place remained accountable to the public by providing an oversight on '*how effectively our approach to engagement is working and have some input into that'*. As well as providing advice about particular pieces of engagement, this group would be the forum to discuss the place approach to the process of engagement (Director, CCG, Case Study 1).

Case Study 3 was also involved in a number of initiatives to strengthen public involvement, such as citizens' panels, engagement through Healthwatch and public engagement work at the borough level. However, visibility to the public of the ongoing work of the collaborative partnerships and hence public accountability remained low.

In general, public engagement was seen as an area still to be developed at place level. In Case Study 2, it was reported that a significant amount of public engagement was conducted at a

system rather than at place level. However, this was seen as a shortcoming, partly because it was an area that had fallen by the wayside due to the impact of COVID-19.

16.5 Conclusion

In their role as supporting and overseeing the development of ICSs, the regional branches of NHSEI followed a range of approaches, from 'hands off' to more close monitoring of progress. This was achieved via a range of meetings, from quarterly meetings for the developmental work of ICSs, to bilateral quarterly meetings with an oversight focus. A key priority of the oversight role was to make sure that systems had in place appropriate mechanisms for resource allocation and financial risk management.

The relationship between regional NHSEI teams and 'places' tended to be mediated by the ICSs to which 'places' belonged. The approach to individual providers was also increasingly through the system architecture rather than direct contact with providers. Examples of cases of intervention were to support system leaders in getting 'places' to adhere to national policy, and where there were performance, delivery or sustainability issues with providers.

In general, the regional NHSEI interviewees reflected that they had a large discretion in their relationships with ICSs, and described the relationships as 'iterative'. The end state of these relationships was envisaged to be one in which the regional teams would cede more and more functions and responsibilities to ICSs, to the point that they become financially sustainable and self-improving healthcare systems. The expectation was that any disputes would be resolved locally within ICSs, rather than being escalated up the NHS hierarchy. It was not yet clear whether and how contracts would continue to be used by systems as a mechanism of holding providers to account.

'Places' were developing with support from systems and the regional NHSEI teams. The development of the assurance relationships between places and systems was ongoing. Organisations within place-based partnerships were accountable to each other (horizontal accountability) and, in turn, 'places' were accountable for delivering their functions to the system and through the system to the regional NHSEI (vertical accountability).

Horizontal accountabilities were starting to be realised through transparent giving account of one's performance to the other members of partnerships during regular meetings, for instance on achieving the elective recovery plan. Not meeting some of the targets could have

consequences for the whole system and lead to escalation to the higher levels of the NHS hierarchy.

Some interviewees strongly objected to the insinuation that the relationship between ICSs and 'places'/PCNs/provider collaboratives was a hierarchical relationship. Instead, the relationship was articulated more as a 'mutual accountability'. At the end of the fieldwork, the collective holding to account both at the place and system level was performed in a 'soft' way 'through trust and belief in a common aim' rather than a formalised or codified way.

Horizontal accountabilities were described as 'underdeveloped' or 'possibly a bit too polite' and perhaps 'lacking in challenge'. However, it was also felt that horizontal accountability was developing among place members to the point where there was a shared responsibility for key areas, particularly with the development of formal leadership across organisations of particular themes, such as quality and governance.

In contrast to ICSs, other collaboratives in the new NHS architecture, such as 'places', PCNs, or 'provider collaboratives', were not destined to be statutory bodies. At the time of the research, it was unclear how and by whom these various collaboratives will be held to account. In future, tensions may rise within the complex network of vertical and horizontal accountabilities in each ICS footprint. For example, since individual providers will keep their independent status, tensions could arise when their organisational statutory obligations are in conflict with system obligations. In such cases, it is not clear whether internal organisational accountabilities would trump external accountabilities to place or system partners.

In the quasi-market regime, one mechanism of holding providers to account was for commissioners to impose penalties on providers for non-performance of agreed targets. In light of the new regulatory framework, in which whole systems rather than individual providers will be accountable for spending their annual allocated funds, using financial sanctions for non-performance of agreed goals would not make sense.

In all our case studies, accountability of the place-based partnerships and individual NHS organisations to the public was generally weak and underdeveloped. At place level, there was not yet an established model of public engagement. The main vehicle for public involvement was via having Healthwatch as members of place-based partnership boards. Discussions focused increasingly on sharing public involvement processes with existing ones in local authorities. A view was also expressed that public engagement would be more successful if the process of public membership was rationalised.

The above presentation shows that the complex relationships of vertical and horizontal accountabilities in the new NHS architecture were at a very initial and underdeveloped stage. This is hardly surprising, since the fieldwork took place in a period of structural transition. Delays in putting in place appropriate or formal frameworks of accountability across the various levels of the architecture were also due to the intervention of the COVID-19 pandemic. We also saw, however, that some case studies were making progress in adopting more collective forms of mutual accountabilities instead of the more traditional performance management type of accountability between commissioners and individual providers. The question is how well those new lines of accountabilities, especially the horizontal ones, will work in practice.

17. Phase 2 - Apportioning functions and decisions between system and place scales

The principle of subsidiarity is central to ICSs, suggesting that ICSs should facilitate decisions being taken as close to local communities as possible, and at a larger scale in cases where there are clear benefits from collaborative approaches and economies of scale. Therefore, the apportionment of functions and decision making between place and system scale is a key issue to be agreed by system members.

If the Health and Care Bill is passed, Integrated Care Boards (ICBs) will take on the commissioning functions and duties of clinical commissioning groups (CCGs), along with all CCG assets and liabilities, including their commissioning responsibilities and contracts. Additional functions will also be delegated from NHSEI including primary care commissioning and some specialised services. It is anticipated that ICBs will have functions including (but not limited to) developing a plan to meet the needs of the local population, allocating resources to deliver the plan, arranging for the provision of services, putting contract and agreements in place, establishing joint working arrangements with partners, establishing governance arrangements to support collective accountability, and leading system-wide action on workforce, digital and data capabilities, estates and procurement.

We asked interviewees about the apportionment of functions and decisions between systems and place scales. This section describes the experience of the agreement of local apportionment in our case studies. The following section describes the activities and responsibilities sitting with place-based partnerships at the time of the fieldwork. The majority of interviews were conducted in the period up to and including the publication of the White Paper, with a small number reflecting discussions in the light of the Health and Care Bill.

17.1 Division of responsibilities between system and place-based partnerships

Systems and their constituent places were actively thinking through how to divide functions and responsibilities between the layers of governance. This was a complex process, which was particularly difficult given the shifting sands of policy, the prioritisation of the COVID-19 response and, in some instances, the resolution of power dynamics regarding who the decision makers were, and where resources, both human and financial, would be situated. It was acknowledged reaching clarity was an important task in order to secure accountability, and to ensure that appropriate resources and capability were aligned with apportionment of functions

and decisions. Complexity was also increased by the expectation of the involvement of all parties in decisions about the location of functions and responsibilities:

> *'ICS mental health approach was brought to the ICP for sign off as a done deal. Okay? So, you start immediately to go, hello, wait a minute, what's all this about? You know, when did this happen. We got our kind of ways mixed up. So, the fundamental point would be, what is a decision-making point or place?'* (Director, Local Authority, Case Study 1)

The complexity of this process was increased in Case Study 3 in the light of the contested two-tier nature of governance at place, where local actors were considering dividing activities between three layers (system, subsystem and borough), two of which were ill defined. One interviewee described the process of refining the remit of place governance while also taking work programmes forward as *'building the aeroplane while flying it at multiple levels'*:

> *'And then at that meeting later today, we're examining the very sort of existential questions it has, so what's its work programme at [multi-borough level], how does it take into account borough work programmes, how does money work, what's the right governance, what's the right devolution of performance metrics as well, so we're sort of building the aeroplane while flying it at multiple levels'.* (NHS Trust Director, Borough-based partnership 1, Case Study 3)

The responsibilities which would sit with place-based partnerships were being worked through on a case by case basis. As mentioned above, in Case Study 2 at system scale an ICS 'architect' had been employed to draw up a full list of where delegation and accountability would sit. This was described as a task being undertaken within systems rather than learning shared pan systems. However, in Case Study 1 it was noted that the regional NHSEI was providing support to help all places think through the role of place and bringing places together to share approaches to the division of responsibilities.

The agreement of a division of responsibilities was a complex task reflecting the volume of activities to be allocated and the lack of clear criteria which could be applied. Functions were understood to cut across system, place and neighbourhood scales, with activities and responsibilities within functions potentially sitting at various spatial scales. For example, in relation to the function of identifying the needs of the population, teams looking at population

health data may sit at system level, while the consideration of that data in relation to local populations sits in place-based partnerships:

> '*The whole point of population health management is that it tries to work at a more granular level based on intelligence about sort of targeting action on particular groups where there's the most demand or the most need. And so we'll need to have something which is strategic and specialist in terms of capacity and capability at [system] level but it gets deployed through place because that's where we can get the sort of local impact. And that's going to be quite a complex thing I think for us to manage'*. (Director, CCG, Case Study 1).

Additionally, further divisions in activities were envisioned according to clinical areas and pathways. For example, in Case Study 1 activities and forums relating to urgent care existed at both system and place scale, with a system scale urgent care forum, and a place scale Accident and Emergency delivery board and urgent care workstream.

Although clear criteria were lacking regarding how to divide such responsibilities and activities, some rules of thumb were deployed to ease decision making. A key factor considered when partners discussed where responsibility for activities should sit was frequency, with the aim of avoiding duplication and increasing efficiency. For example, in Case Study 2 it was noted that service design and delivery sat in places as a point of principle, as long as there was enough critical mass to accommodate this, and not a reliance on specialist skills or limited assets.

There was general agreement that in some instances the scale an activity should be located in was fairly clear cut. Examples of activities which it was agreed should clearly be co-ordinated at system scale included the discussion of future development of acute hospitals, establishment of hubs for specialist services such as vascular surgery, cancer centres and diagnostic services. In Case Study 3, it was also seen as clear-cut that commissioning infrastructure necessary for procurement and contracting would be nested at the system level:

> *'We don't want to turn the Place Based Partnerships into mini CCGs that have an awful lot of their energy diverted into the kind of specification procurement contracting that, well frankly, that we want to do a lot less of anyway, and what we do do, we want to be just once.'* (ICS Director, Case Study 3).

There was also agreement that pan-system co-ordination included elements like the planning and delivery of complex mental health inpatient care and children's services. Population health management (conceptualised as having access to data to support the development of targeted action to meet identified need in the local population), local workforce issues and care design were all activities which were considered to sit within places' remit.

Across the case studies, all place-based partnerships anticipated that at some point, some decision making regarding how money was spent would be the responsibility of places. For many interviewees there was not yet a clear vision of what formal delegations would be made in this regard to place-based partnerships, when this would occur, and the mechanisms through which this would be achieved. Some were clearer, for example in Case Study 2 a number of interviewees suggested that lead provider contracts were the vehicle through which place-led decision making would be facilitated. However, it was also the case that other interviewees were uncertain about the future broad balance of decision making between place-based forums and the ICB:

> *'I would say that probably up until two or three weeks ago, clearly the view was going to be that the ICS would sit almost in kind of shadow form, it would manage the money, but flow the money down into [place], and we would then decide how that money was then going to be spent. I've understood now that there's a potential change within that, that the ICS may be taking a more, dare I say, kind of strategic level, and also a greater control of the money. In the last meeting we had at the place-based service, there was a lot of frustration, about, hold on a minute, one minute we were going to have control, now we're told that about 70 per cent of the money, which would normally go into the acute, will now sit at the ICS level, and then you'll be given the rest to then kind of play around with.'* (Director, Provider 2, Case Study 2)

Even using rules of thumb it could be challenging to work out where activities would best sit. One particular challenge was balancing the need for efficiency and the avoidance of unnecessary duplication of activities, with the desire to allow local ownership and differentiation as much as possible. A similar tension was observed between needing a consistent approach between places:

> *'I suppose one of the challenges is getting the balance right between wanting to have consistency across the population that we serve, but also providing flexibility for*

local…for each place to design its own solutions. And I don't think we've…we've not worked through the detail of, you know, what the answer to that is I don't think yet. But that's certainly one of the things that we will work through as we develop this approach to how we work.'. (Director, CCG, Case Study 1)

Furthermore, while some broad decisions regarding generalities were straightforward, it was still challenging in some instances to finalise the finer details. Alongside ongoing discussions regarding activities to be undertaken in place-based partnerships were decisions regarding the location and management of staff. A concern for place members, particularly in relation to the identification and analysis of the local needs of the population, was that staff to carry out these activities should be managed by place members, rather than existing as a system wide resource. In Case Study 2, members of the place-based partnership were making the case for dedicated resources at place scale to assist with data analysis. A particular concern was that the merging of CCGs at system scale would lead to a lack of dedicated resources within place:

'It was quite a tussle because what that required was for the system team…but it's turkeys and Christmas, isn't it, you know, fundamentally – well, it's certainly at the top of the chain, you don't need all of these director level people because we've already got director level people in our place. We do need colleagues who are possibly more middle management who do the analysing and the data crunching and all of that. So I think there's been a bit of a tussle.' (Director , Provider 1, Case Study 2)

The difficult nature of some decisions can be illustrated through the example of mental health services. Decisions concerning the planning and provision of Mental Health services were noted in all case studies to be difficult. On one hand, it was argued that decision making regarding mental health should rest at system scale in line with the Mental Health Long Term Plan which set clear expectations including around investment in mental health services, changes to care pathways, access to support, for which accountability sat either with the ICS or the Mental Health provider. On the other hand, it was also argued that control of local mental health services should be within the remit of place-based partnerships. For example, in Case Study 2, some place members would prefer that elements of the Mental Health budget were brought into places *'to integrate properly with wider service provision'* (Place Director, Case Study 2). While a later interview with the Case Study 2 ICS leader suggested that the ambiguity around which elements of mental health commissioning needed to be at system and which at

place had been resolved, disaggregating the financial flows to establish what should be aligned with place or system decision making, was proving to be complex.

17.2 Conclusion

The apportionment of functions and decisions was a complex and detailed task, which was being worked through by system partners using a consensus approach. System partners needed to reach agreement regarding the location of all functions and decisions in order to achieve clarity when the Health and Care Bill comes into force and they will be required to produce the Scheme of Reservation and Delegation (SoRD) which sets out functions that are reserved to ICB and those which have been delegated elsewhere (NHS England and Improvement, 2021), and to develop functions and decision map which set out which key decisions are delegated and taken by which parts of the system (ibid.).

Sometimes external assistance was drawn on to help with the task, either from regional NHSEI or consultancies. In some instances, decisions were seen as fairly intuitive, however deciding where decision-making regarding the allocation of funds should be situated was particularly challenging where there were arguments both for vertical silos on a system scale and horizontal co-ordination in places, such as the example of mental health in Case Study 2. The apportionment of functions and decisions also raised issues of ownership and control, including whether expertise would be owned in each place, or grouped as a system resource. Partners saw a balance to be struck between the desire for local differentiation to best address local need in places with the logic of reducing duplication and lack of consistency across places where this was beneficial in terms of economies of scale and/or quality of services.

18. Phase 2 - Decisions and activities being undertaken in place-based partnerships

During our phase 2 fieldwork in 2021, we asked interviewees for examples of the work that was being undertaken by place-based partnerships, and examples of outcomes of place-based collaboration. These are summarised below by case study to reflect the significantly different approaches being taken in three different places. This is followed by a cross case study analysis of the findings.

The main findings are that, regardless of the differences in local context, place-based partnerships were centering their efforts on similar tasks (taking a shared approach to workforce development, developing population data approaches, care design and delivery, and resource allocation), and paying less attention to others. The work of place-based partnerships was interwoven and reliant on activities occurring at other spatial scales, including in other place-based partnerships. Therefore communication and clear governance links were very important. Activities in place-based partnerships were largely focused on NHS services, with some involvement of adult social care. However where the local context encouraged engagement with wider partners (such as lower tier borough councils), this was a driver for many wider initiatives. The activities of place-based partnerships were curtailed by their lack of formal decision space, but there were examples of places seeking to expand their influence informally. Smaller scale initiatives were being developed by place-based partnerships. These were valued locally, but their impact for example in terms of efficiencies was difficult to quantify.

18.1 Case Study 1

The activities of the place-based partnership in Case Study 1 were described as organised around five core work streams: complex care, end of life, healthy ageing, mental health, children and young people, and three 'enabling work streams', which were community transformation, hospital discharge and urgent care', and the underpinning digital and data approach. Members of the place suggested that the remit of the activities undertaken by the partnership was limited in terms of 'real changes'. This was because the scale of changes which could be made to service provision was limited by the difficulty of changing existing contractual arrangements and because of the impact of COVID-19 on the capacity to plan and introduce change. Decision making in the place-based partnership was also subject to the referral of proposed developments back to members' own Boards for approval.

Examples of activities:

- Development of data driven approach to care
    - Establishment of population health unit across local authority and acute trust
    - Data sharing across primary and secondary care
- Appointment of Health Aging Co-ordinators across social, primary and secondary care
- Development of system-wide pathways, such as end of life care strategy

Two of the key developments identified as significant by the place-based partnership related to a shaping of the general approach of the place to co-ordination. Firstly, that leadership of place should centre on primary care, and secondly, that place work needed to be informed by clear data.

Place members had driven through a governance approach which centred in PCNs, with a GP as the place based Medical Director:

> '*So, governance, as I said, we decided that, that our ICP needs to be provider led, and we drove that forward. There was a bit of resistance, but the system understood. We decided that PCNs need to be absolutely at the centre. We decided the place-based Director of Medical Care needs to be a GP, not a consultant, and we agreed that here*.' (Director, Acute NHS Trust, Case Study 1)

The development of a data driven approach to care was an important issue for the place-based partnership. The place-based partnership approach enabled the partners to work together to establish a population health unit between the local authority and the acute Trust. This was significant as it ensured local support and resource was available to understand the health of the local population. A further development was the sharing of data across primary and secondary care:

> *'So one of the changes that we wanted to make was, we had a real issue with data. So, primary care, secondary care data, was never connected together. We've done all that, probably more in-depth than anywhere else in the country. We have real time data for any patients, or citizens across the city, and clinicians have a view of that data. That*

needed a lot of kind of engineering, that's happened as a result of the place-based working, it wouldn't have happened otherwise'. (Director, Acute NHS Trust, Case Study 1)

In terms of care delivery and design, place members also identified the example of the appointment of Healthy Aging co-ordinators who worked across social care, PCNs and the NHS Trust to ensure that the right kind of people were being discharged from the hospital, undertake some preventative work before they went into hospital, and run multi-disciplinary teams if needed, along with social workers and mental health workers for patients who were vulnerable and frail. This appointment was driven by the place-based partnership and was subject to referral to members own boards for approval.

18.2 Case Study 2

In Case Study 2, there were many examples of developments which had been led by the place-based partnership spanning care delivery and design, decisions regarding funding allocations and workforce development. The approach in this place can be characterised as a proactive pushing at what could be achieved within the current restrictions of decision making in place-based partnerships.

Examples of activities:

- Resolution of operational performance issues, including day to day capacity management
- Work with wider partners to situate services outside hospital, including development of new premises
- Development of key worker affordable housing on hospital site
- Development of opportunities for shared service delivery, such as urgent treatment centre
- Decisions regarding the distribution of funding (winter money, COVID-19 contingency funding, transformation funds)
    - Funding of additional district nursing support
    - Increased provision of mental health support to primary care
- Development of 'integrated delivery units' such as discharge team with jointly funded lead
- Pilot for 'step-down' nursing provision to aid hospital discharge

In terms of care delivery, the approach taken by the place-based partnership can be characterised as shared responsibility for operational performance issues. Examples of this

approach included capacity management and co-ordination of the COVID response (which also occurred at system scale as described in section 13 – 'The system role in the COVID-19 response'):

> *'If we're experiencing lots of pressure [in A and E] then, you know, myself and the chief execs are normally on a call, a set of actions are agreed, stuff's done. The operation teams have four calls a day together anyway, and we've just started bringing those teams together as one….We've got a fairly tidy process, and I get a report at the end of each day that sets out how many people in hospital we've got and what their plans are and how many psych issues we've got and so on… If we're still under serious high level of pressure we do have on occasion calls or interactions with an ICS tier of the system that deals with some of the urgent care and urgent care assurance. Personally, I think that's a bit duplicative. It's one of those, people might need to ask you what's going on in reality, does it generate any new actions, new solutions or add value to relieving any of that pressure? Almost certainly not. But it's a process.'* (Place Director, Case Study 2)

The shared delivery approach was supported by the development of a place-based workforce. The aspiration was to build teams to fit around boroughs and places, developing a 'place brand' which staff could identify with. One initiative to achieve this was the development of integrated delivery units, as a way to integrate teams without changing contractual or employment of staff. For example, discharge services, including hospital discharge teams, community, social care teams, community hospitals, were under a single operating structure with a single lead across discharge focused services, jointly funded by place partners:

> *'So, you know, similarly we had one within a discharge team, so, you know, that was led actually clinically by adult social care, but my community hospital team, the acute, they took their guidance from somebody that was actually kind of sitting in adult social care, but funded by all of us. But the lead accountability sat direct into adult social care, but it changed the whole way of working. So, I mean, we've got lots of examples of that, that have either saved money, or spent our money more efficiently'*. (Director, Community provider, Case Study 2)

A further illustration of this approach was that when the contract for the urgent treatment centre which was provided by a third-party contractor came up for renewal, the Acute Trust approached local GPs to provide the service in partnership with them: *'and that's been*

brilliantly, brilliantly successful, way more successful than their arrangement before. So we are kind of making steps towards more shared kind of service delivery…' (Director, Acute NHS FT, Case Study 2).

There were many examples of work which had been co-ordinated between place members to improve care delivery and design. Initiatives included the agreement of additional money for more district nursing support and the provision of more mental health support to primary care. The two-tier nature of local government in the system had driven a novel partnership with the borough councils at place level, who were not previously considered as key partners as they did not have a statutory role in relation to health or social care. There were examples of work resting on the inclusion of wider partners, including estate and service configuration, bringing services into the community through new estate developments and improving the GP estate. One substantial piece of work around community development, brought together the wider stakeholders in places, such as education, local businesses and community groups:

> '*We're also doing a big piece with [a company] around community development, so our sort of borough level reconfiguration building healthy communities prevention agenda l…. So we're looking at a few of our key towns really getting into the grips of those, understanding the sort of opportunities, building new types of premises that brings statutory service together with local businesses in different ways and thinking about how we improve the overall health of the community, whether that be housing or environment or stuff beyond the normal clinical pathways that the NHS would get involved in'*. (Place director, Case Study 2)

Such initiatives were seen as an example of the added difference of place-based partnerships, compared with previous failed attempts by the borough council to help the NHS with estates issues.

Both workforce and population health management were areas where the place-based partnership was keen to establish locally dedicated resources, as it was thought necessary to enable them to identify and act on local needs**.** To address this granular level, the intention was to have a place workforce structure, with a lead HR team across the patch, and to use transformation funding to fund workforce leads.

> *'And then what we're hoping to set up is a system intelligence group led by public health and strengthened by our collective resource that does a lot of the population health analytics, the health inequalities, guiding the work of the alliance. Part of the alliance is the running related set of services together as one business unit. So we have our business unit structures underneath our transformation board*.' (Place Director, Case Study 2)

As explained more fully in section 7, the system in Case Study 2 had been in receipt of considerable transformation monies which had been used to pilot changes to care design and delivery. The place-based partnership had some responsibility for the allocation of funds such as COVID-19 funds, transformation funds and winter money. A point raised in relation to the allocation of these non-recurrent funds, and many of the projects undertaken within the place-based partnership, was difficulty in demonstrating the impact that place-based initiatives were having on efficiency savings, especially when the impact was shared rather than within the activity of an individual partner.

While the place-based partnership did not have responsibility for financial decisions relating to non-transformation funds, place partners had 'shadow' influence over commissioning decisions taken by the local CCG, for example to extend the mental health provision for people who would fall outside the threshold for treatment for the Mental Health Trust:

> *'So actually we've made decisions to commission and support expansion of pilots like, where you've got more mental health input to the GP service, that sort of thing, so tried to commission…we've just commissioned Mind to provide some more sort of universal offering. So yeah, we have started to, but we don't have if you like authority, we've been kind of I suppose in shadow form bringing influence to bear on the 400 odd million that comes into our system'*. (Director, Acute FT, Case Study 2).

18.3 Case Study 3

In Case Study 3 activities were taking place across the 'double-layer' place set up: the intermediate subsystem level and the three lower tier borough-based place partnerships. As described in section 14 (Place governance structures), the remit of these two layers was far from settled, and the role of governance forums was differently understood and described.

