

Time to be radical?

The view from system leaders on the future
of 'system by default'

William Pett



About NHS Reset

COVID-19 has changed the NHS and social care, precipitating rapid transformation at a time of immense pressure and personal and professional challenge. One message from leaders and clinicians across the UK has been clear: we must build on the progress made to chart a new course.

NHS Reset is a new NHS Confederation campaign to contribute to the public debate on what the health and care system should look like in the aftermath of the pandemic. Galvanising members from across the NHS Confederation and wider partners in health and social care, it aims to recognise the sacrifices and achievements of the COVID-19 period, rebuild local systems and reset the way we plan, commission and deliver health and care.

Find out more at www.nhsconfed.org/NHSReset and join the conversation #NHSReset

About the Integrated Care Systems Network

A critical part of delivering the ambitions of the NHS Long Term plan will be empowering local systems and giving them the autonomy they need. At the NHS Confederation, we are supporting emerging systems and helping local areas on the journey to becoming integrated care systems by April 2021. We believe the ambitions of the plan can only be met through greater collaboration, partnerships and system working.

We are undertaking a number of activities to support local systems. Alongside tailored support for ICS/STP independent chairs, programme directors, clinical leads, mental health leads, workforce leads, non-executive directors and lay members, we have now established a national network for ICS and STP leaders. This was set up in response to feedback from ICS/STP leaders across the NHS and local government who told us they wanted an independent safe space to exchange ideas, share experiences and challenges, and develop solutions.

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About the NHS Confederation

The NHS Confederation is the membership body that brings together and speaks on behalf of organisations that plan, commission and provide NHS services in England, Northern Ireland and Wales. We represent hospitals, community and mental health providers, ambulance trusts, primary care networks, clinical commissioning groups and integrated care systems.

To find out more, visit www.nhsconfed.org and follow us on Twitter @NHS Confed

Key points

- With NHS England and NHS Improvement and the government both seeking to recommence 'system by default' over the coming months, the NHS Confederation's ICS Network convened a joint session of sustainability and transformation partnership (STP) and integrated care system (ICS) leaders and independent chairs ('system leaders') in June 2020 to ask the question: 'what next for system working?'
- Through polling of system leaders, we looked to assess which direction of travel systems themselves would like to see, as we begin to look beyond the emergency response to COVID-19 and towards a coherent future vision for system by default.
- In total, 40 responded to our poll, representing approximately half of all STP and ICS leaders and chairs nationwide.
- This short report sets out the results of the questions we asked. They indicate that since the outbreak of the pandemic there has been a growing appetite among system leaders for significant strengthening of system working, with an increasing number favouring a move away from the current 'voluntary partnerships' approach in favour of more formalised working arrangements.

- The questions asked were, by necessity, simplistic in nature and they do not allow for detail and nuance. More work is needed to interpret them and establish what they might mean in practice in terms of policy and legislative implications. That said, they serve as a useful gauge of what the aspirations are for the future as we start to look at what system by default might look like in practice.
- Over the coming months, the NHS Confederation will explore the areas covered in this report in more detail with a wider constituency of members and stakeholders. These will include providers, commissioners, local authorities, primary care networks, provider trusts and the voluntary sector. This will help to identify where there is consensus and disagreement on particular issues across different stakeholders.

