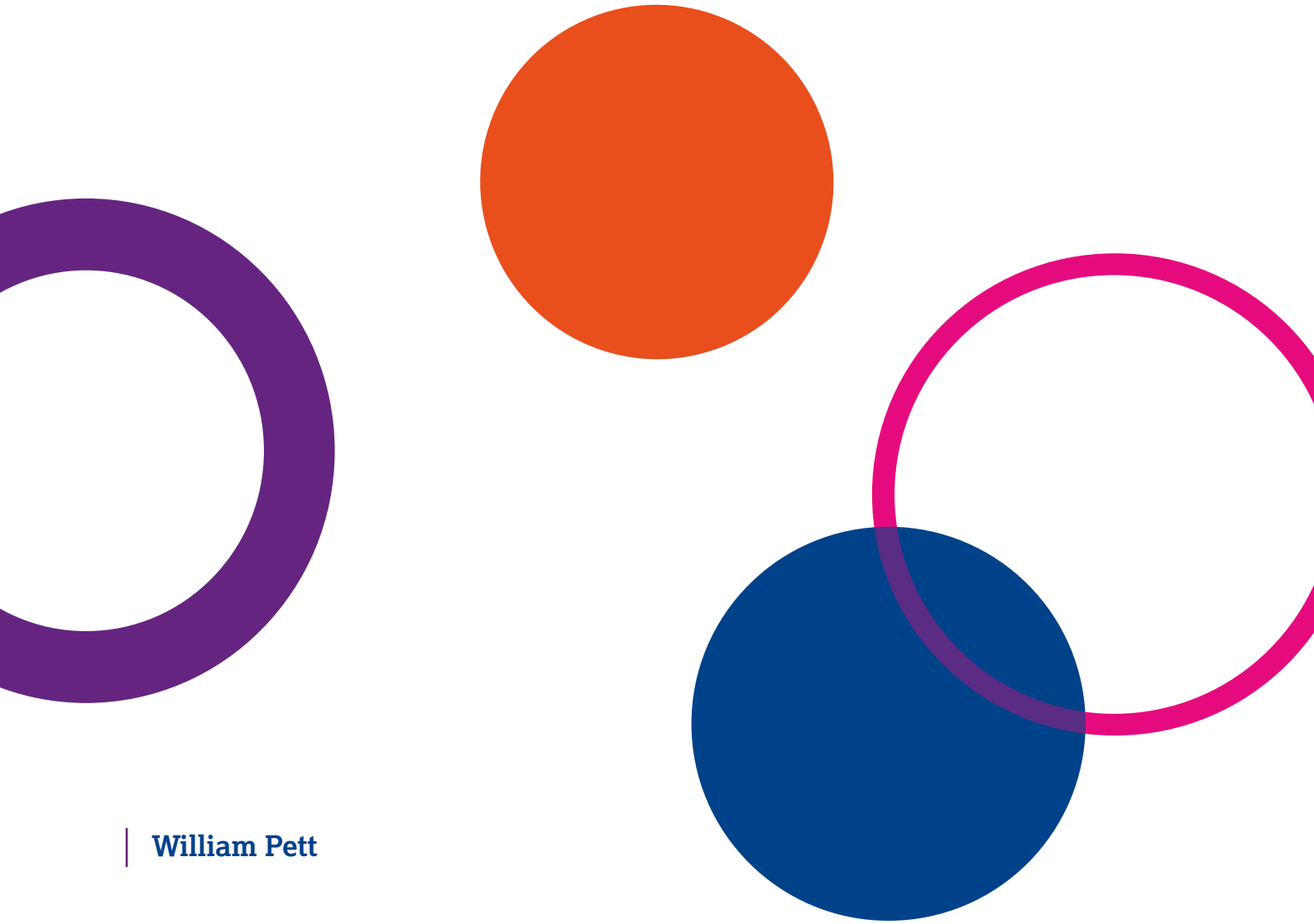
NHS CONFEDERATION
Integrated Care Systems Network

Accelerating transformation

How systems are funding and resourcing 'engine room' staff



William Pett

What is 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 is called the Health and Care Leaders Forum. 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.

Stay in touch by:

- contacting your regional lead – see page 18 for details
- signing up to our integrating care bulletins by subscribing at **www.nhsconfed/newsletters**
- visiting us online at **www.nhsconfed/ICSNetwork**

For these and other ways of staying in touch please see page 19.

