Academy of Medical Royal Colleges

Integrating care – Next steps to building strong and effective integrated care systems across England

Academy of Medical Royal Colleges response to NHSE/I engagement paper

January / 2021

Introduction

The Academy of Medical Royal Colleges (the Academy) is the membership body for medical royal colleges and faculties across the UK. As such it seeks to coordinate the views of its member organisations to drive improvement in health and patient care through education, training and quality standards.

The Academy sought views from members on the Engagement Paper and where there has been detailed response these are reflected here. Many colleges will make their own separate submissions as well as contributing to the Academy response.

We have, in addition, completed the online consultation response.

Overall summary

Detailed views of Colleges are set out below, but the key points are:

- The Academy and its member organisations strongly support the direction of travel towards greater integration of care systems. We have consistently believed that healthcare is better delivered through a collaborative approach and with systems working together rather than in competition with each other
- There is broad consensus that giving ICSs a statutory footing from 2022, alongside other legislative proposals, provides the right foundation for the NHS over the next decade
- There is broad consensus that Option 2 (statutory corporate body) offers a model that provides greater incentive for collaboration alongside clarity of accountability across systems, to Parliament and most importantly, to patients
- There are mixed views as to whether, other than mandatory participation of NHS bodies and Local Authorities, membership should be sufficiently permissive to allow systems to shape their own governance arrangements to best suit their populations needs. Whilst the need for flexibility is recognised there are also concerns over inconsistency and possible exclusion
- There are again mixed views as to whether services currently commissioned by NHSE should be either transferred or delegated to ICS bodies. There is strong support for local clinical leadership but there are again concerns over consistency and potentially equity. The "appropriate safeguards" and "where appropriate" caveats are very important and would need to be clearly defined.

Detailed comments from individual Colleges

1. Royal College of Surgeons of Edinburgh

The Royal College of Surgeons of Edinburgh believes that it is vital for the health and wellbeing of older and vulnerable people that the NHS and social care are integrated as seamlessly as possible. We therefore welcome the new review into integrated care systems (ICS) from NHS England and NHS Improvement. The renewed ambition for greater collaboration is the correct way to go and needs to be considered in detail, especially in light of the Coronavirus Pandemic.

We are particularly keen on the proposed strengthening of local partnerships between the NHS, local government, voluntary organisations and other care providers, to ensure as joined up a service as possible. These organisations need to work collaboratively and not be competing, in order to provide the best and most efficient healthcare. This needs to be done in a universal manner to avoid 'postcode lotteries' and to address health inequalities, whether those of race, gender, socioeconomic background or otherwise, as we seek to ensure a healthier population.

This will require organisations to work closely together, in particular it will require complimentary digital infrastructure and data-sharing across different organisational systems, as well as the efficient distribution or pooling of resources – including financial resources – commissioning, planning and development. This will also all need to be done at scale, in particular as our population ages.

For this the lessons of the Coronavirus pandemic may prove extremely valuable. The recent review by the House of Lords Public Services Select Committee found that local councils in particular played an impressive role in facilitating partnerships between public services – including the NHS – and other organisations, in particular those in the third sector. At the same time the review found that the Covid response was hampered by overly centralised, poorly coordinated and poorly communicated policies. One point which should therefore be strongly emphasised is that decisions should be taken as close to the communities they are affecting as possible, and that local government involvement is key. This cannot be done without adequate resourcing of local councils.

Similarly, the review found that digital technology was used rapidly and innovatively to reach vulnerable people in rural and remote communities as well as urban and suburban areas, particularly with the support of charity and voluntary organisations. Again, this is a lesson that is highly relevant for ICS. Investment in digital infrastructure in the NHS, local government and in such a way as to allow compatibility and data-sharing with other partner organisations is urgently needed.

It is therefore the view of the Royal College of Surgeons of Edinburgh that adequate resourcing of local councils to act as coordinating bodies for ICS and investment in the digital infrastructure of the NHS and local government are key factors in building a seamless integrated care system. These governance factors may be less likely to be considered than frontline, clinical logistics but we feel they are factors which we would ask the Academy to include in its response to the review.

