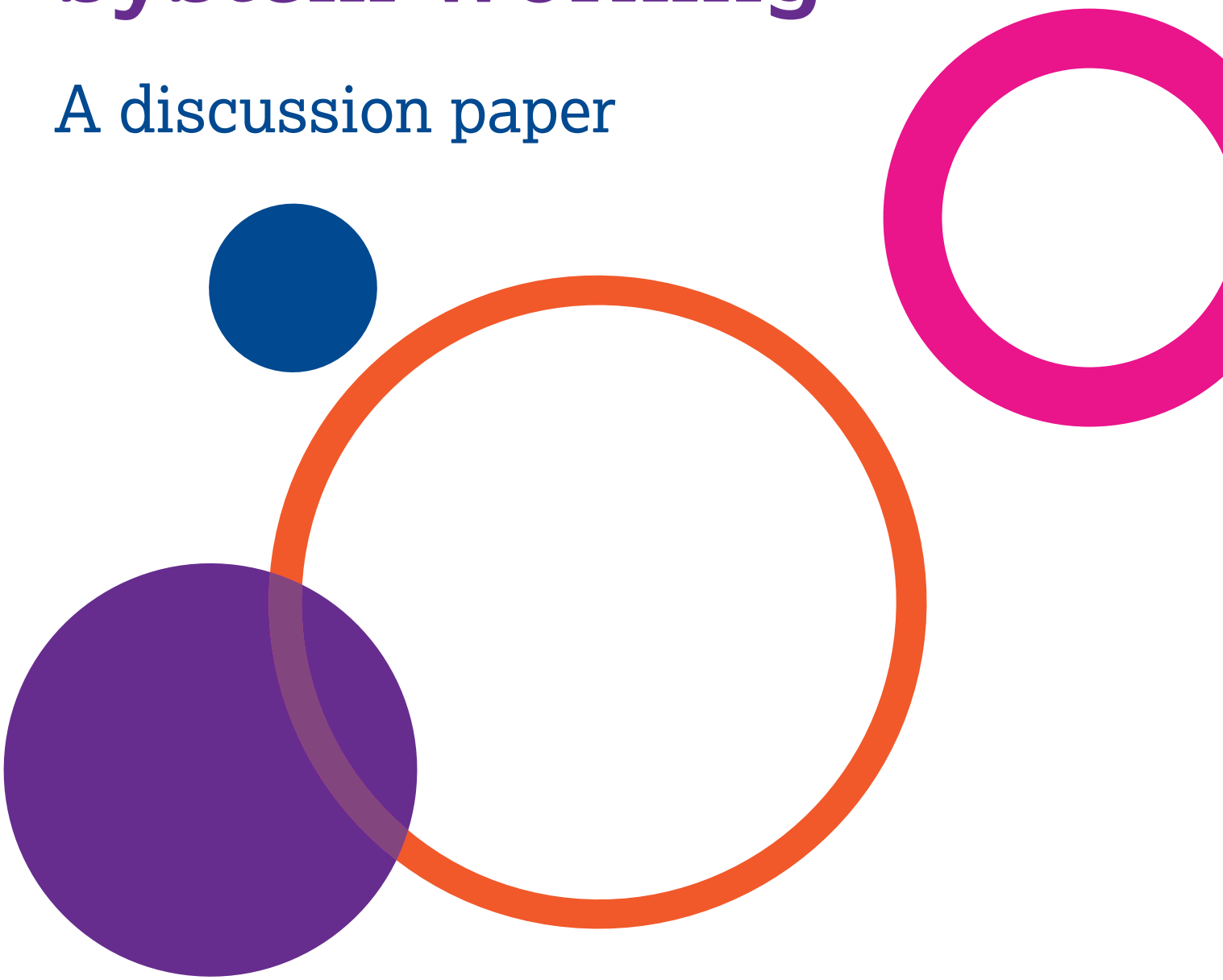
NHS CONFEDERATION
Integrated Care Systems Network

Next steps for system working

A discussion paper



Nick Ville

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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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.

