The King's Fund

Ideas that change health care

Written submission

Written submission to NHS England and NHS Improvement

Integrated care: next steps to building strong and effective integrated care systems across England

The King's Fund is an independent charity working to improve health and care in England. We help to: shape policy and practice through research and analysis; develop individuals, teams and organisations; promote understanding of the health and social care system; and bring people together to learn, share knowledge and debate. Our vision is that the best possible care is available to all.

This submission responds to the specific questions asked in the engagement exercise (NHS England and NHS Improvement 2020b). As well as focusing on the implications of the proposals for possible changes to legislation, we highlight areas where further detail or clarification is required.

Our submission draws on the following sources.

- Policy research: including our work on integrated care, place-based care, sustainability and transformation partnerships (STPs) and integrated care systems (ICSs), as well as our work on payment reform, the role of competition, and patient choice, and our review of the impact of provider mergers.
- Work with ICSs: over the past three years we have provided leadership and organisational development support to ICSs, working closely with local leaders. We also published a review of progress and learning one year into their development (Charles *et al* 2018).
- Leadership and development work with other local systems, including through our integrated care learning networks.

Question 1. 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?

We support the spirit and ambition set out in these proposals. To date, progress in joining up local services has often been achieved via workarounds to the current legislative

framework, many of which are inherently complex and bureaucratic, and can lead to duplication and protracted decision-making processes. We have long argued that legislative changes will eventually be needed to re-establish coherence between local practice and the statutory framework.

In 2019, we indicated our broad support (The King's Fund 2019) for the proposals in Implementing the NHS long term plan (NHS England and NHS Improvement 2019). We understand from Integrating care: next steps to building strong and effective integrated care systems across England (NHS England and NHS Improvement 2020a) that the 2019 proposals still stand. Our detailed view of these proposals can be found in our previous response (The King's Fund 2019) At that point, we suggested that while we broadly supported the proposals, if enacted they would only provide an interim set of enabling flexibilities rather than a definitive blueprint, and that further legislation would be needed at a later date to create more coherence across the statutory framework as a whole.

The proposals set out in Integrating care: next steps to building strong and effective integrated care systems across England (NHS England and NHS Improvement 2020a) seek to go further than previously, in part to embed and accelerate the greater collaboration observed between NHS bodies and their partners during their response to Covid-19. The proposals seek to further the integration agenda, continuing a journey the NHS has been on for many years. In particular, we welcome the explicit acknowledgement in the engagement document of the importance of local government involvement; the emphasis on place-based partnerships as the foundation of effective ICSs; and that the proposals seek to leave room for arrangements at the level of place to be locally determined – for example, allowing local flexibilities to define the size and boundaries of places, and to decide the exact division of roles and responsibilities between place and ICS level. However, there are a number of points we feel it is important to highlight at this stage, as set out below.

The lack of detail underpinning the legislative options

While it is difficult to argue with the direction of travel set out in Integrating care (NHS England and NHS Improvement 2020a) there is a lack of detail underpinning the legislative options that leaves them open to wide interpretation. Some of this detail relates to the specific drafting of the legislation. Some refers to the need for further information on how NHS England intends to manage transition and how it expects this post-legislation system to work even if this is not itself expressed in law.

Some questions that are likely to require resolving within the legislation include the following.

- Exactly what powers will an ICS have over its constituent NHS organisations, particularly over foundation trusts? Related to this, consideration will need to be given as to how foundation trusts will be expected to balance any new responsibilities to the ICS(s) they are part of and to their own organisation.
- What will the accountabilities for local government and other non-NHS partners in the ICS be, particularly in the scenario set out in option two, where the ICS becomes a statutory NHS body accountable for NHS finances and performance?

Beyond any specifics set out in legislation, wider consideration will also need to be given to the role of non-NHS bodies within ICSs.
- In light of the recent announcement to abolish Public Health England, how will these proposals align with the operating model for health protection and health improvement, which is being developed separately?

Recognising that it is not possible or desirable to specify everything in legislation, there are also questions that are unlikely to be answered through the legislation or that may have a legislative element, but will, alongside this, need further information from NHS England and NHS Improvement as to how it expects the system to work. For example:

- what will be the models for new provider collaboratives and how will they be structured to enable mutual support between provider organisations and effective co-operation within sectors at the level of place?
- how will the voices and priorities of residents, service users and patients be captured and meaningfully reflected in the governance and decision-making of ICSs?
- how will delegation of functions (and budgets, in some cases) to the level of place be supported in practice?

The potential disruption to the health and care system

The engagement document states that the ambition is to give ICSs a statutory footing from 2022, alongside other legislative changes. It will be important to learn from previous reforms that have tended to exaggerate the benefits of structural changes and underestimate the costs and disruption they bring. This is particularly the case at a time when the health and care system is focused on managing the pressures associated with the Covid-19 pandemic. It will be essential to avoid a damaging top-down reorganisation that creates a distraction for the service.

