HFMA briefing
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Developing an effective integrated care board finance team

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Introduction

Integrated care boards (ICBs) are expected to work collaboratively with system partners to deliver the health and care that the population needs. While local systems have been moving towards this way of working for some time, the legislative change has altered the emphasis, seeing a move away from 'command and control' to coordination and strategic decision making. Commissioning of services may be carried out by the ICB, by their delegated teams based at place-level, or even within a provider collaborative.

ICB finance staff will need to hone skills of persuasion and negotiation to influence decision making in complex systems, where ICBs have few formal levers. Those decisions will be based on developing a fuller understanding of population needs, through the analysis of activity and financial data from across a system.

Those charged with creating ICB finance teams are facing one of two scenarios: a CCG may have been a one-to-one match with the new ICB, meaning that finance teams have transferred as they are; or several CCGs may have merged to form one ICB, meaning that restructuring will be necessary to ensure that the team structure makes sense for the new organisation. Both scenarios come with their own challenges.

While a one-to-one match may appear the simple approach, changing the culture of an existing team will be challenging. It will be very easy to maintain existing ways of working which will negate the opportunities offered by the ICB and wider integrated care system (ICS). For those where CCGs have merged, restructuring of the finance team will be inevitable to make best use of resources. Alongside the design of the team, the ICB will need to consider the human factors at play as people change role, responsibility, and possibly location.

Having a clear view of how the ICB finance team should be structured to fully realise the potential of the new collaborative approach to designing, commissioning, and delivering care, is essential to successfully establish ICBs and support the wider ICSs.

These challenges, and others, were discussed at a HFMA roundtable in June 2022 where designate ICB CFOs came together with other senior finance staff and non-executive directors from a variety of systems and NHS England.

This briefing sets out the key points covered in the discussion and aims to support all ICBs as they develop their finance functions.

Roundtable participants

The HFMA would like to thank the following for their participation in the roundtable and subsequent support with this briefing.

Paul Brown (chair)	Chief finance officer	Staffordshire and Stoke on Trent ICB
Paul Miller	Non-executive director	Bath and North East Somerset, Swindon and Wiltshire ICB
Alison Needham	Acting chief finance officer	NHS Kirklees CCG
Lee Outhwaite	Chief finance officer	South Yorkshire ICB
Kathy Roe	Chief finance officer	NHS Tameside and Glossop CCG and Tameside Council
Neil Shadbolt	Head of financial planning	NHS England
Sarah Stansfield	Chief finance officer	Northamptonshire ICB
Sarah Truelove	Chief finance officer	Bristol, North Somerset and South Gloucestershire ICB