Examples of activities:

At intermediate subsystem tier:

- Sharing best practice across boroughs
- Performance management and assurance
- Resource allocation
- Operational command for COVID-19

In borough-based partnerships:

- Development of 'multi-disciplinary discharge hubs'
- Pathway development for interface between hospital and wider system
- Operational collaboration during COVID-19 response
- Development of shared workforce strategy
- Decisions regarding the distribution of, COVID-19 contingency funding

The intermediate subsystem tier was described as having a pan-borough oversight and co-ordination function. The approach was characterised as steering activities which in the NHS view required consistency across the three borough-based partnerships, sharing best practice rather than mandating approaches, but recognising where boroughs were addressing similar issues:

> *' I suppose, is to reflect the fact that in reality what the boroughs are trying to do, their populations are different but not that different, you know, their solutions to integrating care and services on the ground, they're not going to be wildly different, you know?'* (CCG Director, Case Study 3)

The subsystem was coterminous with a residual footprint for the discharge of CCG duties, and these duties were reflected in some of the activities undertaken by this layer. The 'support and challenge' approach also involved performance monitoring of service delivery and assurance function, challenging the boroughs where necessary, but also escalating risks to system level. Additionally, the subsystem layer performed a resource allocation function and financial planning and management, alongside the CCG through a committee in common structure, with future plans for the delegation of this function.

In addition, partners suggested that the subsystem footprint was the co-ordinating scale for initiatives relating to interface points between the hospital and the wider system. However, the scope of the subsystem was not clear in this regard, and it was acknowledged that there was possible duplication of decision making with the other spatial scales. Examples include operational command for COVID-19, planning patient pathways, promoting different referral mechanisms like advice and guidance and demand management.

A core initiative set up at the subsystem level and delivered in a consistent way in each borough was integrated multidisciplinary discharge hubs, located at three hospital sites corresponding with three boroughs, to encourage mutual help across three boroughs. The discharge hubs helped the acute hospital to coordinate its discharge processes across its different hospital sites each facing a slightly different community and social care provider context.

The view of the subsystem partners was that the borough layer focused on out of hospital activities.

We gathered examples of the main activities occurring in each of the three borough-based partnerships. One borough partner described the work as focusing on the 'enablers' of partnership working. Priorities identified by the partner included the development of population health and a workforce strategy. Population health was viewed as an important responsibility, but in which progress needed to be enabled through engagement from the system in order to access data and intelligence held at the system level. An ongoing project was the development of a workforce strategy which would enable staff to work across organisations. This was described as working alongside individual organisations' workforce strategies, and focused on *'how we can work together across teams to get some join up around things like recruitment, training, induction, OD .... and actually looking at opportunities where we might create some flexibility so that staff can work across organisations...'* (Borough Director, borough-based partnership 3, Case Study 3).

There were examples of the development of a shared operational focus within borough-based partnerships. One such example was collaborative work during the COVID-19 response, and in relation to elective recovery, although it was noted that it was important that co-ordination took place on a pan-borough basis to address wider issues which might not be possible to address within the borough-based partnership. One borough (Borough 3) was looking at the role of primary care in relation to supporting people on the elective waiting list. In another

borough (Borough 2) partners made collective decisions about allocating funds and risk sharing in relation to the COVID-19 response, taking the decision to establish shared teams before they were certain that they would be receiving the funds.

18.4 Discussion

Looking at activities across the three places within our study raises a number of points.

While the ambition of approach, and scale and volume of activities differed significantly within place-based partnerships, the work undertaken in the partnerships can be broadly categorised into four areas: accessing data to understand population health needs; workforce development; care delivery and design; and, power to make funding allocations. These are areas where place-based partnerships saw themselves as both having a remit and able to effect change. Notably, less emphasis was given to activities in relation to performance management and monitoring, and the holding to account of place-based partners for performance, except where this was undertaken by the intermediate subsystem tier upon the borough-based partnerships in Case Study 3. This suggests that regardless of the differences in local context, place-based partnerships were centering their efforts on similar tasks, and paying less attention to others.

The nature of the activities in place-based partnerships was shaped by the 'decision space' available to them. As discussed in section 18 (Decisions and activities being undertaken in place-based partnerships), place-based partnerships did not have the authority to make decisions regarding most of the allocation of funds, and they also acted within the confines of their authority in relation to the sovereignty of individual partner organisations. The focus of place-based partnerships on the resolution of operational issues, and relatively small-scale service developments reflected the formal decision space available to them.

It is also the case though, that there were examples (most notably in Case Study 2) where the place-based partnership pushed to expand the informal decision space available to it. Examples of this approach can be seen in the attempts to 'shadow influence' commissioner decisions, and taking steps to unite the workforce, short of a formal merger. The venturing into informal decision space may have the effect of expanding the decision-space of place-based partnership decisions over time despite the lack of formal remit. For example, in Case Study 2 it was reported that none of the decisions made within the place-based partnership had required formal sign off from the Board of partner organisations, compared with the commonplace referral of decisions to Boards in Case Study 1. Interestingly, place-based partnerships were willing to

share resources, for instance in the response to the COVID-19 pandemic. However, it is less clear whether this was only an effect of the emergency and short-term nature of the pandemic response, and the suspension of normal financial arrangements during this time.

Members of place-based partnerships were generally optimistic about opportunities for and impact of place co-operation. There were many examples of improvement to service delivery which had been developed within place-based partnerships, including decisions made between partners to share resources between themselves in order for shared gain. One of the issues inherent in this approach was proving the impact that place activities and initiatives were having. Initiatives were either put in place through informal sharing of resources, or the use of non-recurring funding, making it difficult to link them to formal improvements. An associated issue was the integrated nature of the delivery of these initiatives across a number of organisations made it difficult for individual organisations to assess the impact on their organisation.

It is clear that the relationship between activities across spatial scales is important, and that oversight and co-ordination of place efforts is required across place-based partnerships at system (or another) scale. A number of interviewees referred to the necessity of place work relying on activities at another spatial scale. For example, places wished to focus on population health approaches, but the resources to enable this may be held at system scale. In some examples, place-based partnerships were considering the formation of place-owned resources, such as around data and workforce issues. On the other hand, the need to avoid duplication of effort was acknowledged. In Case Study 3, where the roles of the subsystem and borough-based partnerships were contested, it was acknowledged that the same decisions were potentially being taken at multiple scales.

19. Phase 2 - Resource Allocation

The introduction of ICSs means a shift from competition to collaborative working among NHS organisations. The forthcoming repeal of the competitive procurement requirements for clinical services as laid out in the Health and Social Care Act 2012, announced in the Health and Care Bill, was welcomed by commissioners. All our case studies saw a need to overhaul the procurement rules.

19.1 Use of competition and competitive tendering

Our interviewees suggested that competition and the use of competitive tendering were things of the past. They were described as *'yesterday's buzzword'* (Case Study 1) and as *'a waste of time, and energy and effort'* (Case Study 2). One commissioner noticed *'a massive mindset shift'* in terms of moving away from a culture of competitive tendering to collaborative planning and commissioning (Case Study 3).

In Case Study 1, competitive tendering had been avoided anyway even before the policy change towards integrated care services. The place in this case study had an 'integrated' acute Trust, meaning that the acute Trust provided both secondary and community care services. The need for competition had not therefore been prominent in this area. Still, while the procurement regime was in place, commissioners were mindful of potential legal challenges, especially by private sector providers complaining that NHS commissioners had not carried out their legal obligations regarding procurement:

> *'There's potentially issues there in terms of some of the procurement rules that apply to CCGs….There is a bit of a challenge about the ability of us as a sort of local partnership to make decisions that could be challenged by external private providers who might say they're not getting a chance, you know, to be part of that decision-making'.* (Director, CCG, Case Study 1)

Designing services around 'clinical models', was an approach chosen as an insurance against potential litigation:

> *'We've got to be mindful of the procurement law and competition law…We've got to be wary that we have taken enough legal advice, we've made sure that it fits into the right perspectives before we allow things to move forward. So designing it around the clinical model is the way we found has been quite helpful for us. So if the clinical model*

is right and it can be justified then that helps. That's the approach that we've taken'. (Chair, CCG, Case Study 1)

Commissioners noticed '*a massive mindset shift'* (Case Study 3), in terms of moving away from a culture of competitive tendering to collaborative planning and commissioning. In addition, the circumstances of the pandemic encouraged greater collaboration between different organisations. The procurement regime which was officially in place did not have any impact on the collaborative work. The pandemic state of emergency hastened the waning of the competitive procurement regime: '*it's genuinely been all hands on deck, all shoulders to the wheel'* (Director, CCG, Case Study 3).

Although the nature of the new provider selection regime has not yet been decided, some commissioners welcomed the prospect of taking the NHS also out of the Public Contracts Regulations (PCR) 2015, which would '*release us from a lot of very, very futile transactional activity' (Director, CCG, Case Study 3*). At the same time they were aware of the danger that the ICSs might become 'slightly too cosy', and thought that there needed to be other mechanisms in place to ensure value and quality.

'As the policy pendulum swings from competition to collaboration, I suppose we will see in time, won't we, how successfully ICSs can do that or whether in five years' time the Department of Health is saying, my goodness, how could we possibly be so naïve as to think that they could just manage their own money and extract off a value from it? What we need is a competition regime'. (Director, CCG, Case Study 3)

Local authorities still used competitive tendering to commission services and operated to a different business cycle and procurement framework than that of the NHS. There were however some indications that local authorities did not want to destabilise their NHS providers, particularly when there was '*only one game in town really'* (i.e. the main local acute NHS trust). In one case study, for example, instead of going out to tender, a 10-year partnership was struck with the local NHS trust, with a financial review conducted each year.

'Because we're almost coterminous with our local hospital, instead of going out to tender for some of the things that we've done for 2000-2019 and going out for commissioning, there's only one game in town really. And actually if it went out to a voluntary organisation, you'd lose all your staff wouldn't you? The nurses say, I'm not going over there, I'll lose my terms and conditions. So, we started to go down a route of, actually we're just going to enter into a partnership with you, a ten-year partnership,

we'll do a financial review each year, but I'm not going out to tender, but you've got to do this and we've got to do that'. (Director, Local Authority, Case Study 1)

Collaboration, not use of competition, was seen as a means of addressing and resolving thorny issues relating, for example, to struggling providers. Providing support and working together with a struggling provider was preferred to putting services out to tender, which was seen as '*a waste of time, and energy and effort'* (Case Study 2). In Case Study 2, for example, the community services provider, which was a social enterprise, experienced performance issues. In this case, the consensus among interviewees was that this was not going to be addressed by re-tendering the contract, but instead through some form of integration. Working together to resolve issues of performance was the chosen approach, partly because if, according to one interviewee, the contract was re-tendered the staff would probably remain:

'I think there are issues that were a bit thorny. I think our community provider is struggling, and I think how do you help that and how do you move that along? I think the whole thing with the [place partnership] is that actually we come together and try and support that because you can't…the options are that you try and get rid of another provider if they've got a contract and it's on for another few years. But you still end up with the same staff. Staff aren't going anywhere, so I think it is recognising that we're far better off if we do work together. It's not always easy though, and it's bringing those staff along and having the vision of what you can do together.' (Director, Provider 3, Case Study 2)

However, it was reported that in other systems the emphasis on collaboration between NHS organisations had led to contracts being given to NHS providers rather than renewed with social enterprises:

'*Yeah, I mean, we would like to think, and if I look outwardly, I look at some of my other social enterprises, who have already suffered as a result of this, you know, there's two social enterprises who have had long-term contracts, who have been given termination notices in the last couple of months, just on the basis of what's in the White Paper, because people are reading it as, this is an opportunity to get rid of us and make it all NHS.'* (Director, community provider, Case Study 2)

In Case Study 2 an 'integrated model' was developed at place level, with no formal organisational or team merger, but in which all staff were treated as part of the place-based partnership. This more shared approach to 'place resources' was confirmed by the community provider who noted the development of shared roles across organisations, and the development of aligned pathways to agree the use of community beds, including by patients coming from the acute trust. The community provider Director gave the example of leadership for infection control, which was being assumed by the acute Trust, but which had been a very important aspect of the community provider business, particularly due to the COVID-19 response. This was an interesting example because infection control was part of the Quality theme, on which the community provider was leading, but it was agreed the acute Trust should take the lead instead, because of the scale of infection control resources and practice in the acute Trust:

> *'It's probably better that any infection control we have comes under the day-to-day management of 'the acute Trust', because they're doing it 24 hours a day, you know, and we do it in bite-sized chunks, so let's pool everybody into that kind of area of expertise, and they provide the service back into the [place-based partnership]'.* (Director, community provider, Case Study 2)

In Case Study 2, the 'sharing' of resources across the place-based partnership was also evident in the relationship between the GP Federation and the acute NHS FT. During the early stage of the GP Federation, the acute Trust seconded a senior manager to the Federation. This heralded a close relationship between the two organisations, built on personal trust (see below on 'examples of sharing resources').

A primary care interviewee suggested that there had been a sea change locally in attitudes to competition and purchaser/provider relationships, describing an approach under the previous CCG leadership of fiercely guarding the division between purchaser and provider for reasons of conflicts of interest:

> *'We had a CCG who was headed by somebody who was very, very much keeping the provider commissioner separate, absolutely separate. And to the point that I wasn't allowed into some of the meetings of GPs because I was seen as a provider. And locality meetings and things like that, so [the acute hospital] weren't allowed to talk to me. And it was a really, really difficult landscape to get anything off the ground. And that legacy is definitely going, and in most parts, it's pretty much gone, and it is far more*

collaborative. Sometimes you get people who were very much part of that CCG environment who are still around. It still feels a little bit that way. They talk about conflicts of interest all the time. Whereas actually I think in a collaborative system you should all be working towards what's best for the patients…there are obviously going to be some, but everybody knows where they are, they're not hidden'. (Director, GP Federation, Case Study 2)

Under the culture shift towards collaborative working, interviewees were more relaxed about potential conflicts of interest when taking commissioning decisions. Conflicts of interest were seen as inevitable which needed to be managed, but not as a stumbling block since collaboration meant that all parties should be working 'towards what's best for the patients'. Even if service providers participated in commissioning decision-making, the benefits were thought to be stronger than the negatives:

'I think we always have conflicts of interest, we've always had conflicts of interest since we've had GP commissioning. So, I mean, I think we just manage it. There aren't any new or emerging ones. The only one I would call out I suppose is providers being on the boards when we make decisions. But, you know, I think that has more positives than negatives' (Director, CCG, Case Study 3)

There was also an observation that the nature of competition between different providers had changed from straightforward competitive tendering for the market share, creating eventual winners and losers, to the need to self-govern, moderate and more equally distribute competitive advantages and disadvantages associated with service provision between different partners.

'There are different forms of competition though, you know, we were asked to form specialty hubs for different elective surgical services and everyone wanted to do orthopaedics because everyone likes doing orthopaedics and nobody wanted to do general surgery. So in being asked to cooperate, we're being asked to solve problems that have a competitive dynamic. And I think that's quite a deliberate thing, they're saying to systems, you know…we don't care how you decide, but you need to come to a view about who does what and who covers what, so that can lead to debates… And it might lead to different forms of competition within the system, but it's completely different from three or four years ago, [providers] trying to win the same sexual health

service contract when there's a winner and a loser.' (Director, Acute NHS Trust, Case Study 3)

The use of formal tendering or competitive processes as a commissioning mechanism was becoming less of an issue but other forms of competition between providers within the new systems and subsystems remained, for example, competition for allocation of resources or competitive pressures in distribution of services, access to workforce, capital and investment:

'I think in [subsystem], it's looking to be a bit simpler. But then of course there's the inevitable competition for resources between them that we've got to manage'. (Director, NHS Trust, Borough based partnership 1, Case Study 3)

The function of commissioning was seen as valuable as long as it was based on collaboration rather than competition among the different providers. However, interviewees observed that, although competition and procurement would be less significant in the NHS under the new arrangements, they (especially procurement) were never real anyway.

'I don't mind that, to be honest because the reality of some of that commissioning was it was a bit fake anyway, not the comm…the procurement side of it. Who else was ever going to get the mental health contract other than the [mental health] Foundation Trust in [this area]? You know, it's a bit of a phony exercise. So I don't really mind that as long as we don't lose the kind of overarching purpose of commissioning which is not the procurement, in my mind. It's more around the understanding need, the resources, working across the system, that's the bit we need to keep a handle on and that has to be collaborative and that has to be a partnership system-wide approach'. (CCG Director, borough-based partnership 2, CCG 3)

One NHSEI interviewee reflected on the pros and cons of the mechanism of competition as a principal lever for improving services. Whilst they took the view that it delivered some positives, such as better information on costing and activity in secondary care as well as greater clinical involvement in strategic and managerial roles, they thought that competition did not help to improve quality across different providers, arguably further exacerbating the gulf between high quality and struggling providers.

'I think what happened is the rich got richer and the poor got poorer, (…) the logic was the weaker organisations became acquired by the stronger organisations, but the stronger organisations weren't interested.' (NHSEI Director, Case Study 3)

In Case Study 3, although there were no formal Alliance agreements or risk share arrangements at the subsystem level, the partnership was able to make some allocative decisions about prioritization of resources and investment in services working to the same framework. '*There are what I call allocative decisions about the distribution of overall budgets*.' (Director, Acute NHS Trust, Case Study 3). The Medical Director for the subsystem place partnership stated that they used mostly collaborative mechanisms to commissioning and contracting. However, the unresolved issue remained the relationships with non-NHS providers – third sector and private sector, which were outside of the collaborative commissioning framework. As we saw in Case Study 2, however, this was not a problem that could not be overcome.

19.2 Impact of place decisions on individual organisations

Collaborative decision-making and working at place level were influenced to a great extent by the need to respond effectively to the pandemic and also by historical links that had been developed as a result of previous policy initiatives (e.g. Better Care Fund, New Models of Care). As with previous policy initiatives, in the new NHS architecture, integrated care is meant to happen among independent statutory organisations. This is likely to create tensions in cases where there is a conflict between individual and collective interests. Some difficulties with collective decisions arose from considerations of the likely impact of such decisions on the individual organisations of the place-based partnerships.

In one of our case studies, collaboration was not plain sailing. Taking collective decisions relating to reconfiguration of acute services, for example, proved to be difficult, as individual hospitals tended to prioritise their own interests. An ICS Director described how conversations regarding distribution of funds in the present system were still not leading to resolution of difficult problems:

> *'Everybody retrenches over the issue, and you don't get a decision, that's what happens, everybody then retrenches into their statutory obligations and just sits there…That's why we've still got five stroke units in [the area]…you know, it doesn't, the stuff doesn't happen, so you therefore do stuff that you can do, where you have got the energy and you have got agreement, and the other stuff doesn't happen'.* (Director 1, ICS, Case Study 2)

Commissioners observed that a behaviour or culture shift on the part of the secondary care trusts, would need to be a collective agreement to move care into the community.

> *'So by using the population health management kind of information that we get and being more proactive in the way that we manage people, that care is shifting, isn't it, from an acute setting into very much more of a community and primary care setting. So from the acute trust perspective, there's something about how they manage that culture shift and behaviour shift'.* (Commissioning Director, CCG, Case Study 1)

In cases of integrated care acute Trusts, however, moving care into the community would be a desired change since they would not be losing income as a result of such shifts in care.

But one of the challenges that commissioners were foreseeing was how to manage place-based population budgets without destabilising any of the partner organisations. As funds had not yet been devolved to place-level partnerships, possible solutions to such challenges had not been tried in practice.

> *'I don't think formal ICP [i.e. place-based partnership] has changed the organisations yet. I think we've been working in this collaborative way for a number of years through the Better Care Fund. So I think we are used to working in that way. Certainly at an operational and a service delivery level. I think the stumbling block, or the challenge has always been around finance and resources and how that's managed at a system level. I think it's taken quite a while to build trust particularly between primary care colleagues and the acute provider around how do we deliver this together without destabilising any one of the organisations. So we're not at a place yet where we have got that population budget that's being managed by the ICP'.* (Commissioning Director, CCG, Case Study 1)

Another challenge mentioned related to 'joint commissioning' between local authorities and NHS, as each of the potential partners were reluctant to agree to join their budgets:

> *'So I think there is still…I think there's still a lot of protectionism around budgets and resources. I think people want to work collaboratively and want services to integrate but that usually means they want to be in charge of it, not…you know, they're not really comfortable about whoever's in charge of it'.* (Director, NHS Trust, Borough based partnership 1, Case Study 3)

Some organisations, however, were quite sanguine about the prospect of dropping some of their organisational priorities in favour of shared priorities and goals, if they led to an improvement of services in the locality. An example was the Director of the acute Trust in Case

Study 2, who suggested that the Trust would be prepared to spend extra money on areas of need, such as housing, and other services rather than spending it on their own hospital:

> *'So it goes back to some of the capital problem, but I would definitely be choosing to invest some of my capital rather than spending it on the hospital, if I was allowed to spend all the money I've got, I would definitely probably make an investment say in [town] in a deprived population if we thought it was going to improve their health and wellbeing and mitigate the demand that we see, that might be a really sensible thing to do. Or expending revenue in supporting more things like first contact physios or health visiting or probably not even health visitors, but more…I don't know what you'd call them, grandmas.'* (Director, Acute NHS FT, Case Study 2)

19.3 Examples of sharing resources

At the time of our study, decision-making about allocation of resources was still the responsibility of CCGs as statutory bodies, not the place-based partnerships which had no formal legal authority. Interviewees did not report that budgets for decision-making had been devolved to place level. They did report, however, a number of initiatives that had occurred via collective decision-making and sharing of resources.

Some sharing of resources had been triggered by the response to the COVID-19 pandemic , which was reported as having had a positive effect on collaborative working in all our case studies. The GP Federation in Case Study 2, for example, which had run the vaccination sites for the PCNs, had been loaned the CCG primary care team and pharmacy team and the work had been run as a place-based partnership project. Another example of the influence of the COVID-19 pandemic on collaborative working was the management of the Elective Recovery Fund (ERF)[9]. In one case study the ERF was managed at system level via a dedicated Elective Care Board (Case Study 1) which managed the interface with NHSEI:

> *'We've got an elective care board, so all of our work on elective care and recovery across the system is being managed through an elective care board. One of the hospital chief executives is the senior responsible officer for the elective care board. And then one of my counterparts, the MD in [city], is the workstream lead for that, for convening that work across the system on elective care…And then the engagement with NHSEI*

[9] a fund made available by the UK government to help hospitals recover their levels of elective activity, post COVID-19 pandemic

around our elective plans is as a system through the elective care board'. (Director, CCG, Case Study 1)

In another case study, in response to the NHS operational planning guidance, all acute providers collaborated to design a system-wide elective recovery plan. Coming up with a single plan for elective recovery was aided by the experience of sharing resources, such as critical care beds or oxygen supplies, during the height of the COVID-19 pandemic.

'The plan is based, essentially on a pan [system] division of labour, there's the high volume, low complexity work that's being done in hubs, and then across [the system], various hospital sites have taken on responsibility for [system-wide] waiters as they get through particular specialties. So, it really has been about trying to overcome the supremacy of site, and each hospital site trying to work through a totally broad span of procedures, and much more scale in specialisation. That's how that plan has worked…when it comes to the recovery, the scale of the issue is so huge in [system], that actually I think it's just a sensible response to the scale of the problem is what's driven it, and I wouldn't under-estimate, in the consultant body, the level of debate there's been, and we know…that clinical teams are not always massively keen on working at different sites, and they do like the connection with the borough, that comes with the idea of a hospital site catchment. But I think the scale of the issue that's being grappled with here was sufficient to put some of those concerns into perspective, probably'. (Director, ICS, Case Study 3)

One of the borough-based partnerships in Case Study 3, worked collaboratively during their response to the COVID-19 pandemic by sharing the additional funds they received to deal with the pandemic. The partners made collective decisions about allocating funds and risk-sharing. They even took the decision to put in place teams before they were certain that they would be receiving the funds:

'We knew that was many millions of pounds and we didn't know where it was coming from. So as a partnership, we agreed that we would make the investment because we needed to and we would share that, we would risk share that, should there not be a national solution or funded through various national COVID, which I think was incredibly mature. And to accelerate that, one of the partners said, well, we will recruit and establish the teams, we'll do that at risk, but with our trust and faith that you'll help us out if the money doesn't arrive. So I think that was really positive, but again,

that was in a pandemic response when money certainly wasn't the primary factor'. (CCG Director, Borough-based partnership 2, Case Study 3)

The decision to share the risk in case the emergency funding for the COVID-19 pandemic was not formal but was taken by the partnership executive in an informal way:

'So I took it to the partnership Executive to put the problem on the table, so here we go, guys, I don't want to make this decision without it being a partnership one, here are all the reasons why it's a highly challenging one, and it was the Executive that decided to take that risk collaboratively. Did we set out exactly what the financial share would be at that point, no, but we agreed we'd do it, and then in the end, we didn't have to'. (CCG Director, Borough-based partnership 2, Case Study 3)

Commissioners recognised, however, that the real test of risk sharing of funds would come in the future, when decisions about priorities would need to be taken in normal conditions rather than in the middle of a pandemic. Good relationships would then prove to be key:

'I think we will test that certainly as we start to think about, well, to what extent is the waiting list for autism services more important than orthopaedic, and I really think we're in the very foothills of those mature discussions. And that's why I think the relationships are really important, so we can talk about these things in an open, transparent, and non-confrontational way'. (CCG Director, Borough-based partnership 2, Case Study 3)

Case Study 2 was reported as being most proactive when it came to examples of sharing resources at system level. In terms of the Elective Recovery Fund (ERF), it became a collaborative effort between two hospitals.

