Network connection

With just a few months until integrated care systems are due to be launched formally, there is much to do, especially in finance and governance. An HFMA roundtable, supported by Newton Europe, discussed the preparations health and care bodies must make to harness the benefits for service users

Health and local government in England are distinct systems, with different funding streams and accountabilities. Yet, in terms of the interaction between the NHS and social care, they have been moving ever closer over the past few years – for example, building the collaboration on pooled budgets to work together under the umbrella of the Better Care Fund and, in the past year, forming integrated care systems (ICSs).

Within ICSs, integrated care boards and integrated care partnerships are due to gain statutory status by April 2022. But joining up the work of local partners – many of which are also statutory bodies – is a complex task, and though time is short, questions remain.

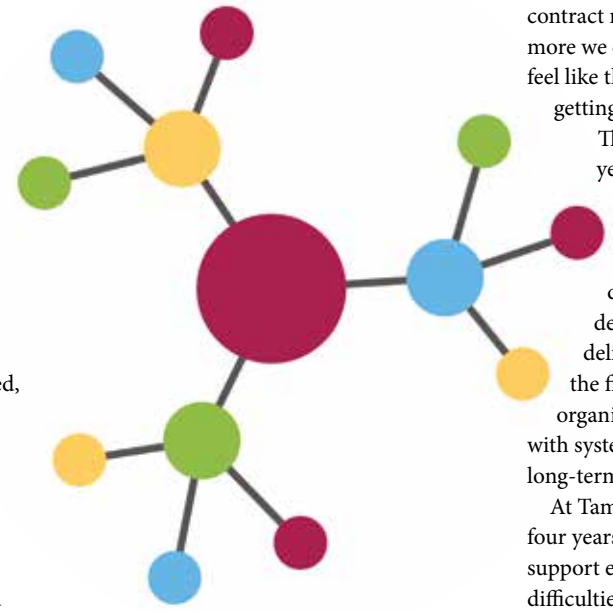
At a high level, questions include how finance teams and processes can support system working, a concern discussed in detail at a recent HFMA integration roundtable, supported by operational improvement specialists Newton Europe.

The roundtable, which brought together colleagues from across the NHS and social care, was the second on integration held by the HFMA and Newton this year. The first examined what a system finance framework should look like; this one focused on the practical aspects of integration and the challenges that have or will emerge.

Participants

HFMA ROUND TABLE

- Kathy Freeman, Lewisham Council
- Helen Gardiner, London Borough of Camden
- Caroline May, Essex County Council
- Julian Miller, University Hospitals Birmingham NHS Foundation Trust
- Chris Randall, Barking, Havering and Redbridge NHS Trust
- Kathy Roe, Tameside and Glossop Clinical Commissioning Group and Tameside Council
- Kath Sargent, Nottinghamshire County Council
- Ric Whalley, Newton Europe
- Rob Whiteman, Cipfa
- Claire Yarwood (chair), Manchester Health and Care Commissioning



Key issues

Several themes ran through the discussion, including how the ICS governance structure could help or hinder integrated services, and the need for partners in health and local government to develop trust in each other.

The NHS in particular has been fragmented, and steeped in the ethos of competition, not collaboration. In the background, there was also a concern that during the run-up to April 2022, the NHS and local government had little spare capacity to think through implementation as both organisations face a difficult winter grappling with Covid, flu and long waiting lists.

On the other hand, participants were keen to point out that 1 April is just a starting point, and ICSs would continue to evolve. Some speakers believed further policy reform, beyond the current *Health and Care Bill*, would emerge.

The roundtable heard first-hand experiences from Kathy Roe, chief finance officer for Tameside and Glossop Clinical Commissioning Group and Tameside Council, who has held the joint role since 2017. She described the Tameside set-up as a 'micro ICS' with a pooled budget of around £1bn.

