The HFMA's response to the Health and Social Care Committee's inquiry into the white paper on health and social care

March 2021

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.

Summary

This submission is based on the views of our members and draws on HFMA publications and research. The HFMA broadly welcomes *Integration and innovation: working together to improve health and social care for all* (the white paper). Our key points are:

- The two-tier approach to ICS governance risks adding complexity and bureaucracy to the system and does not address the conflict between system and organisational statutory duties.
- It is essential that financial allocations to ICSs are fair and transparent, with flexibility to meet local priorities.
- Integration is important to improving care, but it must be supported by sufficient funding to recognise the ongoing impact of the Covid-19 pandemic across the health and care system.

- The continued underfunding of social care means that true system working cannot be achieved for the benefit of those who rely on the health and care system.
- Data sharing is vital for effective system working and the data sharing strategy should be accelerated to provide benefit for patients in advance of any structural changes.
- While many systems are already working in an integrated way, implementation timescales must take account of the volume of work required to close down and set up new organisations, while supporting frontline services to address the care backlog that built up during the pandemic.
- The need for longer term capital allocations continues to be an issue for the NHS and the additional reserve power does not address this underlying problem.
- Changes to procurement and competition rules are welcome but the larger ICS footprint means that it is essential to maintain local relationships to support place-based services.
- Procurement and competition rule changes must be applied equally to all ICS partners to allow joint commissioning of services, and existing regulatory structures such as section 75 of the NHS Act 2006 must be reviewed to enable this.

General comments

Integrated care has been an essential part of the response to Covid-19 and the health and care system has demonstrated how well it can work together when traditional barriers are removed. The HFMA welcomes the move to establish integrated care systems (ICSs) as statutory organisations, addressing many of the issues raised by our members as they try to retain the benefits of the Covid-19 response. However, we are concerned that the proposed changes appear NHS centric and risk alienating local authority colleagues and other bodies in the development of an integrated approach to population health management.

Integrated care does not happen at board level, although a joined-up approach at the top of organisations can set the tone. Integrated care happens around the patient and at service level. At its best, it delivers a patient experience that is not hindered by where budgets are held or who has organisational responsibility. For the patient, integrated care means getting the support that they need to live the life that they want to, regardless of who is delivering that care.

The white paper sets out a legislative structure that begins to support a more widespread approach to integrated care, removing unnecessary barriers and obstacles to working together. But integration is so much more than structures; as is often said, working in the same room does not mean that the service is integrated. It is about culture and an intention to provide the seamless care that true integration can provide. It will be important to assess that integrated care is being delivered and that the proposals in the white paper deliver more than just a name change.

While integration starts at the patient, it is supported by the structure above. The white paper sets out the framework for ICSs to recognise the importance of place for delivering population health and decision making. For this to be effective, central bodies must acknowledge the need for flexibility and a local focus, within the national policy framework. There is a danger that some of the proposed legislative changes will create an environment of centralised control which goes against the intent of a place-based approach.

This white paper is the start, but it must be recognised that there is much more work to do, both nationally and locally, to fully realise the intentions of ICSs and the benefits for the whole population.

Detailed comments

Establishing integrated care systems in law

System governance

Many of the challenges that are currently faced by organisations as they try to work as systems, stem from the lack of formal accountability and legal framework. As we set out in our response[1] to NHS England and NHS Improvement's recent consultation, the establishment of a single body with authority to lead the system would enable clear and transparent accountability.

The white paper sets out a two-tier approach with an ICS NHS body taking on the overall system leadership function, supported by an ICS health and care partnership comprised of providers from across health and care. This approach feels very NHS centric, and it is essential that the governance of these arrangements is clearly defined to ensure that this complex ICS structure does not inadvertently create multiple layers of administrative decision making, nor create dominant organisations within the ICS. Clarity is required around how the dual ICS structure will interact with existing health and wellbeing boards, recognising that these can differ across the country.

Members have reported that the sovereignty of organisations can sometimes limit discussions around system working, but the white paper does not address this.

The roles of non-executive directors and foundation trust governors need to be explicitly defined for the ICS and for their constituent organisations. The clinical and local authority voices that support the individual bodies have been key features in the development of more mature systems, and these must not be lost in a structural reorganisation that seeks to develop a greater level of integrated working. For the ICS itself, the partnerships formed through informal system working with partners across the voluntary, community and social enterprise sector as well as wider public services also need to be maintained.

There is a concern that establishing the system leadership role as an explicit NHS body will damage existing relationships and reduce the involvement of local authority and other partners in population health management and planning. For mature systems, this may undo some of the work already undertaken to develop collaboration and integration. While some standardisation of process is desirable for equity and efficiency, flexibility on how the these are applied is needed within the legislation to allow for the different sizes and maturity of systems.

The white paper sets out the importance of place in addressing health and care needs, recognising that successful integration of services is often most effective at a local level. We support this focus on place as the building block for an effective ICS. It is vital that the numerous areas for additional guidance arising from the white paper maintain this locally determined, place-based focus and do not inadvertently create a centralised control structure.