About the NHS Confederation

The NHS Confederation is the membership body that brings together and speaks on behalf of the whole NHS. We represent over 500 members across health and social care, including hospitals, community and mental health providers, ambulance trusts, independent sector organisations providing NHS care, and clinical commissioning groups.

We have three roles:

- to be an influential system leader
- to represent our members with politicians, national bodies, the unions and in Europe
- and to support our members to continually improve care for patients and the public.

All of our work is underpinned and driven by our vision of an empowered, healthy population supported by world-class health and care services; and our values of voice, openness, integrity, challenge, empowerment.

To find out more, visit **www.nhsconfed.org**

Key points

- 'Engine rooms' within systems help to facilitate and oversee transformation within many sustainability and transformation partnerships (STPs) and integrated care systems (ICSs). They are a team of staff who sit below the executive leadership and provide support to drive forward integration and system redesign. They may include anybody from an energetic programme director to a finance specialist.

- This report highlights the variation in how engine rooms are set up in systems across the country, showing how they are adapting to specific local circumstances and ways of working. However, it outlines that, despite a lot of positive work being undertaken in systems across the country, there are three key obstacles to effective engine room working that are common to STPs and ICSs:

    1. Piecemeal and short-term funding, which is restricting systems' ability to invest in staff and the infrastructure to deliver transformational change.

    2. Limited availability of staff with the requisite skillset, with a lack of resources to train existing staff and limited support on HR and governance issues.

3. Mixed levels of engagement between systems and other key partners, and at times a lack of understanding over who does what at region, place and neighbourhood level.

- The NHS Confederation hopes that this report will contribute to a process of shared learning between systems and provide a platform for solutions to be found in close collaboration with NHS England and NHS Improvement. We would also encourage the organisations to work with systems to develop a sustainable approach to resourcing, supported by a clear stream of funding.

Background

The NHS Long Term Plan (LTP) states that the whole of England should be covered by an ICS by April 2021. These ICSs will be central to the delivery of several ambitions set out in the plan, notably around better integration of services for the public and easing pressure on acute and emergency services.

However, the ability of STPs to evolve into ICSs, and the ultimate success of these systems, will depend on new collaborative relationships being formed between partners across the primary, secondary, community and independent sectors. For some regions, integrated care began well before the introduction of STPs or indeed the vanguard programmes that emerged from the Five Year Forward View. For others, partnership working is a new challenge.

At the time of writing there are 14 ICSs across England, though a small group of STPs chosen for NHS England and NHS Improvement's accelerator programme are likely to make the transition to ICS status by summer 2020. All systems are required to produce five-year plans that respond to the Long Term Plan Implementation Framework and these will set out what systems hope to achieve through to 2023/24. For STPs, these plans will also set out how and when they will evolve into ICSs.

There are several expectations of ICSs:

- **Be clinically led**

  Systems should be driven by senior clinicians and health staff, who are considered to have the best judgement of what transformation is needed in their regions.

- **Be clinically owned**

  Systems should be engaging with key partners across their local communities, and plans should be co-developed with the voluntary sector and local authorities.

- **Be financially balanced**

  Systems will need to show how the ambitions set out in their plans will be resourced, with clear financial modelling demonstrating sustainable funding arrangements.

- **Deliver LTP commitments**

  Systems must include measures relating to improving cancer treatment, mental health and A&E performance, and reducing waiting times for elective care. It is also expected that there will be an overarching focus on the prevention agenda.

To meet these manifold expectations, most systems have had to agree pooled funding between partners such as CCGs and providers. Systems may have benefited from transformation funding through NHS England and NHS Improvement, however this is likely to be delivered on a short-term basis and there has been little transparency on the size and allocation of this funding across systems.

For some STPs and ICSs, the central funding that has been received has been invested into 'engine room' staff. The following sections of this report outline what we mean by such staff, the important work they are undertaking and the obstacles that systems face in supporting and resourcing those in engine room roles.

Material to support the insights outlined in this report has been gathered through desk research and interviews with representatives from five systems: One Gloucestershire ICS, West Yorkshire and Harrogate Health and Care Partnership, South East London ICS, Dorset ICS and Lincolnshire STP.

What do we mean by 'engine room' staff?

Strong leadership within systems will be crucial to their success. It is hoped that STP and ICS leads and independent chairs will take advantage of system knowledge and strong existing relationships with key partners to set out and deliver a uniting vision for integrated care in their regions.

