HFMA response
January 2021

The HFMA's response to *Integrating care: next steps to building strong and effective integrated care systems across England*

Who we are

The Healthcare Financial Management Association (HFMA) is the professional body for finance staff in healthcare. For 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.

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?

Yes, we believe that giving integrated care systems (ICSs) statutory status is a significant step in the right direction. Many of the current challenges facing sustainability and transformation partnerships (STPs) and ICSs result from them being non-statutory organisations with no formal accountability or powers that are trying to fulfil their role of managing the allocation of resource to, and monitoring the performance of, statutory organisations.

ICSs bring together local organisations in a pragmatic and practical way to deliver the 'triple integration' of primary and specialist care, physical and mental health services, and health with social care. They have a key role in working with local authorities at 'place' level. Through ICSs, commissioners will be able to make shared decisions with providers on population health, service redesign and *NHS long-term plan* implementation. Primary legislation is needed to deliver this new way of working and optimise the approach. To function effectively, systems need clear and transparent arrangements and the establishment of a single statutory body with authority to lead the system will enable that. It will provide a clear central path of vertical and horizontal communication and accountability between organisational, place-based, regional and national plans. This will enable managers to focus on the best provision of health and social care that achieves maximum value from available resources, rather than having to consider how these decisions can be made within a statutory framework that does not support collaboration and joint working.

Building on the significant work that has taken place over recent years on collaboration and developing effective relationships, the proposed legislation provides an opportunity to put 'place' and local communities at the heart of decision-making, while leaving the potential to have some bespoke arrangements in particular areas. It is important that smaller parts of the system retain the ability to develop bespoke local services at primary care network (PCN) or 'place' level. It would be helpful if a broad expectation for each element (PCN, place, ICS and region) was clearly laid out.

It will be important that transparency is retained about how allocations are made to ICSs and that the funding flows from the Department of Health and Social Care (DHSC) to ICSs via NHS England and NHS Improvement are clear and understandable. As ICSs take on the role of allocating resources and contracting with providers of healthcare, support will be needed to allow them to do this in a transparent and equitable manner so that it is clear how and why resources have been allocated to a particular service or provider. This will be the same whether the resources are revenue or capital. Where there are limited resources that will not meet demand, it must be clear where the priorities are and why. This should then be reflected in the way that financial performance is managed, reviewed and judged throughout the year. The resources the ICS spends will be different to the ICS allocations with patient flows going across ICSs and specialised commissioning. These complexities will still exist.

The proposed legislation will allow ICSs to focus on the overall system strategy, population health management and wider engagement, providing a clear framework for providers to focus on delivery.

It is important to recognise the following key points that will need to be in place to make this work:

- **Trust and cultural change**: joint working requires trust and cultural change which cannot be imposed by governance structures or statute and takes time to achieve. Developing systems repeatedly highlight the importance of working to an agreed set of shared principles.
- **Common vision**: in order to work effectively systems must work to aligned strategies. The ICS will need to have a clear, coherent and agreed understanding of its role in agreeing a shared vision and objectives as well as putting in place monitoring arrangements. The statutory bodies that form part of the ICS will also need that understanding of their role – to make the ICS's vision and strategy a reality, rather than developing their own separate vision

and strategy. This will require a change in mindset for the leadership of all of the entities involved in the ICS.

