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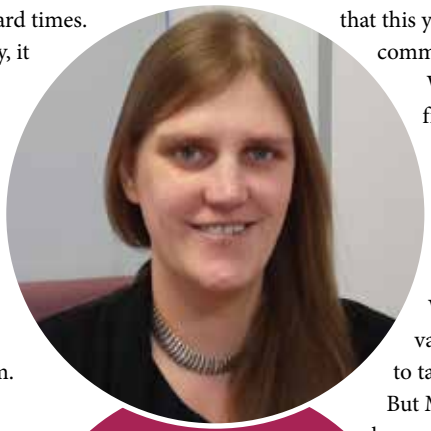
FIRST STEPS

It has been a hard start to life for integrated care systems, with the NHS facing significant service and financial pressures. But while integrated care board chief finance officers see further challenges ahead, they also point to progress towards real system working

Integrated care systems (ICSs) have been born in hard times. As the Public Accounts Committee said in February, it is 'difficult to see how ICSs can fulfil their potential' until a number of longstanding challenges have been addressed – including the elective backlog, workforce vacancies, increasing demand, a crumbling estate and a difficult financial outlook.

The operational and financial context is undeniably difficult. But integrated care board (ICB) finance leaders can identify progress in the boards' first year (or nine months to be exact) of existence. *Healthcare Finance* spoke to three of them.



"We have to start investing in those areas we know give us some of the answers and accept that gives us a higher efficiency target across the rest of care"
Sarah Stansfield

Sarah Stansfield, Northamptonshire Integrated Care Board

Sarah Stansfield, chief finance officer at Northamptonshire Integrated Care Board, says one of the biggest achievements locally has been the way local partners have embraced a different way of working. 'We have been having broader conversations about things that previously only commissioners or providers talked about. Now we talk about them together.'

And it's not just talking – some of the progress is becoming tangible. Ms Stansfield points to a new care model piloted by the system's community stroke service, which captures exactly what system working should be about.

The model involves funding something in health that saves money in local government. 'We have just about got to grips with spending money in one area of health that saves money somewhere else in health,' she says. 'But we've now got something we think saves significant amounts of money in social care.'

The new allied health professional-led community stroke service has 'significantly improved care in the stroke pathway'. It has reduced length of stay and improved outcomes. Therapy and some mental health support (with physiotherapists trained in counselling) have been increased at the beginning of the pathway, just after discharge. This is reducing subsequent care needs in the community – in some cases eliminating the need for packages of social care altogether.

'The challenge now for the integrated care board is how to fund that beyond March,' says Ms Stansfield. 'Ideally, we would like to expand the service beyond the pilot area. And we are working through what the funding mechanism could look like.'

In many ways, Ms Stansfield says the achievements and challenges are tied up together, with the ability to fund and staff new ways of working an undeniable issue. However, she says, it is important to acknowledge that this year's progress has been gained through the commitment and efforts of frontline clinical staff.

Winter has been difficult and there is recognition from everyone that they would want to be providing better access and support to patients.

There is a danger that people will judge the performance of ICSs without due regard for the current NHS context – one defined by financial difficulties and workforce shortages. As Robert White, National Audit Office director of health value-for-money audit, said last October: 'It is going to take time for ICSs to show their worth.'

But Ms Stansfield identifies a further risk if the agenda becomes too focused on cost-cutting and efficiency. 'We have sold a lot of people a vision about integrated care boards – about being new, innovative and exciting and doing things you couldn't do before,' she says. 'But if we say to these new leaders that they need to run their organisations for materially less and eliminate an underlying deficit, it is not as exciting and innovative as you might like.

'I genuinely think that one of the challenges for integrated care boards will be retaining the talent that they have managed quite successfully to recruit initially.'

For Northamptonshire, the financial reality is a forecast deficit for 2022/23 of £35m, rather than the planned break-even. Much of this is driven by pressures in providers, with pay costs increasing in part due to demand-led escalation and Covid sickness backfill, and non-pay seeing much higher levels of inflation than assumed in funding levels.