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Key points

- COVID-19 has demonstrated the galvanising effect of a national health emergency. Over this period, many system leaders have reported a deepening of collaborative working among clinical and frontline staff, more cooperation among providers and closer joint working with care homes and local authority staff.
- As NHS England and NHS Improvement look to strengthen system working through the development of its 'system by default' policy, this paper explores the design choices that need to be made to move the policy and legislative context for system working to the next level.
- The NHS has suffered from a surfeit of reorganisations, few of which have realised the ambitions of their creators. Any proposals for the future of integrated care systems must demonstrate that they will lead to clear benefits for the public, meet the challenges faced by the health and care system and be proportionate.
- ICSs need to be better tied into other parts of national policymaking, such as social care and public health. Without this, there is a risk that we crowd out both medium-term priorities for service transformation and the longer-term changes needed to influence the social determinants of health. Such an approach may also alienate local authorities, whose focus tends to be on the health and wellbeing of their local community.
- It is clear that system leaders have a strong preference for much greater autonomy and discretion in local decision-making, but the journey to this is unlikely to be straightforward. Some reality is required about the level of accountability to central government that would still be needed.

- There are now at least two competing visions for the future operating model of ICSs. The first sees ICSs being formalised as statutory partnerships of providers, streamlined commissioners and local authorities. This keeps the roles and responsibilities of existing partners largely as is. The other vision is to make changes to the local health and care landscape to create greater coherence. There are no ideal solutions, as both approaches carry risks.

- Greater thought is needed within systems about how to involve providers more closely in system working and not re-create old divides. Most of the expertise and knowledge about service delivery rests within provider organisations and they have the capacity to make real change happen. Providers needs to be at the heart of ICS decision-making rather than at the sidelines.

- Although there will need to be a common vision, it is clear that the ICS model will need a significant degree of flexibility locally to accommodate the different stages of development across systems and the extent of the changes that need to happen locally.

Background

The introduction of sustainability and transformation partnerships was announced nearly five years ago in December 2015. This was followed by the introduction of integrated care systems (ICSs) in 2018, which embraced much closer working between organisations to meet the health and care needs of their local population. The NHS Long Term Plan in 2019 announced the intention that ICSs would cover all of England by April 2021. More recently, NHS England and NHS Improvement (NHSEI) has been seeking to strengthen system working through the development of its 'system by default' policy.

At an ICS Network meeting in June 2020, STP and ICS leaders and chairs were polled for their views on the future of system working. The issues covered included whether ICSs should become statutory bodies, the potential statutory integration of health and care, the model of accountability of ICS partner organisations, the future role of NHSEI and the implications of ICSs for commissioning and foundation trusts. Although simplistic, the questions revealed a significantly increased appetite for strengthening system working and for local authorities to be equal partners within ICSs . Despite steadily growing support for strengthening system working in the last 18 months, the pandemic seems to have significantly hastened the process. Many system leaders report a deepening of collaborative working among clinical and frontline staff, more cooperation among providers and closer joint working with care homes and local authority staff.

Most of the work to develop system working is necessarily led locally, but central government controls the policy and legislative framework within which it operates. At the request of ICS and STP chairs and leaders, this paper has been prepared to start crystallising the views of system leaders on what the asks of government might be to support a step change in system working. Through a process of drawing on the collective experience and expertise of system leaders, we plan to reach a shared view on the way forward that would provide the mandate over the coming months for the views expressed to the Department of Health and Social Care, No. 10, HM Treasury, NHSEI and other parts of government.

There are now many ideas in play about how government might help. To help decide what, if any, changes in policy and/or legislation might be helpful, this paper returns to first principles to consider what the purpose, role and scope, accountability and future operating model of ICSs should be and in turn what policy and legislative framework would best support this. It also considers what flexibilities need to be built in to enable tailoring to suit local circumstances. A series of questions are presented throughout to help the process of reaching a clear position on what policy and legislative changes might be helpful.

[1]NHS Confederation (2020), Time to be Radical? The View from System Leaders on the Future of 'System by Default'

Purpose

The NHS has suffered from a surfeit of reorganisations, few of which have realised the ambitions of their creators. In particular, the upheaval created by the 2012 Act has left a wariness of the disruption brought about by large-scale structural change. Hence any proposals for the future of ICSs must demonstrate that they will lead to clear benefits for the public, meet the challenges faced by the health and care system and be proportionate. Without clear purpose and value that commands widespread support and energises all concerned, we risk distraction and division, the loss of leadership talent and the creation of suboptimal and defective new structures.