'In terms of elective recovery, the only two Trusts whose population comes solely from [the area], have come together and we're having conversations about establishing a board between us, and we've been able to capitalise on this electronic patient record programme that we've been doing, so we've been doing that together, bought it together, we're delivering it together, so that's kind of cemented the sort of partnership at a beginning…So we drew up an outline set of principles which said, we would come together, we would use our collective resource and capability to meet the collective population's needs rather than me just doing my bit and you just doing your bit…So we've now had I think three meetings…and the clinicians at my end and [the other

Trust], in the first place around colorectal and MSK to look at how we can use our collective resources in a more productive and efficient way which will help respond to the elective recovery'. (Director, Acute NHS FT, Case Study 2)

Over and above the ERF, Case Study 2 had a 'planned care accelerator programme', in which two hospitals across the system were collaborating on offering complementary care.

'And then the second part is the planned care accelerator, which you might have heard about, which is kind of an incentive programme over and above the elective recovery funding, which requires a system response. So if you like, the trajectories that have been agreed for [the place] are a composite of our collective capabilities to deliver that recovery, and so we're not all contributing equally in all of the areas, but together, we meet the trajectory required of us by NHSE/I. So that's completely been brokered between us dependent on what our individual positions are and we say, well, we'll do a bit more orthopaedic because that's what we do, if you do a bit more ophthalmology, you know. So, yeah, definitely at a system level.' (Director, Acute NHS FT, Case Study 2)

The system in Case Study 2 had been in receipt of considerable transformation monies which had been used to pilot changes to care design and delivery. An example of place-based initiatives linked to transformation money was supporting borough housing projects to help keep people out of hospital by installing remote monitoring in people's homes, to either stop them going into hospital in the first place or to discharge them sooner. However, the usefulness of these non-recurrent resources, or the ability to demonstrate their impact in the longer term was uncertain:

'...so [system name] has been very lucky actually because it's had quite considerable transformation funding, can't remember how many millions now, I mean, I'm not wholly convinced that that money has bought great value to the taxpayer. I think what tends to happen is, particularly when it's not recurrent, is lots of pilot projects to test things are set up, which are great things in and of themselves, but they never have the scale to make the difference. And so demonstrating that those pilots have made a difference in any meaningful way to the big-ticket items of system, financial balance, or system performance, is very difficult. And then they don't always get sustained, so they say, oh, that was very nice, the patients…a very small number of patients who had that particular experience had a great experience, but it didn't make any difference to

the sum. So I think there's been lots of that, and that's a problem I think really' (Director, Acute NHS FT, Case Study 2)

Another interviewee echoed the view that quantifying savings resulting from these non-recurrent funds, particularly for individual partners, was difficult. This interviewee, however, saw the value of these additional funds as creating the potential that existing resources could go further by improving health care delivery processes:

'Now, it's always one of those tricky things, isn't it, when you start talking about savings. This is not necessarily a saving that you go and cash, but it's a system saving for the internalised resources that is under great demand within the health system. It means that the existing level of resources committed can go much, much, further because we have a very efficient intervention process now that has been built up and aligned specifically to marry up to the needs locally so that we can help people all round, but as part of an integrated health system.' (Director, Borough Council 1, Case Study 2)

As noted in section 18 (Decisions and activities being undertaken in place-based partnerships) above, at the time of the research, responsibility for financial decisions relating to non-transformation funds did not sit at place level. place partners had influence over commissioning decisions taken by the local CCG, but this constituted a 'shadow' influence over the decisions of the CCG:

'So actually we've made decisions to commission and support expansion of pilots like, where you've got more mental health input to the GP service, that sort of thing, so tried to commission…we've just commissioned – I'm trying to think, is it – Mind, to provide some more sort of universal offering. So yeah, we have started to, but we don't have if you like authority, we've been kind of I suppose in shadow form bringing influence to bear on the 400 odd million that comes into our system'. (Director, Acute NHS FT, Case Study 2)

Although the 'integrated model' of sharing resources at place level in Case Study 2 did not involve the formal merger of health care providers, it involved developing place 'branding' for all frontline staff:

'And we've got branding underway and so on so that we can use some visual cues to help the teams come together under something that unifies them alongside obviously

some OD support will be necessary. So I think that's where it'll end, so I would imagine ultimately…I mean, long time in the future, I don't know how long it'll take, but I would imagine there will be a provider collaborative in [place] and that the provider collaborative board will run all the provision…' (Director, Acute NHS FT, Case Study 2)

In the above quote, the suggestion is that provider collaboratives would be place-based and would likely include providers from different health care sectors. This is in contrast with the system-based provider collaborative in Case Study 3, which was limited to collaboration of only acute sector providers.

Interviewees in Case Study 2 noted the close collaboration between the GP Federation and the acute Trust as a further example of sharing of resources at place level. The GP Federation was contracted to provide the Urgent Care Centre to the FT, a service which was described as 'jointly managed' in practice, with the Trust providing nurse practitioners, the Federation providing GPs and admin, all under the Trust's CQC registration. Under another arrangement the Trust provided first contact physios to the GP Federation:

'So we also do things like we work with them so that they provide first contact physios to us. We pay them. They've released time. So they release their senior physios to us, and we backfill with juniors so that we get more staff being trained up. And they come out and our GPs can book straight into that and we provide that through our extended access contract'. (Director, GP Federation, Case Study 2)

It was noted however, that this close integration at a senior strategic level was not always mirrored by unity across staff delivering the service.

19.4 Financial incentives

None of the placed-based partnerships in our case studies negotiated local contractual incentives. There were also no agreed mechanisms to share financial risks. This was not surprising since places did not hold budgets, so could not make incentives or investment decisions. Instead, the discussions around negotiating incentives and mechanisms of risk sharing took place at the system level, as this was the footprint for achieving 'system control totals' and Elective Recovery Funding targets.

The place lead in Case Study 2 saw financial incentivisation of place collaboration as counter-productive and believed that co-operation based on relationships would be a more meaningful

driver of behaviour change. This view was shared by the regional NHSEI interviewee who thought that, working towards achieving 'system control totals' would be a stronger motivator for collaboration, compared to the old regime of incentivisation of individual providers. The move from 'technical finance' schemes, riddled with perverse incentives, to 'strategic finance' with greater flexibility to move money around the system, would mean that systems could be given more autonomy, as long as their long-term plans delivered the policy goals and ensured organisational sustainability.

> *'So, the flexibility of just having a control total for an ICS and moving money around, and moving money around to do the right things, I think they're finding more motivational when, you know, we've been through various different attempts at trying to create incentives to approaches, so FRS and all the rest of it. And, frankly, they were just riddled with perverse incentives and complexity. I think it's much more productive to say to people, you know, have you got a really great five-year strategy for your patch that your punters can understand?...And when you're moving money around the system in order to deliver that improvement and that change, can you also show that you're keeping your organisations in the sustainable format? I think that's very much about...which is, kind of, how it should be, it's strategic finance, isn't it? Rather than technical finance'.* (Director, NHSEI, Case Study 3)

In addition to the move to 'strategic finance', interviewees referred to 'softer', indirect, or subtler forms of incentivising collaborative working, for example, the increase in transparency of financial reporting and decision making around allocation of financial resources among system partners.

> *'I think there's more transparency. So I think, there's a couple of planning rounds now, last summer and the one we're just in, where we actually do have sight of, this is the money that's coming into the system as a whole, and this is how we're planning to use it. And, in fact, how we've collectively prioritised to use it, and why we've, you know, why we've chosen A and B. I think that's definitely improved, that in and of itself is a really important change, I think. It's not quite an incentive, but it kind of does incentivise people, actually. Just, you know, the clarity about what are we using, and why'.* (Director, Mental Health Trust, Case Study 3)

According to one regional NHSEI interviewee, there were some incentives set at system level to increase collaboration, such as having a single Patient Tracking List (PTL) or a single

waiting list as one of the criteria for receiving the ERF. Giving systems more freedom in terms of capital allocations could also incentivise work towards system outcomes rather than individual organisational outcomes, whilst at the same time helping to tackle health inequalities.

> *'One system's performance was actually appalling and I told them that it wasn't good enough and I expected it to come back in a fortnight's time with something much, much, much, much better, and they responded entirely appropriately and did so. So they acknowledged that the system hadn't been working the way that the system should and they came back a fortnight later and had really, really made progress in terms of how they were collectively working as a system to manage a single waiting list rather than multiple waiting lists that were not ensuring that people had appropriate and equitable access to care'.* (Director, NHSEI, Case Study 3)

An existing mechanism of incentivisation of individual providers, payment by results (PbR), was described as having 'had its day', having been replaced by more collaborative payment methods such as 'block contracts' with a focus on outcomes. According to an acute provider interviewee, PbR was less appropriate to collaborative working, and incentives should now be focusing on outcomes of collaborative working:

> *'So I think once you make financial incentives, put in financial incentives for genuine authentic partnership working across the health and care spectrum, I think there's an opportunity there…So if you think about an integration framework linked to payments for investment into the place, I think that would be a good thing. But again, people are nervous, and I think if you can put in as many things that you can, to try and make sure that the GPs and the consultants are working together, if you create a framework around that, that would be really, really helpful. So I think PBR has had its day in its current form'.* (Director, Acute Trust, Case Study 1)

PbR drove up activity levels and was thought to be unaffordable in the long run, in the context of limited pots of money for systems. However, due to the large backlog in elective activity created by the pandemic, some nationally imposed financial incentivisation schemes were in place across the system level, such as the ERF framework, which was meant to help tackle elective backlog through system-wide single waiting lists and activity targets supported by additional resources (NHS England and NHS Improvement, 2021a).

The ERF was seen as a form of incentivisation. However, interviewees expressed scepticism about this top-down elective recovery incentive, thinking that it posed challenges to collaboration, as individual organisations gave priority to their immediate interests and patients.

> *'There's a huge variation in the scale and nature of the problem in the different organisations, and we at [hospital] hold most of the problem on elective recovery in terms of the long waits. And if everybody were to suddenly use all their capacity then, for the good of the system, some organisations wouldn't do any operating on their own patients for a very long time, they would spend a long time operating on our patients and not much else. And that's not really a proposition that you can put to the statutory body and expect it to accept that, so while we're making incremental steps in that direction, the glib [regional NHSE/I] vision that we're all suddenly switched to managing waiting lists as a sector, they know that's not feasible'.* (Director, Acute Trust, Case Study 3)

Another form of softer, relational incentivisation was to work towards reducing pressures within the system by moving resources (workforce, funding etc.) around, mainly from acute into community and social care.

> *'If you don't send the inappropriate people into the hospital and we had better community provision for care, then this vicious cycle could be stopped. So there was something in it for everybody, if that makes sense?...If the hospital is going to have an advantage in having more freed up bed space, then that resource could actually be shifted into community to prevent those patients from going into the hospital in the first place. It's about having that movement, not just financial but also workforce and how do we make it work for everybody. That was very apparent when the clinical discussions started happening'.* (Chair, CCG, Case Study 1)

19.5 Risk sharing

In Case Study 2, the place partners negotiated an Alliance agreement but with no pot of money to be shared among the Alliance members. The Alliance agreement was seen as a mechanism or 'a theoretical agreement', setting out broad principles through which sharing of risk or gain would operate. It was envisaged that any risk/gain share would relate to a transformation fund which would not apply to all partner organisations, due to size inequalities:

'In reality we're not going to expect a hospice to indemnify an acute hospital. Some of these are quite small businesses. So I think the main transaction elements on finance, I think, are going to continue to be between the largest financial stakeholders within the health system in terms of if we're struggling with our acute financial position or our community service viability then we'll work through that as an alliance and deploy resources to where they need to be is probably more the reality.' (Place Director, Case Study 2)

The status of delegation of financial decision-making to place was rather unclear. Generally, place members were keen to have decision making responsibility for the money spent in the delivery of place services. At the time of the interviews the place-based partnership boards did not have the authority to make decisions impacting the allocation of resources. But in Case Study 2, it appeared that there was to be an indicative delegation to place, with the place partnership board being able to decide how that money would be distributed and the methodology through which those decisions would be made. The view of the Acute Trust Director was that influence of 'place' members on commissioning decisions had waned since the merging of CCGs: *'Whilst the commissioner was still in place, we were in a position collectively to influence some of the commissioning decisions, for sure.'*.

One risk sharing mechanism mentioned by our interviewees was to have block contracts with the acute Trusts instead of PbR:

'The first thing we actually did was move electives away from the acute Trust from a PBR approach into a block contract. And that helped because the Trust suddenly lost the risk that it had in losing the money that went into it, and we negotiated with the Trust to actually say based on how the number of people go in this year, if the new pathways make a difference, then next year we can actually start reducing it. And the Trust will make money in terms of having freed up bedspace and for them to pick up a more tertiary level of work, which is what the Trust wanted to do'. (Chair, CCG, Case Study 1)

Although all systems in our case studies reported a healthy financial position, one interviewee explained that, in the current climate, due to the COVID-19 pandemic, the notion of financial balance was superficial or even meaningless.

'But there's no such thing as financial balance, is there, really, over the last 18 months, because we've spent what's needed to be spent on the COVID response, and now on

recovery, and it gets topped up to put us into balance. So, [the system] has not, obviously, in the last 18 months, resolved any of those underlying challenges, population growth would be a massive challenge obviously to [system] finances over the next ten to fifteen years, but as a present state, then yes, balance is there, it's just a pretty superficial concept at the moment, I think.' (Director, ICS, Case Study 3)

19.6 Conclusion

The introduction of collaborative working in health and social care was viewed positively by all our interviewees. Interviewees saw the use of competition and competitive tendering as things of the past. They were described as 'yesterday's buzzword', and 'a waste of time, and energy and effort'. Commissioners welcomed the forthcoming repeal of the competitive procurement requirements for clinical services as laid out in the Health and Social Care Act 2012, which they thought would release them 'from a lot of very, very futile transactional activity'. At the same time they were aware of the danger that the ICSs might become 'slightly too cosy', and that they needed to put in place some other mechanisms to ensure value and quality.

The disruption caused by the pandemic encouraged greater collaboration among different organisations and hastened the waning of the competitive procurement regime. There were examples of adoption of more collaborative approaches to 'place resources', e.g. the development of shared roles across organisations, dealing collaboratively with struggling providers, or the development of aligned pathways between some community and acute services. It should be noted that it is not clear from our research to what extent the demise of competition and competitive tendering was occurring in practice, partly reflecting the wider context in relation to the COVID-19 response in which organisations were concentrating largely on operational concerns.

Under the new culture shift towards collaborative working, interviewees were more relaxed about potential conflicts of interest in commissioning decisions. Conflicts of interest were seen as inevitable but also manageable, since collaboration meant that all parties should be working 'towards what's best for the patients'. Participation of service providers in commissioning decisions, was seen to have more benefits than negatives.

Collaboration, not use of competition, was seen as a means of resolving thorny issues, for example, dealing with struggling providers. One view was that, whilst it delivered more transparency in secondary care and greater clinical involvement in strategic and managerial

roles, competition had not helped to improve quality across different providers, but arguably exacerbated the gulf between high quality and struggling providers.

Taking collaborative decisions was not always plain sailing, mainly due to individual providers giving priority to their organisational rather than collective obligations. Discussions about how to re-allocate funds across the system were not leading to resolution of difficult problems, for example, major reconfiguration of acute provision. Some organisations, however, were quite sanguine about the prospect of dropping some of their organisational priorities in favour of shared priorities, if they led to an improvement of services in the locality.

Commissioners were uncertain about using place-based population budgets without destabilising any of their partner organisations. As funds had not yet been devolved to place-level partnerships, however, possible solutions to such challenges had not been tried in practice. Although some examples of collective decisions and sharing of resources were reported (e.g. vaccination processes, ERF management), these occurred during the pandemic when additional money had become available. Commissioners recognised that the real test of financial risk sharing will come in the future, when decisions about priorities will be taken in normal conditions rather than in the middle of a pandemic. They thought good relationships will then prove to be key.

Discussions around negotiating incentives and mechanisms of risk sharing took place at the system level, as this was the footprint for achieving 'system control totals' and ERF targets. Interviewees reported a range of 'softer', indirect, or subtler forms of incentivisation of collaborative working, for example, a move to 'strategic finance', or the increase in transparency of financial reporting and decision-making regarding system-wide resource allocation. Further examples of incentives set at system level to increase collaboration were, having a single Patient Tracking List (PTL) or a system-wide waiting list as one of the criteria for receiving the ERF. As we saw, however, interviewees expressed skepticism about this top-down elective recovery incentive, and there were problems with its application, since individual organisations tended to give priority to their organisational interests and patients. Managing system-wide waiting lists and patient tracking lists were described more as a 'glib vision' rather than reality. Switching to system-wide waiting lists would be a very incremental process. Another form of softer, relational incentivisation was to work towards reducing pressures within the system by moving resources around (e.g. workforce, funding), mainly from acute into community and social care.

One of the existing mechanisms of incentivisation of providers, payment by results (PbR), was described as being less appropriate to collaborative working and had been replaced by more collaborative payment methods, such as 'block contracts'. PbR drove up activity and was unaffordable. It was reported that in future, the focus of block contracts will be on outcomes rather than activity.

At the time of the research, places did not make decisions on investment, incentivization, or financial risk sharing, because they did not hold budgets. In one case study, an Alliance agreement was reached, setting out broad principles for sharing risk or gain. This agreement related only to a transformation fund.

20. Phase 2 - Relationships

Relationships are an important factor in the context of collaborative working. As ICSs are voluntary partnerships, the success in making consensual decisions depends to a degree on the establishment of trusting relationships between partners. As noted in section 15 (Place governance in practice) above, partners are reluctant to formalise relationships, and therefore the establishment of good informal relationships is important to sustain collaborative relationships. This section describes the relationships between partners is our case studies during the second phase of the research in 2021.

20.1 Relationships between place partners

In all our case studies, interviewees were on the whole positive about relationships at place level and the value of bringing different organisations together. The general view was that the place partners had good relationships with each other and were united in a common cause of improving the wellbeing of the population (‘*It feels like we actually all, as I said, like each other, and have one collective view so far, about what we want to try and do.’* (Director, Community provider, Case Study 2)).

Many interviewees stressed the fact that relationships generally improved as a result of working together in place-based partnerships. Others also mentioned the impact of having to deal with the COVID-19 pandemic on improving collaborative working:

> *‘That’s easier now because those relationships are probably so much better than they were. So the chief execs or the chief officers or the managing directors…you know, and at all levels have had so much more contact with their system partners in the last year than we would have done at all. You know, it’s just been one of those, kind of, impacts of COVID has been that organisations have become a lot more outward looking rather than inward looking’.* (NHS Trust Director, Borough-based partnership 1, Case Study 3)

Although relationships were reported to have certainly improved during the pandemic, it was not clear whether this was due to the place configuration or to the need for collaboration in fighting the pandemic.

Relations certainly improved among all NHS partners, such as between acute trusts and primary care services, or mental health and primary care. In Case Study 2, for example, the

Mental Health Trust valued the improvement in the quality of relationships between themselves and GPs/PCNs, and Case Study 1 reported that relationships between the acute Trust and the GPs had certainly improved, due to the deliberate efforts by both parties.

> *'But, you know, genuinely, I think, being able to listen to GPs and understand, you know, who are you seeing in your surgery, what mental health needs do they have, and then talking about things like the community transformation work…We've had some really good conversations, and as with most things, when you get together with a common goal, you work hard to try and make a difference, sure there's some bumpiness along the way. But actually, having the right relationships, and trying to focus on the right thing, does make a difference'.* (Director, Mental Health FT, Case Study 2)

> *'And then what's really changed recently is, you know, over the last year or two, the relationships with the GPs, and the Trust, have been very, very kind of strongly developed. And it's not happened by accident, both parties, the GPs, and ourselves, have worked hard to do that. Because we understand that GPs hold the population base, if you like, the list, yeah. And again, they're the agents of, you know, the people, and for us to kind of engage in a meaningful way, we've not done that in the past, but we are now'.* (Director, Acute Trust, Case Study 1).

20.2 Relationships between NHS and local authority partners

In addition to the improvement in relationships among partners of NHS organisations, interviewees valued the contribution of place-based partnerships to the development of relationships between the NHS and local authorities.

For one local authority, the value of the place-based partnership was the increased familiarity across local partners, and a route to collaborative working which had previously felt inaccessible to them, and which was substantively different in depth from past attempts at co-operation. The value of place was allowing useful connections and networks to be made, for instance with borough councils, so that people could more easily link together to improve service delivery:

> *'It just makes sense that we ought to try to understand what we do and what the respective responsibilities and roles are, and, you know, oddly enough, now, this is one of the simple points, which is that the alliance has helped us, all of us, understand more about what*

other agencies do, because there's a lot of misconception'. (Director, Borough Council 1, Case Study 2)

One NHS respondent reflected on the opportunities for closer collaboration between the local authority and NHS organisations. It was seen as widely understood and accepted that *'local authorities are going to be interested in forming relationships with providers of health and care services around the populations that they're responsible for and interested in'* (Director, Mental Health Trust, Case Study 3). The respondent noted some advantages that local authorities could bring to the delivery of health services, for example, promoting a social model of health and illness, building in some democratic accountability of health services to local communities, and facilitating collaboration around market management, for instance for residential care or supported living services.

At the same time, as noted in section 7 (System action to achieve financial sustainability) in relation to system scale collaboration in Phase 1 of the research, respondents also drew attention to a number of challenges to effective working between local authorities and the NHS. One example of such challenges was the difference in focus between health organisations and local authorities, specifically the wider remit of local authorities (of which social care was only a part), a factor which impacted on the time available to them to focus on care provision and competing priorities. Furthermore, local authorities were political organisations, subject to more internal upheaval and competition or lack of co-ordination across different local authorities:

> *'You sometimes get competition at a council or between the various boroughs, and that then translates into less coordination at a strategy level across the whole partnership'*. (Place Director, Case Study 2)

> *'Local authorities have more freedom in some regards than health organisations do with regard to their…how they finance their priorities. But then of course from a local authority perspective,…we have far more oversight, political oversight in a local authority than NHS organisations do'*. (Director, Borough Council 2, Case Study 2)

Further challenges to the relationships between local authorities and NHS organisations were structural and pertained to different business and planning cycles and rules that govern the two sectors and a different approach to procurement:

'When you start to think about a single place-based business planning cycle it's really quite difficult. We [local authorities and NHS] do things in a very different way, very different timelines, again you have the kind of elected member element of budget settings in local authorities who really doesn't align. And then culturally – and this is going to be exacerbated by the White Paper – local authorities have a very different take on procurement to the NHS. Very often procurement is quite tightly managed, whereas the NHS tends to be a bit more comfortable with risk around that'. (Director, Mental Health Trust, Case Study 3)

From the perspective of the NHS respondents, local authorities are subject to political allegiances which sometimes resulted in conflicting priorities between political preferences and the health and social care needs of the local population:

'The only thing that I would probably sometimes want to hint on, and we've had some conversations around this, is the fact that the local authorities are so reliant on their political allegiances on where they want to be. And sometimes that's not always the best thing because you want to move away a little bit from political influence. It has its place but in terms of what's important for a political party, might not necessarily be the most important thing for the general population or the patients that we cater for'. (Chair, CCG, Case Study 1)

From the point of view of local authority respondents, the place-based partnerships were seen as being too health-led:

'We've got a well-established, good relationship with the local authority through the Better Care Fund. And that's been in place for a while. I think like most areas, the local authority feel that STP and ICS and ICPs are very health-led. And it's very much the health agenda'. (Director, CCG, Case Study 1)

In cases where the place-based partnerships were not coterminous with one local authority, differences in political allegiances among the different local authorities made collaborative working difficult:

'One of the challenges in all of that is the political leadership which I think needs to be really strong but also will be different in each of the boroughs so that doesn't necessarily help from an NHS point of view. I think from a borough point of view that's

going to be key, really' (Borough Director, Borough-based partnership 3, Case Study 3).

In Case Study 3, in relation to the 'double-layer' place set up, interviewees acknowledged that one of the local authorities involved in the footprint was particularly unhappy about the rationale for the intermediate subsystem level. That local authority had a long history of partnership working among different organisations at the borough footprint, and preferred to engage with a borough-based place partnership which neatly circumscribed the population that the borough served and was accountable to. The local authority participated in the operational delivery issues but was more reluctant to engage in strategic commissioning and planning discussions at the subsystem footprint. Perceiving the subsystem partnership as an extra unnecessary layer within the ICS structure, did not help the buy in:

'And there's a bit of a sense that [the subsystem] is just some kind of NHS bureaucratic structure, it's another layer, it's irrelevant, it doesn't help them, and we've got to prove all those things wrong. And I think the way we do that is by not trying to do too much at [subsystem]. If we try and centralise everything, we will do ourselves a disservice, actually, I think, you know?' (Director, CCG, Case Study 3)

However, some interviewees also noted that a lack of buy in might be just down to different perceptions rather than more substantive issues. Nevertheless, the attitudes towards the subsystem level had to be handled sensitively in order to avoid creating in the local authorities the perception of NHS dominance and hierarchy building. Efforts to simplify the system architecture by scaling down the intermediate subsystem tier in this case study, would be welcome by some of the local authorities which advocated a greater role for the borough footprints. However, as one commissioner noted, there may still be different visions between NHS and local authority stakeholders of how the place-based partnerships should be constituted.