But the ICB has also taken a hit in prescribing and increased continuing healthcare (CHC) costs – a result of both the inflationary and demand pressures in this area. The ICB's CHC costs this year represent a material increase, but there are further concerns for next year.

SHUTTERSTOCK

'So, looking at 2023/24, the letters I'm currently getting from our CHC providers are looking for between 8% and 15% in terms of inflation,' she says. 'And the settlement is funding me for 5.5%.'

Ms Stansfield acknowledges that the settlement for the NHS in 2023/24 is a good one – relative to the rest of the public sector. But it comes with a long list of performance targets, and high inflation has eaten into its purchasing power.

As with the rest of the country, workforce shortages are a major obstacle – making service delivery harder and more expensive, as the trust backfills with more expensive temporary staff.

Pay is an issue – the recent industrial action is clear evidence. For Northamptonshire, a particular challenge is being situated at the confluence of multiple motorways, which has led to the area being a logistics hub. 'We are surrounded by warehouses and the dispatch industry, including Amazon,' Ms Stansfield says. 'And you can earn materially more in an Amazon warehouse than you can in some of our crucial healthcare roles.'

A recent HFMA survey raised concerns that the initiatives most at risk from the current financial pressures were those related to prevention, health inequalities and population health management – despite two of the national goals for boards and their wider systems being improving population health and tackling health inequalities. The system's 10-year strategy – *Live your best life* – published in January, sets out 10 core ambitions, only one of which relates directly to health and social care. The rest reflect a determination to contribute towards tackling the wider determinants of health – giving children the best start in life and access to good education; supporting employment that keeps people out of poverty; and good housing.

"The conversation is now about what you do about the problems rather than who owns them"
Lee Outhwaite

But Ms Stansfield is clear that ICBs have to find a way to make progress on these wider ambitions. 'If we genuinely believe what we've written down, then we have to have a different conversation,' she says. 'We have to start investing in those areas that we know give us some of the answers and accept that that gives us a higher efficiency target across the rest of care.

'Otherwise, nothing is ever going to change. It would be a real shame if the core purposes of improving population health and addressing health inequalities were to suffer because we can't make the money work.'

She admits she has no magic solution to enabling investment in these areas. But it has to start with commitment. That means not cutting investment in the key enablers of digital and prevention – locally and nationally. And it means the NHS getting better at benefits realisation.

Lee Outhwaite, South Yorkshire Integrated Care Board

Finding the balance between the operational planning guidance's must-dos and the important local priorities is the key challenge for South Yorkshire Integrated Care Board, according to its chief finance officer, Lee Outhwaite.

The system has some stark challenges – shorter life expectancy than the English average, more years spent in poor health and 37% of its population living in the country's 20% most deprived areas. But it also has some major ambitions in its integrated care partnership (ICP) strategy, including accelerating the focus on prevention and reallocating resources to where they are most needed – tough ambitions in the face of the current financial context, unrelenting emergency demand and a national focus on reducing the elective backlog.

'There is real tension between the ambitious health and wellbeing strategies being developed by all the ICBs and the NHS-centric planning round, which is largely around doing more of the same faster,' says Mr Outhwaite. He admits that ICSs and ICBs have been introduced in a very difficult context. 'The challenge is to get into that positive space about trying to do different things.'

He also detects a different mindset around the system. 'This is a genuine partnership,' he says. 'The conversation is now about what you do about the problems rather than who owns them, which was sometimes a feature of the old system.' He warns that all systems need to guard against 'muscle memory' kicking in. Systems have huge and laudable local agendas, which will require doing things in different ways and spending money in different places. But alongside this they have a national requirement to deliver increased activity, which is directly linked to the funding they will receive. Not everything will be achievable while delivering a balanced budget.

'Trying to integrate care in the current financial context would test even the best international management teams and the trick will be not to default to old competitive behaviours,' he says.