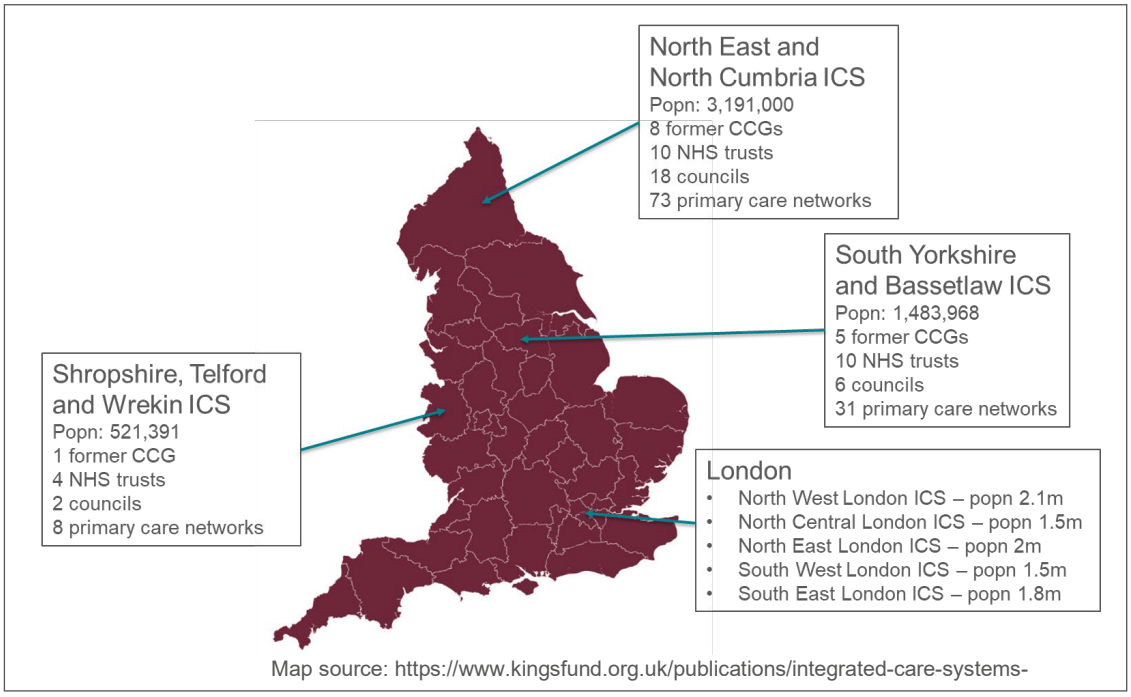
Key messages from the roundtable

- The structure and operating model for an ICB will vary across the country, due to a number of factors such as population size, number of constituent organisations, and existing relationships within the health and care system.
- ICB finance teams will have similar objectives but may be structured in different ways to meet their ICS's needs.
- Finance staff within ICBs may feel bruised from the structural changes, with uncertainty about their future role and will need support as new teams are established.
- Establishing a system finance community will support joint working and sharing of knowledge and experience, to fill skills gaps in all organisations.

What is an ICB?

NHS England defines an ICB as 'a statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in the ICS (integrated care system) area'[1]. However, those at the roundtable agreed that, although the principles of operation were the same, each ICB will be quite different. This difference will be driven by the local CCG history; existing relationships across the health and care system; population size and demographic; and the previous roles that senior level individuals held, to name but a few. These differences will impact how quickly the ICB can establish its role within the ICS; how the ICB will operate longer term; and therefore, what the finance function needs to do to effectively support the aims and objectives of the organisation. Figure 1 gives an example of the differential in population size and number of constituent organisations for selected ICSs.

Figure 1: Example ICS characteristics



The intrinsic differences between the ICSs that ICBs are a part of, mean that it is inevitable that ICB finance team structures and ways of working, will vary. For those at the roundtable, an immediate, fundamental difference, was whether a merger of organisations was taking place at the same time as the establishment of ICBs. The formation of the Greater Manchester ICB, for example, required the

[1] NHS England, *What are integrated care systems?* [accessed August 2022]

merger of 10 CCGs, a shared services organisation, and a health and social care partnership team so, for many staff, the upheaval and uncertainty were increased. The cultural change required to create a single entity after a merger is considerable, meaning that ICBs in this position may take longer to establish their system role as they work through the practicalities of bringing organisations together.

The roundtable attendees represented a wide range of approaches which would have different impacts on the establishment of the finance teams:

- Bristol, North Somerset and South Gloucestershire ICB was created from a single CCG that had been through a merger some years previously, with the CFO remaining in post for the ICB.
- Staffordshire and Stoke on Trent ICB was formed from multiple CCGs but that had been working within a shared management structure, again retaining the CFO. In this case, a formal merger was required but the change for the finance function was minimised.
- Northamptonshire ICB was created from a single ICB, with a new CFO who had previously held a non-finance role in the CCG.
- South Yorkshire and Bassetlaw ICB was formed from multiple CCGs, with a new CFO from a provider organisation in another system, bringing a new perspective.
- Greater Manchester ICB was also formed from multiple CCGs, with a new CFO from a provider organisation within the system.

When considering how to develop an effective ICB finance team, it is important to understand how the team was brought together as this will influence working relationships and willingness to do things differently. It is also important to acknowledge the impact that a change of leadership can have on a team.

What makes an ICB different to a CCG?

Many of the definitions of an ICB describe it as the body that 'will take on the NHS commissioning functions of CCGs'[2] but this is only part of an ICB's role. The second part is the ICB's system role. This is vital to effectively deliver integrated care and realise the benefits of system working, but the definition is more nebulous.

For some, the role of the ICB in the ICS is that of a convenor, a facilitator to bring organisations together and develop a collaborative space to work through health and care challenges together. But there is also an accountability role, with the ICB required to manage the whole system resources, within the set financial envelope.

With 42 ICBs, the geographical footprint of most ICBs is considerable so smaller places, within the ICB boundaries, are expected to be where the practical integration of care takes place. Place based collaboratives between NHS organisations, local authorities, and the voluntary sector will be an essential part of changing the way that care is organised and delivered.

Place based collaboratives will work alongside provider collaboratives, where groups of NHS provider organisations work across several places, to improve services, pathways, and patient flow. For the ICB there are a multitude of relationships to manage and information flows to make sense of. How the ICB works with the organisations within the ICS, and how those organisations form into collaboratives, is down to local determination. As is the delegation of responsibility between them. While most welcome the freedom that the legislation grants them to do things in the way that best suits local circumstances, the lack of guidance and rules can be uncomfortable.