'That local authority, I think, is really welcoming of the emphasis back on the borough. What we've got to work through, obviously, is what that means in practice. Because it doesn't mean what actually that borough would probably like, which is the return of its own single CCG, or an entire place budget, place team, place leadership team and so on.' (Director, ICS, Case Study 3)

20.3 Relationships among NHS partners

In addition to the challenges related to the working relationships between local authorities and the NHS, interviewees identified potential difficulties in relationships between the various NHS place members. In Case Study 2, for example, place working was acknowledged to be relationship driven. While there was an open recruitment process for the place director, it was also seen as a necessity that the post holder was locally embedded, especially in the acute Trust:

> *'So the partners have to select their own individual, then that individual has to be well embedded in their organisations in order to know the detail, particularly with the acute trust. I think that's just an inevitability, the acute hospitals really do set the tone in terms of partnership and the running of the system'.* (Place Director, Case Study 2)

The acute Trust's attitude towards change and openness to co-operating was acknowledged as an important factor in setting the tone for place relationships:

> *'And clearly I think they acknowledge that our acute trust leadership sets a lot of the tone and is very positive and progressive, collaborative tone which I think has allowed us to accelerate I think comparatively faster than a lot of the rest of the country. I think acute hospital's leadership role in doing that and looking beyond the four walls of a hospital trust I think is incredibly powerful…'* (Director, Acute NHS FT, Case Study 2)

A tension was also reported between the acute Trust and primary care. This predated system working and reflected largely professional tensions. However the pandemic had encouraged collaboration as *'there was absolutely no alternative but to work collaboratively and share stuff and come together, which we did brilliantly'* (Director, Acute NHS FT, Case Study 2).

In Case Study 2, the social enterprise viewed its relationship with partners as slightly uneasy, due to not being an NHS statutory organisation, and therefore more at risk from contracts not being renewed:

> *'So, in some ways we could potentially benefit from that, of being the player inside. We'll see. I still take a slightly sceptical view and it's really interesting when I talk to (ICS Director) and I suppose it is part of my role, I always have to watch my back. I just get the feeling, you know, at any opportunity I'll get stabbed in the back, and yeah, (ICS Director) keeps on trying to reassure me, but it's just trust, I don't trust them. And while we're playing the role at the moment, it's fine, but it*

could change tomorrow, yeah.' (Director, community social enterprise, Case Study 2)

20.4 Conclusion

In general, relationships were reported to have improved across the board, and participants were positive about collaborative working, without implying, however, that tensions did not still exist among the different elements of partnerships. It was stressed that relationships had improved as a result of working together in place-based partnerships, and of having to deal with the COVID-19 pandemic. It was not clear, however, whether this improvement was primarily due to the impact of place or the need for collaboration in fighting the pandemic.

NHS respondents were positive about working closely with local authorities, and noted the advantages local authorities could bring into health services delivery, for example, promoting a social model of health and illness, increasing the democratic accountability of health services to local communities, and facilitating collaboration around market management, for instance for residential care or supported living services.

At the same time, respondents drew attention to a number of challenges to effective working between local authorities and the NHS. One example was the difference in focus between health organisations and local councils, specifically the wider remit of local councils (of which social care was only a part), a factor which impacted on the time available to them to focus on care provision and competing priorities. Further reported challenges were differences in governance arrangements and financial controls, and the political nature of local authorities which made them subject to more internal upheaval. Some structural factors, such as differences in business and planning cycles between the two sectors and a different approach to procurement, were also noted.

From the perspective of NHS respondents, local authorities are subject to political allegiances which sometimes resulted in conflicting priorities between political preferences and the health and social care needs of the local population. From the point of view of local authority respondents, the place-based partnerships were too health-led. Lack of coterminosity in some cases between place-based partnerships and local authorities further complicated the relationship.

In addition to the challenges related to relationships between local authorities and the NHS, interviewees reported some tensions between the various NHS place members, for example, the position of provider organisations who were not statutory NHS organisations such as the

social enterprise in Case Study 2, or historical professional tensions between secondary and primary care staff. However, it was made clear that the pandemic hastened collaboration.

21. Phase 2- Future development of system working

We asked interviewees to describe the most important challenges in the future, taking into account the latest policy guidance (including the Health and Care Bill). Their views related to two main points. One was the question of how the different elements of the new architecture will be linked together and how clear the accountability lines will be. The other issue was the role and power of provider collaboratives, especially in relation to place.

21.1 The new architecture and the Health and Care Bill

One view about the new Health and Care Bill was that it put into practice what had been promised in the White Paper i.e. turning ICSs into statutory bodies. However, interviewees were keen not to lose the local focus of place. It was therefore important to get the balance right between the functions of ICSs and those of their individual localities represented in non-statutory entities such as place (see also section 17 on 'apportioning functions and decisions between system and 'places').

> *'I think we are keen locally to make sure that we…although we're putting the system on a statutory footing, particularly in our particular context, that we don't lose that really strong focus on place…So it is really for us getting the balance right within the statutory ICS about doing things at the system level where that makes sense and adds value. But also keeping that really strong connection in with each of our places'.* (Director, CCG, Case Study 1).

One source of dissatisfaction with the legislative proposals was the lack of inclusion of place. This felt to some interviewees to be a 'diminution' of place. There were fears that there would be a pulling back from giving decision making responsibility to place, with the Bill encouraging NHSEI to place most of the control with ICSs:

> *'I would really hate to see that reversed because of things from government and the NHSE wanting the ICSs to have more control, more power, or whatever else it is. Which means that we can't do what we want to do where we live and work…The last year, everything that's happened in [place] has been…most of it has been pretty much bottom up. Because of COVID we had to get on and we had to do stuff. And we did some really amazing things. And we did them really, really quickly. And having that…being nimble enough to be able to do that is what makes the difference. (*Director, GP Federation, Case Study 2)

At the time of the research, resources had not been devolved down to the place level. The members of place-based partnerships were wondering how much power and influence they would have after the establishment of ICSs as statutory bodies. Places were trying to agree their future governance arrangements and clarify their role in the ICS:

> *'The biggest question for us as a partnership is what's the next stage and what's the extent of our ambition as a partnership and how do we then fit into the rest of the ICS development and what sort of partnership do we need to be to make that reality. One of the biggest questions, for example, is around how much influence or decision making the partnership will have in terms of the resources that we have available across our system'.* (Borough Director, Borough-based partnership 3, Case Study 3)

A further issue that occupied our interviewees, was the need to make clearer the lines of accountability within the new architecture (see section 16 on 'accountability').

> *'And the challenge will come now is you stand up these new governance architectures, how are we going to get everything aligned, where will the real accountability be, because at the moment we seem to be having duplication or triplication of blooming everything'.* (Director, Acute NHS FT, Case Study 2)

Another interviewee could not see the need for the policy changes (at least in that area), expecting them to result in less transparency and accountability when it came to decision making:

> *'For us there was no need to change it because again, as I said before, in our health economy, we have one hospital trust, we have one CCG, we have a group of GP practices who are very vocal but very practical and understanding of all the challenges in the system and we worked well. We delivered, why change that? And we don't think that moving to an ICS will make it any easier, we believe it will make it more difficult because you don't know who's making the decisions and you feel like it's more being done to you than the fact that you can influence it'.* (Clinical lead, PCN, Case Study 1).

Some interviewees thought that it was a mistake to leave the sovereignty of NHS Trusts and FTs in place, because a misalignment of 'organisational' and 'system' interests, particularly for acute Trusts, made possible their defection from collaboration and from taking a system view.

> *'So my organisation is very collaborative and we try and encourage our partners and colleagues to be collaborative as well, and hopefully that will get us through. But ultimately, I don't know, if the NHS board for [system] comes up with some sort of plan that means that I'm going to lose 20 per cent of my income, my board are just not going to…because they're going to say, well, we're accountable for the quality of care in this hospital, and unless you're going to take away 20 per cent of the patients, which I very much doubt, then we're not going to…so we'll fight you all the way. So, it is a problem, isn't it?'* (Director, Acute NHS FT, Case Study 2)

One of the challenges the new systems will have to face is dealing with failing organisations within the system, or resolving disagreements in general. '*But I think, as you'd understand, there's a very strong expectation that system leaders will resolve these things locally rather than needing to escalate them up to a regional level'.* (Director, CCG, Case Study 1*)*. One interviewee predicted that ICSs would probably develop into smaller versions of the regional NHSEI and similar to the old Strategic Health Authorities.

> *'I mean, I think what will become increasingly challenging is NHS England/Improvement in its responsibility to support challenged Trusts has struggled to do that with individual sites, wrapping them up into big multi-sites is not always the solution, making it a system responsibility for that makes that even more challenging. And I think that's a real challenge for NHSEI, is how is it going to work with and through these Integrated Care Systems to achieve that. And this is why I can see some of the logic, but also some of the drawbacks of some ICSs looking at themselves like you would have seen a strategic health authority, and some of those worked very well by having, here's my director of performance, here's my director of finance, here's all those things that will oversee these functions on behalf of a region and sort of replicating a sub NHSE/I function'.* (CCG Director, Borough-based partnership 2, Case Study 3)

Systems may therefore face difficulties arising from the need to regulate themselves.

Some interviewees saw the value of the legislative proposals in bringing 'providers in commissioning boards' (ICS Director 1, Case Study 2). However, it was stressed that, since providers will continue to exist as statutory bodies, the fundamental factor which will make a difference to collaborative decision making was the relationships within the partnerships, rather than the presence of providers in commissioning boards *per se.*

Although it was recognised by many interviewees that good relationships were vital to the success of the policy changes, some interviewees thought that good relationships between partners in the collaboratives may not last when faced with real challenges.

> *'I'd imagine there'll be some drift to that as people start to say this all fluffy holding hands and grand partnership stuff will be tested very, very quickly when there is service failure, when waiting times become much more a public interest and so on, I think that will genuinely challenge the happy families that we're talking about in the abstract'.* (CCG, Borough-based partnership 2, Case Study 3)

Interviewees were therefore uncertain that the good relationships will be maintained in the future and thought that retaining the statutory status of providers may prove to be an obstacle to collaborative decision making, when those decisions went against the interests of the individual providers. Some interviewees also thought the new systems may be less transparent in their decision-making processes, while some others doubted the need for another major policy intervention. On the positive side, some interviewees welcomed the prospect of including providers in commissioning decision making boards.

21.2 Provider collaboratives

Although not included in the Bill, policy guidance stipulates the formation of provider collaboratives in each system [(NHS England and NHS Improvement, 2021e). The guidance defines provider collaboratives as 'partnership arrangements involving at least two trusts working at scale across multiple places, with a shared purpose and effective decision-making arrangements' (p.5). It is not clear what form provider collaboratives will take in the new architecture, but interviewees expressed a number of views about them.

There was uncertainty about the definition of 'provider collaboratives'. A prevalent view was that provider collaboratives were nothing more than the partnership working that organisations had been engaged in for a long time, and that it was simply a new phrase to describe existing arrangements. For example, Mental Health Trusts had been working collaboratively for some time across large geographical areas (such as ICS footprints), and in many cases collaborated with the voluntary sector to deliver services. Similarly, various specialty networks (e.g. pathology or urology networks) had been in existence for some time.

Uncertainty regarding the relationship between 'provider collaboratives' and 'place-based collaboratives' was noted at the time of interviews (although this was before the policy

guidance was published (NHS England and NHS Improvement, 2021e)). Specifically, interviewees wondered whether provider collaboratives would supersede place-based partnerships, and whether a burgeoning of collaboratives and membership would spread staff too thinly.

Case Study 3 had made more progress towards formalising provider collaboratives. Interviewees reported that there were a number of forums for developing provider alliances, in particular 'acute provider alliance' and 'mental health provider alliance'. These bodies were holding regular meetings and had specific programmes of work.

Interestingly, the provider collaboratives in Case Study 3 were operating at the system footprint rather than smaller scales of place (anticipating the policy guidance on provider collaboratives). In particular, three acute trusts cooperated on critical care during the pandemic and on elective backlog recovery. That cooperation was supported by joint decision-making around service planning and service delivery on issues such as joint workforce planning and key clinical priorities. Although some collaboration was taking place, it was also acknowledged that the three trusts were still far away from the point where they could be seen to *'just start running with other things [as] if they're one organisation, and we're nowhere near that'*. (Director, Acute provider, Case Study 3). It is also important to note that this was not the only collaborative footprint on which acute providers collaborated, as some collaborations, for instance around pathology services, happened on a different footprint involving different sets of acute providers. This indicates that choosing the right model of collaborative (e.g. loose cooperation, merging of services, specialty networks) in each geographical area may prove to be challenging.

There were also similar collaboratives among mental health providers, building on their experience of participating in the specialist mental health services alliances. The operation of mental health collaboratives, however, was facilitated by the existence of a prescriptive national framework, which was absent in the case of potential community health services or primary care collaboratives.

Some interviewees were positive about the benefits that provider collaboratives would bring, as long as the policy reforms would 'push together' provision and commissioning, and system partners (including provider collaboratives) would be taking collective responsibility for population health and capitated budgets instead of the existing internal market mechanisms.

> *'If the intention is to kind of grab some of the ways of working from the pandemic, and think about how you really focus on population health, and clinical expertise, and commissioning expertise, and services, you know, moving together and so on, then you need to use, one needs to use, the provider collaborative sort of vehicles, to hold the commissioning responsibility. And make the providers around the ICS take responsibility for that kind of set of strategic, population health, commissioning challenges, as well as the provision ones…It will definitely advance us two or three quite significant steps, because we won't be squabbling between providers and commissioners, and multiple boroughs, in quite the same way that we normally do, about where the resources flow, and where the population lead is, and so on.'* (Director, Mental Health Trust, Case Study 3)

This view was shared by the Case Study 3 regional NHSEI interviewee who also envisaged an oncoming change in the function of commissioning, with providers becoming part of a 'community of leadership', responsible for commissioning services within a set funding allocation and for a defined population and a move away from '*old fashioned transactional contracting*'. The interviewee had a rather relaxed attitude about the variety of organisational forms that provider collaboratives may choose to adopt in different systems across the country, as long as they focused their efforts on reducing unwarranted variations in access and outcomes, and delivering financial sustainability and efficiency:

> *'My view is what we should be saying to provider collaboratives, we don't care how you organise yourselves, yeah, but there are three things we're expecting you to do. We're expecting you to take out unwarranted variation in access to and outcomes of care through a consolidation of a single PTL [patient treatment list] and a consolidation of a single way to measuring outcomes and improvement. Secondly, to ensure that each constituent part of your infrastructure is clinically and financially resilient, yeah?... And thirdly reducing back and middle office costs.'* (Director, NHSEI, Case Study 3)

Regional NHSEI interviewees saw provider collaboratives as potentially addressing a wide range of material problems depending on local context. Examples given were provider sustainability and quality issues. The expectation was that some provider collaboratives would take the form of 'horizontal' integration, for example collaboration across elective services, where economies of scale would solve problems in a better way than individual organisational

solutions. Mental Health provider collaboratives were seen as a successful test bed for *'giving providers more autonomy and flexibility of the use of resource in order to deliver the right pathways for their populations'* (Director, NHSEI, Case Study 2). It was also anticipated that there would be more 'vertical' integration, *'knitting together primary care, community services, acute, all that in that pathway re-design stuff'* (Director, NHSEI, Case Study 2).

One regional NHSEI view was that the reforms would create more shared accountability across providers, and that the relationship between place configurations and provider collaboratives was a 'happy combination' of partners, scales and problems to be addressed. The NHSEI role in relation to these arrangements would include encouraging reticent areas to be more ambitious with their plans for collaboration between providers. However, another view was that, although provider collaboratives offered a lot of opportunities to take on delegated responsibilities, they might complicate accountability relationships even further, and the interface between provider collaboratives and place-based partnerships remained unclear.

> *'I do think that the provider collaboratives are a really significant element of our thinking going forward. (...) quite what provider collaboratives and these delegated responsibilities mean for [Place Based Partnership] organising I think it is to be decided. It makes my brain hurt a bit when I try to think about it too hard.'* (Director, Mental Health Trust, Case Study 3)

Some interviewees expected that provider collaboratives would develop into key decision makers and budget holders, covering whole pathways from prevention to specialist services, and working across multiple levels and footprints simultaneously. They were seen therefore as an obvious example of the difficulties partners would have to face when deciding on the governance arrangements of the new system architecture.

> *'So the money comes into the ICS, it's then delegated to someone who can with partners take those decisions. And I think the same goes for provider collaboratives that are emerging as well, so we're looking at provider collaboratives taking sort of cradle to grave, specialist to primary prevention budgets…they have to do that in a context of they will be accountable for the outcomes of money…because it's increasingly going to look like a bit of a plate of spaghetti, where different people at different abstractions are responsible for different levels, and I think that's why the governance is very hard to describe'.* (CCG, Borough-based partnership 2, Case Study 3)

One of the main advantages of provider collaboratives was the expectation that it would be 'their responsibility to try and drive efficiencies through redesign'. Specifically, it was noted that the assumption of commissioning responsibilities by provider collaboratives was a significant sea change, which would necessitate their boards accepting risk for excess demand.

> *'And, I know, certainly, in the last wave of provider collaboratives, mental health, you know, that's been quite a focus of attention for the board, is, what risk are they now taking on? Because some of these more specialist child and adolescent mental health stuff is growing like topsy because of COVID, but the resource for that service isn't growing like topsy because we have a finite budget.'* (Director, NHSEI, Case Study 2)

In future, the creation of 'self-governing systems' would mean that the role of regional NHSEI will diminish but it will not disappear.

> *'You know, as we're expecting them to become self-improving systems and to lead on more of this, kind of, quality improvement approach, that our presence in it should start to diminish a bit, but we won't get out of that business, because we can't'.* (Director, NHSEI, Case Study 2)

21.3 Conclusion

The views of interviewees on the future development of ICSs focused mainly on the issues of the connection among the parts of the new architecture and the position and role of 'provider collaboratives'. Interviewees noted that there was no mention of place in the Health and Care Bill and feared that the role of place may be diminished in future arrangements, with the danger that the local focus will be lost. They stressed that it was therefore important to get the balance right between the functions of ICSs and those of their constituent localities, represented in non-statutory entities such as 'places'.

Some thought that the policy changes will result in less transparency and accountability when it came to decision making, while others foresaw that systems will be facing difficulties arising from the need to regulate themselves when it came to settling disputes. One interviewee predicted that ICSs would probably develop into smaller versions of the regional NHSEI and similar to the old Strategic Health Authorities.

Including providers in commissioning decisions was seen, in general, as a positive development. It was stressed, however, that, since providers will continue to exist as statutory bodies, the fundamental factor that will make a difference to collaborative decision making

will be the relationships within the partnerships. On the other hand, some interviewees feared that good relationships may not last when collaboratives will be facing real challenges.

It was noted that provider collaboratives were not a new innovation since they had been operating for some time in some form or another. Mental health and other specialties (e.g. urology, pathology) were mentioned as examples of existing provider alliances or networks. Importantly, interviewees wondered whether provider collaboratives would supersede 'places' and whether a burgeoning of collaboratives and membership would spread staff too thinly.

Interviewees were positive about the future merging of the functions of provision and commissioning (encapsulated in provider collaboratives) and the abolition of 'old fashioned transactional contracting' that such merging entailed. The view from policy agents (NHSEI) was that provider collaboratives were expected to bring about efficiencies by taking the risk of excess demand. One regional NHSEI interviewee had a relaxed attitude about the variety of organisational forms that provider collaboratives across the country may choose to adopt, as long as they focused their efforts on reducing unwarranted variations in access and outcomes, and delivering financial sustainability and efficiency.

The expectation was that provider collaboratives would take forms of both 'horizontal' and 'vertical' integration. An example of 'horizontal' integration would be collaboration across elective services, where economies of scale would solve problems in a better way than individual organisational solutions. Mental Health provider collaboratives were seen as a successful test bed of provider collaboration. It was also anticipated that there would be more 'vertical' integration, 'knitting together primary care, community services, acute care', via pathway re-design processes.

Significantly, some interviewees were not clear about the interface between provider collaboratives and place partnerships, and feared that provider collaboratives would blur further the accountability lines within the NHS hierarchy.

22 Quantitative evaluation of the effect of ICS status on health system outcomes

An aim of this research study is to establish whether ICSs are able to allocate resources more efficiently across sectoral boundaries, and thus provide improved services which better address the needs of the population. In order to assess the impact that being an ICS is having on the delivery of integrated services, we conducted a quantitative analysis to establish if ICS status could be linked to an improvement in outcomes.

We assessed the impact of ICS status on health system outcomes through an analysis of routine data about health and care activity. We used non-experimental programme evaluation methods to estimate the impacts of ICSs on distribution of spending across sectors, indicators of integration and care quality, and health outcomes. We used the following national data: the GP patient survey, specifically whether indicators regarding whether patients with long term conditions had their need met; ONS data concerning preventable mortality; and delayed transfer of care data.

The analysis exploits the different waves of adoption of ICS status across the country. ICS status was granted, as STPs matured, to the most advanced local partnerships within which collaboration was well progressed. As the waves of systems obtaining ICS status are non-random, we used advanced programme evaluation methods to attribute any changes in outcomes to ICS status. As we expected the effect of being an ICS to be gradual we paid particular attention to developing impacts over time.

22.1 Methods

Onset of the policy

The designation of ICS status to different systems was staggered over time, and ICS status was first granted from April 2015. There are only two waves of ICSs used in the analysis. In this study we define the first wave of ICSs as systems which were granted ICS status up to and including June 2017. The second wave of ICSs is those systems granted ICS status from July 2017 up to and including May 2018. Appendix A1 details the systems included in each wave in this analysis.

Estimation strategy

To estimate the impact of ICS status on each of the outcomes, we adopted a Difference-in-Differences (DiD) approach (O'Neill et al., 2016). DiD estimates the overall effect of ICSs on outcomes by comparing the change between the outcomes for ICS units (treatment group) before and after the introduction of ICSs with control units. Control units in this study are systems which have not yet gained ICS status within the time period of the data. The main assumption of DiD is that the outcomes between the treatment and control units are parallel before the introduction of the intervention. If the parallel trends assumption does not hold for an outcome, we adopted a Lagged Dependent Variable approach. This is less prone to bias and is more efficient than DiD for cases where the parallel trends assumption is violated (O'Neill et al, 2016).

Lagged Dependent Variable approach uses a fixed vector of lagged values of the outcomes prior to the intervention as explanatory variables. The analysis is conducted only on the time points following the intervention (O'Neill et al., 2016). Unlike the difference-in-differences method, the lagged dependent variable approach does not require the assumption of parallel trends between the control and treated units.

We display all results using coefficient plots with 95% confidence intervals. All estimations were conducting using Stata 17 and were clustered at the organisational unit (Upper Tier Local Authority or Clinical Commissioning Group). The parallel trends graphs are displayed in the appendix.

Measuring treatment unit

For the purposes of this analysis, a treatment unit is defined as the Upper Tier Local Authorities and/or Clinical Commissioning Groups within a system that became an ICS in the first wave. The choice between using Upper Tier Local Authority and/or Clinical Commissioning Group as the treatment unit is determined by the organisational level the data is provided, e.g if data is provided at the GP Practice level, our analysis will be at the Clinical Commissioning Group level. We measure the treatment unit using a binary indicator taking values of zero if the organisation was not involved in wave one, and one if the organisation was. We also extend this analysis to measure treatment intensity. Treatment intensity refers to the number of statutory organisations and independent sector service providers (CCGs, upper tier local government, NHS Trusts, and independent sector providers) recorded as ICS partners on ICS websites as at April 2021. Intensity relates to the complexity of the integration challenge. The

hypothesis is that in the short-term higher intensity is likely to produce less good outcomes, as the integration task is more onerous as the volume of separate organisations involved increases. It may be in the long term that there is also more to gain from integration involving more organisations but long-term data is not available to test this.

We include a list (Table A1) in the Appendix A1 which includes all wave one and two ICSs and Clinical Commissioning Group and Upper Tier Local Authority members and the value of the intensity measure.

Robustness

The observation period is limited to the period up to 2019 in order to exclude the disruption caused by COVID-19 pandemic on all the health system outcomes used in this study. Over the observation period of the study, organisations involved in wave two of the ICS roll out are in the control units in all models. This is expected to reduce the effect size of ICS status on outcomes as some treatment units are in the control units. We did not include wave two units (granted ICS status in May 2018) as treatment units. This is because the period to 2019 may be too short of a time frame to attribute any impact of ICS status for wave two ICSs. To mitigate this potential limitation, we estimate all models removing all wave two units from our sample.

22.2 Data

We obtain health system outcomes from three sources of data (GP Patient survey, preventable morality and delayed transfers of care), each indicating different performance measures across health and social care.