Having said that, he recognises a different mindset across senior finance. 'There is a recognition that if one of us has got a financial problem, then we've all got a financial problem,' he says. 'It sounds like a little thing, but it is actually quite big, because that isn't how it has operated in the past. 'We need to test this in anger in the context of next year's plan, but it feels a little more collegiate and supportive.'

He adds that having a local authority director of adult social care as one of the ICB's place directors has really helped to strengthen engagement with local government.

He describes a recent health inequalities event, bringing together NHS providers with local government, public health and health and wellbeing boards. 'People were getting very animated, talking about doing things differently and getting into communities that are sometimes forgotten and the health benefit of doing that,' he says. 'There was some real energy in the room that I can't remember for quite a few years.' Backing this up with investment is the challenge.

Mr Outhwaite says the answer to making progress on the transformation agenda has to lie with 'tracking down the inefficiency in the incumbent spend'. 'That is what will give us the headroom to get into moving support upstream and dealing with previously unmet need,' he adds. 'Investing in prevention has to be a good idea, but the only thing that gives us permission to do that is stopping spending on the things we don't need to do right now.'

He is under no illusions about how difficult this will be. Finance reports to boards of providers and systems up and down the country are littered with examples of under-delivered efficiency programmes in a further year of Covid-19-disrupted care delivery.

Mr Outhwaite believes the real leaps forward in health outcomes and value for money will be in allocative efficiency – allocating resources to the programmes of care that maximise health. The spotlight is on the elective backlog, but should there be more focus on the waits for child

and adolescent mental health services assessments, he asks. And he has a similar question about speech and language assessments for pre-school age children. 'I think we have to stress test this new operating model to see if we can make that different partnership working deliver allocative efficiency in a different way,' he says. 'We are not going to get through this by all running faster on the spot anymore.'

Shared plans will be needed at place level that make the case for interventions in social and domiciliary care that release beds occupied by patients who are medically fit for discharge. 'We have to mobilise around the broader transformational change agenda and build some confidence in it,' he says.

Simply asking individual organisations to deliver their contribution to the efficiency target will not be enough. Instead the efficiencies will be delivered by working across organisations and optimising pathways.

What would success look like in a year's time? 'If we've taken two or three projects forward in each of the four places and they have begun to have an impact on clinical and cost-effectiveness in a small subset of areas and we've grown a bit of confidence that we can do multi-organisational change – if we've done that over the next year, I think that would be a fair achievement while working in a different way,' he says.

Sarah Truelove, Bristol, North Somerset and South Gloucestershire Integrated Care Board

For Bristol, North Somerset and South Gloucestershire, the creation of the integrated care board has felt more evolution than revolution.

It was not born out of the merger of numerous clinical commissioning groups and has not had the additional complication of pulling together multiple organisations. Even so, 2022/23 has brought considerable new demands – a first system capital prioritisation process, for example.

But perhaps the biggest change has been a state of mind. 'What we have really tried to get on top of is that we are planning for ourselves,' says Sarah Truelove, the board's chief finance officer. 'This is about our population and driving population health improvement and reducing health inequalities. We do need to respond to what NHS England asks for, but our primary focus has to be looking at our populations.'

She says this can be seen in the board's planning process, in which reducing health inequalities carries as much weight as more traditional performance metrics.

'There is as much focus on community services as there is on acute,' she says. 'There is still more to do, still more to improve. The integrated care partnership has only been in place a short amount of time and we have a strategy framework rather than a clear strategy at the moment. But it is good progress.'

The determination to address health inequalities means there has been a lot of preparatory work identifying better data sets to support better targeting of healthcare and improved decision-making around the needs of different population groups. That may not yet be visible to the population, but it is an essential foundation for focusing on improvement in population health, not just the delivery of healthcare.

Similarly, the system has established a GP collaborative board as part of developing a new relationship with primary care. This has helped create a powerful primary care voice as part of system discussions. And its involvement in prioritising capital spend has highlighted how the areas of greatest need in terms of estate are also the areas of highest inequality.