ICBs are also taking on a number of roles that CCGs did not have. For example, the ICB is charged with coordinating the capital programme within the ICS, although it will incur minimal capital expenditure itself. From April 2023, it is expected that the commissioning of most specialised services will transfer from NHS England to ICBs. From April 2023, all ICBs should be taking

[2] Department of Health and Social Care, *Health and Care Bill: Integrated Care Boards and local health and care systems*, March 2022

delegated responsibility for primary care commissioning, expanding beyond GP services to include ophthalmology, dentistry, and some pharmacy.

System oversight and assurance

A new role for ICBs is that of providing system assurance. This is a tricky balancing act for the ICB, which needs to be part of the system but also needs to be able to step back and review performance across the system, acting on any issues that arise.

Roundtable participants were particularly concerned by what the national demands may be concerning assurance and performance management. While it was acknowledged that assurance that the ICB is meeting the requirements placed upon it, was important, there was a worry that this could become all consuming, leaving little time to develop the ICB and wider ICS to its optimum state. Developing a new and effective finance function for the ICB may have to take a back seat if the demands for national reporting are too high, which could have a long-term detrimental effect.

Those at the roundtable hoped that a joint working approach would be taken by NHS England with ICBs, using the ICS plan as the means to hold the ICB to account, rather than developing new national metrics. In addition, the regulation and oversight of the provider sector was highlighted as an area of potential conflict, if providers were assessed against metrics and standards which contradicted the objectives of the ICS's plan.

Challenges to address when developing ICB finance teams

Attendees at the roundtable highlighted several areas where they had either encountered challenges for ICB finance teams or were anticipating an area of concern.

As a support function and enabler, the finance team should be designed in the way that best suits the operating model and priorities of the ICB, rather than creating a finance model that the ICB then has to work with. However, the speed of implementation of ICBs and the inability to make any meaningful changes or even discuss future structures prior to 1 July 2022 due to the employment guarantee[3], has meant that many finance teams have entered the ICB with not only a lack of clarity about the future, but also immediate demands upon them to start to work differently. It should be noted that finance resource was also required to close down the CCGs and prepare final accounts, at the same time as setting up a new organisation. This also happened at the same time as many of them were going through a merger and the associated uncertainty at all levels about what their future role might be. It is essential that this context is kept in mind as ICB finance teams are developed.

Cultural change and system working

While most areas have been working as an informal system for some time, the move to ICBs is still a significant cultural change for many. For those going through a merger, the change of employer and the loss of their smaller organisation may feel uncomfortable. Many staff will feel a loyalty to their CCG area, with the ICB feeling large and remote from them. Work will be required to support people to feel part of the ICB and wider system.

Attendees at the roundtable highlighted that the finance function is already good at building networks across organisations, with system-wide directors of finance groups well established in many areas. However, this may not be true for the whole finance team. Developing a system-wide finance community, would support staff to form relationships and understand the skills that exist in teams in different organisations.

Concern was also raised that other staff groups may not have the existing networks to build upon. The finance function therefore has a role to play in modelling behaviours across organisational boundaries, to support the wider ICB and ICS to work together.

The need for a cultural change is not restricted to commissioning staff and ICBs. Those working in provider organisations, who may feel unaffected by the changes, will be required to work in new

[3] NHS, *Guidance on the employment commitment*, June 2021

ways. The requirement to collaborate and share information may be difficult to implement as quickly as ICBs may wish, depending upon the history of joint working and the operating model chosen by the ICB. It was noted at the roundtable that there will need to be a system wide refresh of schemes of delegation to establish where decisions can be made.

Team structure

How an ICB finance team should be structured caused considerable debate during the roundtable discussion, with many different options under consideration. Some ICBs are developing a business partnering model to work with place-based collaboratives, recognising that there is a need to really understand the population to enable service transformation, working with different partners at a local level.

An alternative model was proposed elsewhere, where each member of the finance team would be aligned with both a place and a functional responsibility, such as mental health or urgent care. This would enable staff to have both a place and a system view, as well as building resilience through having multiple staff linked to each function.

A third model was structuring the finance team to reflect patient pathways, to ensure that the finance function truly reflected system working by looking across all organisations involved in a patient journey. Concern was expressed that this approach may be too narrow and may miss opportunities to innovate through not being linked in with workstreams such as digital or estates. However, it would align with the programme focus often taken nationally.

It was noted that the options available to an ICB may be limited by the size of the team inherited from the legacy CCGs. For example, where multiple CCGs have come together, there is potentially more scope to provide finance resource in a number of ways, to support multiple approaches – the three options described above are not mutually exclusive. However, smaller ICBs may find themselves with more elements to support than the finance team is able to service, as new place-based and provider collaboratives are established.

Attendees at the roundtable agreed that everybody was trying to achieve the same aims, but it was likely that there were several effective ways to do that. While patience was urged by some to wait and see how the ICB would be set up and which model would be most appropriate, others were concerned that waiting too long to change would entrench traditional ways of working. It was widely accepted however, that the way the ICB looked and operated in year one, would be quite different by year three.