2. Royal College of Obstetricians and Gynaecologists

a] Do you agree that giving ICSs a statutory footing from 2022, alongside other legislative proposals, provides the right foundation for the NHS over the next decade?

The RCOG agrees with this statement.

Current fragmentation in the way our healthcare services are designed and delivered mean that many women are struggling to access basic services including contraception, abortion care and cancer screening. The consequences of this include, but are not limited to, an increase in the number of unplanned pregnancies (resulting in poorer outcomes for women and their babies), a rise in requests for abortion, especially among women in older age groups, and later diagnosis of cervical cancer, which can adversely impact on survival rates.

Put simply, the current fragmentation of governance and commissioning responsibilities in England has created confusion and barriers for women when trying to access healthcare. This is

most acutely seen in sexual and reproductive health (SRH) services, the commissioning of which is currently split between CCGs, Local Authorities and NHS England. This means there is no single body invested in providing women's basic healthcare needs.

This lack of accountability and ownership has led to variations in access to services and quality of care. It has also created a system where there are few incentives to prevent health problems developing. Resultant poorer health outcomes are invariably more expensive to resolve than preventing the problem in the first place.[1]

It is arguable that the 2012 Health and Social Care Act reinforced the fragmentation of the health and social care service by, for example, splitting health commissioning responsibilities amongst a range of different organisations, most of which were newly created in 2013. This meant that there were, and still are, multiple providers in competition with each another.[2] Although subsequent policy initiatives promised local collaboration and joint working, without appropriate legislation and frameworks, only so much can be achieved.

Furthermore, as the Department of Health and Social Care's (DHSC) 'Busting Bureaucracy' report rightly notes, there are many sources of excess bureaucracy that are exacerbated by poorly integrated systems at a national, regional and local level and due to the multiple levels of hierarchy.[3] We agree that ICSs have the potential to reduce bureaucracy through increased collaboration and through streamlined structures.

To date, concerns have also been raised by various bodies, including the RCOG, regarding the seeming lack of accountability and transparency of ICSs.[4] This consultation is therefore welcomed and will work towards addressing some of these concerns.

The College is also in agreement with point 2.14 of the consultation document: "Many crucial features of strong system working — such as trust between partners, good leadership and effective ways of working — cannot be legislated for."

It is therefore vital that we continue to work towards the ambitions laid out in the Long Term Plan and NHS People Plan, to ensure that the NHS has the right leadership in place and that services are underpinned by sufficient resources, staff and budget to deliver a sustainable and consistent high-quality service to England's diverse population.

Furthermore, there is also an important opportunity for ICSs to improve access to women's health services and embed women's health services in the heart of community systems that should not be missed.

Although women make up of 51% of the population, as noted earlier the current tripartite commissioning arrangements cause significant barriers for many girls and women trying to access their basic health needs, including contraception.[5] Access is made more difficult for a number of additional reasons including stringent cuts to public health budgets, difficulties for women juggling work, childcare and other family commitments to get a convenient appointment, and pressures on GP surgeries. These barriers are considerable for many women, but for those who are socioeconomically disadvantaged or have difficulties accessing the health system, the barriers can become insurmountable.

The fact that women have to book several appointments to get their basic health requirements met is not only counterproductive for clinicians and women alike in terms of their time, but it is also expensive and unsustainable for the health service to continue. It also augments health inequalities and unwarranted variation in service delivery.

1. RCOG, Better for women (2019)

2. E. Gadsby et al., Commissioning for health improvement following the 2012 health and social care reforms in England: what has changed? (2017), The King's Fund, A new settlement for health and social care: Final report (2014) and RCOG, Better for women (2019)

3. DHSC, Busting bureaucracy: empowering frontline staff by reducing excess bureaucracy in the health and care system in England (November 2020)

4. The King's Fund, Integrated care systems explained: making sense of systems, places and neighbourhoods (2020)

5. APPG SRH, Women's Lives, Women's Rights: Strengthening Access to Contraception Beyond the Pandemic (2020)

It is for this reason that the RCOG recommended in its report *Better for women* (2019) for women's healthcare services to be implemented into ICSs. This will ensure a more joined-up approach to women's health, reduce unnecessarily long referral times and ensure that women can access high quality integrated health care.[6]

Do you agree that option 2 offers a model that provides greater incentive for collaboration alongside clarity of accountability across systems, to Parliament and most importantly, to patients?