Background

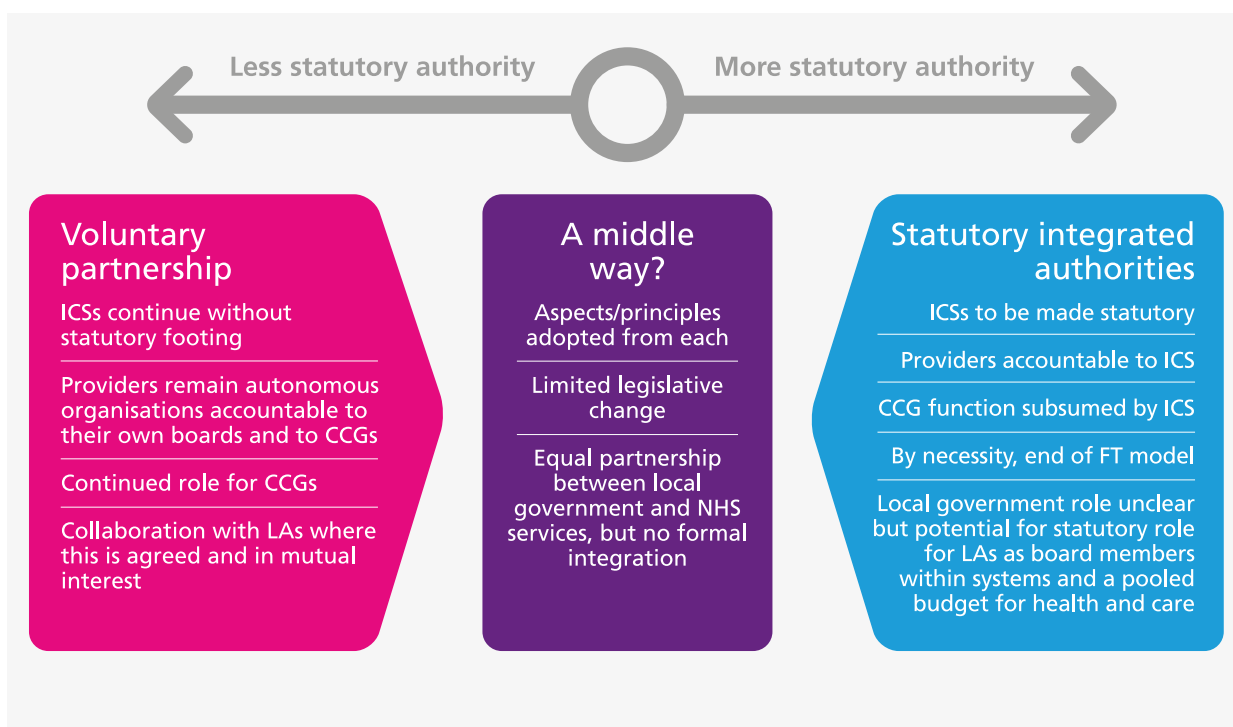
There has been understandable speculation about the extent to which COVID-19 will impact on the move to system working, and the introduction of integrated care systems (ICSs) that was set out in the NHS Long Term Plan.

Questions have been raised, for instance, on what COVID-19 will mean for the commitment of universal coverage of ICSs across England by April 2021. At national level, NHS England and NHS Improvement (NHSEI) has paused the 'system by default' initiative intended to grant more control and decision-making powers to local systems.

Given such uncertainties, the NHS Confederation's ICS Network has been exploring with our members the issue of what is next for system working. At a recent joint session of sustainability and transformation partnership (STP) and ICS leaders and independent chairs ('system leaders') across England, we have started discussions as to what next steps systems themselves would like to see, as we begin to look beyond the emergency response to COVID-19 and towards a coherent future vision for system by default.

This short report sets out the results of polling of system leaders conducted during the ICS Network's joint session in June 2020, on a range of issues relating to the future of system by default. In total, 40 responded to our poll, representing approximately half of all STP and ICS chairs and leaders nationwide. The results indicate that since the outbreak of the pandemic there is a growing appetite for significant strengthening of system working, with an increasing number moving away from the current voluntary partnerships approach in favour of more formalised working arrangements. There is also a strong sense that local authorities need to be equal partners in ICSs and not an afterthought.

Prior to the session, the ICS Network had identified three broad schools of thought on system by default. The typical features that these might include are shown on page 6, and further detail on each can be found at the end of this report in the appendix.



It should be noted that the questions asked in our poll were by necessity simplistic, as they were developed to gauge a sense of current thinking amongst STP/ICS leads and chairs. More work is needed to interpret these views and establish what they might mean in practice. However, while they do not allow for detail and nuance, they do offer a broad indication of the direction of travel that system leaders feel that NHSEI and the government should follow on system by default.