In common with many other developed countries, our health and care system faces three main issues:

1) The morbidity of all age groups in the population is increasing and the incidence of co-morbidity is growing significantly as a result of an ageing population.

2) Health inequalities are significant and widening, as economic disparity has grown in the last 40 years.

3) Rising costs, demand and expectations of healthcare combined with the need to adapt to deliver the new technologies and treatments becoming available.

The NHS budget has grown on average by 4 per cent in real terms since 1948 as it has responded to these issues. Some argue that increasing the level of expenditure on healthcare should not be a concern as it simply reflects changing public priorities as our country becomes more affluent. This is probably true, but within a publicly funded healthcare system it has also led to an ongoing battle with the Treasury as funding increases well exceed the underlying rate of increase in GDP that sustains our taxation base.

To help mitigate this funding problem there has been for many years a strong emphasis on improving the efficiency with which health and care services are delivered. The internal market model introduced in 1991 and sustained by different governments was one of the policy measures designed to help deliver this. But this thinking has been eclipsed in recent years as it has become clear that improvements in technical efficiency are insufficient to close the funding gap. The key realisation has been that sustainability can only be brought about by a 'left shift' that maximises prevention, sustains independent living, provides health and care in community settings as far as possible and draws more on the social infrastructure[2] available to individuals, families and local communities. This in turn requires integrated services with care pathways which allow people to receive timely and seamless care and a much greater focus on interventions that keep people as healthy as possible and living independently in their own homes.

As this has been more widely accepted, the paradigm has changed away from local organisations seeing themselves as islands of activity competing for resources towards collaborative and integrated approaches designed to improve the health and wellbeing of the population that all partner organisations serve. The House of Care[3] model developed by the King's Fund sets out a vision for what a new integrated approach to providing care services should look like. At the heart of the model is personalised care planning that brings together the perspectives and expertise of both the individual and the professional(s) involved in providing care. Care will increasingly be provided by multidisciplinary teams and involving staff from primary care, community and mental health services and social care. It also requires reliable systems for identifying and contacting people with long-term conditions and that can be used to document and share care plans, and to monitor outcomes.

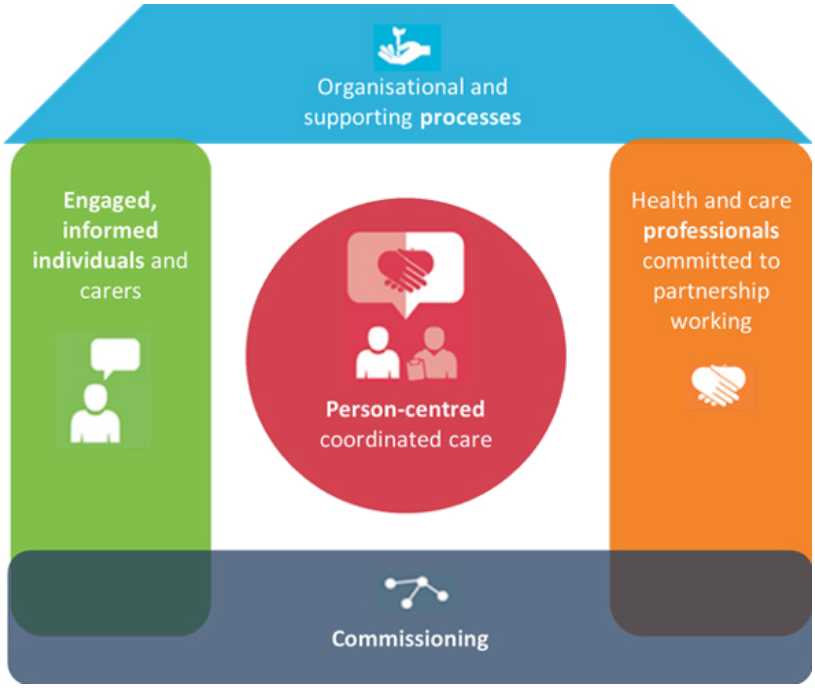
These benefits[4] can only be delivered through partnership working and integration and ICSs are the means of delivering this. There may be debate about how ICSs should operate, and the approach will differ according to local circumstances, but the centrality of system working to delivering integrated care is inescapable.