But there are also more tangible early developments. There's been an improvement in the learning disabilities services, with more physical health checks being undertaken. This may be a change in inputs at the moment, but the ICB anticipates it will lead to improved outcomes downstream. The changes have included service reviews to ensure that the particular needs of learning disability patients are being met – including when visiting accident and emergency departments.

Elective recovery remains important for the system, albeit challenging. Ms Truelove says that the system understood early on that the current year's 104% activity target, compared with pre-pandemic levels, was not achievable. 'But that doesn't mean we aren't trying to do as much as we can in terms of elective recovery,' she says. 'It is just recognising that we've got a heavy weighting on things like dental and ophthalmology, which had particular challenges during Covid and are taking a little longer to recover.'

There have been significant improvements in cancer waiting times and the system delivered the required reduction in long waiters, but it couldn't achieve the 104%. This year's target is more demanding in terms of a higher than average year-on-year increase in activity, but a lower absolute target of 103%.

Like other systems, Bristol, North Somerset and South Gloucestershire has faced major capacity and staffing challenges. But it also experienced some of the highest levels of patients in hospitals with no criteria to reside. With the end of the national discharge to assess funding, the system had developed its own business case for a continuing programme and was implementing this.

'It was really challenging because we wanted to increase home care capacity so we don't rely so much on community beds, but recruitment is very difficult in a very high employment area, with lots of competition from other employers,' she says.

However, the ICB worked with the care sector and with the Local Government Association to get a better understanding of current practice.

This revealed how cultural changes and better trust between clinicians and practitioners could enable the demand to be better met without a major increase in capacity.

It realised that there were more patients being

"There is as much focus on community services as there is on acute. There is still more to do, still more to improve"
Sarah Truelove

allocated to the P3 pathway (typically a care home) than seemed necessary. As Ms Truelove points out: 'Once they go into those beds, it can be harder for them to come back out and so they are more likely to end up in long-term care. It appeared that more people could be going to the P1 pathway, which is going home with home care support.'

Addressing this involved improving understanding among clinicians about the services delivered in the community and gaining confidence in those services.

The review also found that there was the possibility for a higher number of patients to be allocated to a P0 pathway rather than P1 – still being discharged home but just with informal input from support agencies and voluntary bodies.

These kind of changes can't be delivered overnight – or in just nine months. But over time, they do provide an opportunity to make much better use of existing capacity.

Ms Truelove acknowledges that the financial context is challenging. But she says that a strong directors of finance group in the system, with an agreed medium-term financial plan, is a real asset.

'We have an underlying deficit at the moment, but we've got a plan to address it and some short-term measures to break-even on our way to getting to recurrent break-even,' she says.

Break-even in the next two years is especially important as the writing-off of an historic clinical commissioning group deficit depends on it. Having to repay that former overspend would be a major blow for future system plans.

As for all systems, next year looks particularly difficult in terms of finances. Temporary staffing costs are another issue that the finance directors are grappling with. The work around discharge should enable providers to close escalation capacity, which will reduce some agency usage. But there are trickier problems around mental health nursing shortages. And with the local university reporting a 50% drop in intake for mental health nursing, there would appear to be no medium-term solution to filling the gap.

International recruitment will help but won't address the whole problem. Instead, Ms Truelove says, the system will need to explore the creation of alternative roles and ensure it is using existing staff in the best way. For example, it is looking at how specialling arrangements may be tying up mental health nurses unnecessarily.

For Bristol, North Somerset and South Gloucestershire, the biggest financial headache is the current level of inflation, which is significantly above the level allowed for in-system allocations.

Locally, the ICB has significant private finance initiative costs, which are linked to the retail price index, far higher than the GDP deflator used by the Treasury to allow for inflation in departmental settlements.

It is a key issue as it impacts directly on the savings the ICB must deliver to achieve break-even and on the investment it can make to meet local priorities.