- **Aligned performance oversight**: a common system oversight framework approach that sets clear and consistent expectations for systems and their constituent organisations is welcome. However, clarity over what interventions can be made, when and how, is vital to ensure that required behaviours for system oversight are practised to resolve an issue in the system when it does occur. There needs to be clarity over the ICS role in the performance and quality agenda. As part of developing this, there also needs to be clarity over the ICS role in setting priorities and in system resource co-ordination (beyond setting initial allocations). For example, is there a national expectation on an ICS to harmonise service quality and performance between partners?
- **Place-based and provider alliance support:** while recognising that arrangements within the ICS are for local determination, further guidance to support the development of place level (including place leaders) and provider alliances, would be helpful. As provider alliances develop further it would be helpful to review options to reorganise this sector within a statutory footing.
- **Funding**: the challenge, regardless of structure, will be how to allocate limited funding fairly and equitably and drive system level value for each ICS pound when the funding envelope is insufficient to allow for both transformation and recovery. It is important that the proposals reduce wasted resource to release funds for direct provision of health and care services.
- **Clarity on the relative and revised responsibilities of the NHS and local government:** to improve population health, address inequalities, improve allocative efficiency, and help to support broader social and economic development, there will need to be real clarity on the relative and combined role of NHS and local government bodies on these agendas. For some systems this will need a stepped change in joint working.
- **ICS governance arrangements:** With the ICS made up of a large number of constituent organisations, partners and sub-systems, agreed and transparent governance arrangements must be in place. ICS governance will need to ensure meaningful representation from across all organisations (executives and non-executives), patients and the local public including those from under-represented groups.

During 2020, as a result of the Covid-19 pandemic, the normal NHS financial regime has been paused and much simplified payment mechanisms and contracts have been put in place. This has removed many financial barriers to co-operation and innovation and has demonstrated how organisations can work together to a achieve a shared, although single, objective when traditional areas of conflict are removed. HFMA's *The future NHS financial regime in England: recommendations*, makes a number of recommendations to support the development of the future financial regime for the NHS in England.

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?

Option 1 is very similar to what is in place at the moment and option 2 is a significant reorganisation which, although as stated the aim is to avoid, will lead to at least some initial disruption.

Both options have positives and negatives. For some systems that are already working well together option 2 may feel like a constraint, whilst for others in the same position it may provide the opportunity to use the statutory footing of the ICS to build on the systems of collaboration and collective decision making that are in place now. For those less mature systems it will be helpful to prompt action. However, there is also the danger, particularly for those less mature systems, that the

new body will see itself ‘in charge’ and try to impose its will rather than encouraging and nurturing cooperation and integrated working.

Overall, whichever model is introduced, the culture of collective working needs to continue to be built and must be the foundation of the ICS.

On balance, we agree that option 2 sets out the best way forward for the NHS in the longer term. It will enshrine collaboration in statute and remove almost 30 years of competition between providers. It provides the clearest, simplest mechanism of the two options. It will provide one strategic body to make investment decisions based on population needs and have oversight of delivery.

There are areas that will need to be considered to ensure the option is developed in line with its aims, these are explored further below.

Behaviour and maturity are key no matter the model. Both models could work, although the latter will need to mitigate the risk of encouraging the wrong behaviours. For example, there is the risk that under option 2, the ICS will be seen as, or become, a large commissioner, with a command-and-control structure, rather than being a genuine partnership within the system. Ideally, option 2 would allow for some flexibility in governance arrangements to reflect the relative maturity of different ICSs.

The role of NHS England and NHS Improvement also needs to be considered as part of these developments. Our members are concerned that ICS structures will rapidly grow just to support demands being placed on them by NHS England and NHS Improvement. National and ICS governance needs to be complementary and constructive to the whole of the NHS.

We are concerned that engagement with local partners, especially local authorities and the voluntary, community and social enterprise (VCSE) sector will be affected as ICSs are developed. Some of our members have raised concerns that existing links with local partners at a current CCG level may be harder to maintain across a larger footprint.

It must be clear that while the ICSs will incorporate existing CCG functions, the ICS will have a different role in relation to the allocation of resource and the setting of strategy. The ICS has a vital role in working with local authorities and addressing public health, which can be taken forward by both models. If the change is merely shifting statutory functions from CCGs to ICSs, it will not deliver a great enough shift to deal with social determinants of disease or health inequalities and will not lead to optimised care integration.