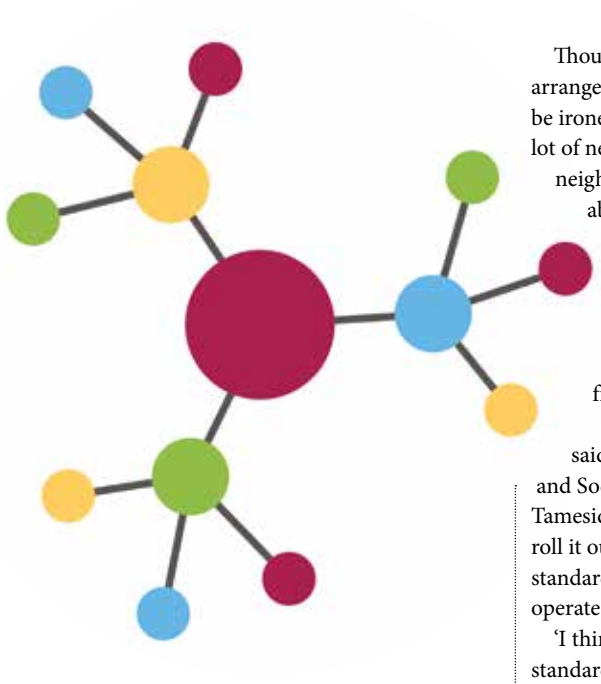
Ms Roe said that around a decade ago, relationships between NHS organisations locally, and with the council, were poor. However, in 2014, they decided to try to overcome their differences, working from a list of principles that aimed to foster trust and improve relationships. The principles included risk sharing and a commitment not to cost-shunt to another organisation.

'I remember putting forward some proposals and ideas around how we could agree a financial framework that would encompass a longer period,' she said. 'One-off annual contract rounds – working out how much more we could get from others, and who would feel like they won that negotiation – were getting us nowhere.'

The first integration roundtable this year agreed that in a system financial framework, funding should be allocated to individual organisations based on system objectives, with decisions based on the cost of delivering services. Incentives to deliver the system's priorities, even to the financial detriment of individual organisations, should be included, together with system oversight and mechanisms for long-term planning,

At Tameside, the framework covered four years, with cash flows that aimed to support each organisation with their financial difficulties, and a focus on key pressure points such as discharge and outpatients.

At one point this led the provider to decline to agree its national control total, forgoing



capital funding as a result, to ensure the CCG budget remained in balance. Ms Roe added: 'This had a knock-on effect, as the CCG could then agree to amend its assumptions on the enactment of the risk share arrangements with the local authority, and the council was subsequently able to offer support.'

The CCG financial turnaround was successful over two years, allowing it to help the local authority with the child social care pressures it was having. Over the four years, pooled budget arrangements in adult social care helped transform the financial position, saving more than £80m non-recurrently.

Ms Roe said a strategic commissioning board was created, similar to the locality boards ICSs could set up. However, she pointed out that the Tameside strategic commissioning board doesn't include providers – a key area that will need to change to make current arrangements fit for purpose under the new ICS arrangements.

'I think the test for me going forward in the new ICS is what financial frameworks we want to put together. They need to be longer than one year to really give us a chance of succeeding on some of this,' she said.

'What are the principles of joint working that we need to agree? How are we going to manage those relationships between councillors, clinicians and governors of foundation trusts? Where does the duty to co-operate for foundation trusts blend into something that's system-wide?' she asked.

Commissioners and providers in the NHS will have to put aside years of competition, she added. 'How will provider collaboratives help us to manage that system working that will have to blend providing and commissioning like we haven't seen for an awful long time?'

Though the focus is at ICS level, the arrangements at place level had yet to be ironed out, Ms Roe said. 'There's a lot of nervousness in communities and neighbourhoods about how they are still able to influence the spend in those areas. How much money will they have delegated to them in the future in comparison with what they've got now? There's an awful lot to learn, and I don't think we're going to get it right from 1 April.'

Cipfa chief executive Rob Whiteman said that if a Department of Health and Social Care official was listening to the Tameside experience, they would wish to roll it out as standard across the country. But standardising the way ICSs are structured and operate is both a risk and an opportunity.

'I think national rollout and guidance and standardisation can help one area and stop another because they're doing it in a different way,' said Mr Whiteman. 'Difference is a good thing because different places are going to do it in different ways. The Department could come along and sort of steamroller everything into one way of working, which could undo what one area has done because it has to follow the pattern of another.'

Questions of autonomy

University Hospitals Birmingham NHS Foundation Trust chief financial officer Julian Miller wondered how much real autonomy systems can, and will, be given.

'National programmes and priorities will be cutting up against system working,' he said. 'And as much as I agree that to get the benefits of system working you need to have that freedom to set yourselves up in a way that works for your local circumstances, it's how that then works.

'As a provider, we've got big contracts with a huge number of commissioners from different systems and, frankly, it's going to be extremely difficult to marry it up. If everyone wants to run their system differently and have a slightly different financial framework locally, how on earth do we interface with that?