GP Patient survey

GP patient survey (GPPS, 2018) is a survey that invites patients from all GP practices in England who are over the age of 18 years old and been registered to their current GP practice for over one year to complete. This survey is weighted to become representative of the GP practice population. We obtain this data from this data series which are published in April (data collected between January and March) every year from 2012 until 2018. We aggregate this data to the April 2020 configuration of the CCGs. From the GP patient survey we extract the percentage of respondents that:

1. Have a long-term condition that have health needs met from the available care services.
2. Have a long-term condition that have health needs that are partially met from the available care services.

3. Always see preferred GP when requested
4. Sometimes see preferred GP when requested
5. Record having good overall experience with the GP practice

Using GPPS data, we have obtained one post intervention time period being 2018. GPPS data published in April 2017 was sampled in January to March of the same year, and therefore sampling was conducted in the pre-intervention period. In total our estimation sample consists of 938 CCG-years.

Mortality

Preventable mortality in the UK (ONS, 2019) for each CCG (April 2020 configuration) as a rate per 100,000 population. The International Classification of Disease version 10 (ICD-10) is used group causes of death which were preventable. We obtained this data for each calendar year from 2001 until 2019. We specify that 2018 and 2019 will be considered as post intervention periods. Although the intervention start point was June 2017, as the data is in calendar years, the first five months of 2017 would be prior to the intervention, and as such, we treat the whole years as pre-intervention. Our estimation sample consists of 2,546 CCG-years

Delayed Transfers of Care

The number of Delayed Transfers of Care (DTOC) (NHS England, 2020) days per 100,000 population. We obtain this monthly data for each Upper Tier Local Authority (2018 configuration) between January 2011 until November 2019. We obtain this data for:

1. All causes for DTOC
2. DTOC due to NHS
3. DTOC use to social care

We specify that June 2017 until November 2019 are post-intervention. Our estimation sample consists of 15,943 UTLA-months, where 4,917 UTLA-months are in the post-intervention period.

22.3 Results

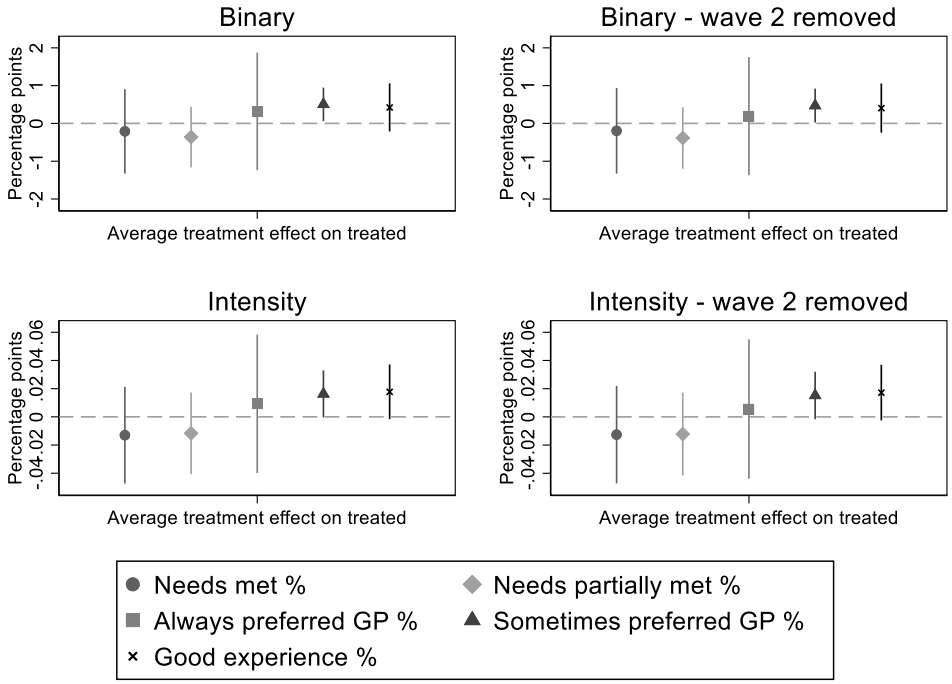
GP Patient survey

Figure 4 shows the estimated effect of ICSs on outcomes from the GP patient survey. We find that ICSs are associated with a lower percentage point probability of patients with long term conditions to have their needs met or partially met when compared to CCGs that were not a part of an ICS, although this result is not statistically significant at the 95% level. We find that

ICSs are associated with an increased probability of patients being able to always see their preferred GP and have an overall good experience, however both are not statistically significant at the 95% level. These results are similar when removing wave two organisations or when using an intensity indicator.

We find that being in an ICS organisation is associated with an increase in the probability (0.5%) that patients sometimes see their preferred GP. This is statistically significant at the 5% level, and holds when removing wave two organisations. We do not find a statistically significant result at the 5% level when using an intensity treatment measure.

FIGURE 41: ESTIMATED EFFECT OF ICS ON OUTCOMES FROM GP PATIENT SURVEY

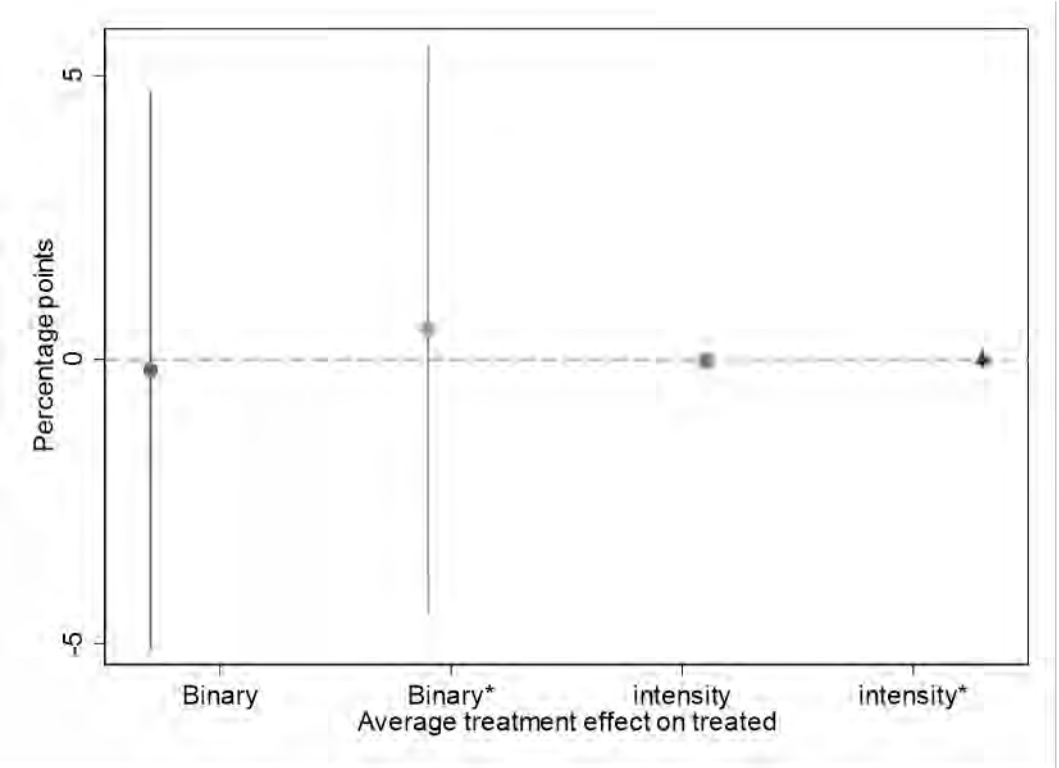


Notes: coefficient plots are from Different-in-Differences estimations. 95% confidence intervals are displayed. The top left pane shows the entire sample using a binary indicator for an ICS. Bottom left pane shows is the entire sample using intensity as the number of organisations within the ICS. Top right pane using a binary ICS indicator removing all wave two organisations. Bottom right pane shows ICS intensity with wave two organisations removed.

Mortality

Figure 5 shows the estimated associations of ICS status on preventable mortality. We find that wave one and two systems have very different rates of preventable mortality as removing wave two organisations change the estimated effect of ICS status from lowering preventable mortality (-0.18 percentage points) to an increase in preventable mortality (0.5 percentage points). This relationship is similar to one found using the intensity measure. We do not find a statically significant relationship between preventable mortality and introduction of ICSs.

FIGURE 5: ESTIMATED EFFECT OF ICS ON PREVENTABLE MORTALITY



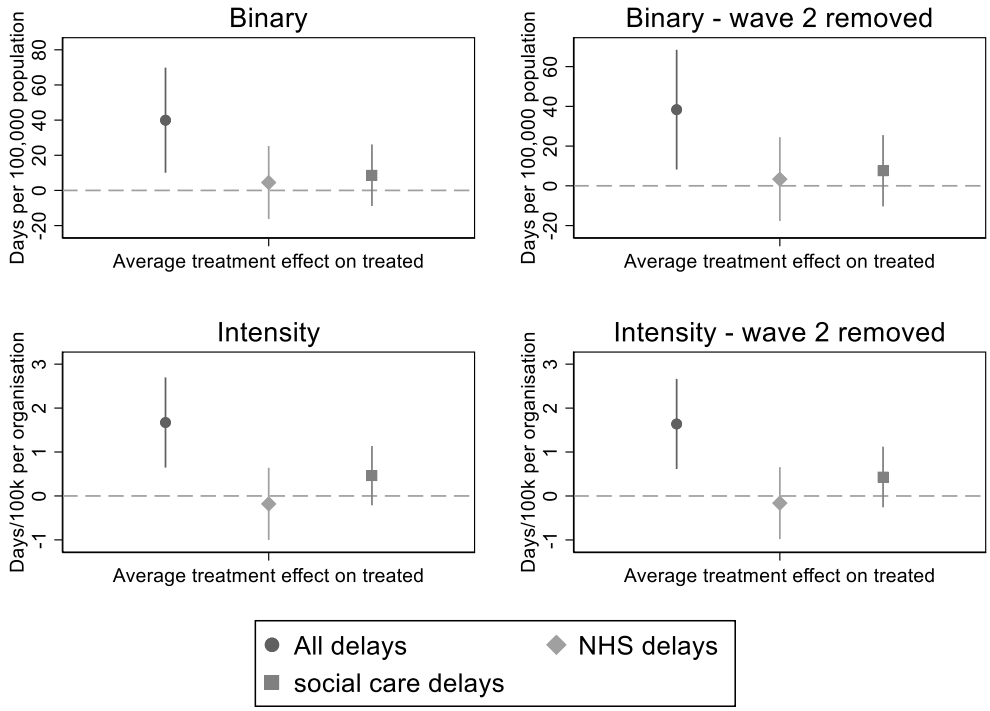
Notes: coefficient plots are from Different-in-Differences estimations. 95% confidence intervals are displayed. *signifies that the estimations remove organisations that are involved in wave two of an ICS

Delayed Transfers of Care (DTOC)

Figure 6 shows the effect of being in an ICS on all delayed transfers of care, delays due to NHS and delays due to social care. We find that being an ICS is associated with increased DTOC (40 days per 100,000 population, $p<0.01$), however, when estimating DTOC due to NHS or social care separately, we do not find a statistically significant effect. When using the intensity measure, we find that an increase of one organisation within an ICS is associated with an increase of 2 days ($p<0.01$) per 100,000 population.

When using a binary indicator, we find no effect of ICS on DTOC due to the NHS or social care, with or without wave two organisations. We find that when using an intensity measure, being an ICS led to a reduction in DTOC due to NHS (-0.3 days per additional organisation in the ICS per 100,000 population), however this is not statistically significant at the 5% level.

FIGURE 6: ESTIMATED EFFECT OF ICS ON OUTCOMES FROM DELAYED TRANSFERS OF CARE



Notes: coefficient plots are from lagged dependent variable estimations. 95% confidence intervals are displayed. The top left pane shows the entire sample using a binary indicator for an ICS. Bottom left pane shows is the entire sample using intensity as the number of organisations within the ICS. Top right pane using a binary ICS indicator removing all wave two organisations. Bottom right pane shows ICS intensity with wave two organisations removed.

22.5 Conclusions

We largely do not find an effect of being an ICS on the set of outcomes from the GP patient survey. This result may be due to the limited impact that a CCG or ICS could have in the day to day running of a GP practice, especially on matters such as how a GP practice should allocate appointments. We find that preventable mortality did not have a statistically significant relationship with being an ICS, however, our follow up period may be too soon to find any impact of being an ICS on preventable mortality. We find that being an ICS is associated with an increase in the Delayed Transfers of Care, however, we did not find a statistically significant effect when assessing delays caused by NHS or social care separately.

In relation to the intensity measure, the data does not bear out the hypothesis that in the short-term higher intensity of separate organisations within an ICS is likely to produce less good outcomes.

These findings suggest that being an ICS is not having a discernible effect on outcomes to date. These findings are highly caveated as the limitations below indicate. In this analysis ICS impact against outcomes is compared against the progress of STPs. One argument that may be made is that system working itself will improve outcomes, and comparing STP impact on outcomes to ICS impact may be lessening the perceived impact of ICSs. Furthermore, it is also the case that some of the impact of partnership working on outcomes is likely to be ascertained in the long rather than short term. Therefore it is recommended that the analysis is repeated in the future.

22.6 Limitations

This study has a few limitations:

1. We identify a treatment organisation when an organisation is involved in wave one of the ICS roll out. This means that the control group will have organisations which will become a part of an ICS within our study period, i.e. wave two ICSs. We would also expect that some wave three ICSs would have planning in place before the roll out, which may also affect our measured outcomes. To mitigate the effect of this limitation, we re-estimated all models, excluding all organisations that are a part of the wave 2 ICS roll out, this resulted in similar findings to models that included wave two ICSs in the control unit.
2. The onset of the ICS roll out during wave one across all organisations was not at June 2017, it was instead staggered where more wave one organisations became a part of ICS over a two-year time period. Our analysis states the onset of ICS was June 2017 which is up to

two years after the first ICS deal in Greater Manchester was agreed. This means our results would be a modest estimate. However, preliminary research investigating the effect of Devolution in Manchester largely found no impact on a range of outcomes across the health and social care system. That study, not published, concluded that a two-year post policy period was not sufficient to find any effect of the intervention.

3. To mirror limitation two, this study may not have sufficient post intervention time points to effectively evaluate the effect of an ICS on outcomes. When we take the case of preventable mortality, in particular, the impact of an ICS on preventable mortality may not be found when using data only two years after intervention.
4. The onset of the COVID-19 pandemic means that it is not recommended to assess the effect of being an ICS on health and social care outcomes after March 2020. The COVID-19 pandemic affected different regions differently. Therefore we cannot account for the effect of COVID-19, and extract the effect of the pandemic from all outcome data. This means that we may not appropriately attribute all changes to being an ICS.
5. Any changes that exist after June 2017 on populations which is not attributable to being an ICS may also affect our estimates. The estimation methods used require that changes to our outcomes in the post intervention period are attributable to being an ICS. If there are changes to the outcomes from any other external policy that affect the organisations differently, we will not be able to adjust for these differences.

23. Discussion

This report presents the findings of our research to investigate the development of ICSs in order to find out how effective these new forms of collaboration are in achieving their goals, and what factors influence this.

23.1 Research Questions

The study was split into two phases. The research questions of the first phase were 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 Long Term Plan, and subsequent guidance. 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 and subsequent guidance.
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 ICSs. In particular, how is co-ordination achieved between ICS plans, local priorities and existing programmes of work such as any local new models of care?

The second phase of the research focused on the development of place-based partnerships, and the developing role of the regional NHSEI function. The research questions of the second phase of the research are:

1. How the local leadership and cooperative arrangements with stakeholders (statutory, independent and community-based, including local authorities) are governed in place-based partnerships, and how arrangements are developing to facilitate co-ordination between the the ICS and place-based partnerships.
2. How functions and responsibilities are evolving in place-based partnerships, and whether different types of commissioning functions are evolving at different system levels.
3. What decisions are being made in place-based partnerships, and how disagreement between members and conflicts of interest are being addressed.
4. How individual organisations are reconciling their role in place-based partnerships with system responsibilities, individual accountabilities and statutory responsibilities
5. How regional NHSEI is responding to the changes in modes of planning and commissioning and actual service configurations.
6. How accountability relationships are developing (between place members, between place and system scales and with national regulators), and creating clear accountability for and facilitating the achievement of, system and place-based partnership aims.
7. How system leaders view the future development of collaboration in the light of the proposals of the Health and Care Bill.

This discussion section summarises and discusses the findings of both phases of research, discusses the limitations of the research, and the implications for policy and practice.

23.2 Summary of research findings

This section summarises the research findings in relation to each of the research questions.

Phase 1 research questions

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 Long Term Plan, and subsequent guidance. 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.

During Phase 1 of the research (in late 2019/early 2020) system arrangements were developing within a complex landscape of pre-existing governance arrangements, structural tensions between the NHS and local government, and a regulatory and legislative structure in the NHS which focused on individual organisations' performance. Complexity increased where the

configuration of spatial scales was disputed among local partners. Previous research has suggested that where there are strong local relationships these will benefit most from the permissive policy context (NHS Providers and NHS Clinical Commissioners, 2018). Our research suggests that in addition to strong local relationships, the permissive policy context works better where there is a clear footprint for the arrangement of spatial scales.

In late 2019/early 2020, governance arrangements were found by some to be burdensome, duplicative and unclear, lacking clarity regarding where decisions were to be made and by whom. Our research found that the focus of attention on ground work and preliminary activities noted by earlier studies (Charles et al., 2018, Walshe et al., 2018) was still a prominent aspect of system activity at this time. Governance arrangements were evolving to balance potentially competing interests such as: those of representation/inclusivity and streamlining operational decision making; and of the principle of subsidiarity and the need for oversight. Additionally, the drive to establish partnership working at the location closest to delivery, in line with the principle of subsidiarity, necessitated further refinement of governance arrangements. This ongoing refinement, together with a lack of clarity on how to distribute power, resources and responsibilities between different levels of governance, lead to decision making arrangements which were unclear to some.

During Phase 1 fieldwork, system leaders were building relationships and trust across system partners to exert personal, informal authority and leadership within the system. The 'soft' power of network leadership and informal horizontal accountability was supplemented by the incorporation of vertical accountabilities into system structures, driven by the need to increase the status of system decisions and streamline governance arrangements. Examples included the incorporation of statutory decision-making forums into system governance, the delegation of decision-making functions from statutory organisations, and the recruitment of system leaders who held positions of authority in statutory bodies within the system. Additionally, systems were considering the formalisation of commitment to collaboration through the adoption of Memorandum of Understandings.

Commissioning was under development at various spatial scales. Structures to co-ordinate commissioning decisions across CCGs and local authorities were being developed. 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.

The ongoing development of leadership and cooperative arrangements during Phase 2 of the research (January – September 2021) is summarised in relation to place-based partnerships below.

2. Whether ICSs are able to allocate resources more efficiently across sectoral boundaries and bring their local health economies into financial balance.

It is still relatively early days in the development of system working, and due to this and the disruption caused by the pandemic, it is difficult to assess the extent to which ICSs are achieving their aims concerning the allocation of resources more efficiently across sectoral boundaries and the achievement of financial balance within the system.

In Phase 1 of the research in early 2020, system partners were keen to collaborate, and embrace the opportunities for improved planning and provision of services through collaborative decision making regarding the allocation of resources and sharing of budgets. Interviewees were hopeful that system working offered an opportunity to achieve a fairer and more effective allocation of resources. 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. Further sharing of resources between system partners was triggered by the pandemic, where partners made collective decisions about allocating funds and risk-sharing in the course of the pandemic response. It was recognized, however, that the real test about sharing of resources would come in the future, when decisions about priorities would need to be taken in normal conditions rather than in the middle of a pandemic.

Action to achieve long term financial sustainability had not been agreed or implemented in the case studies. In Phase 1 of the research (in early 2020) it seemed in part this was because time had been spent building the necessary relationships to weather difficult decisions, but Phase 2 of our research (Jan-Sept 2021) suggests that difficulties in addressing difficult decisions through the consensus model of decision making were continuing despite strong relationships. Further impediments 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.

Our quantitative analysis did not establish any significant link between ICSs' existence and indicators of integration, which can be regarded as their goals. While, in both phases of our research, we gathered multiple examples of work being carried out at system and place scale to share resources, change resource allocation and improve partnership working, the impact of these initiatives in terms of efficiencies and quality markers is difficult to quantify (see discussion of limitations below).

3. How individual organisations are reconciling their role in an ICS with their individual roles, accountabilities and statutory responsibilities.

In Phase 1 of the research in early 2020, balancing individual organisations' roles in an ICS with their individual roles, accountabilities and statutory responsibilities was seen as a difficult task, and a potential stumbling block in systems' capacity to address difficult issues. While at times organisations appeared quite sanguine about the prospect of dropping some of their organisational priorities in favour of shared priorities and goals, like Walshe (2018) we also found that interviewees doubted that the separate statutory obligations of individual organisations would always be best served by taking decisions on a best-for-system perspective. In particular, statutory NHS providers were concerned that decision making on a best-for-system basis might inhibit their ability to ensure that risks to the organisation and the public were managed and mitigated effectively. A common belief was that organisations would prioritise organisational interests over system aims in such circumstances, or that statutory accountabilities would be cited to allow 'retreat' from confrontation of difficult issues. Our research suggests that balancing individual and system priorities was also difficult for non-NHS partners such as Local Authorities and social enterprises, who had their own financial obligations and sat outside the evolving supportive policy context of the NHS.

Findings regarding how partners in place-based partnerships were reconciling ICS and individual responsibilities later in 2021 are summarised in relation to the Phase 2 research below.

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 and subsequent guidance.

The role of NHS England has changed significantly in response to the development of system working. Our research did not focus on the role of the quality regulator, the CQC, as this did not appear to have changed significantly in response to the development of system working.

In early 2020, 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. In general, the regional NHSEI interviewees reflected that they had a large discretion in their relationships with ICSs, and described the relationships as 'iterative', moving towards an end state of these relationships where regional offices would cede more and more functions and responsibilities to ICSs.

Earlier studies of ICSs, and their predecessors STPs, highlight the lack of clarity about accountability arrangements (NHS Confederation, 2020, Moran et al., 2018), and our case studies suggest that at this point in early 2020, accountabilities were still not clear. The emerging 'alongside' relationship between systems and the regional NHSEI made it less clear to some interviewees at this point how systems were being held to account. The 'system first' approach, through which NHSEI treated system leadership as the first point of contact (rather than individual organisations with whom NHSEI had a vertical accountability relationship) was reported to be enacted unevenly, causing further confusion and frustration regarding how accountability relationships were structured in practice. 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. Despite this lack of clarity, the expectation was that any disputes would be resolved locally within ICSs, rather than being escalated up the NHS hierarchy.

Furthermore, at this time in early 2020 during Phase 1 of the research, horizontal accountabilities were developing within places and between places and systems. The capacity of 'soft' power to hold partners to account was seen as limited, and there were concerns regarding a lack of resources available to systems to carry out this function, and examples of holding to account within systems, for instance in relation to poor performance, were lacking. The case study systems were developing routes to public engagement of various kinds, seeking

to understand the priorities, needs and preferences of 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.

The ongoing development of accountability relationships in 2021 is summarised in relation to the Phase 2 research below.

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?

The NHS institutional context in which ICSs are situated was subject to an ongoing a shift from competition to collaborative working, and a changing environment regarding commissioning mechanisms, pricing structures and financial incentives. In Phase 1 of our research in early 2020 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 as competitive culture and behaviour in the NHS were perceived to be deeply ingrained. In contrast in Phase 2 of the research (January – September 2021) interviewees suggested that in their view competition and the use of competitive tendering were largely things of the past. Collaboration, not use of competition, was seen as a means of addressing and resolving thorny issues relating, for example, to struggling providers, and was the dominant approach to commissioning and contracting. This was generally welcomed, although questions were raised about the implications of the shift away from competition for non NHS providers, in particular whether contracts let to independent sector providers would be renewed. This uncertainty threatened to disrupt the formation of trusting relationships with system partners from the independent sector.

Financial incentives to incentivise system working were deemed largely ineffective. In the first phase of our research, NHS system control totals were viewed as unattainable, and unsupported by the wider regulatory context. Later, in the second phase in 2021, collective financial incentives, such as the ERF, were perceived as insufficient to stop individual organisations giving priority to their organisational interests. Collaborative payment structures, such as 'block contracts' and 'blended payments' were under discussion, as were mechanisms of risk sharing between organisations but had not been agreed at system scale in Phase 1 or place scale

in Phase 2. Some interviewees reported that collaborative working was incentivized in softer, more relational ways such as through an increase in transparency of financial reporting and decision-making regarding system-wide resource allocation, and there was a faith in relationships to drive co-operative behavior.

The function of commissioning when understood as planning was still seen as valuable, with the proviso that it was based on collaboration rather than competition among the different providers. Commissioning was evolving to reflect system working, and in anticipation of the changes of the Health and Care Bill. Opportunities for joint commissioning with local authorities, such as the Better Care Fund which established pooled budgets between the NHS and local authorities, which predated the establishment of system were being continued. However, local government bodies were also concerned about their potential exposure to financial risk, and loss of control over limited council resources. Some NHS providers felt commissioning had become more distant and less locally influenced as CCGs merged to fit system footprints.