[2]Civil Exchange (2018), Valuing Social Infrastructure.

[3]The King's Fund (2013), Delivering Better Services for People with Long-Term Conditions.

[4]The essential characteristics of an integrated system are set out in Stepping up to the Place (2016) published by the NHS Confederation, Local Government Association, Association of Directors of Adult Social Services and NHS Clinical Commissioners.

Figure 1: House of Care



Source: The King's Fund, 2013

COVID-19 has demonstrated the galvanising effect of a national health emergency. The ongoing challenges facing our health and care system are significant and in response we need clarity of shared purpose that brings people together around a shared endeavour. Locally, many systems have already articulated this and set out a vision centred on delivering a defined set of tangible improvements in the outcomes achieved by care services and in population health. ICSs now need to be able to demonstrate that they are making progress with these issues.

Questions

1) Do you agree that the purpose of ICSs should be to deliver tangible improvements in:

- health outcomes
- reducing health inequalities
- the quality of health and care services
- the integration of primary, community and secondary services, physical and mental health services and health with social care services.

Role and scope

The NHS Long Term plan describes the role of ICSs as follows:

> 'An ICS brings together local organisations to redesign care and improve population health, creating shared leadership and action.'[5]

NHSEI's guidance expands on this and sets out two key roles for ICSs in respect of coordination of system transformation and collective management of system performance. In practice though, NHSEI places a heavy emphasis on the performance of the NHS. This is perhaps unsurprising in light of the day-to-day pressures on health and care services, but it is not always sufficiently counterbalanced by the other priorities. ICSs need to be better tied into other parts of national policymaking such as social care and public health. Without this, there is a risk that we crowd out both medium-term priorities for service transformation and the longer-term changes needed to influence the social determinants of health. Such an approach may also alienate local authorities whose focus tends to be on the health and wellbeing of their local community. Our discussions with system leaders suggest that they see themselves as balancing these shorter, medium and longer-term priorities in locally developed place-based plans for improving care services and population health. If they are to succeed though, there needs to be more of a shared national and local view about this and the role of ICSs in practice.

As part of this there also needs to be a shared view about the range of care services that ICSs are seeking to coordinate and integrate. The NHS Long Term Plan states that:

> 'ICSs 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.'

[5]NHS England (2010, NHS Long Term Plan.

Many of the major service integration challenges exist within the health sector. Effective management and integration of patient pathways across the large number of different health conditions involved and across planned and urgent care can make a significant difference to population health and use of health resources[6]. Yet as the recent pandemic has underlined, the interdependence of health and social care is also an important issue facing local services. There is agreement about the need for significant degree of joint working to meet effectively the needs of a vulnerable population of children, adults and the elderly. This has always been variable in local systems. Beyond this there are a large range of other public services that impact on prevention, wellbeing and tackling the wider determinants of health. These encompass public health, housing, education and local economic policy. How far and in what ways do ICSs wish to go in joining up with this wide range of public services?

As we broaden the scope of ICSs, it should bring opportunities to shape population health and wellbeing and in turn have an impact on the level and nature of demand for health and care services. However, embracing a wider scope is also likely to increase the complexity of the task. The organisational changes required could be more significant and a less focused approach could reduce the ability of the ICS to make a difference.

Questions

2) Which is your preferred option for the scope of ICSs?

a) The integration of health services and a looser partnership working model with local government for social care*, public health and wider determinants.

b) The integration of health, public health and care services and a looser partnership model with local government for wider determinants of population health.

c) A wide approach to the health and wellbeing of the population that also embraces housing, education, police, environmental services etc without responsibility for these services.

*This could cover social care of older people, adult social care as a whole or all aspects of social care, including children.

3) Please set out why you have chosen this option.

[6]There is also the thorny question of the potential devolution of specialist health services currently commissioned by NHSEI.

Accountability

ICSs encompass a wide range of health and care services organised and provided at neighbourhood, community or place level alongside services covering large populations, such as specialist care or ambulance services. As such, their focus is clearly on the delivery of frontline services where most decisions about health and care will be made. However, the design of ICSs cannot be considered in isolation from central, regional and local government, which also have an important part to play in overseeing the management of the health and care system.