However, equally as important as those leading STPs and ICSs will be the staff supporting them – what can be referred to as the 'engine room' of systems. Depending on the system, these staff may form a project management office (PMO) and include programme directors, finance specialists, communications and engagement directors or local authority leads. They may also include those working in communications and engagement, an area which the NHS Confederation is separately assessing systems' capacity in (with work so far revealing a mixed picture).

It should be noted that in recent months some STPs and ICSs have begun to look to a more 'diffuse' model of system working, with transformation work in areas such as mental health being overseen by individuals from partner organisations such as CCGs and providers. This model places less emphasis on a central engine room. That said, for many systems, PMOs remain the vehicle through which transformation programmes are being delivered. It is the role of PMOs, working directly with system partners, to deliver the vision set out by the executive, overseeing and facilitating transformational work as organisations within their localities try to adapt to new integrated ways of working.

The strengths of engine room staff are varied and will differ by system. However, the NHS Confederation has heard from system leaders that those working in these roles tend to offer particular assets:

- **Local knowledge**

  Those who take up positions in system engine rooms bring with them a strong knowledge of the health of their populations, as well as a nuanced understanding of stakeholder relationships within the system. Engine rooms may include a mix of staff who have worked across providers,

community organisations, commissioners and local authorities, and this bespoke knowledge is used to offer invaluable strategic advice on stakeholder engagement.

• Time and dedication

In common with other staff groups across the NHS, engine room staff often work 'above and beyond' what is expected of them. They are driven by a commitment to improving care for their populations and ensuring that integration works as effectively as possible. Working hours and practices may be irregular and, as shall be addressed in this report, many engine room staff across the country live with perennial job insecurity.

• Problem-solving skills

Many of the programmes that systems are trying to deliver represent new territory for local health economies. For example, there are no established processes for how local authorities should be involved in system strategy. It is up to engine room staff to judge how best to approach stakeholder engagement, ensure that partners are invested in the direction of system working, and capitalise on the skills and knowledge within constituent organisations.

Despite how critical engine room staff are to many systems' ability to deliver the ambitions of the LTP, there is a significant degree of uncertainty and instability surrounding them. As the NHS Confederation has previously highlighted, contracts may be piecemeal, with 12- or 24-month placements common, and some have even had to work out of contract while partners within the system try to find funding.

This report will later outline how this uncertainty is affecting individual systems, in doing so demonstrating why there is widespread concern within systems about the future of their engine rooms.

How systems are setting up their engine rooms

Most, but not all, systems we spoke to structure engine room staff around a PMO. This is the team responsible for promoting and helping to deliver transformation work across the system, ensuring that budgets are used efficiently and overseeing the management of specific programmes. However, there is generally a degree of devolved autonomy to specific programmes:

- The One Gloucestershire ICS has 15 staff, most of whom are based within the PMO. The system operates a distributed model, with a central PMO that provides support to individual programme managers (most of whom also have a separate role within one of the partner organisations). The ICS PMO also supports the system governance and assurance processes. There is a single project document for all programmes at system level and a central decision-making matrix that helps individual programmes determine where decisions should be made.

- In Lincolnshire STP, there is a central PMO called the system delivery unit. This ensures that each programme has a clear plan and supports the delivery of monthly progress reports against objectives, savings, resources, issues and risks. This is visible to all partners across the system through shared project management software. Programmes are somewhat interdependent and are encouraged to share knowledge and skills.

PMOs tend to be directed by a small executive team that meets regularly to ensure that the system is working effectively. Meetings such as these provide oversight of the performance of specific programmes, a shared understanding between system and programme leaders and a forum to discuss and resolve issues that arise in relation to system working.

While we only spoke to five systems, the size of PMOs ranged from around 15 to 25. There was no obvious correlation between population size and PMO size, however a much wider review of systems across the country would be required to accurately evaluate any relationship between the two.

Of those we spoke to, the most devolved autonomy to programme teams was found in the West Yorkshire and Harrogate Health and Care Partnership (WY&H), which is understandable given the significant size of the system:

- WY&H does not consider itself to have a PMO as such. The system operates, as the name suggests, as a partnership. The ICS is delivering a range of around 17 workstreams – or 'programmes' – with each programme responsible for its own governance and programme management. These programmes therefore range in how they are structured. Some programmes, such as improvement of cancer outcomes, has a team that operates similarly to a PMO, in accordance with direction from NHS England and NHS Improvement. Other programmes, such as supporting carers, have a more flexible structure. Each programme has its own programme board and programme lead and works by engaging relevant staff from across the system. They are required to report on progress quarterly to the partnership's system oversight and assurance group.