Financial allocations

In our response to the integrating care consultation, we also highlighted the importance of transparency in financial allocations to ICSs and this is an area of particular concern for our members. It will be essential to understand the basis upon which financial resources are allocated in order to ensure that ICSs take ownership and responsibility for financial performance. The changes brought about by the *Health and Social Care Act 2012* left local legacies of unclear budget distribution which compromised commissioners' abilities to support service transformation until financial responsibility to deliver particular services was established. This must not happen again.

[1] HFMA, *The HFMA's response to Integrating care: next steps to building strong and effective integrated care systems across England,* January 2021

The devolution of specialised commissioning and primary care budgets to ICSs will add a level of complexity to the financial allocations. Transparency of the allocation process will be vital to ensure a smooth transition with no impact on patient care.

Allocating resources to a larger ICS footprint will mean that there is more local control on how that funding is used. While this gives greater autonomy and flexibility to ICSs to meet the needs of their population, it is paramount that there is also local transparency in the allocation of funding. Guidance is necessary to ensure that any move away from national formula allocations, is based on a clear rationale and evidence base. It is recognised that local variation may be required, and ICSs have the opportunity to review place-based funding. However complex national formulae have been used for many years to recognise the numerous drivers of health expenditure and due regard must be given to this knowledge base when allocating local resources.

However, this autonomy will only be possible if funding flows are not restricted for use on specific policy areas only. Financial flows can support policy areas and ring-fenced funding can be useful to address areas of national concern as the restrictions remove arguments on how the funding should be used. However, if too much of the funding is restricted, the benefits of local joint working will not be realised.

Restrictions around funding can also be imposed inadvertently through the short-term nature of funding allocations. In order for ICSs to plan effectively to meet the needs of their populations, certainty of funding is required over a longer term. Financial constraints in recent times have seen larger amounts of funding allocated on an annual basis, driving a short-term outlook. This limits investment in service development and, again, will have an adverse impact on the potential benefits of joint working.

Financial flows

The Covid-19 pandemic has clearly illustrated the impact that financial flows can have on system working. NHS England and NHS Improvement is working to develop a new way of moving money around the NHS to support system working and recognise whole pathways rather than individual units of activity. The HFMA supported[2] the proposed changes to the national tariff in the annual engagement exercise, again highlighting the need for transparency in any payment system. We welcomed the increased focus on pathway costs and the potential reduction in transactional process, freeing up both staff time and resource to support wider system work. The white paper proposals to enable greater flexibility for the national tariff are therefore supported.

Financial control

The white paper sets out a duty for ICSs to meet system financial objectives and deliver financial balance. It does not address the current dichotomy of meeting both system and organisational financial duties. In fact, the white paper explicitly states that the statutory financial duties of trusts will remain, along with their current structures and governance. While this offers some certainty to the provider sector and gives a stability for the delivery of healthcare, it maintains one of the contradictions in delivering an effective system. While the ICS will promote and support system wide working, the personal and organisational statutory responsibilities of executive and non-executive directors will continue to require an inward focus within organisational boundaries.

The proposed legislation sets out a duty for ICSs to deliver financial balance, which includes the financial position of providers within that ICS. However, providers are only required to 'have regard to' system financial objectives. The white paper encourages integration but recognises that legislation can only go so far, with local relationships being essential. This approach does not set out sufficiently

[2] HFMA, *The HFMA's response to the NHS England and NHS Improvement 2021/22 tariff engagement survey*, November 2020

robust requirements to ensure integrated working in less mature systems, where relationships may not be as well developed or positive.

It is essential that clear processes, and potentially statutory mechanisms, are established to support the movement of funds within an ICS to ensure that any transfers of cash or funding between constituent organisations are transparent, with an unambiguous and robust audit trail.

Data sharing

We welcome the recognition of the importance of sharing data across a system to design and deliver effective health and care services. In our briefing on the future financial regime in England[3] we highlighted that the response to Covid-19 had been supported by the acceleration of existing plans to share information across organisations, allowing data to be shared to identify vulnerable people and for patient care. However, the legal basis for this sharing of data only relates to information that is shared with the purpose of tackling Covid-19 and was a temporary measure under the Health Service (Control of Patient Information) Regulations 2002.

The joint working that this has allowed, and the co-ordinated support that it has enabled for vulnerable people, should be continued. The white paper alludes to future work in this area, and this should be progressed as a matter of urgency. While the ability to share data will support ICSs, it will have an immediate beneficial effect for patient care and can have an impact prior to any structural reorganisation.

Implications for workforce

The delivery of good integrated care requires cultural change. The white paper sets out changes to competition and procurement rules but operating in a new way requires different relationships and a belief that collaborative working will ultimately benefit the health and wellbeing of the community and the success of the organisations. Without cultural change, ICSs will be a tick box exercise that deliver integrated care on paper, but not in practice. Cultural change takes time and will continue to require focus for some time after the structural reorganisation has taken effect.