The RCOG agrees with this statement.

Historically, there has been confusion among NHS leaders, staff, patients and partner organisations regarding who is accountable for what service, with variation spreading across the country. Model two would therefore hopefully deliver a clearer structure of ICSs for users of the heath service, as well as for those that work within it.

We are therefore in agreement with paragraph 3.26 which states that *"Option 2 is a model that offers greater long term clarity in terms of system leadership and accountability".*

c] Do you agree that, other than mandatory participation of NHS bodies and Local Authorities, membership should be sufficiently permissive to allow systems to shape their own governance arrangements to best suit their populations needs?

The RCOG disagrees with this statement.

ICS governance is currently based on voluntary arrangements and is largely dependent on goodwill and mutual co-operation of those that work within it. Added to this, the organisational landscape in many ICSs is complex, especially in areas where there is more than one Health and Wellbeing Board, Primary Care Network, STP, local authority, and other local partners.[7] This complex geography, current administrative boundaries and a system reliant on goodwill is unsustainable.

As a result, to date ICSs have varied in size and reach and whilst some have performed well in integrating services, others have struggled to align work with partner organisations.[8]

While some lenience as to membership should be allowed as there is not one ICS area that has exactly the same number and spread of partners, it is important for a blueprint for membership to be developed so that leaders are aware of minimum expectations and can more effectively work together to tackle the current issues summarised above. Differences in membership, and thereby engagement with partners, could cause tension and unwillingness to cooperate, which may lead to differences in success rates with the ultimate goal of integration.

We are in agreement with point 2.28 which states: *"Systems have told us from recent experience that good partnership working must be underpinned by mutually-agreed governance arrangements, clear collective decision-making processes and transparent information-sharing."*

Paragraph 2.32 also importantly notes that *"Integrated care systems draw their strength from the effectiveness of their constituent parts. Their governance should seek to minimise levels of decision-making and should set out defined responsibilities of organisations, partnerships at place, provider collaboratives and the core ICS role. Each ICS should seek to ensure that all the relevant bodies feel ownership and involvement in the ICS."*

To achieve these two aims, it is important that all relevant parties form part of the membership, even when levels of decision-making are diminished. Therefore, although some lenience is required, the absolute minimum requirements should be set centrally by NHSE/I.

The RCOG agrees with point 2.24 which states that: *"Clinical and other frontline staff have led the way in working across professional and institutional boundaries, and they need to be supported to continue to play a significant leadership role through systems. ICSs should embed system-*

6. RCOG, Better for women [2019]

7. The King's Fund, Health and wellbeing boards and integrated care systems [2019]

8. The King's Fund, A year of integrated care systems: Reviewing the journey so far [2018]

wide clinical and professional leadership through their partnership board and other governance arrangements, including primary care network representation." It is important that this is embedded and mandated within the minimum requirements.

Furthermore, the College considers that it is important for leaders to communicate effectively how ICSs will run, how they plan to work with local authorities, who will form part of their membership and their overarching powers and responsibilities. It is arguable that to date, the public, NHS staff and other partners have been confused by what responsibilities ICSs have, what the ambitions are, and for patients, how access to their healthcare may change. This is an opportunity to make ICSs visible and transparent that should not be missed.

Do you agree, subject to appropriate safeguards and where appropriate, that services currently commissioned by NHSE should be either transferred or delegated to ICS bodies?

The RCOG broadly agrees with this point, but considers that centralisation of commissioning needs to go further than what is outlined in this consultation.