6. How locality priorities, including those of local authorities, are reconciled with the wider priorities embodied in ICSs. In particular, how is co-ordination achieved between ICS plans, local priorities and existing programmes of work such as any local new models of care?

At the time of the first phase of fieldwork in early 2020, evolving NHS policy was facilitating the reconciliation of locality priorities and existing programmes of work with the wider priorities embodied in ICSs. NHS planning mechanisms, such as capital allocations, were increasingly arranged around systems, easing the co-ordination of system and partner priorities. In one case study, ICSs were described as the sum of their parts, in which the local priorities of places were drawn together at system scale to form system priorities. The reconciliation of system priorities with those of partners outside the NHS appeared more challenging. The co-ordination of plans across health and local councils was subject to structural factors, such as differences in business and planning cycles between the two sectors, the wider remit of local councils (of which social care was only a part) and differing approaches to procurement. Planning footprints were particularly important facilitators of co-ordination of plans across health and local councils. Where system and local council footprints aligned (as in Case Study 2) statutory planning bodies involving local authorities, such as Health and Wellbeing Boards, could become incorporated into system architecture. Where footprints did not align, or were

disputed (such as two-tier place in Case Study 3) local councils were more reluctant to engage in strategic commissioning and planning discussions.

Phase 2 research questions

1. How the local leadership and cooperative arrangements with stakeholders (statutory, independent and community-based, including local authorities) are governed in place-based partnerships, and how arrangements are developing to facilitate co-ordination between the the ICS and place-based partnerships.

Phase 2 of the research (conducted in 2021) focused on places. In relation to the development of governance arrangements, our main finding is that at place scale, governance arrangements at times remained unclear to local partners. This echoes our earlier findings in relation to arrangements at system scale in early 2020.

Place-based partnerships were devising terms of reference, appointing chairs, and considering the adoption of agreements (such as an Alliance agreement) to formalise co-operative working. As some place-based partnerships matured, there was an emerging focus on the prioritisation of place collective voice and cross cutting interests over representation of individual organisations. Governance arrangements were developing to increase the influence and status of place-based partnerships' decision making, such as undertakings from partner organisations to delegate decision-making authority to the 'place-based partnership' and the alignment of place-based partnerships with bodies which had statutory responsibilities. Perceptions varied regarding the latitude of place-based partnerships to make decisions without reference to partners' own boards, reflecting variations in practice across our case studies, but also uncertainty among partners as to the decision-making scope allotted to place-based partnerships.

There was some frustration regarding diminishing returns from the ongoing refinement of governance arrangements when it was informal relationships between partners, rather than formal governance arrangements, which were perceived to be fundamental to the achievement of effective collaboration.

2. How functions and responsibilities are evolving in place-based partnerships, and whether different types of commissioning functions are evolving at different system levels.

At place scale, we found that at the time of the research in 2021, place-based partnerships were also making collaborative decisions regarding the allocation of resources and sharing of budget. Place-based partnerships, were largely focused on the delivery of NHS services, with some involvement of adult social care and were centering their efforts on taking a shared approach to workforce development, population data approaches, care design and delivery, and limited resource allocation.

It was anticipated that in the future, the ICS scale would be used to address more 'strategic' commissioning challenges, while place-based partnerships, or provider collaboratives, would assume more responsibility for making local planning decisions. There was not yet certainty regarding what formal delegations would be made in this regard to place-based partnerships, when this would occur, and the mechanisms through which this would be achieved. The practicalities of this process were also still to be resolved at the time of the research in 2021. The apportionment of functions and decisions was a complex and detailed task, which was being worked through by system partners using a consensus approach, and systems were struggling to specify exactly which decisions would be made by which fora. A further practicality was the feasibility of disaggregation of budgets to reflect places without destabilising any partner organisations.

3. What decisions are being made in place-based partnerships, and how disagreement between members and conflicts of interest are being addressed.

We found many examples of improvement to service delivery which had been developed within place-based partnerships, including decisions made between partners to share resources between themselves in order for shared gain. Where wider partners, such as lower tier borough councils, were included in place-based partnerships this resulted in the development of novel initiatives. Case Study 2 appeared most proactive in sharing resources at system and place level, and this had in part been enabled by considerable transformation monies which had been used to pilot changes to care design and delivery. The scale of changes which could be made within place-based partnerships in this respect were dictated by the decision space allocated to them by system scale arrangements and the attitudes of place partners, and the difficulty of making changes within existing contractual arrangements. Nevertheless, members of place-

based partnerships were generally optimistic about opportunities for and impact of place co-operation.

Partners acknowledged that, as ICS commissioning responsibilities evolved, conflicts of interest were inherent in this partnership mode of commissioning, but were fairly sanguine about this. The view of local actors was generally that the benefits of collaborative decision making outweighed the risks of conflicting interests. As described in more detail in relation to RQ 4 below, confrontation of difficult discussions in place-based partnerships was inhibited by the fear that, despite good relationships, disagreement would disrupt collaboration

4. How individual organisations are reconciling their role in place-based partnerships with system responsibilities, individual accountabilities and statutory responsibilities

In Phase 2 of the research in 2021 we found a similar dynamic regarding the reconciliation of roles, as had been found at system scale earlier in Phase 1, suggesting that the balance between in collective and organisational concerns was not resolving over time, and did not differ across differing spatial scales of collaboration. In place-based partnerships partners reported concerns about the impact of 'best for place' decisions on individual organisational responsibilities in areas such as patient safety, and reported a reluctance to discuss difficult issues. In relation to Phase 1 findings (in early 2020) it was suggested that relationships needed to strengthen before difficult decisions could be addressed. However Phase 2 findings suggest this reluctance was not related to a lack of strong relationships. Indeed, like Timmins (2019) we found that collaboration was improving relationships between partners. Instead, confrontation of difficult discussions in place-based partnerships was inhibited by lack of formal decision-making power and the fear that, despite good relationships, disagreement would disrupt collaboration. Local actors anticipated these tensions, together with the lack of formal arrangements to deal with disagreements, could become significant fault lines as statutory ICBs formally assumed commissioning responsibilities, and the scale of collaborative decisions occurring at place scale increased. However it was also the case that the consensus model of decision making was valued, particularly by smaller partners such as GPs who welcomed the opportunity to have an equal voice in discussions.

5. How regional NHSEI is responding to the changes in modes of planning and commissioning and actual service configurations.

Phase 2 of our research indicates that in 2021 there was a growing cultural shift towards a core relationship between NHSEI and the system rather than individual NHS providers, with the relationship between regional NHSEI teams and 'places' mediated by the ICSs to which 'places' belonged. While in Phase 1 (relating to 2020), our research found a lack of clarity regarding vertical accountability relationships between NHSEI, systems and NHS providers, interviews conducted with place partners and NHSEI regional offices suggests vertical accountabilities were becoming more settled by 2021. In their role as supporting and overseeing the development of ICSs, the regional branches of NHSEI adopted a wide range of approaches, from 'hands off' to more close monitoring of progress. NHSEI was developing a role supporting system leaders in interactions with providers when they lacked 'tools in the box' due to lack of regulatory relationships.

6. How accountability relationships are developing (between place members, between place and system scales and with national regulators), and creating clear accountability for and facilitating the achievement of, system and place-based partnership aims.

Our findings suggest that the complex relationships of vertical and horizontal accountabilities in the new NHS architecture were still underdeveloped during Phase 2 of the research in 2021. This is hardly surprising, since the fieldwork took place in a period of structural transition. Accountabilities within systems were weak and less clearly developed than the growing clarity regarding the NHSEI and system relationship described in relation to RQ 5 above. In particular there were areas of uncertainty including how collaborative system structures, such as place-based partnerships were held to account, and the interface between provider collaboratives and place partnerships. Horizontal accountability was developing among place members to the point where there was a shared responsibility for key areas, particularly with the development of formal leadership across organisations of particular themes, such as quality and governance. Interviewees thought that there needed to be other mechanisms in place to ensure value and quality. Measures to formalise internal horizontal accountabilities were under development. It was not yet clear whether and how contracts would continue to be used by systems as a mechanism of holding providers to account.

Accountability of the place partnerships and individual NHS organisations to the public was generally weak and underdeveloped.

7. How system leaders view the future development of collaboration in the light of the proposals of the Health and Care Bill.

Looking ahead, system leaders viewed the future development of collaboration in the light of the proposals of the Health and Care Bill in a largely positive light. Including providers in commissioning decisions was seen, in general, as a positive development. Areas of concern going forward focused mainly on the issues of the connection among the parts of the new architecture and the position and role of 'provider collaboratives'. It was also stressed that, since providers will continue to exist as statutory bodies, the fundamental factor that will make a difference to collaborative decision making in the future will be the relationships within the partnerships.

23.3 Discussion of findings

Our research suggests that the move to a more collaborative ethos has been welcomed, and system partners widely support the development of system working, and the opportunities for improved planning and provision of services which they believed system working offers. Local actors felt that collaboration in systems led to improvements to service planning and delivery in ways that did not occur previously. However, our findings also suggest that there are a number of key themes which need to be considered in relation to the capacity of systems to achieve their aims, including bringing their local health economies into financial balance. These are: the ongoing influence of competition; the importance of context; clarity of governance arrangements; limits of the consensual model of decision making; the development of accountability; and management of conflicts of interest.

The ongoing influence of competition

The first theme relates to the pendulum swing from competition to collaboration in the NHS. 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 1990s, there has been a continuing reliance on collaboration, and a long history of local organisations working together under the co-ordination of commissioners. However, in recent years since the Five Year Forward View published in 2014 the pendulum has swung further from competition towards collaboration. This culminated with the publication of the White Paper and the Health and Care Bill in 2021 which seek to formally remove competition as a co-ordinating force in the NHS by changing

how competition law applies to the NHS, procurement requirements and how the payment system operates, and to enable collaboration through increased flexibilities for joint working and the introduction of statutory ICSs.

Our findings may suggest competition is no longer used as an organising principle. The rejection of competition is perhaps unsurprising given that evidence suggests that it did not fully take hold as a dominant co-ordinating force in the NHS (Le Grand et al., 1998, Mays et al., 2011). In relation to the balance between competition and co-operation previous PRUComm research suggests that NHS commissioners have used a judicious mix of competition and co-operation (Allen et al., 2015), and commissioner behaviour was tilted towards co-operation rather than competition by 2016/17 (Allen et al., 2017). However, it is not the case that competition has disappeared completely. Phase 1 of our research suggested that in early 2020 competitive behaviour was deeply ingrained in the NHS, and while this message appeared to have altered by 2021 in relation to the Phase 2 research findings, this may be a temporary effect of the COVID-19 pandemic which reduced incentives for competition, and increased the need to collaborate. Furthermore, while competition may be lessening for NHS bodies, this was not the case for non-NHS partners in ICSs, with our findings highlighting that for local authorities and non-NHS providers such as social enterprises, competitive tendering remained a significant motivator of behaviour. It is also the case that the Health and Care Bill does not remove the competition principle from the NHS entirely (Osipovic and Allen, 2021). For instance, the Bill does not remove a provider licence competition condition (Condition C2 –Competition oversight) which prohibits the providers from engaging in anti-competitive conduct (such as collusion) where this is detrimental to patient interests nor any other licence conditions contained in Section 96 of the HSCA 2012. NHSEI also retains its power as a regulator of NHS provider mergers and enforcer of the provider licencing conditions. Furthermore, patient choice in the NHS will remain in place under the proposals of the Health and Care Bill, and competitive procurement will remain an option when planning services. For these reasons it is premature to state that the pendulum has swung completely away from competition. It will be necessary to observe the decisions made by ICSs as they become statutory bodies from July 2022 with responsibility for decision making regarding the allocation of resources, including the interaction between the collaborative ethos of systems and ongoing competitive incentives for system partners.

The importance of context

Our findings confirm the significance of context in relation to the ease with which collaboration can be achieved. Context, the local physical and material conditions, and community values, is an important influencer of collaboration (Ostrom, 2005). In relation to system working in the NHS, the importance of the degree of fit between shared understandings of 'places' and system boundaries has already been noted (Charles et al., 2018). Our case study sites were selected partly due to their different system membership and configuration. 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, which when fieldwork commenced spanned seven CCGs and eight Local Authorities. We found that of particular relevance to ease of collaboration was the existence of shared understandings between health and local government of meaningful configurations of partnership working. Case Study 3 was distinct as an illustration of the difficulties encountered where system and place spatial scales are not considered as coherent or meaningful groupings across health and local government. While NHS statutory providers are subject to policy initiatives which encourage their contribution to system working the incentivisation of local government engagement is much weaker, and our findings suggest that awkward boundaries can threaten local government 'buy-in' to strategic commissioning and planning discussions. In the other case studies, where the configuration and purpose of place-based partnerships was clear to local actors, the partnerships were able to progress more quickly to collective work.

Wider context, referring to the broader contextual variables in which collaboration takes place, can also enable or inhibit collaboration (Ostrom 2005). During the period of our research, there were significant changes to the wider context in the NHS which were designed to facilitate collaboration between NHS system partners. These included financial incentives for collaborative working (although these were deemed largely ineffective by our interviewees), supportive policy directives and changes in regulatory approaches. The structural tensions in place between NHS and local authorities were much more intransigent, with fixed areas of difference such as degree of local independence, accountability of local authorities to local politicians and the public, differing financial rules and regulations, the use in local authorities of competitive tendering to procure services and a reliance on private sector providers. The locally derived, political mandate of local authorities led to a focus on immediate, locally

circumscribed strategic interests and less uniformity in their actions than NHS organisations. It is also the case that, unlike the NHS, local authorities are required to balance their budgets.

It is not necessarily the case that such differences inhibit or prevent collaboration. The work of Ostrom (2010) references 'polycentric' systems (which contain multiple centres of decision making, each of which operates with some degree of autonomy) in which partners successfully collaborate with each other in relation to a shared resource. However, 'polycentric' collaboration requires sufficient co-ordination between 'decision centres' (Carlisle and Gruby 2019). The proposals of the Health and Care Bill seek to increase flexibilities and drivers for joint working across health and social care, including a new duty to collaborate on NHS organisations (both ICSs and providers) and local authorities, new flexibilities for the joint exercise of functions with local authorities, and the creation of Integrated Care Partnerships (ICPs), statutory committees which bring together all system partners including local authorities and independent providers of care. However, the extent to which these changes will provide sufficient drivers for collaborative across health and social care remains to be seen.

Clarity of governance arrangements

A further important theme relates to the clarity of system governance arrangements. Ostrom points out that, for collaboration to be successful, actors need to understand the rules of the game (Ostrom 1994). Our findings suggest that agreeing clear local rules of the game takes time and effort. This is particularly the case for place-based partnerships where there is no centrally prescribed requirement for governance arrangements. Negotiation is necessary to reach clarity about rules, for example where functions and decisions are situated across system and place scales, in order to facilitate collaboration and to increase accountability. On one hand it can be argued that the iterative development of governance arrangements among local parties is important in developing norms of trust and reciprocity between partners which underpin increased collaborative working, and encourage fairness and adherence to local rules (Ostrom, 1994, Sydow, 1998, Gambetta, 1988). However, where a similar process is occurring in parallel systems, it can also be argued that 'reinventing the wheel' should be minimised. There is a balance to be struck between retaining flexibility at local level regarding rules, and being able to draw on support and guidance The case for increased support for systems in their task of putting in place clear 'rules of the game' is highlighted by the local actors' belief that, despite the amount of effort they dedicate to the development of formal structures to support collaboration, these are not as important in securing collaboration as other factors, such as

strong relationships. Additional guidance should aim to share learning and solutions between system, or provide scaffolding which can be locally amended to reflect local circumstances and preferences.

The lack of clarity in relation to governance arrangements and accountability relationships, led to confusion about the amount of 'decision space' available to system partners. 'Decision space' (Bossert 1998) refers to how much autonomy decentralised bodies have to develop policy, allocate resources, and define programs and services. Decision space is 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. Our findings suggest that 'decision space' varied greatly between case studies, both in relation to the wide variation of approaches of the regional NHSEI teams to systems, and in relation to attitudinal differences of local sovereign organisations to collaborative working. This local variation is one of the outcomes which was anticipated from NHS ICS policy, in which arrangements are anticipated to develop to suit the local context. However it will be important to examine the differential development of decision space across systems as ICSs gain statutory footing from July 2022, and the implications of this.

Limits of the consensual model of decision making

A further important theme relates to the apparent limits of the consensual model of decision making in the light of organisational sovereignty. Experience in our case studies points to the challenges of addressing contentious issues without independent arbitration and hierarchical control. Organisational sovereignty has the potential to significantly disrupt collaboration, a dynamic which is not changed by the proposed reforms. Alongside the anticipated sea change in the policy, regulatory and legislative environment, collaboration necessarily remains a voluntary, consensual model of co-ordination. Networks have multiple forms of accountability (e.g. vertical within their individual organisations and horizontal towards the network partners), which may be incompatible or undermine each other (Moran et al., 2020). Providers remain separate organisations with their own organisational interests, and accountabilities, and freedom to dissent. Making ICSs statutory bodies does not overcome this problem, since many of their members (e.g. healthcare providers) will continue being independent statutory bodies with their own vertical accountabilities to observe. Furthermore, key partners are outside of the NHS and subject to their own rules regarding priorities, ways of working and financial

mechanisms. Additionally, as our research also indicates, it is not the case that competitive impulses are completely removed by the absence of formal competition mechanisms.

The development of accountability

The development of strong accountabilities within systems is an important precursor to collaborative working, allowing system partners to develop the necessary sanctions to build trust and ensure adherence of agreed 'rules of the game' (Ostrom 1994). In the future ICBs' role as resource allocator, and the new regulatory framework in which whole systems rather than individual providers will be collectively accountable for spending their annual allocated funds, may create sufficient leverage to encourage system partners to address difficult issues. Under the proposals of the Bill, ICBs will be vertically accountable to NHSEI and horizontally accountable for the workings of the system as a whole. Previous PRUComm research suggests complementing horizontal accountability with vertical accountability may make systems more effective (Moran et al 2020). The developing relationship between NHSEI, the system and providers characterised by the 'system first' approach, whereby NHSEI approach individual providers through the system architecture rather than direct contact with providers, and extending the development of a shared 'horizontal' accountability between system leaders and NHSEI for regional issues may further increase the influence of system leadership. However, given the complex landscape of emerging accountabilities it is not at all certain how system influence will work in practice in the future. Indeed the presence of NHSEI 'alongside' the system could be interpreted as an *ex ante* mechanism of directing system behaviour (Bovens, 2007) reducing system autonomy.

Furthermore, ICB leverage may be less influential in decision making forums away from the ICB itself such as place-based partnerships or provider collaboratives which are anticipated to be the site of significant strategic decision-making going forward including regarding the allocation of funds. The development of horizontal accountability arrangements is an important factor in the development of robust collaborative governance (Ostrom, 1994), and is an important way of holding organisations and collective bodies such as place-based partnerships to account for decisions they make. Our research indicates that such structures are underdeveloped, and it is unclear how well those new lines of accountabilities, especially the horizontal ones, will work in practice.

Management of conflicts of interest

Structural conflicts of interest, which cannot be adequately addressed with governance structures and regulations that stress transparency, will be inherent in future strategic decision making as NHS organisations are being tasked with making strategic decisions which concern themselves. Interestingly, the view of local actors was generally that the benefits of collaborative decision making outweigh the risks of conflicting interests. Despite the removal of market incentives, NHS providers will continue to have obligations to maintain their own financial viability as well as a role in strategic planning. It is likely that these two functions will not always coincide. For example, it might be strategically necessary to reduce hospital funding in order to reallocate resources to out of hospital care in order to improve population health and patient experience, as well as constituting a more efficient use of limited resources. Arguably, in pursuit of 'financially sustainable and self-improving healthcare systems', provider organisations are being asked to act in the interests of the system, while also prioritizing the interests of their own organisation.

As our quantitative analysis indicates it is not clear yet what impact the work of ICSs is having. Assessing the extent to which system working is achieving its ends is a long term endeavour, and any judgement that could be made in a shorter-time frame, such as regarding the effect of system working on the attainment of financial balance, has been impaired by the impact of the pandemic. Developments that systems would have pursued, such as the development of horizontal accountabilities, may have been delayed by the focus on operational issues. Disruption from the pandemic may also have limited the degree to which systems have been able to engage with wider partners, and address the wider health and wellbeing agenda. It is clearly important to continue to study the development of system working in the future to see how these issues are tackled as the effect of the pandemic diminishes and systems have longer experience of working together.

23.4 Limitations

The findings reported here are from two phases of a study which adopted a qualitative case study research design. The study has certain limitations.

Firstly, the implications of the findings of this 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), 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 report. Additionally, the context in which ICSs are operating has changed significantly since the first phase of the fieldwork ended due to the changes associated with the COVID-19 response, such as to financial mechanisms. The White Paper was issued during the second phase of the research, followed by the Health and Care Bill. These events may have impacted on the views of people at ICS level, but we did not re-interview most ICS level people in phase 2 of the field work, as it concentrated on place level interactions.

Secondly, as the study design consisted of three in depth case studies, it is not possible to make statistically based generalisations to the whole NHS. However, as the study is based on a strong theoretical framework, it is possible to make analytical generalisations. We have noted the extent to which findings from the three case studies themselves converged and diverged.

Thirdly, given the disruption of the pandemic, it is very difficult at this time to evaluate the extent to which ICSs are going to be able to allocate resources more efficiently across sectoral boundaries and bring their local health economies into financial balance.

Fourthly, our methods focused on understanding the development of collaboration in ICSs through interviewing the senior representatives of the formal ICS partners. Therefore, we did not speak to local providers of health and care services to the system population who were not involved the ICS governance structures. We did intend to interview representatives of local community groups in each case study to find out about those not included in ICSs, but as explained more fully below, it was not possible to undertake these interviews. It is also the case that we did not speak to other providers, such as providers of publicly-funded adult social care or services including care homes, nursing homes and day care, who were not formally represented in the main ICS governance structures at system or place scale, but are important partners in securing co-ordination at the level of service delivery.

Fifthly, there were two deviations from the study protocol in terms of the interviewees for the research. We indicated in the protocol that we would seek to interview the CQC, and would also interview representatives of local community groups in each case study to find out about those not included in ICSs. We decided not to interview a CQC representative in light of the limited function of the CQC in relation to system working at the time of the research. Unfortunately, it was not possible to undertake the interviews with representatives of local

community groups in light of the disruption to the research caused by COVID-19, and subsequent time restraints on the research team. As indicated in section 23.6 below, PRUComm is due to continue its research in this area with a study investigating how the developing forms of statutory and non-statutory collaboration interact to support the achievement of system and national goals.We intend to include both these sets of interviews into the new study.

23.5 Implications for policy and practice

Our study has several implications which will need to be considered as ICSs develop in the light of the proposals of the Health and Care Bill 2022. The main implications are summarised here, with further detail below:

- Collaborative working is well supported, and is thought to have the potential to support improvements in service design and delivery
- The consensual model of decision making means difficult decisions are not being taken.
- Guidance regarding governance arrangements should be increased to obviate individual systems spending too much time on discussing universal common issues.
- Current guidance regarding the management of conflicts of interest is not adequate, and conflicts of interest at an organisational level should be acknowledged and mitigated as far as possible
- Systems need to strengthen both horizontal accountability and public accountability
- Financial incentives for collaboration have not driven behaviour
- Collaboration with partners outside the NHS is challenging

Some of the implications of the research have already been resolved. The Health and Care Bill has addressed some of the issues raised by Phase 1 of the research regarding the future status of system working, and the difficulties of dealing with uncertainties regarding the future direction of travel. In particular, local actors wanted the resolution of the questions regarding the future legislative status of ICSs in order to clarify future direction.

System partners are embracing collaborative working with enthusiasm, and believe it has great potential to achieve significant improvements in the planning and delivery of health and care services to local populations. There are examples of collaborative decision making resulting in new solutions and initiatives.

An important implication of the research concerns the consensual model of decision making which is central to ICSs. The concern raised is that difficult decisions are not being addressed through system working due to the sovereignty of organisations and difficulty of using consensus decision making approaches to drive through change. This issue is very significant in the light of the proposed responsibilities of statutory ICSs in the future for decision making regarding the allocation of resources. It appears that some issues are more amenable than others to collaborative approaches. It is not clear how the increased authority of ICSs and use of shared financial targets for systems will enable organisations to address difficult issues which they consider will adversely affect statutory obligations. An independent arbiter may be required. It seems likely that the regional directors of NHSEI could undertake this role in practice.

There are many matters, such as governance arrangements in place-based partnerships and the division of functions between spatial scales, which systems are trying to address in parallel. It may be that national or regional guidance can be increased to obviate individual systems spending too much time on these common issues while retaining scope for local flexibility.It is important, given the lack of a formal mediator or brokerage figure, that conflicts of interest at an organisational level are acknowledged and mitigated as far as possible. The proposals in the Bill regarding the management of conflict of interest rest on the declaration of individual conflicts of interests, and indeed current guidance to NHS organisations is framed from an individual perspective. These are not adequate to address the forms of conflict of interest of concern in relation to ICSs, where conflicts of interest are inherent and exist at an organisational rather than individual level. It is important to clarify, as ICBs assume responsibility for the allocation of resources, what action should be taken regarding conflict of interests and to address conflicts from an organisational rather than individual perspective. This issue goes to the heart of how ICBs will be able to operate in the interests of the local population as opposed to prioritising those of powerful organisations. It is not clear how ICSs will be able to plan and commission services which best meet the needs of local populations when there is no organisation (such as a CCG or other commissioner) whose sole role it is to achieve these results without having undue regard to the effects on the finances of individual local organisations.