Currently ICSs bring together a pre-existing set of statutory organisations with differing accountabilities. NHS organisations are in the main accountable nationally to NHSEI via regions, although there are also lines of accountability to ministers and parliament. There are local accountability mechanisms such as foundation trust boards of governors, local authority health and wellbeing boards and scrutiny committees, and local Healthwatch organisations. But in practice these have less influence than the centre on most aspects of NHS activity. Local authorities on the other hand are accountable to their local communities through locally elected representatives. However, there is some central government oversight of local authorities for key national priorities.

It is generally accepted that devolving more decision-making to local leaders can lead to better results. In the best examples, services can be tailored to meet local needs and in turn resources put to best use. The ambition to devolve powers away from central government has been growing over the last 20 years as the limitations of managing from Westminster have become apparent across a wide range of areas of public policy. This is echoed in the NHS where among local leaders there is a strong desire to roll back aspects of central control which are seen as significant inhibitors of effective decision-making. In a recent NHS Confederation report[7], empowering local leaders was seen as the single most important measure that could be taken to enable the successful delivery of the NHS Long Term Plan.

[7]NHS Confederation (2018), Letting Local Systems Lead: How the NHS Long Term Plan Could Deliver a More Sustainable NHS.

However, in recent months there have been reports of a wish for greater control of health and care emanating from parts of central government, including the Department of Health and Social Care and No 10. Some of this arises from powers currently held by NHSEI and some of it comes from a desire to have greater control over how local authorities deliver social care. This has, however, led to significant concern among system leaders that increased central control could worsen the quality of decision-making at all levels and undermine further the ability of systems to solve local problems.

It seems likely though that central government concerns are in essence about accountability. The Secretary of State is ultimately accountable for health and care in the public's mind as the concept of a National Health Service is part of our social contract and non-negotiable. Hence the public have high expectations of the Secretary of State's overall stewardship of the NHS. The considerable sums of public money involved in funding healthcare also means that the Treasury will always seek better control of expenditure, improved use of resources and delivery of clear results. Such strong national sponsorship of the NHS also brings advantages in terms of the practical and financial support available to the service.

It is clear that system leaders have a strong preference for much greater autonomy and discretion in local decision-making, but the journey to this is unlikely to be straightforward and some reality is required about the level of accountability to central government that would still be needed. Nonetheless, it is not insuperable. The current national oversight model of the NHS is highly directive, not just about the what but also the how. This gives an illusion of accountability, as in practice the responsibility of local leaders for their actions is much diluted.

Much higher levels of local discretion consistent with effective delivery of services could be designed into the working of the NHS and combined with a clearer model of accountability that provides sufficient comfort and reassurance to DHSC and NHSEI. This would probably need to be accompanied by much higher levels of transparency and clear and agreed data about the delivery of care and health outcomes, combined with some very clear national requirements in key areas that would have to be met. One option would be to express this as a national outcomes framework.

If ICSs were to move to a more devolved model, the other issue to consider is whether it should be accompanied by a strengthened model of local accountability[8]. Local authority health and wellbeing boards (HWBs) already have responsibility for conducting a Joint Strategic Needs Assessment (JSNA) and developing a health and wellbeing strategy. Does the contribution of ICSs to the health and wellbeing strategy need to be articulated locally and promoted publicly? Should HWBs have some decision-making powers over health and care services? There is also the question of what form local accountability for health services that serve large populations and straddle multiple authorities might take. One possibility is for combined authorities that pool responsibilities across local authorities to have a role in health, as in Greater Manchester. Then there is the thorny question of boundaries: where health institutional flows and local authority boundaries do not align, should the local authority footprint be the decider? Any proposed changes to local accountability will also need to take account of the proposals in the forthcoming devolution white paper, which is likely to lead to more unitary authorities and mayors.

Questions

4) Do you support increased autonomy and local discretion for ICSs over how national priorities are implemented?

5) In a more devolved model for ICSs:

   a) should local accountability of ICSs be strengthened and if so how?

   b) what would remain national priority areas, for example mental health, waiting lists, outcomes, finances, quality etc?

   c) what powers of support and intervention would DHSC/NHSEI have in ICSs that are underperforming and how would those be exercised? (for example external oversight, peer review)

   d) what might be the role of the Care Quality Commission in holding systems to account?