The polling was conducted on an anonymous basis to allow system leaders to answer freely. However, this anonymity means that we do not have a breakdown of the demographics of respondents, for example the proportion of respondents who are chairs/leads and the geographical spread.

It must also be stressed that this report does not necessarily represent an NHS Confederation policy position, but simply outlines the views of the individual leaders polled. The view of the future of system working also need to be tested with a wider range of leaders from across the health and care system, including providers of primary, community and secondary care, commissioners, local government and the community and voluntary sectors. These views are central to the future of system by default.

With these caveats in mind, it is hoped that this report offers a platform for NHSEI, government and those across the health and care sectors to consider what the future approach to system by default might start to look like.

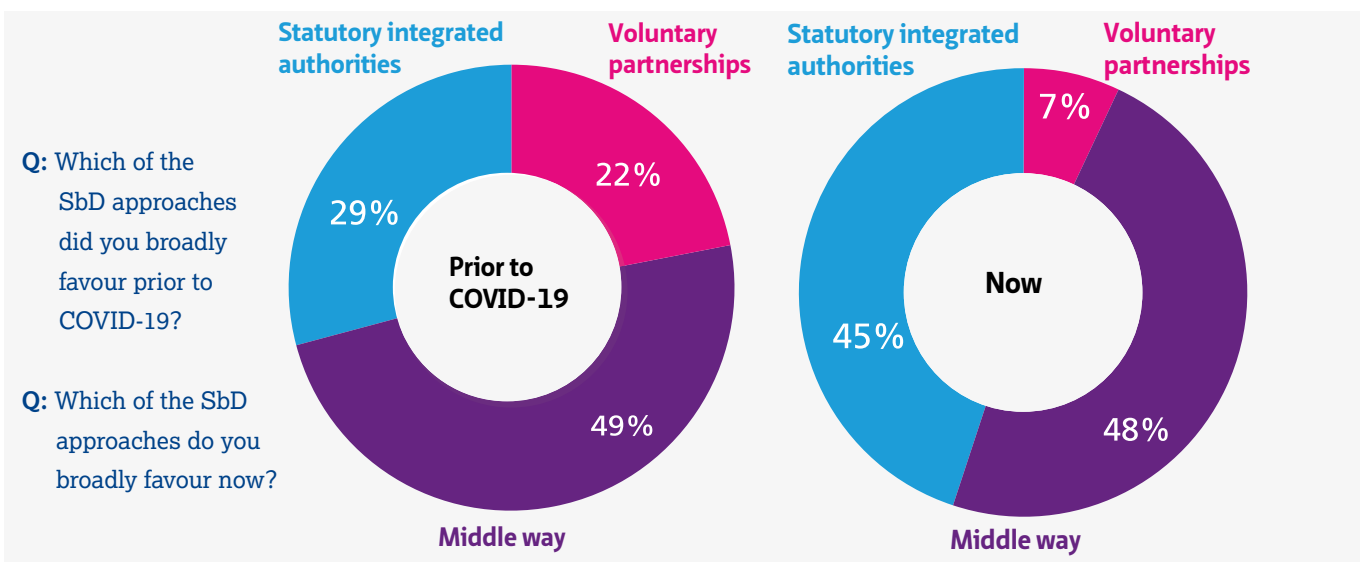
What do system leaders believe system by default should look like?

Overall direction

To understand how views had developed in recent months we firstly asked which of the system by default approaches did system leaders broadly favour prior to COVID-19.

The response to this was relatively evenly split between the two ends of the spectrum. Just under a quarter (22 per cent) of system leaders indicated that they favoured a voluntary partnerships approach, with half (49 per cent) favouring a middle way approach and just over a quarter (29 per cent) favouring statutory integrated authorities.