We agree with point 3.18 which states: *"In this option, ICSs would be established as NHS bodies partly by "repurposing" CCGs and would – among other duties – take on the commissioning functions of CCGs", and we are also in favour of an earlier point made in paragraph 2.40: "We will create a 'single pot,' which brings together current CCG commissioning budgets, primary care budgets, the majority of specialised commissioning spend, the budgets for certain other directly commissioned services, central support or sustainability funding and nationally-held transformation funding that is allocated to systems."*

While the above is welcomed, the RCOG considers that fragmentation of SRH services will remain until there is only one, single accountable commissioner.

The RCOG, the Faculty of Sexual and Reproductive Healthcare (FSRH), the Royal College of General Practitioners (RCGP), the Royal College of Pathologists (RCPath), the Royal College of Paediatrics and Child Health (RCPCH), and the Academy of Medical Royal Colleges have long called for holistic integrated commissioning of sexual and reproductive healthcare with one body maintaining oversight and holding accountability for all commissioning decisions.[9]

As noted earlier, women continue to struggle to access high quality sexual and reproductive healthcare services which remain fragmented across the country. Women should have all their sexual and reproductive health needs – such as cervical screening, family planning, contraception and STI testing – met by a single service. A single accountable commissioner is essential to achieving this goal. It would also ensure that sexual and reproductive healthcare services are more joined up for women and the workforce is better supported and resourced.

The ideas laid out in paragraph 3.22 suggest that there would be a more joined up approach to commissioning: *"Many commissioning functions for which NHSE is currently responsible could, for the most part, be transferred or delegated to the ICS body, but with the ability to form joint committees as proposed through our original recommendations, with NHSE, if and where appropriate."* However, it remains unclear and confusing as to what commissioning responsibilities would remain the responsibility of NHSE, which would be passed onto ICSs and whether there would be a consistent approach across the country.

As it stands, this report also raises the question of where commissioning responsibilities currently held by Local Authorities will lie, and how they will work in practice with the commissioning responsibilities of ICSs as well as those that remain with NHS England.

Clarification and accountability are still urgently required to end fragmentation of service delivery and access to healthcare, and to achieve a fully joined-up system for women.

9. AoMRC, RCOG, FSRH, RCGP, RCPath and RCPCH Position, Holistic Integrated Commissioning of Sexual & Reproductive Healthcare (2019)

3. Royal College of Physicians

- COVID context and health inequalities context across the UK
- Not a lot of clarity on what the proposals will entail or mean in practice
- We support the formal merging of NHSE/I
- We support greater integration and working at a local level between organisations, but we need to make sure that all relevant organisations and bodies are included.
- We need to pay close attention to the workforce planning element of integration for it to truly work. The development of a national workforce accountability framework is going to be key and must be agreed between the NHS, HEE, government and other relevant organisations.
- Look forward to commenting on future details.

Do you agree that giving ICSs a statutory footing from 2022, alongside other legislative proposals, provides the right foundation for the NHS over the next decade? Agree

The RCP believes there is a strong case for putting ICSs on a statutory footing from 2022, to provide the framework for a more integrated and collaborative approach to the delivery of healthcare across the NHS and social care. We will need to consider how this change can happen in a phased way, so the practical challenges can be properly assessed and addressed.

As this and other legislative proposals develop, the practical implications for patient care and ways of working need to be more clearly spelt out. There is nervousness among NHS staff about another 'top-down reorganisation', especially in the context of the severe ongoing disruption to services that COVID-19 has caused. It will require a detailed communications plan to ensure broad understanding, as the aims and plans for integration are still unclear to many. We look forward to seeing and engaging with the detail, of both the proposals and communications, in the coming months.

The pandemic has also exposed and exacerbated existing health inequalities, and legislative change will need to be underpinned by measures to address these inequalities and support greater funding for public health. There will also need to be greater clarity on the role that NIHP will play and where responsibility for population health will sit.

Workforce planning must also be a central part of these proposed legislative changes. We strongly support the development of a national workforce accountability framework, which needs to be agreed between the NHS, HEE, government and all relevant organisations.