The proposed changes come at a time when the NHS workforce is tired. The pandemic has affected staff at all levels and in all roles across an organisation. The impact of these changes on staff must be carefully managed, recognising the potential damage that could be caused to staff morale at a time of particular fragility. For those whose roles are changing, in local commissioning organisations, commissioning support units and within NHS England and NHS Improvement, practical support is needed to provide training and mentorship in order to manage the transition.

The white paper sets out a new way of working but it does not address the ongoing shortages of staff in many areas of healthcare delivery. It is imperative that these shortages are addressed in order to deliver healthcare within any NHS structure but especially as the government designs the NHS of the future.

Timescale for implementation

The timescales for change must be considered in the context that the NHS is currently operating in.

While there is much support to make the changes, this represents a significant reorganisation of the NHS with a large reduction in the number of organisations. The process of closing down organisations and establishing new ones, is lengthy. Bringing together a number of organisations into one requires due diligence processes to be carried out, financial ledgers to be closed and set up, all business processes to be unified and a considerable investment of time and support for the impact of organisational change on staff. If this process also requires the redrafting of ICS boundaries, then it is possible that public consultation maybe needed which will further shorten the time available to effect the change. Add to this the ongoing demands of addressing the pandemic related backlog of care,

[3] HFMA, *The future NHS financial regime in England: recommendations*, December 2020

the changes in the financial regime that are yet to be unwound and the delays to normal planning processes which are already expected to impact on 2022/23 and the challenge facing those effecting this transformation is immense.

The pandemic has pushed NHS staff across all professions to work at an intensity that was previously unimaginable. The response to Covid-19 has not just affected frontline staff. This transformation to NHS structures will place further significant demands on executive and senior staff, finance and governance teams, and many back-office functions at a time when the service needs operational support to recover the delivery of healthcare.

We believe that there is a willingness to make these changes and that the result will ultimately be a better, more collaborative, NHS. But it must be recognised that support and time will be needed to implement the new structure effectively.

Capital spending limits

The white paper sets out the intention to establish a reserve power over foundation trusts' capital spending limit, to be used where systems cannot work effectively to prioritise capital expenditure. But this does not address the underlying problems in the NHS capital system which are the short-term nature of capital budgets and the inability to roll budgets forward for complex, multi-year projects. It is this that leads to inefficient capital allocation, not rogue trusts spending at will. Our 2018 report *NHS capital – a system in distress?*[4] sets out many issues that are still relevant in 2021.

Changes to procurement and competition

The proposed changes to the competition and procurement rules are a welcome move towards more collaborative working. Removing the necessity to tender for services will also remove a sometimes burdensome process that does not add value. However, there is a concern that the lack of competition could reduce choice for patients, as the number of potential providers of services could reduce without the ability to gain income through winning a tender. Care must be taken to avoid the return of monopolies of healthcare provision.

The establishment of larger ICSs may threaten some of the local relationships between the NHS and small voluntary sector organisations. It is essential that these relationships are nurtured and maintained to support the local population. The white paper states that voluntary and independent sector providers will continue to play an important role. NHS ICS bodies must ensure that they engage well with their local voluntary, community, and social enterprise sector to give them the opportunity to provide appropriate NHS funded services, outside of formal tender processes.

The white paper sets out the intention to remove the current procurement rules which apply to the NHS and public health commissioners. However, the intention to move to greater system working through statutory ICSs means that all parties within the system should be bound by the same procurement rules. If local authorities continue to have to tender for some services, then it will be difficult to jointly commission as a system or will negate the benefits of removing the rules from the NHS.

The current differences in VAT regimes between the NHS and local authorities add complexity not only when jointly commissioning but also when sharing staff across the system. In November 2020, the HFMA responded[5] to the review of VAT refund rules supporting the proposed simplification of the system. However, it is unlikely that the VAT reforms will be enacted before these proposals so these complexities will continue to take up time and resource to ensure that arrangements are compliant with the current VAT regime.

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[4] HFMA, *NHS capital – a system in distress?* November 2018
[5] HFMA, *The HFMA's response to the VAT and the public sector: reform to VAT refund rules,* November 2020

In addition, the legislation that allows NHS bodies and local authorities to work together and pool budgets (s75 of the NHS Act 2006) has some key limitations[6], such as a restriction on the services that can be pooled and a limited role for the providers of healthcare, that constrain many aspects of health and care integration. These regulatory limitations all need to be addressed if full benefit is to be achieved from changing procurement and competition rules.

Social care

The move to define the role of adult social care more clearly within the structure of the ICS NHS board is welcomed. However, the white paper does not address any of the issues that will allow adult social care to play a full and active role in the ICS. It is essential that social care funding is reviewed so that the full health and care system can operate efficiently and effectively. Covid-19 demonstrated how fundamental social care is to the effective delivery of care and the beneficial impact that it can have on demand for NHS services; the non-recurrent additional funding during the pandemic enabled delayed transfers of care to be almost eradicated across the country. However, the continued underfunding of social care means that true system working cannot be achieved for the benefit of those who rely on the health and care system.

[6] HFMA, *Pooled budgets and the integration agenda,* November 2016