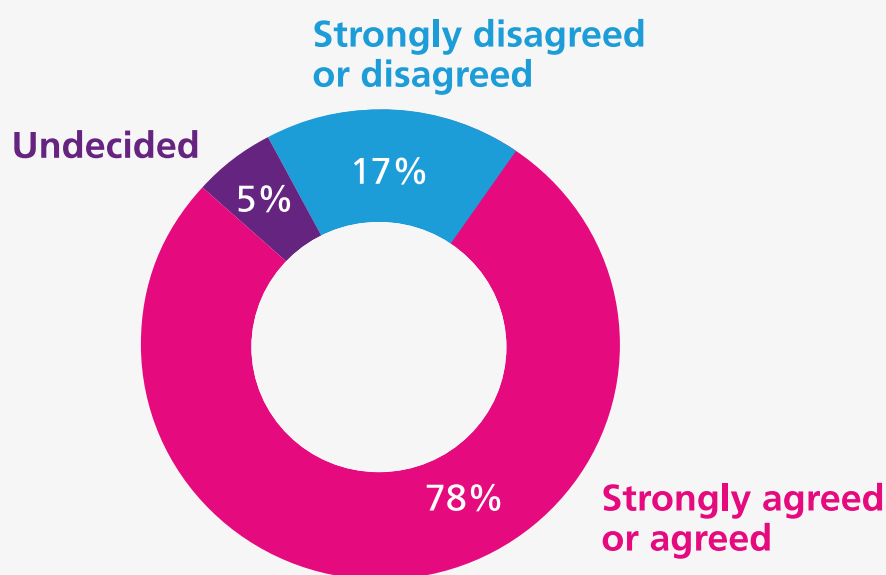
However, when asked which of the system by default approaches they favoured now, the response here was far less equivocal. Less than one in ten (7 per cent) now indicated that they favoured a voluntary partnerships approach. Those favouring a middle way approach remained consistent at almost half (48 per cent), with a significant increase – now over two fifths (45 per cent) – favouring statutory integrated authorities.



We also asked system leaders to indicate the extent to which ICSs should be driven from place-based working, with only a limited number of strategic issues dealt with at system level.

The response to this was clear. The vast majority (78 per cent) indicated that they agreed, with less than one in ten (7 per cent) stating that they disagreed.

Q: The ICS should be driven from place-based working, with only a few strategic issues dealt with at system level.

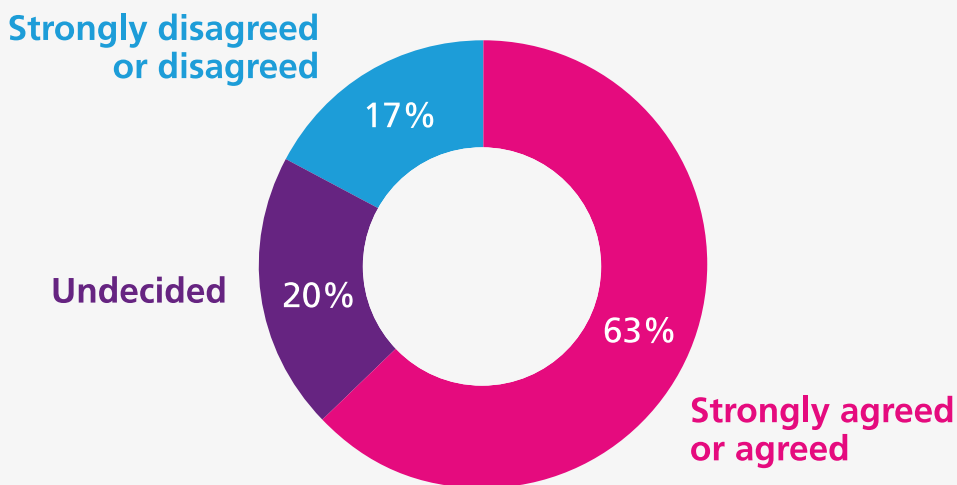


Health and care integration

A key consideration of the scope of system by default is whether, and how far, health and care services should be integrated. We therefore wanted to test whether there was any appetite among systems for a model such as in Scotland, where statutory integration of health and care has led to an emphasis on joining up services and a focus on anticipatory and preventative care.