[8]The report of the Health Devolution Commission 'Building Back Health and Prosperity' calls for metro mayors, leaders of combined authorities and designated leaders in non-combined authority areas to be given a formal health role.

Functions and operating model

ICSs bring together a set of local organisations that plan, commission, deliver and assure a wide range of services relevant to the health and wellbeing of the population. Much of the work of STPs and ICSs to date has been about developing the right relationships and a pragmatic set of local working arrangements to support effective joint working and integration across the different parts of the ICS. However, while there remains concern about a wholesale structural reorganisation, the move towards greater integration and joint working has thrown a spotlight on whether some changes to the policy and legislative framework are now needed and how far that should go.

There are now at least two competing visions for the future operating model of ICSs. The first sees ICSs being formalised as statutory partnerships of providers, streamlined commissioners and local authorities[9]. This keeps the roles and responsibilities of existing partners largely as is. The other vision is to make changes to the local health and care landscape to create greater coherence. There are no ideal solutions, as both approaches carry risks.

A statutory partnership model faces inherent problems when agreement cannot be reached or where decisions are based on a lowest common denominator leading to unsatisfactory compromises. Changing the local organisational landscape risks re-creating divisions and losing the sense of ownership and the distributed leadership important for a system to function effectively. There is also the disruptive impact of a reorganisation to consider on local relationships and ways of working – not an insignificant issue as in many systems there has been considerable investment in developing these. However, it could also be seen as another option for ICSs that wish to adopt it while also providing future flexibility in the design of the health and care system.

Greater clarity over the purpose, role and accountability of ICSs would certainly go a long way to delivering a more cohesive and focused management of the local health and care system. Against this background one option could be to reinforce partnership working by introducing a shared duty on all partners to work together to deliver the triple aim[10]. This could be combined with some specific changes to the powers of foundation trusts[11]. This would strengthen the ability of ICSs to make decisions that not everyone would support but are judged to be in the best interests of the local population. However, without any

single owner of overall system interests and enough capacity and capability to underpin this, there is also a risk of a leadership deficit. Many systems have significant and long-standing challenges and we must make sure not only that the powers, responsibilities and accountabilities of integrated care systems are fit for purpose, but that they have means to exercise them. Currently, in many areas they are distinctly under-powered.

One option would be to incorporate clinical commissioning group (CCG) commissioning responsibilities into the fabric of ICSs which could be set up as new statutory bodies. As the internal market is rolled back, the associated contracting and commissioning apparatus is withering on the vine. Many CCGs have merged and some 20 ICSs now have a single CCG for their footprint. The latest NHSEI phase three guidance goes further than previous guidance and calls for a single CCG per ICS. This could then provide for a single leadership team that supported system working on issues such as workforce, use of resources, data sharing, population health management and care transformation alongside coordinating system-wide planning and performance.

However, there are also risks associated with this approach as merging CCGs at system level would need to be accompanied by careful consideration of how to maintain existing place-based working and relationships. A variant on this model would be to merge commissioning responsibilities with local authorities. There are already powers in place for local authorities and the NHS to jointly commission and pool budgets, but this would take it to the next level in terms of integration of health and care. The question would then be whether you locate these responsibilities in local authorities, the NHS or a joint structure.

Regardless of whether to strengthen existing partnership working or reconfigure local responsibilities, greater thought is needed within systems about how to involve providers more closely in system working and not re-create old divides. Most of the expertise and knowledge about service delivery rests within provider organisations and they have the capacity to make real change happen. Providers needs to be at the heart of ICS decision-making rather than at the sidelines.

At whole-system level there are issues to consider about the configuration of specialist services and use of resources for health and care pathways across larger geographies. Provider collaboratives involving groups of acute, mental health, community and integrated providers working together to share resources and optimise the configuration of more specialist services between them are emerging as a model. Place level is the centre of gravity for service delivery in many ICSs as 'natural' communities for managing the support and care of populations of vulnerable children, adults and older people. In response, local integrated care partnerships have developed in some areas to enable better integration and coordination of services.