Our research found various forms of accountability to be underdeveloped. In particular public accountability was lacking. As ICSs become statutory they will need to develop public accountability. *The Design Framework (NHS England and NHS Improvement, 2021c)* makes clear that the involvement of patients, unpaid carers and the public is expected at place and

system levels, with requirements for public meetings and published minutes by both the Partnership and NHSIC Board. However it is not specified how other forums such as provider collaboratives, where significant decisions regarding the planning and provision of services may be made, will be publicly accountable. At the very least, the requirements for public transparency of provider collaboratives should be strengthened, possibly through requiring minutes of provider collaborative meetings to be included with ICS public papers and for such meetings to be held in public. More fundamentally, the role of provider collaboratives in relation to ICS decision making needs clarification, and the extent to which ICBs may delegate powers and decisions to these non-statutory groupings should be clarified. Moreover, how provider collaboratives themselves are to be governed is a matter of public concern.

Our research suggests that, to date, financial incentives aimed at driving collaboration are not considered to be effective drivers of behaviour on the ground. During the period of the research, collaborative behaviour among NHS partners was incentivised by system control totals, and later, the Elective Recovery Fund. Both of these were not considered by participants to be sufficient to ensure the prioritisation of collective interests above individual interests.

Our research also indicates that collaboration with partners outside the NHS is challenging, particularly in the case of local authorities, where structural differences have inhibited collaboration. The proposals of the Health and Care Bill may go some way to easing these challenges by strengthening commitment to NHS/local authority collaboration. The Bill also provides potential flexibilities regarding joint exercise of functions, subject to further guidance. Our research suggests these are important flexibilities which should be pursued.

23.6 Implications for future research

Given the likely commencement of legislative changes from July 2022, and the ongoing introduction of provider collaboratives mandated by NHSEI, it is important to understand how governance, accountability and decision making arrangements are developing to support the interplay of these layers of bodies and partnerships in order to ensure collaboration achieves system and national goals, particularly in the light of the newly introduced statutory footing of systems.

PRUComm is due to continue its research in this area with a study investigating how the developing forms of statutory and non-statutory collaboration, together with the existing landscape of statutory organisations and forums, interact to support the achievement of system

and national goals. This new study will seek to address its research questions through the lens of two 'tracer' issues (elective recovery and hospital discharges for frail elderly) which will provide examples of how decisions across the various collaborative bodies are shaping the system response to key challenges, and the kind of changes which are being implemented as a result.

It is clear from our research, that given the relatively early stages of ICS development at the time of the fieldwork, there remains much that is currently unknown about the capacity of the ICS model to address its aims. In particular, it will be important to develop and sustain quantitative analysis of the kind undertaken in this research to ascertain the impact that ICS working is having on the planning and delivery of services, outcomes and financial sustainability.

Our research indicates that competition is likely to remain an active co-ordinating force in statutory ICSs. It will be necessary to observe the decisions made by ICSs as they become statutory bodies from July 2022 to understand the implications of the interaction between the collaborative ethos of systems and ongoing competitive incentives for system partners.

Our research found that although conflicts of interest will be inherent in decision making when ICSs take on CCGs commissioning responsibilities, local actors consider the benefits of collaborative working will outweigh the risks of conflict of interests. It is important to monitor how this plays out in the future, and to understand how conflicts of interest are recognised and mitigated in practice when commissioning decisions are made.

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Appendix A1- Wave one and wave two ICS

TABLE A1: INTEGRATED CARE SYSTEMS AND MEMBER CLINICAL COMMISSIONING GROUP AND UPPER TIER LOCAL AUTHORITY (AS AT APRIL 2021).

Wave	ICS name	CCG name	UTLA name	Intensity
1	Bedfordshire, Luton & Milton Keynes	NHS Bedfordshire Luton and Milton Keynes CCG	Bedford, Central Bedfordshire, Milton Keynes and Luton	12
1	Dorset	NHS Dorset CCG	Bournemouth, Poole and Dorset	9
1	Frimley	NHS Frimley CCG	Surrey, Hampshire, Bracknell Forest, Windsor and Maidenhead and Slough	14
1	Greater Manchester	NHS Bolton CCG, NHS Bury CCG, NHS Manchester CCG, NHS Oldham CCG, NHS Heywood, Middleton and Rochdale CCG, NHS Salford CCG, NHS Stockport CCG, NHS Trafford CCG, NHS Tameside and Glossop CCG and NHS Wigan Borough CCG	Bolton, Bury, Manchester, Oldham, Rochdale, Salford, Stockport, Tameside, Trafford and Wigan	32
1	Lancashire and South Cumbria	NHS Blackburn with Darwen CCG, NHS Blackpool CCG, NHS Chorley and South Ribble CCG, NHS East Lancashire CCG, NHS Fylde and Wyre CCG, NHS Greater Preston CCG, NHS Morecambe Bay CCG and NHS West Lancashire CCG	Blackburn with Darwen, Blackpool, Cumbria and Lancashire	18
1	Nottingham and Nottinghamshire	NHS Nottingham and Nottinghamshire CCG	Nottingham and Nottinghamshire	7
1	Surrey Heartlands	NHS Surrey Heartlands CCG	Surrey	10
1	South Yorkshire and Bassetlaw	NHS Barnsley CCG, NHS Bassetlaw CCG, NHS Doncaster CCG , NHS Rotherham CCG and NHS Sheffield CCG	South Yorkshire	17
2	Gloucestershire	NHS Gloucestershire CCG	Gloucestershire	N/A
2	Suffolk and North East Essex	NHS Ipswich and East Suffolk CCG, NHS North East Essex CCG and NHS West Suffolk CCG	Essex and Suffolk	N/A
2	West Yorkshire and Harrogate	NHS Bradford District and Craven CCG, NHS Calderdale CCG, NHS Kirklees CCG, NHS Leeds CCG and NHS Wakefield CCG	North Yorkshire and West Yorkshire	N/A

Notes: Intensity is the number of statutory organisations (CCGs, upper tier local government, NHS Trusts and independent sector organisations) in each ICS