Required skills

New ways of working and new responsibilities mean that some different skills will be required within ICB finance teams. It was noted that commissioning finance staff had a number of excellent skills around dealing with complexity and scale, which would stand them in good stead as ICB finance teams were developed. In addition, traditional technical finance skills will continue to be essential.

However, there are some areas that ICBs are required to cover, where commissioning finance staff will not necessarily have the skills and experience to do so. A key example of this is capital planning. ICBs are responsible for overseeing the capital plan for the ICS and supporting the prioritisation of spend, however this is an area that has traditionally been the domain of provider organisations, where the bulk of capital expenditure is incurred. It was noted that, while staff could be trained or additional staff recruited to fill the knowledge gap, this was an area where system working could be utilised to share skills and experience. Movement between finance teams within the system is expected to optimise people's skills and ensure that they are working where they can have the biggest impact. Again, this will be unsettling for some staff and will need to be managed carefully.

An additional skill set highlighted by some roundtable participants was the need to be able to resolve conflict. As ICBs are established and new working patterns are developed across system partners, disagreement is likely around where responsibilities should lie, who should accept what level of risk, and how resources should be allocated. While the aim of ICSs is to develop all of these solutions jointly across partners, the reality is that agreement may be difficult to reach, requiring finance staff to negotiate, influence, and resolve issues.

Working with providers

The consensus at the roundtable was that provider organisations are generally feeling unaffected by the legislative changes that have created ICBs. However, as previously discussed, there are some quite fundamental changes required to how all NHS organisations work together.

Provider collaboratives are likely to be quite powerful within a system and it is expected that most of the work around improving patent flow will occur within them. In some ICB areas, there is a move to delegate some areas of commissioning to providers, for example the management of independent sector contracts to acute trusts. This will require provider finance staff to develop skills around commissioning and contract management that they do not currently have. However, in the same way that ICBs can acquire capital planning skills through staff movement within the system, so providers can gain the commissioning expertise that they require.

The provider sector needs to play an active role in the development of ICBs and the broader ICS. Service transformation requires a range of skills that may sit within multiple organisations. The ICB has a role in bringing people together, regardless of sector, to deliver change. Projects may be led by people from any organisation and the financial support for the project may be most effective if it is a joint team across the ICB and one or more providers. System working presents a fantastic opportunity to acknowledge and utilise the skills of the finance function as a whole, beyond organisational boundaries.

A provider sector that was causing concern for most roundtable participants was primary care. The closure of CCGs means that GPs have stepped down from their formal commissioning role and have reverted to being a provider within the system. However, the disparate nature of general practice means that ICBs are struggling to get good engagement and involvement from the sector. In addition, the lack of good financial and costing data for primary care means that understanding whole system impact of a change, will be a challenge.

Conclusion

ICBs will not be a homogenous group. The way that they are set up and operate will vary widely, depending upon a variety of factors such as size and population demographic. While all ICBs will be working to the same aims, the differences between them means that there is no one size fits all, when it comes to establishing an effective ICB finance team.

The development of ICBs and system working represents an opportunity for members of the NHS finance function to showcase their skills and develop new ones. However, changes to organisations, roles, and reporting structures will be unsettling for many staff and care needs to be taken during the transition period to acknowledge and address concerns.

Senior finance staff need to work together across the system to ensure that the complementary skill sets in their organisations are identified, celebrated, and optimised as new ways of working are developed. Establishing a system finance community will be key to this, enabling staff to build relationships at all levels and specialties and to understand different skill sets.

The cultural change for finance teams across the whole system is likely to be significant. It is not just ICBs who need to look at how to make their finance teams fit for purpose, provider organisations also need to consider how they will meet the challenges of system working for finance.

NHS finance staff have a key role in ensuring the success of ICSs, regardless of the sector that they work in. An effective ICB finance team will not work alone, it will be part of a wider system finance network.

About the HFMA

The Healthcare Financial Management Association (HFMA) is the professional body for finance staff in healthcare. For over 70 years, it has provided independent and objective advice to its members and the wider healthcare community. It is a charitable organisation that promotes best practice and innovation in financial management and governance across the UK health economy through its local and national networks.

The association also analyses and responds to national policy and aims to exert influence in shaping the wider healthcare agenda. It has particular interest in promoting the highest professional standards in financial management and governance and is keen to work with other organisations to promote approaches that really are 'fit for purpose' and effective.

The HFMA offers a range of qualifications in healthcare business and finance at undergraduate and postgraduate level and can provide a route to an MBA in healthcare finance. The qualifications are delivered through HFMA's Academy which was launched in 2017 and has already established strong learner and alumni networks.

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