NHS Providers

Briefing

9 May 2019

WHAT THE LONG TERM PLAN MEANS FOR SYSTEM WORKING

The long term plan, published in January 2019, set out ambitions for ensuring the NHS is sustainable and efficient, with the consolidation of system working at its core.

This briefing is a part of a series of updates from NHS Providers on the progress of sustainable transformation partnerships (STPs) and integrated care systems (ICSs), and the implementation of the long term plan.

We hope this will support trust board directors, their line reports and foundation trust governors to make sense of the rapidly evolving national policy direction with regard to system working.

This briefing addresses the commitments set out in the plan and analyses what they mean for providers within a system context under six key themes: the future of system working, legislative change, governance and accountability, regulation, finances and population health and integration.

We hope this briefing will support trust board directors, their line reports and foundation trust governors to make sense of the rapidly evolving national policy direction with regard to system working.

Key points

- As expected, the long term plan consolidates the national policy direction since the *Five year forward view* in placing considerable onus on system working as the key driver of change and improvement in the NHS. The opportunity to support collaboration and develop more integrated services is welcome, and we look forward to working with providers and their partners and the national bodies to make the long term plan a reality.
- However, the plan raises a number of new questions about how this vision can best be implemented and how local systems will be supported to deliver meaningful five-year plans. We hope that the national implementation framework due in spring 2019 will address some of these questions.
- The plan includes a commitment for ICSs to cover the whole country by April 2021. Given that progress in moving to a model of system working will be vastly different from place to place, this deadline is ambitious. If the ICS 'brand' is to remain meaningful, all systems will require tailored support and investment on their journey to developing new, collaborative relationships.
- The long term plan makes clear the expectation that every ICS has a partnership board with a non-executive chair, held to account for system-wide goals and performance measures. These proposals raise unanswered questions about governance and accountability within a system context, where responsibilities and accountabilities remain held at organisational levels.
- Given the key roles that public health and social care play in effective health and care systems, it is unfortunate that the long term plan had to be published in the absence of the green papers expected on these topics. Securing sufficient funding for public health, social care, capital spending and education and training remains fundamental to the successful delivery of the plan.
- The new integrated care provider (ICP) contract would offer one means to successfully integrate primary, community, acute and mental health care while also allowing trusts to influence population health. However, this remains one vehicle among many different partnership options for commissioners, trusts and their partners and it is vital that local areas are not pushed into any one arrangement.
- Integration and population health management is likely to be easier to achieve in areas where good relationships already exist but more challenging in areas where this is not the case.
- While the proposals for legislative change included in the plan rightly identify a number of the challenges which local partners are experiencing as they seek to implement system working, in our view, legislative change may not be the most appropriate means to remove these barriers to change.

1 Context

ICSs are the most recent national initiative to deliver joined-up care, preceded on a smaller scale by the vanguard programme announced in the *Five year forward view* and then by accountable care systems (ACSs) and STPs, a development from the original sustainability and transformation plans. Crucially, systems have no statutory basis in their own right and rest on the willingness of their component organisations – trusts, clinical commissioning groups (CCGs), local authorities, primary care and the community and voluntary sector – to work together to plan how to improve health and care.

The *2018/19 planning guidance*[1] suggested that all STPs would become ICSs over time and the long term plan subsequently set out a deadline of April 2021. Although further guidance has yet to be issued, STPs and ICSs are importantly expected to submit five-year operational plans for approval by Autumn 2019.[2]

Forty-four areas of England were originally identified as the geographical footprints for STPs. Following the merger of three STPs in the north east, we now understand there are 42 STPs, 14 of which have already been confirmed as ICSs.

Progress in developing ICSs varies from place to place. Trusts are under pressure from regulators to focus on improving their own performance as well as responding to the challenges of transformation in an extremely tight financial climate. Timescales for developing meaningful system level plans are tight and a key concern. In addition, issues with public and local political engagement and in engaging key partners such as local authorities in system working, persist in many areas.

1 https://www.england.nhs.uk/publication/refreshing-nhs-plans-for-2018-19

2 https://www.england.nhs.uk/operational-planning-and-contracting

2 Thematic analysis

Future of system working

The long term plan confirms system working as the paradigm through which patient centred, integrated care will be delivered. The increased focus on collaboration and the opportunity to develop services is welcome, but the plan raises a number of questions about how this new direction will be implemented. The national implementation framework, setting out the detail of how the vision of the plan will be implemented will hopefully address these questions. We now expect NHS England/Improvement to publish the implementation framework, and an accompanying timetable in May or June 2019.