We also support the introduction of a duty on the Secretary of State to ensure sufficient workforce. Better long-term workforce planning is crucial to the ability of the NHS to deliver better integrated care, and these two mechanisms should together help to incentivise long-term thinking. Close working with the education system will also be needed, for example to expand the number of medical school places available.

Do you agree that option 2 offers a model that provides greater incentive for collaboration alongside clarity of accountability across systems, to Parliament and most importantly, to patients? Neutral

We agree that option 2 offers a model that provides greater incentive for collaboration, but both options have their challenges.

Greater collaboration is difficult to achieve but greatly needed; it requires enthusiasm to cross boundaries. Option 2 would provide that, with greater accountability and autonomy at a local level but it is not clear what the full impact would be of a new system, given that the indirect impacts are likely to be extensive.

It is clear that there is support for putting ICSs on a statutory footing but there are many unknowns and uncertainties amongst physicians about the full impact each model will have.

Do you agree that, other than mandatory participation of NHS bodies and Local Authorities, membership should be sufficiently permissive to allow systems to shape their own governance arrangements to best suit their populations needs? Strongly agree

It is essential that systems have the necessary flexibility to develop governance arrangements that work best for their populations. To enable greater integration at a local level, systems need to be able to work closely with all relevant organisations and bodies, including the voluntary, community and social enterprise (VCSE) sector.

During the pandemic, with fewer regulatory constraints at the local level, there has been a huge amount of innovation in terms of service delivery and working practices. As we rebuild the NHS, we must learn from this and ensure local systems have this flexibility built-in so they can deliver care in the way that works best for their populations.

Do you agree, subject to appropriate safeguards and where appropriate, that services currently commissioned by NHSE should be either transferred or delegated to ICS bodies? Agree

It is important to consider the impact on public health of changes to both ICSs and Public Health England. Local autonomy is important in commissioning services and procurement has been historically challenging. Regional needs vary greatly so transferring authority would enhance the autonomy of ICSs.

Transparency and clarity about changes would be needed, as widespread confusion about the system already causes problems. This must be, as you say, subject to appropriate safeguards.

Concerns remain regarding the impact of the change, particularly regional variation. Success often depends on local factors and cooperation, which we cannot allow to impact negatively on patient care. Some regions do not have experience of joint commissioning, so varying levels of initial support will be needed to ensure success across each region. There also needs to be greater flexibility on tariff setting and commissioning should be quality driven.

4. Royal College of Physicians and Surgeons of Glasgow

NHSE/I has failed to understand how the NHS has changed in the pandemic and that we have to have new ways of planning and functioning. Local is not necessarily good particularly if it does not have enough funding. (the English NHS has less per capita than Scotland because of the Barnett formula (£9296 versus £11247).

It stresses collaboration and has four strands (Partnership, Providers, Commissioning and use of Digital mechanisms and sharing of data). It views Primary Care at the centre. Has primary care the ability to do this? The reduction in Public Health budgets for local Public Health Consultants (employed by Councils) and the health prevention measures e.g. for reducing obesity and smoking will enhance health inequalities. A paper in the last few weeks has shown Public Health Medicine budgets have been reduced in the most socially deprived communities. This paper does not address health inequalities. In fact, health inequalities are not even discussed.

It believes CCG have been successful. Our view is they are really not proving their worth and duplicating function with extra cost.

The document stress use of technology. This is fine in terms of planning and communication but does not address those who cannot use technology who are often the most needing in our society, the elderly, the disabled and the homeless.

There is nothing in this paper about patients. The biggest issues for patients are that they don't know where they are in the system either if they are waiting for treatment or follow up. This document does not even look at follow up for long term or multiple comorbidities.

In terms of legislation, this will allow for reorganisation – do we need it at this time. It also talks about responsibility and accountability. In my view, this lies with government and not local devolved powers. I am reminded about the recent criticism of PHE which was viewed as a separate independent agency when actually it was a direct arm of government receiving its instructions and priorities from them. Brexit in January was deemed more important that a pandemic.