Thinking is still evolving about how best to make these collaboratives and partnerships work effectively. In particular, there needs to be a real sense of equity among these partners and ensure that partners working in the community such as primary care networks, community and mental health services and social care are equally influential in decision-making. This is essential to ensuring patient and populations needs are the central driver in service integration and to develop a much greater focus on interventions that keep people as healthy as possible and living independently in their own homes.

Questions

6) Should ICSs become statutory joint committees of streamlined CCGs, providers and local authorities?

7) Should there be a shared statutory duty on all partners in ICSs to deliver the triple aim[12]?

8) Do you believe that under a future model of system-working, the foundation trust model should:

   a) remain in its current form
   b) be tweaked to make it more compatible with ICS working
   c) be abolished.

Why do you prefer this option?

9) Do local authorities and the NHS need more statutory powers[13] to pool budgets and commission services jointly beyond the current s75 agreements? If so, please state in which areas.

10) Should ICSs be set up as new statutory bodies and the commissioning functions of CCGs incorporated into them, effectively ending CCGs in their current form?

11) Should the commissioning of health and care be merged, and if so, should the NHS, local authorities or a joint committee have the responsibility for it?

12) How should providers be more closely involved in ICS decision-making at system, place and neighbourhood level?

[9]The NHS's recommendations to government and parliament for an NHS Bill (September 2019) suggested that NHS commissioners and providers should be allowed to form joint decision-making committees with local authorities able to join.

[10]A triple aim duty was proposed for the NHS Bill.

[11]It is important to note though that the foundation trust integrated care licence condition already requires NHS providers to not act or behave in a way that would be reasonably regarded as against the interests of people who use healthcare services.

Future development

The final issue to consider is what is our route map for the future development of ICSs? STP and ICS leaders and chairs strongly support the move to create ICSs covering the whole of England by April 2021 and to continue the momentum for increasing system working. However, the reality is that across the country systems are in different stages of readiness and a one-size-fits-all approach does not reflect this or recognise the need to support and sustain the significant changes in culture and relationships that are happening in many areas. Although there will need to be a common vision, it is clear that the ICS model will need a significant degree of flexibility locally to accommodate the different stages of development across systems and the extent of the changes that need to happen locally. A more nuanced approach would be to map out a development path that offers key moments for local systems to opt into a different policy and legislative context when they are ready to do so.

This approach could encompass choices over scope, accountability and operating model. A more limited scope for ICSs could be set as a minimum initially, but then systems could choose to move to a wider scope over time (for example, taking responsibility for different care groups in turn such as children, adults, elderly). Local systems could agree and build a new model of local accountability over time with legislative powers which enable them to opt into different stages.

Underpinning this development path or route map would need to be a steady process of capacity and capability building at place and system level that enables the creation of a new operating model that can secure the quality and volume of service delivery across the health and care system. This model is more evolutionary and perhaps more in tune with the more organic change we have seen in recent years.

Questions

13) Should a revised policy and/or legislative framework for ICSs be underpinned by an 'opt-in' element to allow for differing local arrangements as appropriate?

[12] Improving the patient experience of care (including quality and satisfaction), improving the health of populations and the per capita cost of healthcare.

[13] In addition to the current s75 powers of the NHS Act 2006, which enable the NHS and local authorities to pool budgets and commission jointly.

Next steps

This paper discusses the design choices that need to be made if we are to move the policy and legislative context for system working to the next level. It deliberately considers a future beyond the current constraints and what might work in response to the central problem that ICSs are designed to address. If agreement can be reached about the answers to these design principles, it should then be possible to be clearer about which of the policy and legislative proposals under consideration are likely to offer the best way forward.

In doing this it will be important to explore these issues with all the partners involved in system working, including primary care networks, trusts, CCGs and local authorities to see whether it is possible to reach a broad consensus on the way forward. This will be critical to building a firm foundation for system working in the future that commands support and draws effectively on the knowledge and experience of leaders from across the system. Such a shared view would also provide a strong basis for influencing government and NHSEI on what the ICS of the future needs to look like if we are to make a difference to health and well-being of our local communities.

Your views are invited on the questions set out in this paper. Please send your responses to: kerry.mcquade@nhsconfed.org

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