The plan sets out an aspiration for ICSs to cover the country by April 2021 – an ambitious deadline, particularly for areas that have only recently started working together as a system partnership. These areas have the longest journey ahead of them. Trusts which are facing performance issues will particularly need flexibility from the regulators to balance system responsibilities with requirements to improve organisational finance and performance.

The plan recognises this, helpfully acknowledging that local systems are in different states of readiness and those who are most challenged will need to be supported through a peer support programme with help from colleagues in more developed systems. Flexibility and clear guidance will also be required from the national bodies to support local systems in their transition. It would be helpful to clearly define the role of an ICS, including the criteria that need to be satisfied to achieve ICS status.

Commissioning

The plan also states that commissioning organisations will become streamlined and strategic, with 'typically' one CCG per ICS. This is the first time the end point for CCG consolidation (through mergers, joint workforces and shared accountable officers) has been set out so explicitly in a national policy document. The ongoing consolidation of CCGs creates both challenges and opportunities for providers. NHS Providers welcomes the more strategic role this will allow CCGs to play and the potential for providers to take on some activities previously undertaken by CCGs. However, in some local systems, changes to commissioning structures will mean disruption and the need to quickly build new relationships. Providers will also wish to ensure they have a full seat at the system partnership board, if the partnership board is hosted by the local CCG.

Partnerships with primary care

The plan introduced primary care networks (PCNs), to be set up across the country by 30 June 2019, as a new means for primary care colleagues to organise at scale to cover populations of 30-50,000, and to ensure primary care is represented at the 'partnership board' of any ICS/STP.

We are conscious that many trusts already have successful partnerships in place with primary care which operate in a wide variety of different forms of vertical integration including direct ownership of GP practices, joint ventures and looser partnership structures.

Primary care colleagues in many areas are also organising at scale in different ways, including GP federations (usually covering a larger population than 30-50,000, often in different parts of the country) and existing networks. The development of PCNs will therefore vary across the country, dependent on local relationships and existing arrangements.

Primary care is a fundamental partner in system working so we welcome the move to support primary care colleagues to organise at scale and to engage in debates about system working. Local systems will however need to be allowed considerable flexibility to develop PCNs which support existing relationships. We would strongly urge all partners to engage in open and transparent discussions to support the development of PCNs without destabilising existing services in the short term.

Social care and public health

Although the long term plan helpfully sets out the role of the NHS in supporting a preventative approach, and in delivering a range of early intervention services, the delivery of the plan (and of ICSs) depends on the wider context of health and social care in England. Without the publication of the government's social care and prevention green papers, and clarity about the funding settlements for these key services, uncertainty about delivery and implementation will remain.

Population health and integration

The shift of focus away from hospital care and into the community in the plan represents a significant shift in how the NHS interacts with the population it services. The plan states that commissioners will make shared decisions with providers about population health from 2019, using a number of new tools that aim to better manage health events and reduce hospital admissions. Ultimately, the plan says, providers will be required to contribute to system wide goals on population health. As providers take on greater responsibility for population health management they are likely to need support to build their analytical capacity and capability.

Integration and population health management is likely to be easier to achieve in areas where good relationships already exist, and more challenging in areas where this is not the case. There have already been a number of challenges between local government and existing ICSs, with some council representatives pulling out of ICSs due to issues with process and governance. This could continue to be an issue in areas where functional, collegiate relationships do not exist between the NHS and local government.

The plan's renewed focus on integration and population health depends on a foundation of strong relationships between providers, commissioners, local government, community, primary and secondary care and others. The plan proposes a new 'duty to collaborate' within the proposals for legislative change, as one means to address this, but the role of local government mustn't be underplayed. The relationship between providers and local government to work together to deliver population health strategies that work at system level is critical.

2

Legislative change

The plan sets out the NHS England/Improvement view that current policy direction towards collaboration and integration within local systems can "generally" be achieved within the current statutory framework, but "legislative change would support more rapid progress". The plan included an overview of barriers to collaborative working which NHS England/Improvement would like to address via legislative change. NHS England/Improvement have published an engagement document, *Implementing the NHS long term plan: proposals for possible change to legislation*,[3] setting out their top level proposals for change.