'That, to me, is one of the biggest fundamental tensions. Can systems really have that autonomy, or do we still need to remember we're part of a national health service? And where do you draw that line between what you can do locally to suit your own needs and what you have to do in a fairly standard way to fit in with the bigger system?'

Other participants spoke of the difficulty of working across ICS boundaries – where a large

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Kathy Roe, Tameside and Glossop CCG and Tameside Council

trust is a major provider in more than one ICS, or a local authority has more than one ICS in its area. Kath Sargent, senior finance business partner at Nottinghamshire County Council, said the county has two ICSs, one of which includes six districts and two councils. In addition, Bassetlaw in the north of the county, is currently in the South Yorkshire ICS.

Mrs Sargent said ICS partners must prioritise finding a way of joining up their financial reports, which will reduce disputes and duplication. 'For example, there is the formal reporting for NHS partners only and then there's an added bit to show the other partners – it would be better to agree one report with all parts formally reported.

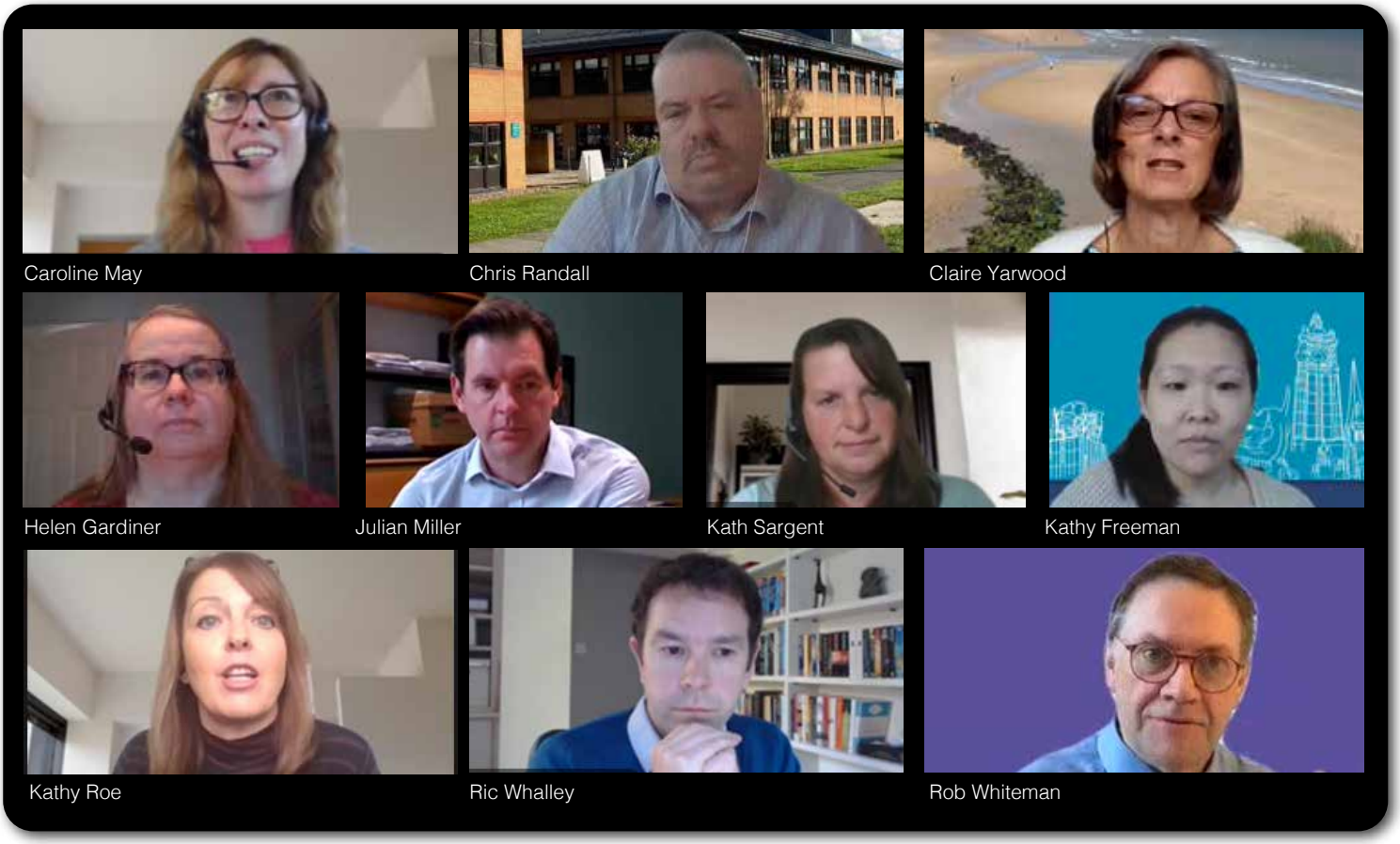
'Everybody needs to be looking at everything, because if you don't have a complete view, you can't know that you're definitely making the right decisions and for what purposes,' she said.