Funding for engine room staff

The NHS Confederation has found that funding, as well as training and support, for engine room staff is consistently raised by leaders as a key challenge facing systems across the country. There is significant variation in how, and indeed how easily, different systems have been able to recruit and retain such staff.

Some systems have told us that they rely heavily on being able to pool a budget between partners in the system. For these systems, there may be an imbalance between the levels of funding that commissioners and providers contribute:

- In South East London, CCGs account for the lion's share of funding in the system and this is how at least 50 per cent are funded. The system has had a limited amount of central funding, including funds from Health Education England and transformation funding through NHS England and NHS Improvement, and this covers approximately a quarter of PMO staffing costs. The rest comes from other sources of finance within the system, including a small amount from the three acute providers. Mental health providers make a contribution in kind through the south London partnership, a mental health collaborative.

It should be noted that there may be good reasons why in certain local areas some partners contribute more than others. However, there is variation across systems when it comes to pooled funding, with some having an agreed level of contribution across providers and commissioners:

- The system delivery unit within Lincolnshire STP is resourced from across the partnership and central roles are funded from a pooled budget. All CCGs and providers have committed to contributing the same amount of their own budgets, though this can be contributed either in finance or provision of staff. It is capped at an agreed amount as a system. The pooled budget enables a clear delivery focus and works well, with staff seconded in for periods of time from across disciplines. The system has had some central funding, some of which has been to fund digital transformation work through the estates and technology transformation fund, however the pooled budget between partners is by far the system's main source of funding.

While the ability to create and sustain a pooled budget is crucial for many systems' ability to hire and retain the right staff, another key factor is the amount they receive through NHS England and NHS Improvement in the form of transformation funding or other central funds. The WY&H partnership has been able to fund a sizeable proportion of its staff using central funding and resources from NHS England and NHS Improvement:

- Staff working within the WY&H partnership are funded in one of four different ways:

    1. Approximately 40 per cent of staff are funded non-recurrently through transformation funding, with the future of such staff largely dependent on continued funding from NHS England and NHS Improvement.

    2. Around a quarter of staff are permanent and paid for through a pooled budget among partners within the system.

    3. Another quarter are employed by NHS England and NHS Improvement staff but aligned with the ICS.

    4. Approximately 10 per cent of staff are 'gifted' to the partnership by an organisation within the system, such as a CCG or foundation trust.

The core team, which is seen as the fulcrum of the partnership, is primarily funded through CCG recurrent contributions but is supported by transformation funding.

However, as the following section outlines, even systems that have been able to fund a sizeable proportion of engine room staff through transformation funding, still face significant obstacles.

How effectively are engine rooms working?

The NHS Confederation has found that across the country, systems speak positively of the progress that can be made in improving services when there is a clear shared vision between partners, either with respect to specific clinical programmes or at system level.

Conversations with leads, chairs and programme directors have revealed certain factors that may be considered as ingredients for success for effective working:

- **Long-term planning**

  Where possible, long-term planning of programmes can help to nurture progress, especially when this is aligned with stable, long-term funding. For example, South East London ICS talks positively of the improvements in joint working being made in maternity care. Successes in this area have been partly put down to a more stable planning and funding base. The funding, which comes from NHS England and NHS Improvement's Better Births programme, was set out on a three-year basis and has allowed the system to attract high-performing professionals who are supporting the partners to deliver encouraging progress.

  Of course, securing long-term funding for systems is a perennial challenge, as is addressed later in this section.

- **Effective use of software**

  Joint working within systems has been made easier and more efficient when partners can rely on good programme management software. This is something that Lincolnshire STP feels it has benefited from. While programmes within the system are faced with different objectives, programmes are somewhat interdependent and are encouraged to share knowledge and skills between each other. Joint working is helped significantly using software that allows people across the system to access the same documents and digital resources.

However, despite the many examples of successful projects within systems, the overall effectiveness of engine rooms is being severely inhibited by three key factors:

1. Piecemeal and short-term funding

A fundamental obstacle that has been raised unanimously across the systems we have spoken to is the piecemeal and short-term nature of available funding. This is true both for central financial support, such as transformation funding, as well as pooled budgets. NHS England and NHS Improvement has not committed to offering any kind of multi-year funding to systems and, with commissioners, providers and local authorities all facing their own financial challenges, trying to secure pooled funding among them for one year, let alone several, is a significant challenge.