Do you agree that giving ICSs a statutory footing from 2022, alongside other legislative proposals, provides the right foundation for the NHS over the next decade? Unconvinced

Do you agree that option 2 [statutory corporate body] offers a model that provides greater incentive for collaboration alongside clarity of accountability across systems, to Parliament and most importantly, to patients? Unconvinced. There needs to be accountability to parliament and patients. Neither appear clear in the document

Do you agree that, other than mandatory participation of NHS bodies and Local Authorities, membership should be sufficiently permissive to allow systems to shape their own governance arrangements to best suit their populations needs?

There needs to be a statutory framework of governance. Otherwise these organisations will fail and not be accountable.

5. Royal College of Surgeons of England

Do you agree that giving ICSs a statutory footing from 2022, alongside other legislative proposals, provides the right foundation for the NHS over the next decade? Yes

Do you agree that option 2 [statutory corporate body] offers a model that provides greater incentive for collaboration alongside clarity of accountability across systems, to Parliament and most importantly, to patients? Yes

Do you agree that, other than mandatory participation of NHS bodies and Local Authorities, membership should be sufficiently permissive to allow systems to shape their own governance arrangements to best suit their populations needs? Yes

The RCS are submitting their own fuller response which

- Recognises the role of ICSs and supports the absorption of CCG powers.
- Places some emphasis on the prospect of elective hubs.
- Promotes local involvement from their network of regional directors.

The RCS is planning a wider discussion (post-consultation) with its Council and membership at large.

6. Royal College of Paediatrics and Child Health

Do you agree that giving ICSs a statutory footing from 2022, alongside other legislative proposals, provides the right foundation for the NHS over the next decade?

Do you agree that option 2 offers a model that provides greater incentive for collaboration alongside clarity of accountability across systems, to Parliament and most importantly, to patients?

We agree that integrated care systems (ICSs) will benefit from a statutory footing from 2022. This will help to provide stability and accountability for planning, commissioning and delivery of services. The consultation paper outlines two options that would put ICSs on a statutory footing: Statutory committee model, with an accountable officer or Statutory corporate NHS body, bringing CCG statutory functions into the ICS. NHSEI preference is for Option 2 as it offers greater long-term clarity in terms of system leadership and accountability. RCPCH noted in State of Child Health 2020, our landmark report into the health and wellbeing of children and young people, that greater integration and working in partnership to deliver shared priorities is essential to reduce inequalities, to prioritise public health and prevention, and to improve health services for children and young people. We have considered the options put forward by NHSEI and we agree that Option 2 is the better model for integrated care systems for the reasons NHSEI have described.

Do you agree that, other than mandatory participation of NHS bodies and Local Authorities, membership should be sufficiently permissive to allow systems to shape their own governance arrangements to best suit their populations needs?

The consultation paper proposes that mandatory participation in ICS' governance arrangements should extend to NHS bodies and Local authorities, alongside a chair, chief executive and chief financial officer [paragraph 3.19]. Beyond this, the proposal is that the ICS body can appoint other members as it 'deems appropriate' and giving flexibility to shape the membership to suits the needs of their populations. Elsewhere the consultation paper argues strongly for an important role for clinical and professional leadership in delivering integrated care. It also states that ICSs should embed system-wide clinical leadership throughout governance arrangements [paragraph 2.24]. This is welcome but could fail to materialise if these roles are not mandatory in ICS governance arrangements.

There is a clear and pressing need for a system-wide leader for children and young people's health. The NHSEI proposals covers the period to April 2022. During that time, we expect ICS will be contending with the backlog of demand exacerbated by the coronavirus pandemic, alongside the need to address issues identified by RCPCH's State of Child Health 2020.