Almost two thirds (63 per cent) were supportive of some form of statutory integration, but 17 per cent disagreed and 20 per cent of respondents were undecided. We know that system leaders view joint working between the NHS and local government as central to the work of ICSs, but it would seem that more discussion is needed about putting this on a statutory basis.

Q: A key problem is 'offloading' between the health and care sectors. To fully address the future needs of our populations, health and social care sectors should be integrated on a statutory rather than voluntary basis.



We then asked about the possibility of systems holding pooled budgets for both health and care. In this respect there was much more support for pooled budgets, with over three quarters (78 per cent) supporting this approach.

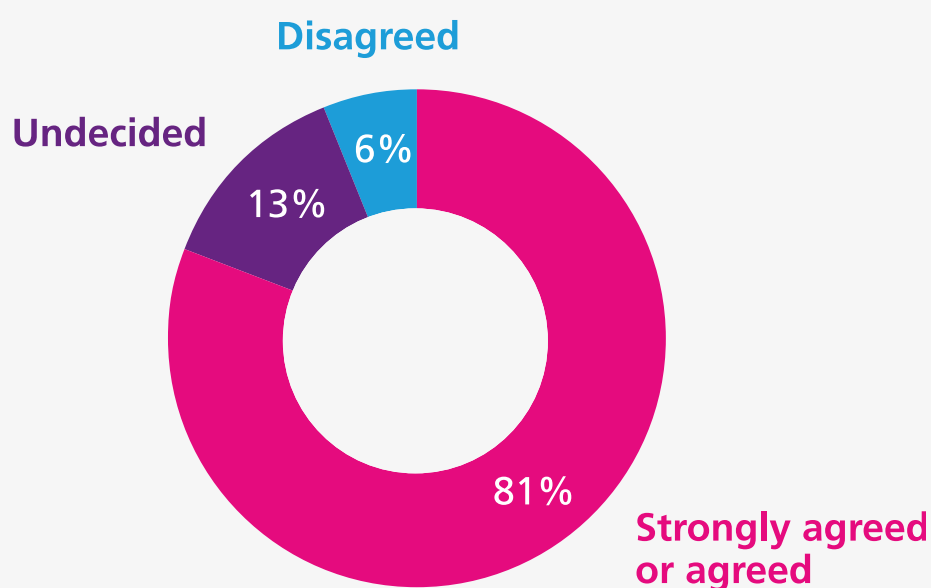
The role of ICSs and NHSEI

A key question for the development of system by default is how the model of accountability of ICS partner organisations develops and in turn, the impact of this on the future role of NHSEI. In particular, there has been speculation about what system by default may mean for the foundation trust (FT) model across England.

Over three quarters (76 per cent) of system leaders considered that ICSs should be able to manage the performance of partners within their system. However, for this to work, nearly three quarters of system leaders felt it needed to be underpinned by sufficient authority and powers for ICSs. When asked about the independence of FTs, some 73 per cent of system leaders considered that they should have some form of accountability to the wider system.

To further test the implications of systems taking on an increased role in performance management and regulation, we also asked system leaders whether the role of NHSEI and CQC should be rolled back as systems take on an increased regulation and performance management role. Over eight out ten (81 per cent) indicated that they supported this, suggesting a strong preference for an increasingly devolved model for ICSs. It should be noted, however, that several respondents indicated that they would have preferred for there to be separate questions on NHSEI and CQC as their views on their future role differed between the two.

Q: The role of NHSEI and CQC should be rolled back as systems take on increased regulation and performance management role.



Commissioning

Finally, we wanted to begin to explore system leaders' views on what the future of system by default may mean for commissioning, and the role of clinical commissioning groups (CCGs). There is clearly some appetite for statutory reform, as just over two thirds of system leaders considered that strategic commissioning should move to ICSs at system or place level. However, a quarter disagreed and some system leaders stressed the importance of maintaining commissioning in any new system architecture. This suggests that more exploration of this issue is also needed.