The limitations of what legislation can achieve

It is important to recognise the limitations of what legislative change can achieve. The proposals seek to facilitate wider system-working, which will be critically dependent on new collaborative ways of working between leaders and teams across health and care. While legislation can remove some barriers to collaboration and co-ordination of local services, it will not deliver the changes in behaviour that are needed to fully harness the potential benefits of the integration agenda. Instead, behaviours and relationships that support collaboration will need to be developed, nurtured and modelled right across the health and care system, including within NHS national bodies themselves. Consideration should be given to how this cultural change will be supported, and how staff at all levels will be supported to genuinely collaborate across organisational and professional boundaries.

We also recognise that there is a careful balance to be struck between using legislation to clarify and improve accountability and transparency, while also creating the flexibilities to allow systems to develop the arrangements best suited to their local contexts and

population needs. Difficult trade-offs will be involved in resolving some of the issues we have highlighted in this section and we do not underestimate the complex nature of the decisions involved in doing so.

Question 2. 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 lack of detail underpinning both legislative options makes it hard to come to a view on this. By definition, placing ICSs on a statutory footing could and should provide greater transparency and accountability. However, each of the legislative options outlined in the document raises important questions over exactly where the balance will be drawn between system collaboration and organisational accountability.

Our understanding of option 1 is that new decision-making bodies could be created through joint committees, enabling partners to make decisions collectively. However, the responsibilities of existing organisations would remain unchanged. The risk of doing this is that lines of accountability could become increasingly unclear and confusing, while at the same time limiting the pace of change that can be achieved in terms of genuine integration. When setting out the powers and duties of joint committees, careful thought needs to be given as to how they will sit alongside existing organisational accountabilities. In addition, new provisions relating to the governance of joint committees would need to build in appropriate scrutiny and challenge, for example, through lay and non-executive involvement and local democratic oversight.

Under option 2, ICSs will be given their own accountabilities and clinical commissioning group (CCG) functions will be wrapped into them. Without more detail about exactly what these accountabilities are and how they will work, it is difficult to be confident that these arrangements provide greater clarity than option 1. For example, it remains unclear exactly what powers an ICS will have over its constituent NHS organisations, particularly foundation trusts, and how any conflicts will be managed. There is a particular risk under this option, where the ICS becomes a statutory NHS body accountable for NHS finances, that ICSs move away from being genuine multi-agency partnerships and increasingly act as NHS bodies, undermining meaningful system-working with local government and the voluntary and community sector. This option also implies significant change for staff working in commissioning bodies, with the associated risks that come with this level of disruption.

Whatever their legislative form, ICSs should be rooted in, and connected to, the concerns of places, communities and patients. Both scenarios imply significant change for commissioning bodies and the staff who work in them. While we welcome the move toward more strategic, outcomes-based commissioning, if it is to achieve its full potential in improving population health it will be important to retain clinical input in commissioning processes and not undermine the value of strong, place-based working in smaller, more local geographies. In addition, under both options, it is unclear how the voices and priorities of residents, service users and patients will be captured and meaningfully reflected in the governance and decision-making of ICSs. Further detail should be provided on this point.

Finally, alongside the two options for enshrining ICSs in legislation, the engagement document also refers to the need for parliament to define in legislation the mechanisms by which the formally merged NHS England and NHS Improvement will be held to account by both the Secretary of State for Health and Social Care and by parliament itself. We agree that these accountabilities will need to be clarified in legislation. However, a key consideration in our response will be how any change in powers still ensures the clinical and operational independence of NHS England and NHS Improvement.

Question 2. 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?

ICSs should be genuinely collaborative, recognising the critical roles that all partners (not just local NHS bodies) will need to play to harness the benefits of integration and bear down on inequalities.

We support an approach to ICS governance that allows systems to develop arrangements best suited to their local contexts and population needs. We believe it would not be appropriate to create a detailed blueprint for all ICSs given the wide variation in their size, maturity and local contexts. The experience of the most advanced ICSs is that governance arrangements need to go through successive iterations over time as systems mature, with form following function. To support systems to develop effective governance, NHS England and NHS Improvement should publish further guidance on possible approaches, drawing on examples and experience from the most advanced systems. This should continue to be updated as arrangements evolve.

However, there are a number of issues where local systems will need earlier clarification to help inform design of governance models.

- **Clarifying what mandatory participation of local NHS bodies and local authorities entails**: this relates to many of the unanswered questions articulated earlier in this submission, including what the new framework of duties and powers of ICSs will be under the proposed options. In setting this out, it will be necessary to clarify which board members will have statutory accountability (and for what) and which members will have partner status.
- **Clarifying how NHS providers will be represented in ICSs in practice**: in particular, the balance between direct representation from individual provider organisations and representation via provider collaboratives. This will require careful thought, particularly in relation to providers spanning multiple ICSs, as in the case of many tertiary and ambulance providers. This should be set out in further detail as part of the guidance on potential models for provider collaboratives expected in early 2021.
- **Ensuring adequate representation of primary care**: the requirement for primary care to be represented on ICS boards is welcome, however this will require careful implementation given the diversity of the sector. This should draw on learning from systems that have already established representative models across

their primary care networks and places to bring together the voice of primary care at the level of the ICS.