We welcome NHSEI's explicit commitment to clinical and professional leadership. As part of this, we consider that it is essential that a strategic lead for children's health services is identified as a mandatory role in ICS governance arrangements. This role would provide leadership for a system-wide view across all services for children and young people, for high quality, safe and effective integrated services. It would also demonstrate a clear commitment to meeting the specific public health and healthcare needs of this group and the workforce that is needed to deliver this. This role could be mirrored by similar positions within place-based partnerships that ensure all children and young people can access preventative services, joined up care and clear advice on staying well.

We understand that some flexibility in membership gives ICS the opportunity to tailor their governance to the needs of their population, but this approach does introduce a risk that key perspectives and experience may be missing from planning and commissioning decisions. To address this, we would expect further details will be provided regarding external oversight of overall governance arrangements. This will help to assure system partners and collaboratives, patients and their public that ICSs' overall strategic purpose and objectives can be met by their locally determined appointments.

7. Royal College of General Practitioners

The College is supportive of the overall aims of the integrating care agenda. However, there are significant concerns from GPs that the proposals as they currently stand do not give adequate safeguards to ensure that the smaller providers in a system are embedded at all levels of decision making and resource allocation, and to shape strategy and transformation. We would also like to ensure that the implementation of any legislative changes incorporate a more realistic timeline to prevent an unnecessarily disruptive reorganisation of current system partners. There appears to be clear agreement across the healthcare sector that a top-down restructure of organisations and accountabilities would be counterproductive. However, the proposals to put ICSs on a statutory footing, and for commissioning responsibilities to be absorbed into these organisations by 2022, is too short a timescale to enable bottom-up, localised development.

The success of Integrated Care Systems (ICSs) will not be on the basis of legislative change, but on the relationships and engagement of the workforce delivering care for patients. The current proposals use Primary Care Networks (PCNs) as a favoured unit of primary care for engagement at the system level. This is an unrealistic expectation for many PCNs over the next few years, which are typically small groups of practices that have recently started working together to deliver directed enhanced service. These networks need far more time to mature in order to fulfil the system role envisioned for them. In the meantime, systems must include general practice networks and assets that already exist to ensure strategies can take a holistic system wide view of care.

While we agree that there should be legal provision for ICSs to become statutory bodies eventually, effective integration within the NHS would be much more likely if systems were given the space,

time and resource to develop the necessarily relationships and structures first. This could take a decade. This might mean using the first option of convening a system board as a stepping-stone within legislation. This could then lead to a system absorbing CCG responsibilities and structures when it is mature enough to do so.

A strong primary care system is a crucial element of effective healthcare systems. Primary care, and within that general practice, will need to be the foundation of any successful integrated care system. There must be clear mechanisms in place within any future system to ensure that the voice and influence is woven into healthcare systems at all levels. This will be essential for managing the growing shift of care into the community expected over the coming years.

The College is concerned at the lack of safeguards relating to resource allocation across the system. The proposal to put ICS on a statutory footing, absorbing all commissioning responsibilities, seems to put resourcing decisions solely in the hands of ICS providers large enough to be included in the ICS board. This risks creating gaps within decision making, of the expertise of primary care providers. We are concerned that the transformation necessary for implementation of the Long Term Plan will fail if resources are not sufficiently directed to support primary care delivery. Systems must have clearer guidance and adequate safeguards to support this strategic aim of NHSE/I.

8. Royal College of Pathologists

Do you agree that giving ICSs a statutory footing from 2022, alongside other legislative proposals, provides the right foundation for the NHS over the next decade? Yes

Q2 - Do you agree that option 2 (statutory corporate body) offers a model that provides greater incentive for collaboration alongside clarity of accountability across systems, to Parliament and most importantly, to patients? Yes

Do you agree that, other than mandatory participation of NHS bodies and Local Authorities, membership should be sufficiently permissive to allow systems to shape their own governance arrangements to best suit their populations needs? No

Do you agree, subject to appropriate safeguards and where appropriate, that services currently commissioned by NHSE should be either transferred or delegated to ICS bodies? No

In addition, pathology is not mentioned in this document at all but is a cornerstone of the service. You cannot have modern healthcare without diagnostic testing, so Pathology must be included & resourced from the earliest planning stages.