This, in turn, has implications for other areas. It means that systems are unable to invest in some of the necessary infrastructure, both physical and digital, that would usually be required to deliver transformational change. However, it also has implications for staffing and management. Financial uncertainty means systems are forced to offer many staff members fixed, short-term contracts and this often creates a conflict of interests for leaders. One senior system representative told us that while they are desperate to retain good staff, if they had team members' best interests at heart, they would advise them that working for another organisation, such as a provider, would offer them a more stable and promising career path.

> *An ongoing issue is prioritisation of funding and resourcing. With immediate and short-term pressures on services, it can be hard to invest in long-term transformational changes. The system is learning as it develops.*

2. Limited availability of staff with the requisite skillset

System leaders we spoke to were grateful for the dedicated teams they have at their disposal. However, several were concerned about the ever-changing skillset that those working in PMOs are required to possess as systems evolve.

Part of this problem lies in the fact that, given the significant limitations on systems in regard to funding and resources, there is little opportunity for the provision of training for staff. Unlike traditional organisations, most systems lack any kind of dedicated HR personnel. As such, PMO staff are required to pick up new skills quickly on the job, adapting to new demands on them as system processes, governance structures and programmes develop over time. It should be noted that another

implication of the lack of HR personnel for system leaders is that they often feel ill-equipped to deal with issues like contract extensions, not least as contractual arrangements are often complex. Support or guidance on HR issues and governance more broadly is evidently a need for certain systems.

Another issue relating to skills concerns staff that are 'offered' to STPs and ICSs by partners within the system. As has been outlined earlier, several systems rely on pooled budgets between partners, though under such arrangements partner organisations can offer staff instead of funding. While staffing boosts are always welcome, these individuals can lack the skills and knowledge of the system to operate effectively.

> *While the system employs experienced and talented people, trying to ensure that the system consistently has a stable base of staff with the requisite skills is an ongoing difficulty.*

3. Mixed levels of engagement between systems and other key partners

As part of the shift to integrated working, it is hoped that systems will work with other organisations with responsibility for people's health and wellbeing, and co-produce strategies to improve population health. Notably, these include local authorities and primary care networks (PCNs).

However, the NHS Confederation has heard from systems that the level of engagement with such partners has been mixed. The key reason for this is that there are significant pressures being placed on both. In relation to local authorities, one system leader told us that with spending on local authorities having faced such a sustained squeeze over recent years, local government representatives have often said that they do not have the time or resources to dedicate to working with systems. This is also an issue that has previously been highlighted by the NHS Confederation.

PCNs, meanwhile, are under pressures of their own. Clinical directors leading PCNs are trying to find their feet in a new and unfamiliar role, yet they are expected to start delivering progress against five service specifications from April 2020, with two others in the pipeline. Furthermore, there are likely to be tens of PCNs per ICS and so it remains unclear about how a large group of clinical directors can usefully contribute to discussions at system level. Such factors mean that, while they may be enthusiastic about engaging with STPs and ICSs, there are challenges for PCNs about how to do so.

> *While relations with PCNs have been constructive, integrating work with them can be difficult.*

The NHS Confederation perspective and next steps

Given the significant obstacles facing systems, the NHS Confederation believes that engine rooms within systems across the country face a difficult challenge if they are to help to facilitate health and care service reform within their localities and help systems deliver the ambitions of the LTP.

While this report has recognised that some systems are looking to a more diffuse way of system working, many are still dependent on PMO staff to oversee transformational working. Equally, no matter what structure systems adopt, they need support in several ways. For example, it has become evident that there is a clear need for more stable funding, either from within or from outside of systems, as well as support in areas such as HR and governance.

The NHS Confederation is working with system leaders to develop possible solutions to the problems they face. This engagement will, in part, be facilitated through a new network for STPs and ICSs, run by the NHS Confederation. The network will support chairs and leads with policy resources, convene discussion and networking events, and influence national policy-makers on their behalf.

In light of the obstacles identified in this report, the Confederation encourages NHS England and NHS Improvement to work with systems to establish sustainable staffing models. These must be backed with a clear stream of funding so that systems are better able to plan future staffing arrangements. Importantly, however, the Confederation believes that responsibility for finding solutions to engine room issues cannot lie solely with NHS England and NHS Improvement; systems themselves must think critically about how they can bring local partners together to improve the stability and effectiveness of their engine rooms.

Further to this report, the Confederation hopes to act as an honest broker between systems and NHS England and NHS Improvement, facilitating productive discussions on how long-term solutions can be found to the issues set out in this report.