'I'm really interested to see how we build the personal relationships into concrete things we can take forward, which don't fall down at each of the challenges and discrepancies or change in policy. When this happens, it seems to set you back to square one, or at least take you so many steps back after you've just taken all the steps forward. You just keep going around the same loop sometimes, and I would like to find a way to really push that forward and make change that sticks.'

The landscape is made more complex by the fact that ICSs are at different stages in their development. Caroline May, acting head of finance, adults, at Essex County Council, said this was true of her local ICSs. The council must work with all three to achieve a degree of synergy and collaboration, and is working on a joint finance strategy with one ICS, with strategies to be agreed in all three ICS areas.

'Governance is a key thing for me. Obviously, the NHS and local government have very different governance regimes. How do we facilitate making joint decisions and place-based budgets?' she asked.

'We're moving towards a localities model in Essex, which we were doing anyway, but how do we make sure we've got sufficient devolved



decision-making in those localities while maintaining that line to the corporate centre and section 151 oversight? We need to be mindful of the different governance regimes.'

Kathy Freeman, Lewisham Council's executive director for corporate resources, said there could be a tension where one body in an ICS makes an investment, but another receives the benefits. She said the benefits must be verified and linked directly to the initial investment, but it will also require a leap of faith from all parts of the system.

'We need to start by recognising that although one party makes an investment over here, the benefit might fall outside their organisation. It might fall outside their system.

'But who's going to do that in such a financially and fiscally constrained environment, because we're working on one-year settlements and we don't have a longer view of what the funding picture is going to look like? At what point do we put our money where our mouths are collectively to do that?'

Ms Freeman added: 'A lot of what I've heard today is around what a local authority can do, what health partners can do. But it would be good to spin the conversation and turn it on its head and think about it from a resident or service user perspective – a look at it through their pathways and through their eyes in terms of what they deemed to be a good, seamless, end-to-end service from the various points that they may enter into the system.'

Chris Randall, Barking, Havering and Redbridge University Hospitals NHS Trust associate director of finance, said they were looking locally at the system drivers of deficit, but it was a struggle to see data on all parts of the system. 'We're probably very good at describing what drives the deficit within the NHS parts,' he said, 'but I suspect we don't have the same level of visibility and understanding in social care.

'I think there's a big education piece here for us to actually learn a lot more about the drivers in social care. If you don't understand that and you fix one part of the system, the other part will break again, and it will bring the whole system with it.'

Mr Randall said he would like appropriate governance arrangements agreed that do not hamper innovation and joint working.

Whatever the governance arrangements, to ensure integration and real benefits emerge it was important to understand the evidence to inform change, and 'make change stick', said Ric Whalley, who leads large-scale improvement programmes across health and social care at Newton.

HFMA ROUND TABLE

"Can systems really have that autonomy, or do we still need to remember we're part of a national health service?"

Julian Miller, University Hospitals Birmingham NHS FT

Taking up the point on the importance of seeing the whole picture, he added: 'Discharge to assess is an example of one of those wicked problems where, for one party, it can look brilliant and it has improved flow, but for another it can place a huge amount of long-term care costs on the council if done wrong. Done right, it can offer massive benefits to both.'

Consistently, in integration work, Mr Whalley said, he had seen the need for someone to take a lead and push forward ideas everyone can work with. There should be a focus in key areas, he added. 'How are we going to pick a few areas where we're going to work together on something that's meaningful – that's where you form relationships. That brings me back to the discharge to assess example – it's a great opportunity where something can benefit all the partners, but it needs to be done right.'

Integration projects must be 'wired in' and communicated to those on the front line, Mr Whalley said. He had seen urgent community response teams (UCRTs) established and funded in some areas, but failing to have the expected impact. This was often because the

referring service, such as 111 or ambulance crews, didn't know about the UCRTs or did not understand them well enough to trust them.