Appendix A2- Parallel trends tests

GP Patient survey

Figure A1: parallel trends test for % needs not met

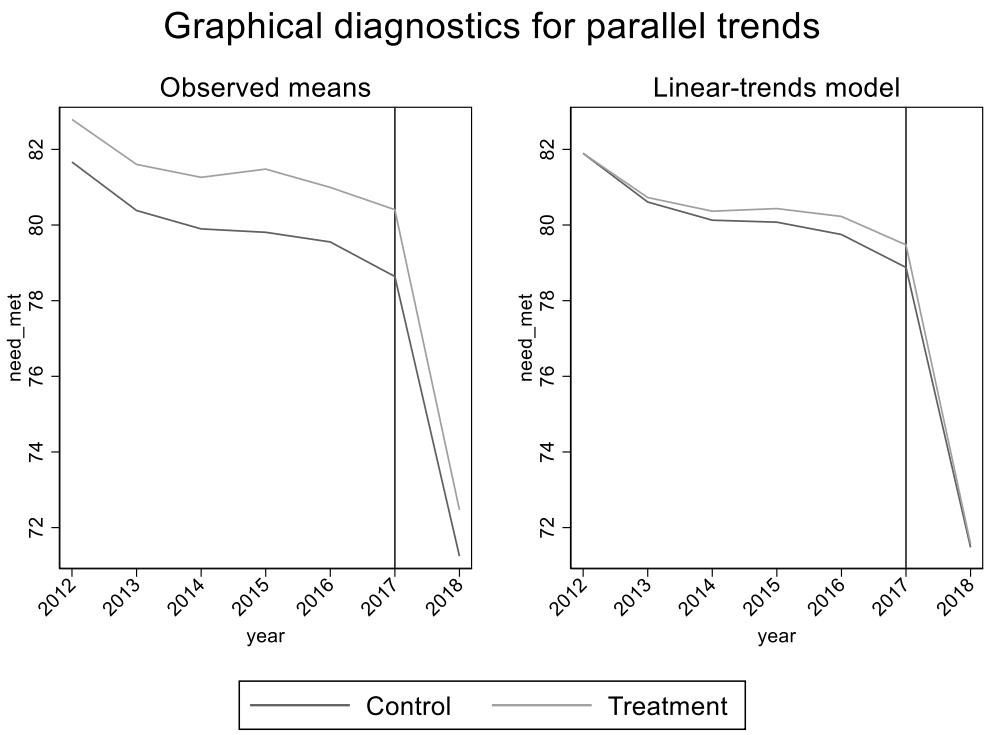


Figure A2: parallel trends test for % needs not met and wave two removed

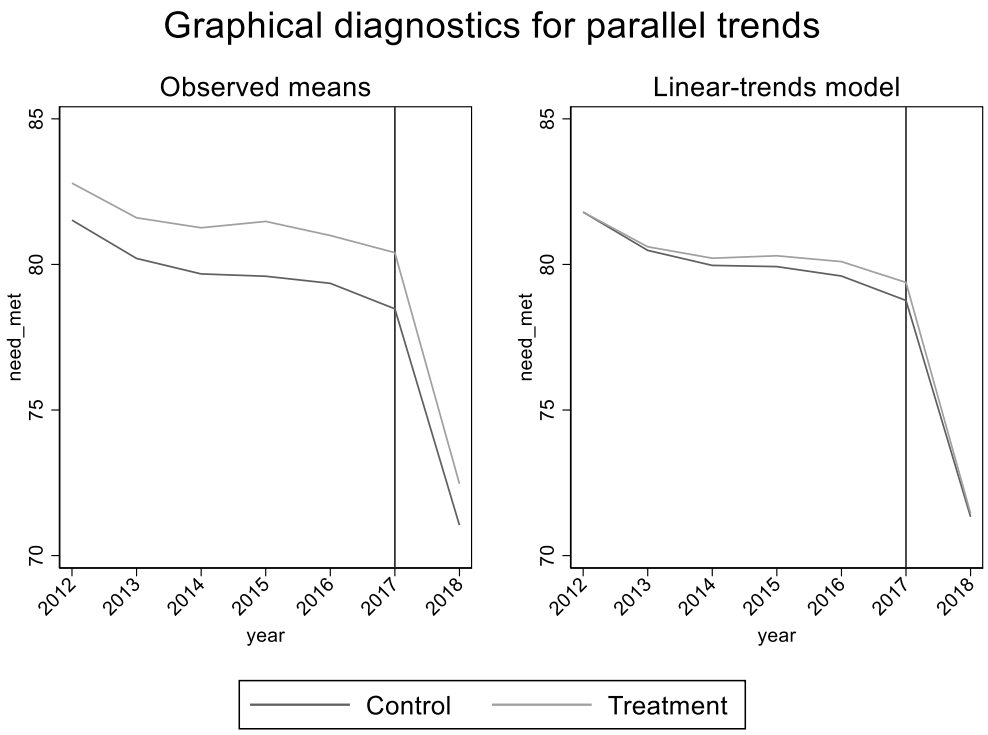


Figure A3: parallel trends test for % needs partially met

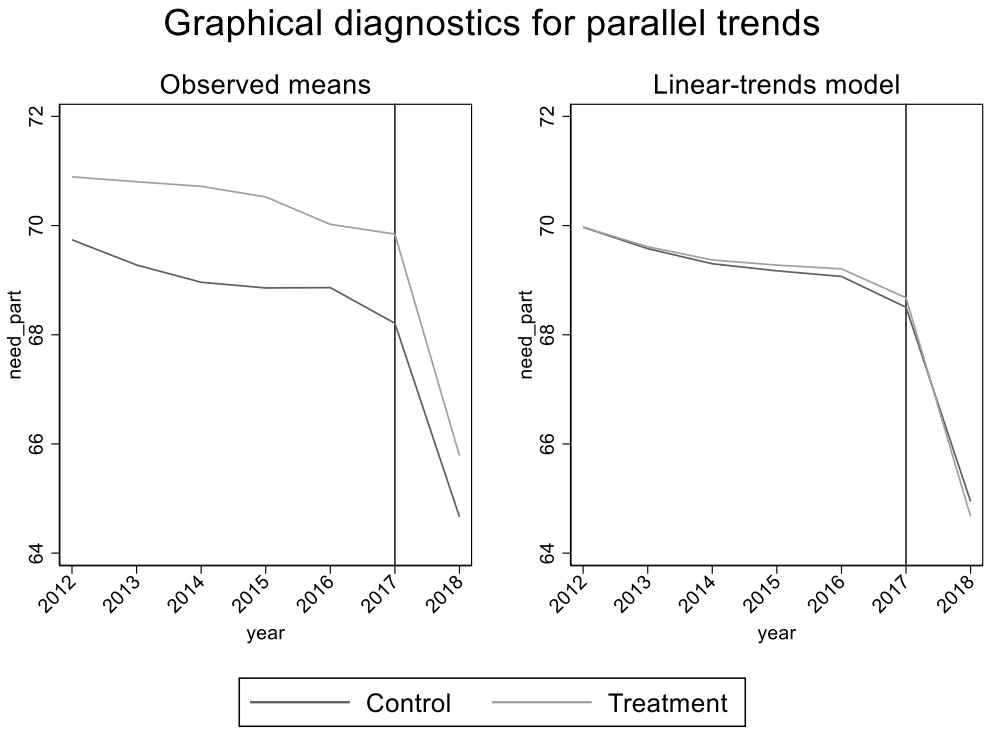


Figure A4: parallel trends test for % needs partially met wave two removed

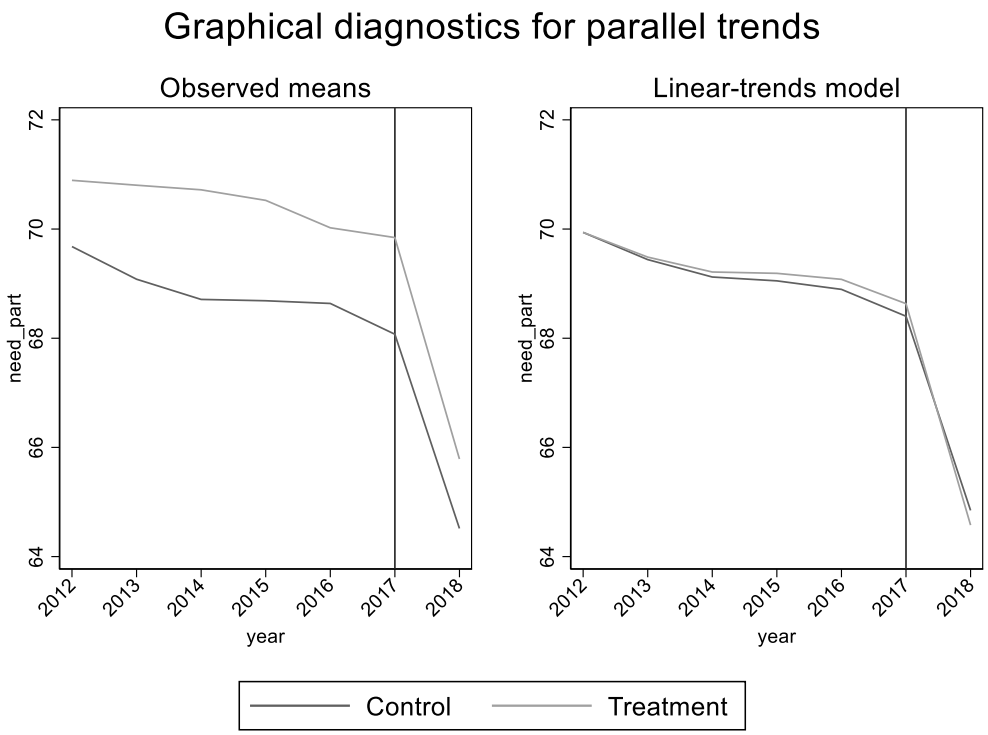


Figure A5: parallel trends test for % always see preferred GP

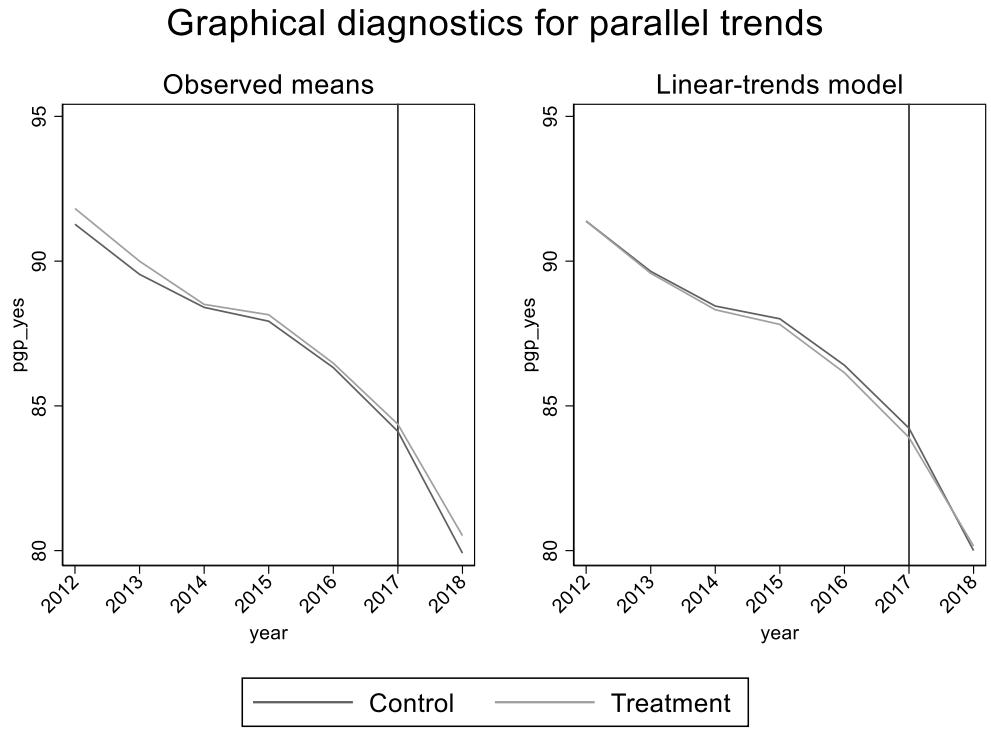


Figure A6: parallel trends test for % always see preferred GP wave two removed

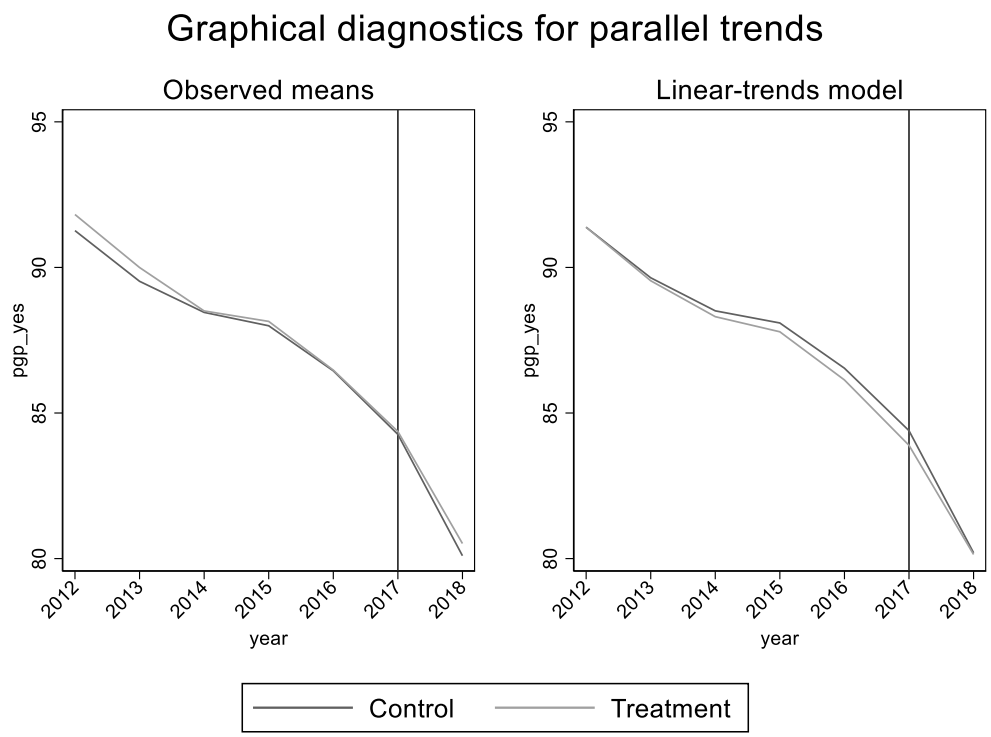


Figure A7: parallel trends test for % sometimes see preferred

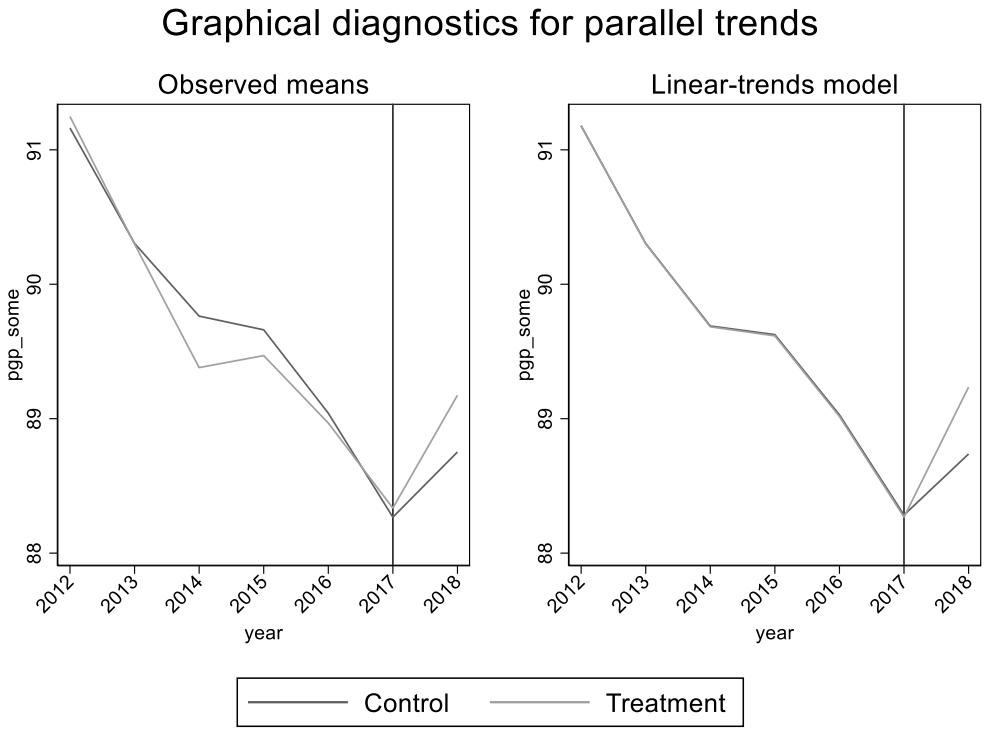


Figure A8: parallel trends test for % sometimes see preferred wave two removed

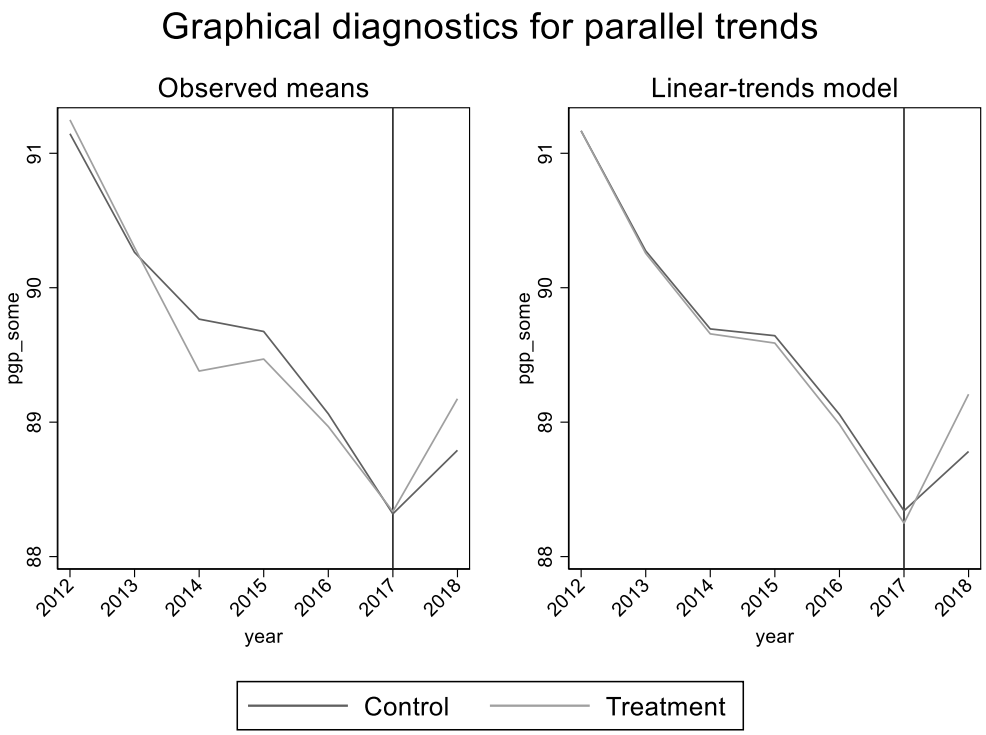


Figure A9: parallel trends test for % respondents have good overall experience

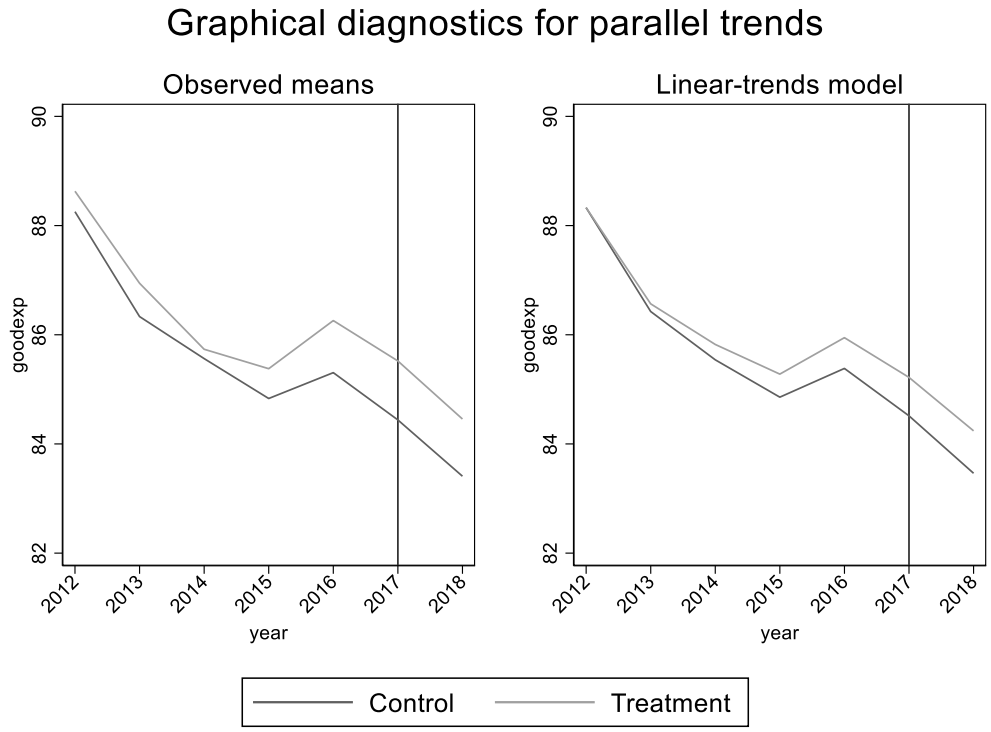
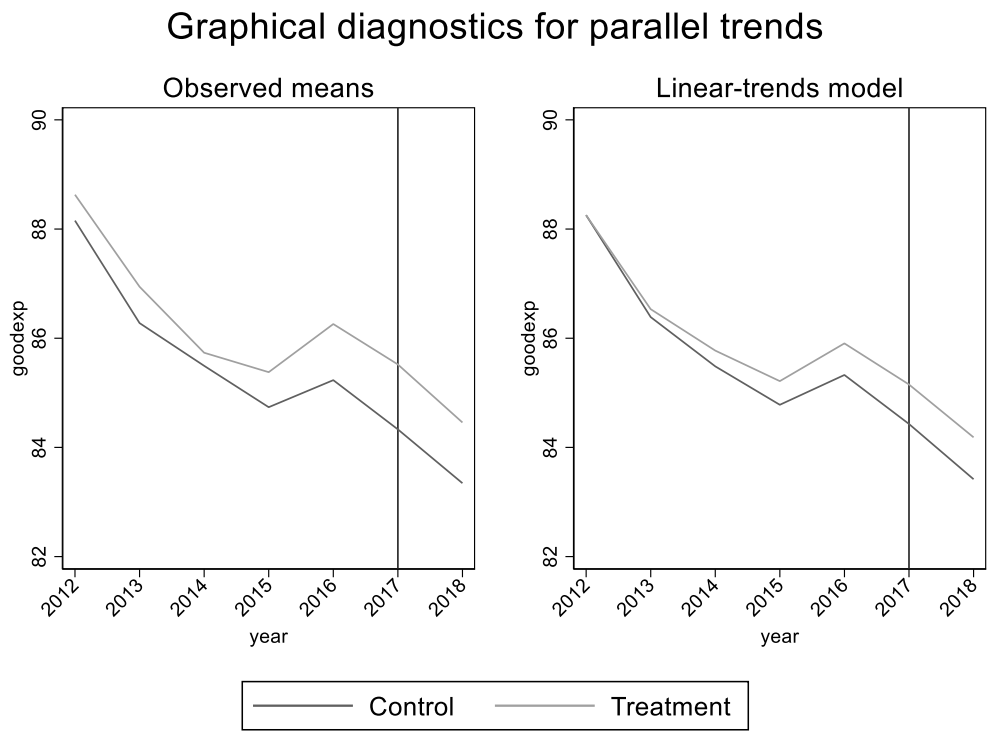


Figure A10: parallel trends test for % respondents have good overall experience wave two removed



Mortality

Figure A11: parallel trends test for preventable morality

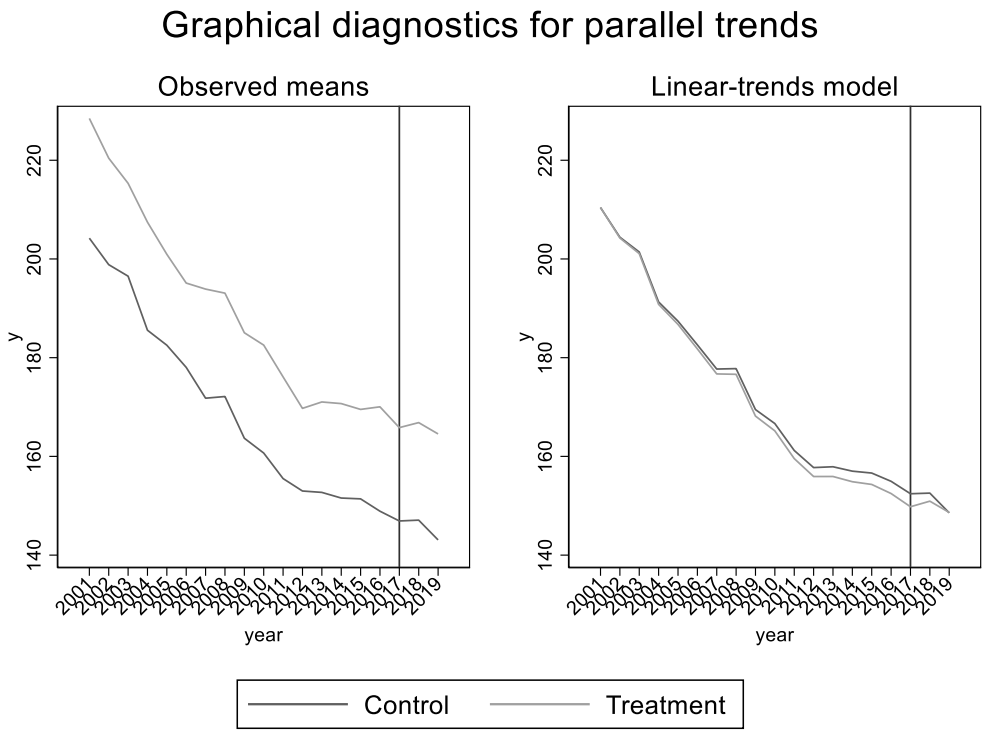
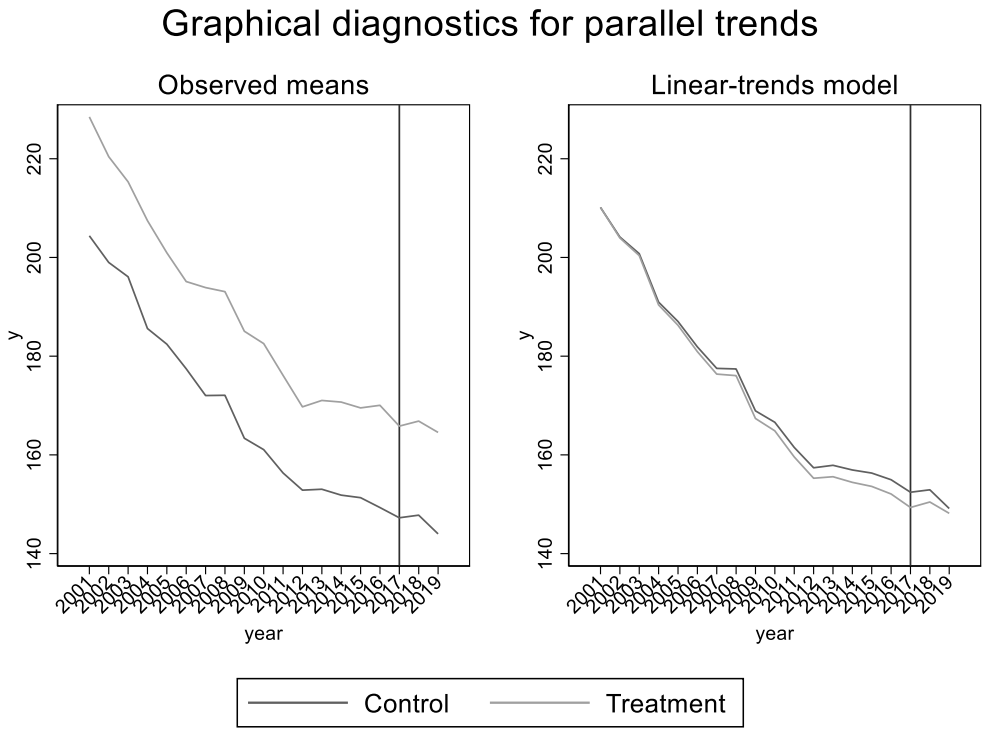


Figure A12: parallel trends test for preventable mortality wave two removed



Delayed Transfers of Care

Figure A13: parallel trends test for all Delayed Transfers of Care

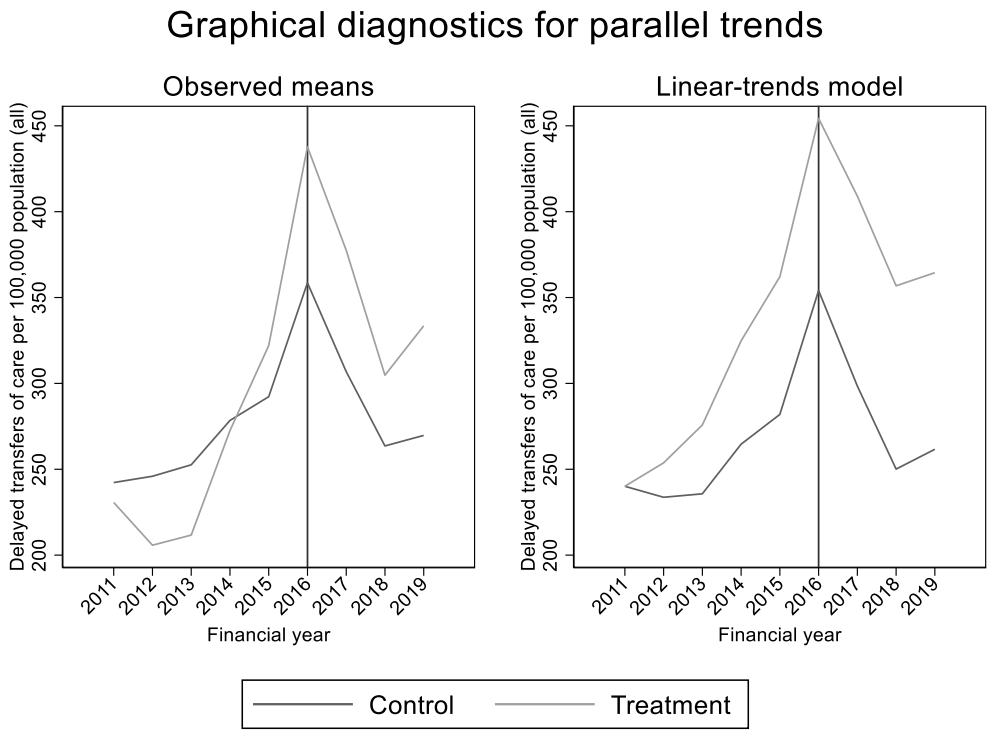


Figure A14: parallel trends test for all Delayed Transfers of Care wave two removed

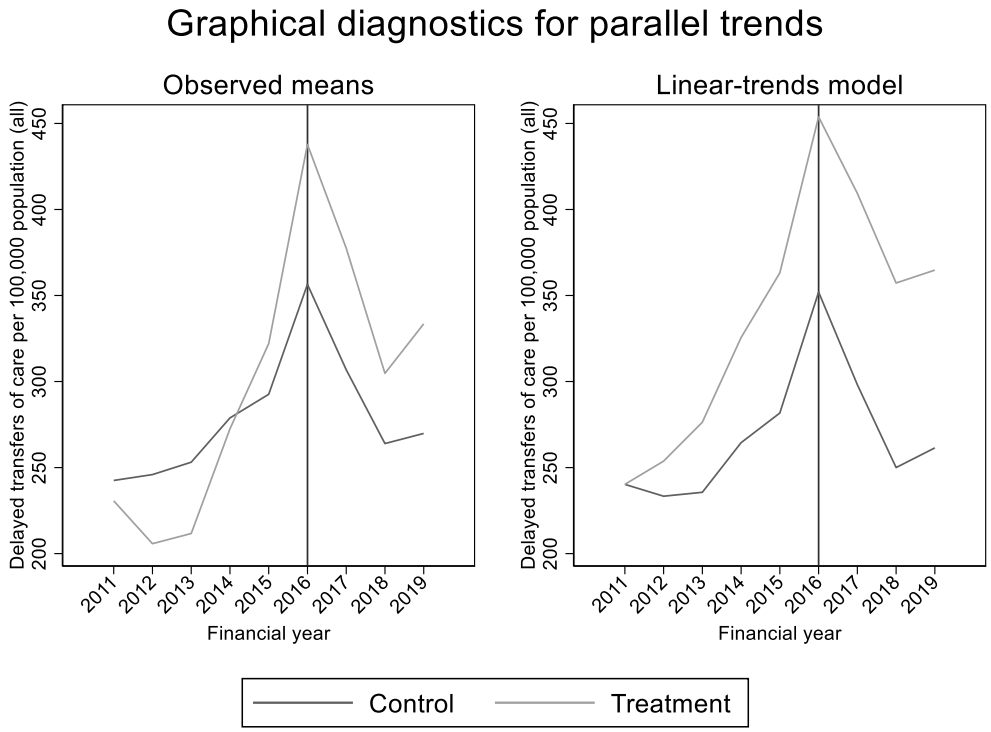


Figure A15: parallel trends test for Delayed Transfers of Care due to NHS

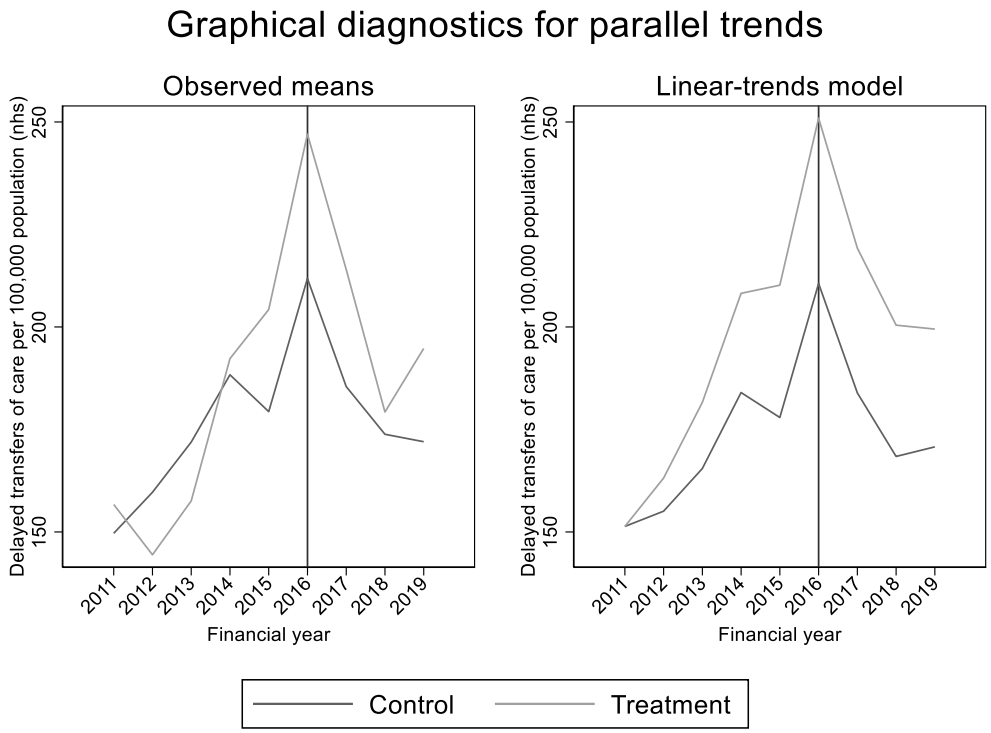


Figure A16: parallel trends test for Delayed Transfers of Care due to NHS wave two removed

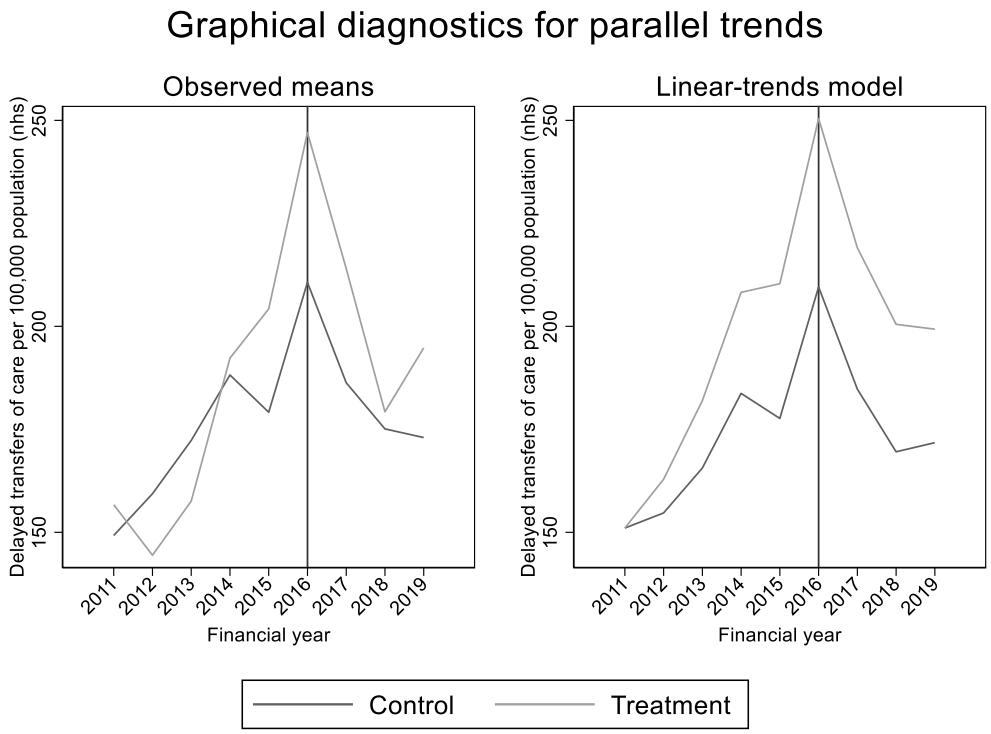


Figure A17: parallel trends test for Delayed Transfers of Care due to Social Care

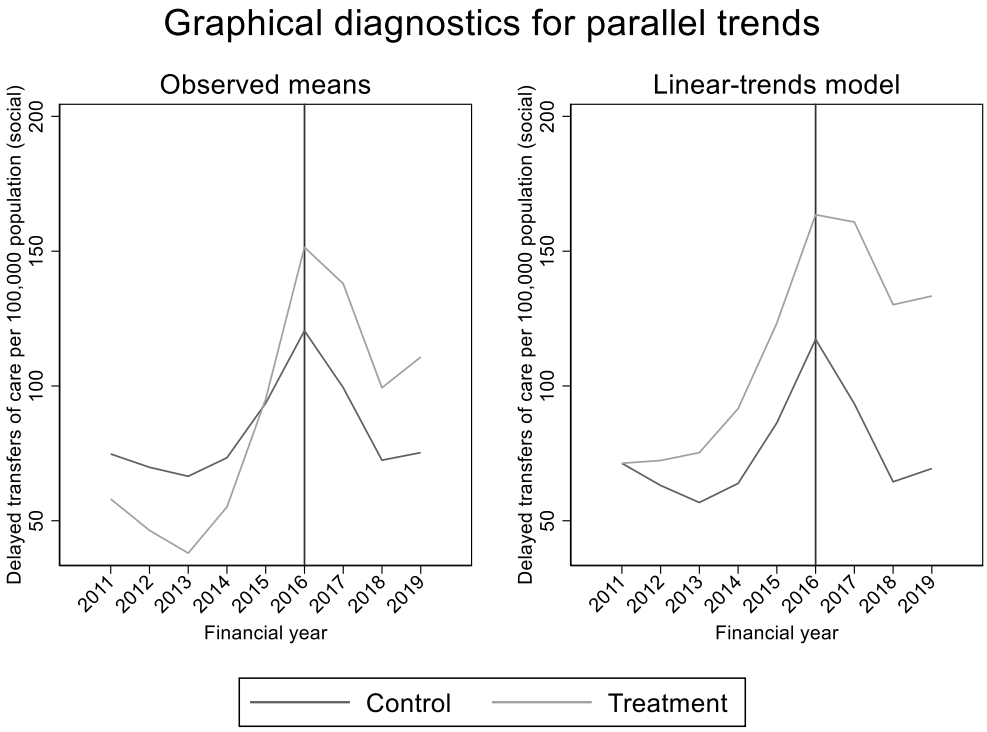
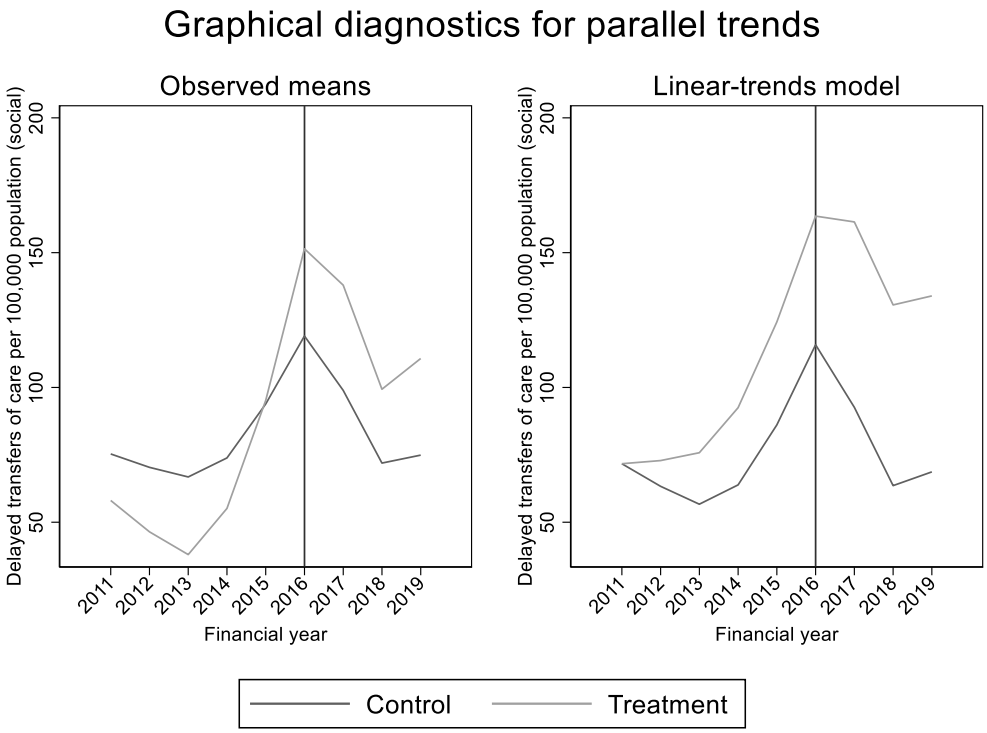



Figure A18: parallel trends test for Delayed Transfers of Care due to Social Care wave two removed