However, when considering any proposal to change existing legislation, the current political environment must also be considered and currently, there are a number of difficulties facing any amendment to NHS legislation. There is the practical issue of Brexit dominating the parliamentary timetable for some time to come. There is the political sensitivity for the Conservative government in bringing forward health legislation after the Lansley reforms. There is also the tension between wishing to avoid further upheaval for the frontline, even while current structures may be presenting unnecessary barriers. The Labour Party has also committed to revoking the 2012 Act which could mean that any piecemeal changes that are made now could be eclipsed by a revocation of the entire act if the Labour Party were to be elected. These factors and others confirm the political landscape against which these proposals will be debated and considered, is complex.

NHS Providers is currently engaging with members and the national bodies to discuss the suggested legislative proposals. The combined effect of the proposals seems to represent a move toward greater collaboration between health and care organisations within local systems, as well as renewed focus on population health management. However, whilst we broadly welcome a number of the proposals, we are concerned that there are two potential negative impacts:

- The proposals do not only enable more effective, rapid, and consistent integration. There is also a danger that they increase the strength of the NHS arm's-length bodies ('the centre') at the expense of the autonomy of local health care delivery organisations. They give the national NHS bodies significantly increased powers of direction without an attendant increase in accountability.
- In some cases, the proposals appear to cut across the central principle and importance of the accountability of trust boards, creating a lack of clarity which adds to the considerable risk present in moving the power to make decisions further away from the point of service delivery. National bodies can never have the appropriate level of information or local knowledge to make decisions at a local level. The principle of subsidiarity is tried, tested and successful, but we are concerned that these proposals would move the NHS in the opposite direction.

Health legislation is complex and often controversial. Where legislative change is the appropriate route, further consideration is needed as to how to avoid unintended

3 https://www.engage.england.nhs.uk/survey/nhs-long-term-plan-legislation

consequences. This will be particularly important since any individual changes on particular issues need to work within the continuing wider legal framework and maintain its clarity and consistency.

You can find a more detailed analysis of each proposal in NHS England/Improvement's engagement document, *Implementing the NHS long term plan: proposals for possible change to legislation*, in our *On the day briefing*.[4]

Governance and accountability

The plan sets out further expectations in regard to the governance arrangements which could underpin system working across England by 2021. The plan states that:

- Every ICS will have:
  - a partnership board (including commissioners, trusts, primary care networks, local authorities, the voluntary and community sector and other partners)
  - a non-executive chair (locally appointed, but subject to approval by NHS England and NHS Improvement) and arrangements for involving non-executive directors.
- All providers within an ICS will be required to contribute to ICS goals and performance, backed up by:
  - potential new licence conditions (subject to consultation) supporting NHS providers to take responsibility, with system partners, for wider objectives in relation to use of NHS resources and population health
  - longer-term NHS contracts with all providers that include clear requirements to collaborate in support of system objectives.
- NHS Improvement will have a new fast-track approach to assessing proposed merger transactions involving trusts that have been accredited as 'group' leaders.
- ICSs will have an opportunity to earn greater authority as they develop and perform.

We welcome a locally-led approach to system change but the proposals in the plan raise questions about governance and accountability. As we set out in the section on legislative change above, the plan does not propose to establish ICSs or other system leadership groupings as statutory bodies. They are not bodies corporate and have no powers to make decisions. Rather, they rely on the delegated authority of each member, or on committees in common to make their own individual decisions. This means that partnership boards, the decision-making board of an ICS, cannot make binding majority decisions and responsibility continues to rest with their component organisations – trusts, CCGs and local authorities.

It is therefore still unclear how ICSs will be held to account, and how they in turn will be expected to hold partners to account, particularly given the proposal within the plan to introduce system-wide goals and performance measures. There is also a lack of clarity on

4 https://nhsproviders.org/resource-library/briefings/briefing-proposals-for-possible-changes-to-legislation

how ICSs and health wellbeing boards (HWBs), especially as providers are not consistently included in HWBs, could work together and this will also vary across the country dependent on local relationships.