It could be worthwhile linking an ICS's financial framework with organisational development, particularly for middle managers and frontline workers in all partner bodies, Mr Whiteman said.

HFMA ROUND TABLE

Benefits can be assessed by piloting new services or pathways, which can be rolled out across the system, said Mr Whalley. 'Piloting and iterating it can give us a really good view on what actually happens, but can we monitor the financial flows when we do this thing differently?' he added.

In one example in Birmingham, Newton found some people having 13 different assessments through a pathway. A solution was to create integrated assessment hubs out of hospital, which was implemented and iterated in one part of the city.

'There was a lot of work,' said Mr Whalley, 'but we could measure it, and we knew the benefit it had, what the cost was, and where the benefit sat. That really helped the conversation when we looked at scaling it up. We knew what the business case was behind it and still had to navigate all sorts of difficult conversations.

'In this case, it involved £2m funding in the community trust to save £10m in the local authority. But because that transparency was there, because that had been proved and iterated with those partners, that was a conversation that was able to happen.'

Helen Gardiner, the London Borough of Camden's head of finance for people services, put the case for including prevention – in all its forms – in ICS work. Some parts of Camden Council have invested heavily in this, particularly for younger children, she said.

'This has reduced some of the costs in our statutory children's services, but it has also let us absorb demand. So, although we've not taken savings out, we have managed some of the demand. Growth in that area now is very much in unaccompanied asylum seekers that are well outside our control.

'There's something about being clear with business cases that what you're trying to do is stem the problem as opposed to delivering cashable savings. I tend to use the phrase "invest to manage" rather than "invest to save"'.

Prevention in adult services often falls outside social care, she added. For example, improving housing conditions can prevent people ending up in the health system, or investing in the voluntary sector can create

> **"I tend to use the phrase 'invest to manage' rather 'than invest to save' "**
> **Helen Gardiner, Camden Council**

or maintain strong community support for local residents. 'One of the challenges of looking at health and care is that they are the most expensive parts of the system, and actually a lot of prevention can be somewhere else in the council.'

Roundtable chair Claire Yarwood, Manchester Health and Care Commissioning chief finance officer, added: 'That's a really important point on why we need a financial framework that covers local government and health together, and not just social care and health, which is where some of us have definitely started. The development of the integrated care partnership and the integrated care system is about all those wider determinants of health, so that financial framework has to cover everything, and I'm not sure we've all got to that place yet.'

Manchester had used some of the transformation funding received as part of its devolution deal to set up projects on prevention. Despite close monitoring and the achievement of some milestones, it has proved difficult to make cash-releasing savings and therefore fund recurrently. However, actions now will save costs in the future by reducing long-term activity growth.

Framework concerns

While not disagreeing a financial framework could cover all local government and health activities, Julian Miller wondered how they could marry up, particularly with health performance managed on finance by NHS England and NHS Improvement.

'Balancing it up is quite hard, and it's not just the local authority, there's also primary care. You know it drives a lot of cost in the system, but it's not necessarily roped into what NHS England and NHS Improvement are measuring.'

He added that a 'sensible multi-year settlement' would help systems make better decisions about prevention.

Newton's Mr Whalley said the key to prevention was measurement, and opportunities were emerging to do so via population health management-style tools. It was early days, but such tools can identify where similar populations live, and whether there are differences in need – for residential care, say – which can then be investigated. If services are funded as a result of such an analysis, the impact can be measured using the same tools.

Participants discussed how health and local government learn from each other. Mr Whiteman said there was a feeling in local government that its improvement structure had to be revisited, though regional and professional groups, including finance directors, regularly share best practice.

Ms Gardiner said social care peer reviews were 'incredibly helpful', but she was less convinced about benchmarking based on statutory returns alone as this was a very crude way of looking at complex systems.

There are strong networks in health, Mr Miller said, particularly in finance with the HFMA. But with integration developing, perhaps new networks of health and local government partners should be created.

Ms Roe suggested health and local authorities could engage on capital, given the need for health and local authority access to capital within the prudential rules. But Mr Whiteman warned that if councils spent capital on health, it would count against the health capital expenditure limit (CDEL).

'We need local authority borrowing on health to be outside CDEL, which would give us a huge opportunity to join up,' he said.

The roundtable agreed that while trust between partners is vital, it will not happen overnight because of regulatory requirements and a generation of NHS managers and board members rooted in competition. However, organisational development, clear financial frameworks and governance, and practical action together will play a part in supporting implementation of this huge agenda.