Future direction

To contribute to the future direction of our work on engine rooms, or to find out more about the NHS Confederation's work in supporting STPs and ICSs, please contact William Pett at william.pett@nhsconfed.org

More information about the NHS Confederation and its member networks can be found at www.nhsconfed.org

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.

Fiona Claridge
London and East
fiona.claridge@nhsconfed.org

Kerry McQuade
North East and Yorkshire
kerry.mcquade@nhsconfed.org

Rory Deighton
North West
rory.deighton@nhsconfed.org

Denise Vittorino
West Midlands
denise.vittorino@nhsconfed.org

Sarah Walter
South East
sarah.walter@nhsconfed.org

Gemma Whysall
East Midlands and East
gemma.whysall@nhsconfed.org

Helen Wolstenholme
South East
helen.wolstenholme@nhsconfed.org

How to stay in touch

We offer a wide range of email newsletters, including:

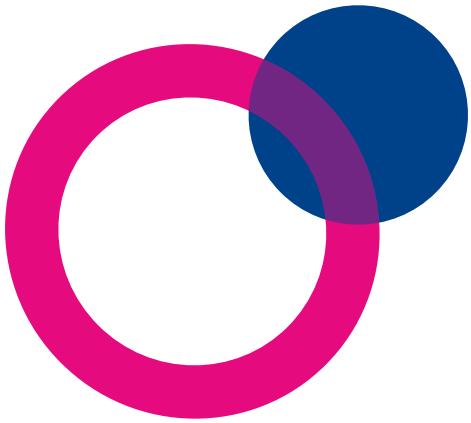
- Regional integrating care bulletins
- Media summaries
- Member update
- Health policy digest
- Local growth bulletin
- NHS European office update
- Mental Health Network update

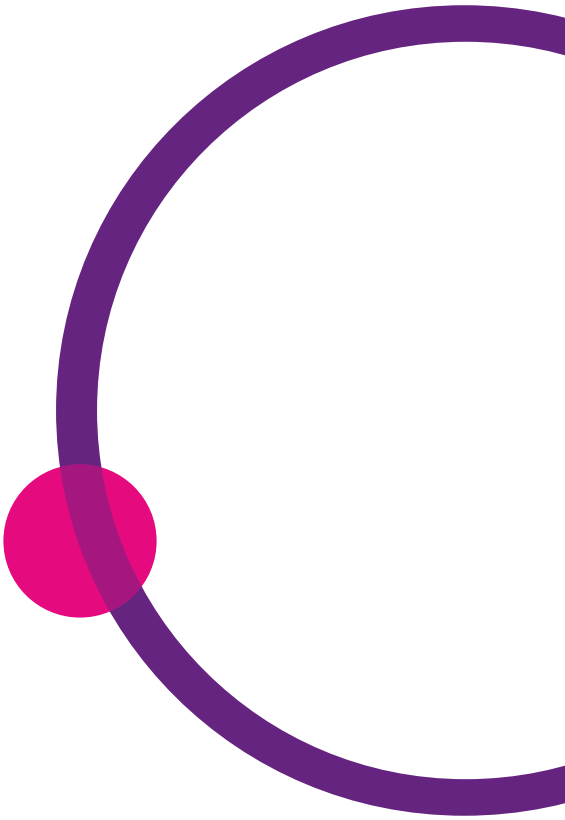
Visit us at **www.nhsconfed.org/ICSNetwork**

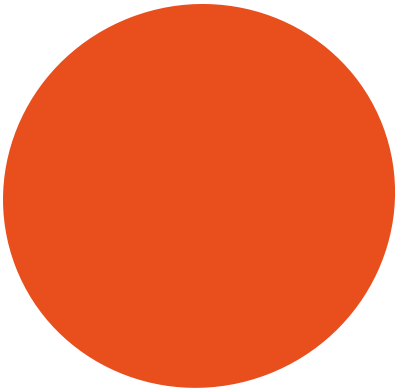
Contact your regional lead – **see page 18 for details**

Blog with us on NHS Voices – visit **www.nhsconfed.org/blog**

Showcase a case study of innovative work – visit **www.nhsconfed.org/resources**







NHS CONFEDERATION
Integrated Care Systems Network

Floor 15, Portland House, Bressenden Place, London SW1E 5BH

Tel **020 7799 6666** Email **enquiries@nhsconfed.org**

www.nhsconfed.org Follow the NHS Confederation on **@nhsconfed**

If you require this publication in an alternative format, please email **enquiries@nhsconfed.org**