Next steps

The results above show that a notable majority of the system leaders polled by the NHS Confederation's ICS Network support the prospect of greater levers and powers for system working through system by default. It appears that a consensus is emerging that, with systems expected to deliver many of the ambitions set out in the NHS Long Term Plan, they need to be given the tools, powers and levers to develop and effectively implement strategies for their populations.

It appears that for a sizeable proportion of the leaders we polled, COVID-19 has been an influencing factor in this growing consensus. Through reports such as [STPs: One Year To Go?](#) the ICS Network has highlighted how, in many areas, transformation has accelerated rather than stalled as a result of the pandemic. Many system leaders have told us that now is the time for systems to be empowered through system by default, to embed this transformation and ensure that they are able to drive the processes of recovery and reset for their populations.

Though this report has been produced by the ICS Network, the broader NHS Confederation represents health leaders across all areas of the NHS and it will be vital to ensure that the voices of providers, commissioners and primary care networks, among others, are heard as we look to the future of system working. It will be crucial, too, to ensure that the perspectives of local authorities are considered in the future of system by default and we have been clear that too often local government is treated as separate to, not a part of, systems. This must not continue.

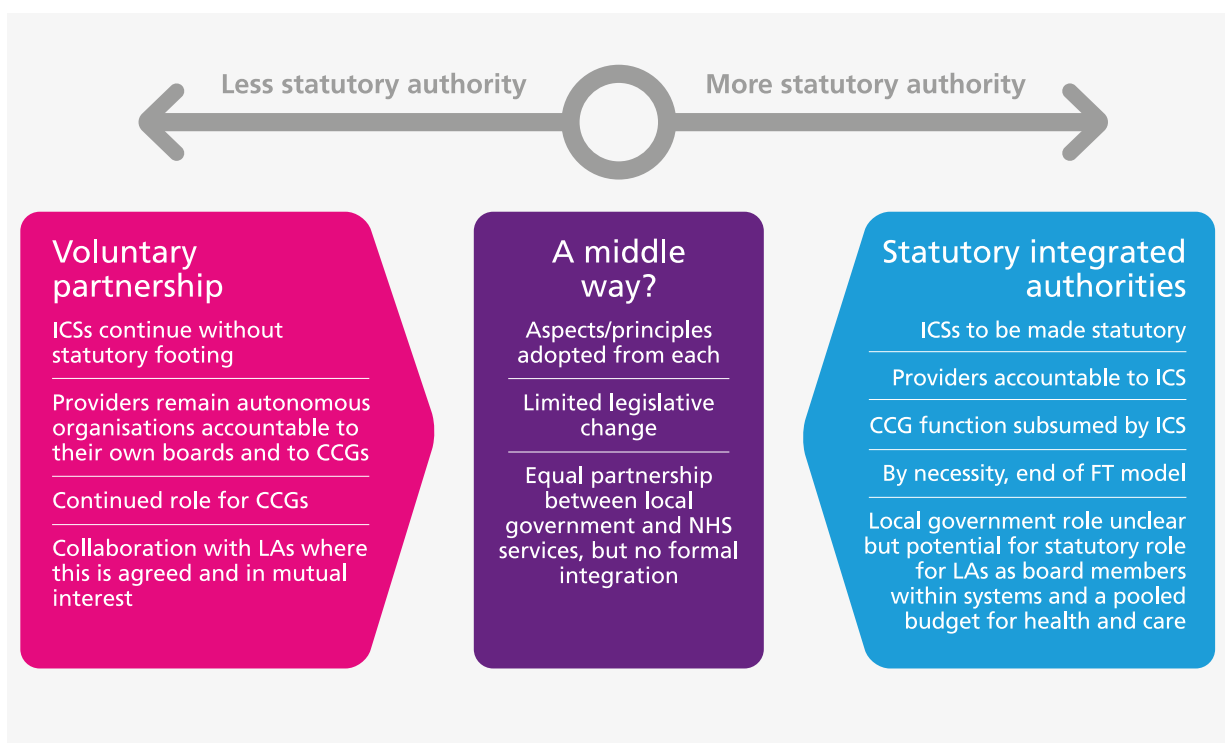
While this report hopes to highlight the direction of travel that systems themselves would like system by default to move in, there remain many issues to resolve before workable solutions are devised. Over the coming months, the NHS Confederation will explore more detailed solutions to some of the areas covered in this report, identifying where there is consensus and disagreement on particular issues across different stakeholders.