The strategic nature of commissioning is important for ensuring that the full range of population health needs are met. As ICSs develop, the strategic commissioning function should form part of the overall system architecture, rather than a separate organisation within the system. With the national move towards system working and co-operation, it is the right time to review the traditional purchaser/ provider split which tends to foster competition and can cause unnecessary conflict. However, the split in functions has played an important role in improving data quality and providing scrutiny around care quality and patient safety. ICSs must have a duty to ensure that taxpayers’ funds are spent well and that quality outcomes are achieved.

The process for ICSs being responsible for new money and additional funds needs to be simplified and encourage non-competitive behaviours that consider representation from across the system. It should not, however, be used to exclude existing providers simply because they are not NHS bodies. We welcome that provider collaboratives do have representation at an ICS level, but this is not necessarily equal. ICSs could consider having a lead provider for each sector to ensure balanced influence on decision-making. It is important to ensure all voices – acute, community, mental health, ambulance, local authority, VCSE, and independent sector – are heard with the actions locally backing that representation and collaboration up.

One benefit of creating a single oversight organisation for the whole system is that it is easier to provide a consistent approach across the population it serves. Counter to this is the need to support places within that system to do what is necessary for smaller subsets of the population, accepting

that this may differ within one ICS. Clear accountability for place-based decisions will need to be established within the wider ICS structure. Health and wellbeing boards may be an option to maintain that place-based focus but, if the funding allocations through the ICS are primarily health based, clarity will be needed on relative priorities and multiple reporting lines if a local authority mechanism is used to assure place-based decisions.

Budgets should not be shifted to the ICS automatically but should remain where they can be used most effectively. Any budgets held separately by individual organisations should not be stripped back under the name of economies of scale and sharing of functions unless there is a clear and compelling reason to do so.

Whichever model is selected, the impact on the governance arrangements of all the existing statutory bodies needs to be considered. For example, what are the roles of foundation trust governors and provider bodies' non-executive directors and do they need to change? How does the new organisation work with and consult the local population and service users? Should they have a formal role? Some arrangements may be considered duplication and could be transferred to ICSs to avoid additional bureaucracy and administrative cost. The accountability of an ICS needs to be clearly set out, specifically how it connects with and meets the needs of the local population. We are hearing that in some areas there is unease at the growing role of decisions taken at an ICS level with no formal role for non-executive director challenge until proposals are presented to organisation boards.

There also needs to be clarity about how ICSs can ensure data and information technology systems are enablers to system wide working rather than barriers. There needs to be a clear aim that data transfer between organisations is enabled and metrics can be identified, collected and used to make sure care is safe, effective and value for money when different agencies are contributing to the same patient pathway. Working collectively as a system will both remove data duplication and help to pool system wide analytical expertise.

While the proposal is not for a wholesale reorganisation of how the NHS is managed, the establishment of new statutory bodies and the arrangements that will need to be put in place to allow those new bodies to meet their new objectives will take time. The benefits of what could be quite a large reorganisation need to be measured against the disruptive effects of doing it.

It is clear from the many previous changes to the organisation of the NHS that considerable management time must be invested in the process both before and after the implementation date. This can be a significant distraction for senior staff and boards. Given that the Covid-19 pandemic will still be an issue throughout 2021, and likely into 2022, and the work that the NHS has to do to recover, the timing of these proposals needs to be carefully considered. For more mature ICSs, the establishment of the statutory body will simply formalise existing arrangements but for others, there needs to be time to make operational changes as well as develop trust and embed a new culture and way of doing things. The oversight framework needs to take account of this.

Finally, we suggest that it would be helpful if any future guidance contained a diagram which clearly shows how responsibility and funding for services would flow from the Secretary of State for Health and Social Care to citizens.

Question 3. 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?

Yes, we welcome the ability for local determination. It is helpful to have a set of central core rules and governance requirements alongside leaving room for local direction and flexibility. This is particularly helpful in addressing how to tackle variation and health inequalities across a local population. It also

reinforces the objective of making decisions as close to the patient as possible. Local arrangements will not all be the same so the flexibility will be needed to allow the ICS to reflect them.