- **Clarifying the role of local authorities as members of ICS boards and ensuring their involvement is meaningful**: this will need to reflect the fundamentally different accountabilities across local authorities (accountable to local communities through local democratic structures) and the NHS (accountable nationally to the Secretary of State). Local authorities cannot be held accountable for NHS budgets or performance and the governance of ICSs will need to reflect that. As councils are independent from one another, we assume the requirement for mandatory participation means that all upper-tier local authorities in an ICS area will be represented on the ICS board unless local councils have reached a voluntary agreement to designate a lead representative (a single local authority cannot routinely act on behalf of other local authorities). While the mandatory involvement of local authorities is a very welcome signal that local government must play a central role in ICSs, there is a question of how to ensure this is meaningful. Under both proposed options, there is a risk that ICSs will move away from being genuine multi-agency partnerships and increasingly act as NHS bodies. We believe that this risk is greatest under option 2, and we would like to see assurances about how this will be mitigated as further details emerge on the proposed options.
- **Clarifying expectations around the involvement of other bodies in the work of ICSs**: while rigid requirements prescribing membership would not be helpful, we believe that NHS England and NHS Improvement should set clear expectations and guidance about other key groups that will need to be involved at a minimum in the work of ICSs and place-based partnerships to support their ambitions. As well as local government officers and statutory NHS organisations, that should include voluntary and community sector organisations, clinicians of different types, local authority elected members and lay people. Involvement in governance forums should not be framed as the full extent to which non-statutory partners (and particularly service users) are involved in system-working; they also need to be involved in the day-to-day work of ICSs and place-based partnerships, and be engaged in setting and delivering the system's agenda.
- **Clarifying how statutory ICSs are expected to relate to pre-existing governance forums, including health and wellbeing boards (HWBs) and overview and scrutiny committees (OSCs)**: it will not be possible to define a one-size-fits-all model for these relationships given the different configurations of ICSs and place-based partnerships relative to local government boundaries (and therefore to HWBs and OSCs), but setting out minimum expectations and key principles for how the connections between them should be managed would be helpful in supporting partners to work through these issues locally. Again, guidance should build on models that are already under development, as a number of advanced systems have made significant progress developing their connections with HWBs and OSCs both at the level of place and ICS (often involving the formation of joint HWBs and joint OSCs).

Finally, we support the flexibility in the document for arrangements at the level of place to be locally determined. This will be important in ensuring that these can be genuine multi-agency partnerships able to determine local priorities and design solutions that make the

best use of wider local assets. NHS England and NHS Improvement should continue to emphasise the critical importance of place-based partnerships as the foundation of effective ICSs and support their development. As part of this, NHS national bodies will need to avoid placing central demands on ICSs that distract from or undermine the work at place and should support systems to make use of the proposed flexibilities to delegate functions and money to place-based committees.

Question 4. Do you agree, subject to appropriate safeguards and where appropriate, that services currently commissioned by NHS England should be either transferred or delegated to ICS bodies?

We agree that specialised services currently commissioned by NHS England should be transferred or delegated to ICS bodies where appropriate. There should be a clear methodology to define which services remain commissioned by NHS England and this methodology is likely to be a mix of the rarity of the condition along with possible complexities in treatment that mean only very limited number of national providers are sustainable. For services transferred to ICSs, ICSs should be allowed to come together to commission services where appropriate and this is likely to vary across England given the differences in population density and the number of providers.

We believe that NHS England should request the Advisory Committee on Resource Allocation (ACRA) to provide advice on the population-based needs formula to allocate the resources for specialised services. In doing so ACRA should be given a broad remit that could include allocating some resource via the existing CCG formula (NHS England 2019) if this was appropriate. Alternatively, a new formula could be developed for some or all specialised services. However, we do not believe that there should be a separate ringfence around this resource at ICS or national level and ICSs should be free to move resources in line with local population need and costs, as long as they maintain national standards.

There will be concerns that the move from a provider-based allocation to a population-based allocation will cause disruption. These concerns are not new to NHS policy on allocations. Rather than alter the endpoint (a distribution of resources that supports equal access for equal need), these concerns should be met through the pace of change policy (NHS England 2019). This can ensure the trajectory toward target equitable allocations avoids excessive disruption.

ICSs should also be allocated the resources for primary care, with the expectation that much of this is likely to be delegated in turn to place-based partnerships.

When transferring or delegating responsibility and budgets to ICSs it will also be important to ensure that they have the staff and access to expertise needed to undertake these functions.

Across all these areas, we believe it is better to delegate spending to the local area closest to population need that can sustainably design services to determine the best ways to meet this need and improve population health.

References

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