The NHS Confederation remains supportive of the development of system working and will work collaboratively to ensure that the future of system working is fit for purpose and informed by the views of the Confederation's members.

APPENDIX

The below was sent by the ICS Network to system leaders in advance of the polling outlined in the report.

The future role of systems: a spectrum



Voluntary partnerships



The ICS Network is aware that certain systems have performed well under the current partnership approach. We have spoken to some system leaders and chairs who want this approach to continue, with a sense that making ICSs statutory and giving them sweeping new powers would undermine the trust and co-operative relationships that have evolved in many parts of the country between autonomous organisations across health and care.

The voluntary partnership approach in practice: place-based partnerships

There is a risk that as we look beyond COVID-19, we look for simple, centralised solutions to complex problems and lose the goodwill and partnership working we have seen in many ICSs. In reality, the NHS is not one standardised national service, it is a diverse matrix of organisations with complex interdependencies. It is essential to know and understand local systems, and to work with them to deliver high-quality patient care.

Some take the view that NHS management would be much easier if we amalgamated providers and created larger single structures. However, a criticism of this is that there are great benefits to be had from the varied provider base.

Without the need for significant legislative overhaul, the future vision for systems could include:

- working with providers at a place level to create higher quality patient pathways based upon local need
- shared responsibility for health and social care at place level, where agreed, between partners (not enforced)
- ICSs not to become another arm of regulation and oversight
- authority and strength of ICS leader to come not from structural position or authority, but from the trust in them within the partnership.
- rather, ICSs to hold strategic commissioning functions (e.g. high-level planning, population health management, financial oversight, and leadership and organisational development)

Advantages of voluntary partnership:

- Supporters argue that this approach avoids another disruptive reorganisation of health services at a time when partnership working has already shown to be working in many parts of the country.
- The legislation already allows for a good degree of flexibility. Budgets, for example, can already be pooled between stakeholders if individual parties agree to this. Is legislation necessary?
- Local authorities remain autonomous and have an important role – local government likely to support.

Disadvantages/unanswered questions of voluntary partnership:

- This approach favours areas where strong relationships have been built between stakeholders such as system teams, commissioners and providers. However, what about areas in which there are independent-minded FTs or where levels of trust in CCGs and/or systems are low? Systems have no 'teeth', relying instead on goodwill to make progress on efforts towards integration. Critics argue that this is a fragile base for progress.
- Many ambitions set out in the NHS Long Term Plan rely on the success of ICSs. Public funds are already being channelled through them and yet they do not exist under the law. Is it right that there is such little certainty and public accountability over organisations that are so pivotal to the future of the NHS?

Statutory integrated authorities

More statutory authority



Some system leaders and chairs believe that the NHS should take the opportunity of a government willing to implement new legislation to get to the root cause and break down the barriers between health and social care, empower systems and make ICSs statutory bodies.

The statutory integrated authorities approach in practice: integrated health and care in Scotland

The Public Bodies (Joint Working) (Scotland) Act 2014 set out the legislative framework for integrating health and social care. It created new public organisations, known as integration authorities, to break down the barriers to joint working between NHS boards and local authorities.

Key features of the Scottish integrated health and care system:

- Statutory integration of the governance, planning and resourcing of adult social care services, adult primary care, community health services and some hospital services
- Each integration authority required to develop a strategic commissioning plan outlining how services will be planned and delivered using integrated budgets, as well as an annual financial statement.
- Integration authorities jointly accountable to Scottish Ministers, local authorities, NHS board chairs and the public for delivering the nationally agreed outcomes.
- Integrated authorities either adopt 'integration joint board' model, where the NHS board and local authorities delegate responsibility for planning and resourcing service provision, or the 'lead agency' model, where the NHS board or local authority takes the lead in planning and delivering integrated service provision in their area.