While there is flexibility in the current legislation to allow for collaboration between local partners, the move to system working has led to the creation of complex structures. This complexity, with the additional draw on directors' time, brings with it different types of risk for trust boards, and their partners, to manage.

NHS England's move to appoint non-executive chairs to systems is a positive in acknowledging the need for independence and challenge at the system level. However, we are concerned that new system-level, independent chairs will face a series of challenges given their roles lack a statutory underpinning and therefore clear lines of accountability.

NHS Providers would also suggest that an independent chair is not an adequate substitute for a unitary board made up of executive and independent non-executive directors (NEDs). The strength of unitary boards, with NEDs forming a majority, is that they can practice proper corporate governance with strategy implementation and risk management being subject to rigorous challenge from directors with an independent perspective. The implicit, if rarely used, powers of NEDs to exert a veto gives constructive challenge real teeth. All of this means that the existing independence, expertise and challenge exerted by NEDs is missing at system level.

Emerging leadership arrangements at system level still leave trust boards, and other partners, accountable for the decisions they are party to, whether they agree with them or not. This leaves boards liable should things go wrong at system level even though the board itself may not be responsible for any oversight or error.

Regulation and oversight

The changes set out in the plan suggest that the regulatory frameworks will be realigned to support system working, with providers being held accountable to agreed system wide objectives and goals, in addition to existing organisation-level accountabilities. The plan states that:

- NHS England/Improvement will work more closely with other regulatory bodies to set clear and consistent system-wide expectations and commits to keeping assurance and oversight proportionate.
- ICSs will agree system-wide objectives with the relevant NHS England/Improvement regional directors, who have responsibility for oversight of health care in their regions, and be accountable for their performance against these objectives – this will be a combination of national and local priorities for care quality and health outcomes, reductions in inequalities, implementation of integrated care models and improvements in financial and operational performance. ICSs will then have the opportunity to earn greater authority as they develop and perform.

- A new ICS accountability and performance framework will consolidate existing accountability arrangements and will provide a consistent and comparable set of performance measures, including the new 'integration index'.
- Care Quality Commission (CQC) intends to place greater emphasis on system-wide quality in its regulatory activity so that providers are held to account for their activity to improve quality across a local area.

It is logical that the regulatory framework should adapt as systems develop. However, there is a great deal of variability between local areas on their journey to becoming an ICS so there needs to be flexibility in the application of regulation and oversight during this transition.

Oversight at a collective system level is important because the consequence of contributing to a system-level plan may be that some individual organisations are disadvantaged or advantaged. The potential risks and gains need to be shared appropriately across organisations and monitored at a system level. Trusts which are facing performance issues will particularly need flexibility from the regulators to balance system responsibilities with requirements to improve organisational finance and performance.

As ICSs are not statutory bodies, it remains the case that any regulatory intervention or enforcement action can only be taken at individual organisation level. It is crucial that system oversight does not add an extra layer of performance management or burden, and that trusts and their local partners are not subject to multiple judgements or 'double jeopardy'.

It is also crucial that the national bodies and regulators agree a shared view of quality across a system and are aligned and coordinated in how they assess quality and offer support to local areas. There is much that the national bodies can learn from the CQC's programme of local system reviews – for example, some providers have noted that a benefit of the system reviews is the focus on improvement, as opposed to performance management or pleasing the regulator, because the CQC can't take regulatory action against systems. Successful development of collective responsibility will depend in part on the relationships and trust developed between trusts, CCGs and the new regional directors. It is essential that there are clear lines of responsibility, accountability and decision making but this clarity seems unlikely given the transitional nature of current and proposed governance structures and legislation.

Finances

There are a number of proposed changes within the plan that support the transition to integrated care by incentivising system-based working. These include a shift from activity based payments to population based payments and, as part of the move toward system control totals, further reforms will give STPs and ICSs greater control over their resources. There is still a lot of important detail to work through with regard to these policies to strike an appropriate, and workable, balance between provider boards' autonomy and the need to contribute, financially to the sustainability of a broader system. The plan also assumes that system working will deliver savings which may well not be the case.