There does need to be a mechanism for resolving conflict and ensuring that different views do not result in an impasse. Even locally, there will be conflicting opinions, a clear mechanism for managing conflict and differing views and priorities needs to be agreed and understood by all parties.

While legislation does not determine the membership, it is important not to lose the opportunity to formally engage with the VCSE sector in the development of integrated systems. Further guidance should be provided based on common success factors to date to inform local developments and encourage the benefits of wider engagement. This guidance should include the inclusion of the VCSE sector; the role of primary care; clinical leadership; the role of universities; as well as other factors identified by successful systems.

The mandatory participation of local authorities will not address the barriers to working with local government, such as the differing VAT regimes[1] and the impact of the national tariff on local authority commissioned services, raised in the HFMA's response to the previous consultation[2].

These proposals will bring local authorities to the table, but further work is required to ensure they are genuinely involved in tackling system wide issues and, to do that, local authorities need see the benefit to them and the population they serve of being part of the ICS. It is likely that the NHS will dominate the ICS but the social determinants of health (housing, heating, employment, education, leisure and exercise, homelessness, regulation enforcement, licensing of premises) are most influenced by local government. Shared commissioning is one way to use the ICS to drive this joint agenda.

As we have said above in relation to the governance of existing bodies, there are potential overlaps with the existing role, and partners, of health and wellbeing boards that will need to be considered both nationally as legislation is drafted and locally as it is implemented. It is important that this legislation does not simply add to the existing statutory framework but makes the whole framework fit for purpose and, as far as possible, flexible enough to allow it to develop and change over time to meet developing and new needs.

The legislation does present some risk that county councils whose boundaries are not coterminous with health systems may seek to redraw footprints, which would be counter-productive, risking progress and momentum. We wonder if there is an opportunity through the proposed local government reorganisation being discussed within the Ministry of Housing, Communities and Local Government whether there is an opportunity to better describe coterminous boundaries with local government and address the 'right size' for each ICS.

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?

Overall, we agree that commissioning and funding decisions should be made at the most appropriate level. In many cases this will mean the transfer or delegation from NHS England and NHS Improvement to ICS bodies.

The advantage of transfer over delegation is that is provides a simplification of the resource management process and would also represent a further positive step towards population budgets. However, this would require specific legislation.

There are some services, such as ambulance services and highly specialised services, that should continue to be commissioned at a pan regional or national level as they need specialist expertise or a national view. But we would expect these examples to be relatively few and also to include a local

[1] Although this is being addressed through an HMRC consultation that the HFMA has also responded to (HFMA, *The HFMA response to the VAT and the public sector: reform to VAT refund rules*, November 2020).
[2] HFMA, *Proposal's for possible changes to legislation*, April 2019

connection at an ICS or place level. This would also ensure that NHS England and NHS Improvement continues to have first-hand experience of devising, developing, commissioning and improving healthcare services. For specialist services such as mental health secure services, wider systems are developing under a lead provider or provider collaborative model and should continue to do so.

It is important to consider the right population size to plan and deliver services that enable pathways to be transformed to improve health outcomes and deliver efficiency. In cases where delivery of services is across multiple ICS footprints, there needs to be clear, flexible arrangements in place to best meet the needs of the population.

In some cases, particularly for small ICSs, it may not make sense to have parallel commissioning processes in more than one ICS. Where specialist tertiary services are managed across a footprint wider than one ICS, there will need to be both risk pooling in place across ICSs, as well as clarity of arrangements to effectively manage the needs of the local population.

General comments

The clarity of direction for system working is positive and has been the focus of the work of the HFMA's System Finance Special Interest Group. The Group is currently overseeing work, alongside the HFMA's Governance and Audit Committee, on system finance and governance. While recognising that one size does not fit all, this research aims to share lessons learnt to support NHS organisations as they develop their own arrangements. The HFMA is happy to provide support in developing national policy and guidance if that would be helpful.

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