In England, an integrated system could implement integrated care authorities (whether building on ICSs or introducing a new type of organisation) covering large populations (2–5 million) with authority for a joint health and care budget. At the radical end, this could, but would not by necessity, involve the abolition of NHS England and NHS Improvement and their regional teams, with a direct link between DHSC and the authorities themselves. As such, it may reinstate certain elements of the model of strategic health authorities (SHAs). Equally, it is likely that this model would effectively mean the end of the FT model, with providers accountable to their integrated care authority.

Advantages of statutory integrated authorities:

- Supporters of this approach argue that many of the problems with the existing health and care system stem from the fragmented nature of commissioning and service delivery across, for example, public health, social care, community services, primary care and secondary care. This has led to 'offloading' of patients between services. Solving the root cause of this issue would involve bringing these services under one authority, simultaneously allowing greater integration and efficiency, and improving service delivery for patients and the public.
- This approach would prevent poorer trusts from struggling financially while rich neighbouring trusts sit on big financial reserves. Money and resources could move much more freely between areas and organisations.
- Supporters argue that when the 'going is good', a system based on trust is fine. The problems arise when things go wrong, and at this point organisations revert to statutory responsibilities. As such, these need to be clear and they should support integration.

Disadvantages/unanswered questions of statutory integrated authorities:

- Critics would argue that to force integrated working between organisations is the wrong approach. One system representative has told us, for instance, that the establishment of all-powerful authorities would be akin to introducing regional monopolies and that state-sponsored monopolies 'do not have a good history.'
- Giving ICSs statutory footing and/or integrating authority over health and care planning/delivery, would require significant upheaval. Is there appetite for this across the system after the poorly received Health and Social Care Act 2012? While supporters of sweeping new legislation argue that it could be based on a bottom-up approach, many may see it as yet another top-down reorganisation.
- What is the role of local government – do they lose their autonomy? (Though could a joint committee approach alleviate this?).

A middle way?

An important consideration is whether there may be potential for a middle way between these two competing visions. This may introduce limited legislation to encourage integrated working and break down barriers between organisations that exist under the Health and Social Care Act 2012, but leave many of the fundamental pillars of current system working in place

A middle way approach in practice: partnerships that service the NHS and local government

A middle way approach may stem from two factors. Firstly, the recognition that there is already some flexibility in the existing legislative framework and, secondly, the fact that the Level 4 incident command and control structure has brought about measures that could be harnessed and continued as part of a system by default model.

This model may include:

- Clear subsidiarity of neighbourhood, place, ICS. This would be assisted by levers brought in through emergency response measures (block contracts, shared data, collaboration, transfer of management and operational capacity from CCGs to PCNs/ providers, local resilience forums and ICS collaboration).
- Specialised services delivered through a provider collaborative in each place, with CCG capacity on planning, finance, accounting, service design allocated to the collaborative, including PCNs and the voluntary and community sectors.
- Public health and wider determinants work at place level through local authorities, including impact of COVID-19.
- Services commissioned once in place by local authorities and the NHS for their population, for which they receive their allocation. Pool budget at ICS level to commission at scale in areas such as cancer.
- CCG functions therefore operate at ICS, place and provider collaborative levels.

Some have suggested that a middle way might incorporate an 'opt-in' statutory structure. This would allow an ICS to choose such a structure by agreement with partners, but with no obligation to. A 'committee in common' approach may help to facilitate this.

Who to contact – your regional lead

Our regional leads are on hand to support ICSs and STPs across the different regions in England. They provide access to learning and good practice, support relationships and leadership development, and create opportunities to influence national policy and thinking. They also provide a stronger and more direct link between members and the NHS Confederation, acting as a conduit to transmit messages and concerns to national bodies.



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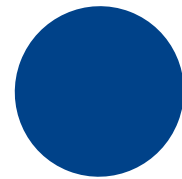
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