The plan confirms that five-year indicated funding allocations will be made for commissioners to support local plans to implement system working. This will offer greater financial certainty for STPs and ICSs and help with medium-term planning. However, the capital settlement and workforce strategy will be required before meaningful plans can be made. Further questions also remain over how capital allocations get to where they are most needed, and what relationships are needed between STP/ICS boards and provider boards to ensure effective capital prioritisation and allocation.

The plan says that every ICS will have longer term NHS contracts with all providers that include clear requirements to collaborate in support of system objectives. There will be greater certainty following the award of a long term contract, less time will be lost to the annual contracting round and more collaborative working will therefore be enabled within each ICS. This is based on an assumption that partners will be able to collaborate within an ICS and the ability of a system to forecast accurately and plan adequately for multiple years into the future. The move away from the annual contracting round and associated administrative burdens is welcome, as is the greater certainty a longer-term contract offers. However, it will be important to build flexibility into these contracts to allow systems to adapt if initial plans do not work or forecasts prove to be incorrect.

A new integrated care provider (ICP) contract will be made available from 2019. It is expected that ICP contracts will be held by public statutory providers rather than private providers. This would allow for the integration of primary and secondary care, offering the potential to successfully integrate primary, community, acute and mental health care while also allowing trusts to influence population health for the first time. There is a need here to engage local GPs and build strong relationships with commissioners and other local trusts as necessary. The difficulties presented by the GP contract, procurement laws and partnership working have meant it has taken longer to establish the ICP contract than initially expected. A single long term population health contract has the potential to fundamentally change the role of providers in a local system but it is vital that areas are not pushed into these arrangements before they are ready: getting the relationships right and developing cooperation between partners will enable the ICP contract to succeed – not the other way around.

Finally, the plan suggests the probable conclusion of the Better Care Fund (BCF). The fund is currently being reviewed, with the review to conclude this year in 2019. The National Audit Office has said the BCF is too complex and there is a lack of clarity on the return on investment it gives. The review of the BCF offers an opportunity to review the administrative burden it creates. Over £3bn of the BCF is spent on non-social care services, with the majority going to community care, so the rules governing this fund are very important to trusts. The increasing integration between health and social care must continue, but the BCF is too onerous and built on the flawed premise that taking £1 out of the health budget and spending it on social care will generate £1 of added value for the NHS. There are also concerns over NHS funding being used for core council services. What is most desperately needed is a sustainable solution to social care funding.

3 Unanswered questions

Is the April 2021 deadline for ICSs to cover all of England too ambitious?

Providers will need to understand the criteria (as yet unpublished) for ICS status to understand the true impact of the 2021 deadline.

However, given that progress made to move to a model of system working will be vastly different from place to place, this deadline seems to us to be extremely ambitious. Some of the most advanced ICSs have been working on their transformation for many years and have had considerable time to develop critical relationships and address other issues. Yet in other areas, relationships between key partners do not exist and other issues may influence their ability to progress to an ICS, such as a lack of funding, lack of capital, workforce issues, the need to focus on recovering organisational or financial performance and more. All systems will require tailored support and investment to achieve ICS status by 2021 or beyond. It is vital that this support offer is designed collaboratively with those who it is designed to support.

What is the definition of an ICS and what criteria need to be satisfied for a health care system to progress to becoming an ICS?

The NHS England website begins its definition of ICSs with an introduction to STPs. It suggests that an ICS is a type of 'even closer' collaboration, going on to say that in an ICS "NHS organisations, in partnership with local councils and others, take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve."

This definition is very broad and places emphasis on the relationships within an ICS as a method to execute its mission of improving population health, but doesn't delve any further the legal, financial or regulatory complexities of integration.

In order for these complexities to be addressed, and in order for providers to make further progress, further clarity from NHS England/Improvement is required on the criteria to achieve ICS status by April 2021. These criteria should be co-created with local frontline leaders.

What functions should an ICS adopt?

Broadly, ICSs are a helpful forum for agreeing shared priorities and undertaking population health analysis. ICSs have the potential to share resource more effectively across a patch, so it may be that devolving workforce planning to an ICS could be effective. However, there are some functions that it may be difficult for an ICS to adopt due to conflicts of interest between partners, and in some cases, the geographical footprint of the ICS. The NHS has always operated on a series of footprints best suited to population need and the requirements to deliver services to different population sizes – for example, ambulance trusts

and specialised services cover a number of STPs, whereas primary and community care are often more neighbourhood focused. It should be recognised that ICSs are a meaningful vehicle for collaboration and the provision of integrated, patient centre care and won't always be the correct vehicle to deliver all government or arm's-length body policy initiatives. It is therefore important for national and local NHS leaders to agree what functions should be delivered at each of neighbourhood, place, system, regional and national level.

Should there be an assurance process to assess whether STPs are ready to become ICSs and take more collective responsibility on behalf of the component organisations within their partnership? If so, what should that process comprise?

It is our view that peer review and self assessment should be an important component of the journey to becoming an ICS. This shouldn't be a regulatory process but rather an iterative set of discussions between the STP and all local partners, and colleagues in the national bodies. This process needs collaborative design between national and local leaders.

How should the national bodies' oversight role develop with regard to local systems?

The role of oversight from the national bodies with regard to local systems is still developing. The current legal framework applies to individual organisations, but we understand the direction of travel is to develop oversight mechanisms at a system level. These levels of oversight will need to complement each other, rather than implicate providers within multiple levels of scrutiny. CQC is not calling for powers to inspect and rate systems, but rather supporting systems to deliver on their objectives.

What forms of support should be put in place to support all systems to develop?

All systems will need support to develop into ICSs. This support should include technical analysis, for example, to assist with the analysis of population needs, the building of new infrastructure for the partnership, and crucially, on relationship building. NHS England/ Improvement have outlined their plans to create a development offer to support systems to undertake the required organisational development to deliver the plan, including assessing population health management maturity, creating a national learning network for health and care professionals and delivering an accelerator programme that provides support to a small number of STPs. We welcome this support and emphasise that all systems will require support to develop and that this support will need to be flexibly tailored to meet the needs of individual STPs.

3

How will ICSs work with providers that cross more than one STP/ICS or geographical footprint?

The STP or ICS isn't an appropriate delivery mechanism for all policy initiatives, especially those which may not align with patient flow. Horizontal integration is more likely to take place across one or more STP or ICS footprints, or indeed between trusts in different STP and ICS footprints. In our view, it would be helpful for the national bodies to acknowledge these nuances more clearly.

How can we ensure key partners such as local government and primary care remain engaged in ICSs?

The success of STPs and ICSs will hinge on the ability of local partners including providers, local government and primary care, to work together. Both primary care and local government are central to the delivery of integrated care, but there is tension in some areas about the 'top down' nature of NHS policy and appropriate inclusion in its development. Many systems have adopted a local brand for system working which is more appealing to local partners and the public.

4 Conclusion

The plan offers a positive vision of what the NHS could look like in the future and, in doing so, addresses a number of existing problems within the current system. NHS Providers welcomes this direction of travel, but acknowledges that a vast amount of work is needed before the benefits of such a vision will be consistently realised.

In our view, ICSs play a helpful role as a forum for local partners to agree shared vision and priorities, and to discuss how to make best use of their collective resource for patient benefit. However, the role of an ICS should not automatically become the default mechanism to deliver national policy initiatives.

The April 2021 deadline is ambitious for providers to transition to ICS status, especially in challenged areas where functional and collegiate relationships do not exist and are perhaps hampered by a culture of competition or long-standing historic differences. NHS England/Improvement have outlined their plans to create a development offer to support systems to undertake the required organisational development to deliver the plan, which we welcome. It is vital this is developed collaboratively between national and local leaders.

The question of governance and a lack of statutory framework that would underpin the vision outlined in the long term plan remains unanswered. The proposed legislative changes go some way to support more effective, rapid and consistent integration, but there is a danger they reduce local autonomy, and cut across the central principle and importance of accountability of unitary trust boards.

For the aspirations outlined in the long term plan to be realised, it is essential that providers, and their partners are fully engaged in co creating emerging guidance and frameworks – and that the upcoming implementation guidance address some of these questions, providing a supportive atmosphere for providers to progress this work and supporting a constructive central/local partnership between the frontline and the national bodies. NHS Providers looks forward to working with NHS England/Improvement colleagues to support this approach.

Your feedback on this briefing and the development of our wider offer is very welcome – to share your learning so far or offer feedback on our approach, please contact kacey.cogle@nhsproviders.org

For more information:
www.nhsproviders.org/what-the-ltp-means-for-system-working

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