Good Governance Institute

NHS England and NHS Improvement

Response to consultation from the Good Governance Institute on

'Integrating Care: Next steps to building strong and effective integrated care systems across England'

NHS England and Improvement

December 2020

Introducing the Good Governance Institute and our work

The Good Governance Institute (GGI) exists to help create a fairer, better world. Our part in this is to support those who run the organisations that will affect how humanity uses resources, cares for the sick, educates future generations, develops our professionals, creates wealth, nurtures sporting excellence, inspires through the arts – in short, all aspects of being human.

We work to make sure that organisations are run by the most talented, skilled and ethical leaders possible and work to create fair systems that consider all, use evidence, are guided by ethics and thereby take the best decisions. Good governance of all organisations, from the smallest charity to the greatest public institution, benefits society as a whole. It enables organisations to play their part in building a sustainable, better future for all.

We are an independent organisation founded in 2009 and headquartered in London, funded from taking on paid consultancy assignments, but whose main purpose is to ensure that, as a force for the good, governance is able to have impact and achieve meaningful outcomes in our public services, these being:

- Ethical culture
- Higher performance and adding value
- Effective control
- Legitimacy

We promote governance not as an end in itself, but as a platform for change, improvement and better outcomes.

The main sectors where we work are the public and third sectors, and the majority of our work is in healthcare and higher education.

Our systems work

GGI has engaged with almost all of the Integrated Care Systems (ICSs) across the country, many through direct programmes of work. We have a strong track record in assisting ICSs at different levels of development including strategic commissioning, outcomes frameworks, provider alliances and developing models of shared decision taking.

In addition to our direct client work, we host numerous regular events (seminars, workshops and peer-to-peer symposia) focused on the NHS. Our weekly NHS Non-Executive Director peer-to-peer webinar has had over 1,200 separate NHS NEDs attending from across the country. Since March 2020 this has amounted to 42 webinars with 101 presenters. Each week we also co-host with the NHS Confederation a similar webinar but exclusively for the Chairs of NHS mental health trusts. In collaboration with the University of Chester we host the North West NHS Chairs Network.

GGI also holds a range of system-specific events, most notably our 2020 six-part Integrated Care System webinar series, which received in excess of 300 participants. A similar series will run February to March 2021. We also host the annual Festival of Governance.

GGI's contact with ICSs is extensive. We are currently developing a White Paper on ICSs and care homes with Care England for which we have spoken to a third of the ICS Chairs across the UK. This research has complemented our wider NHS outreach and events that has seen us engage with almost all ICSs in one way or another.

Our client and knowledge management work has generated significant original content on ICSs, developing thinking on concepts such as Place, strategic commissioning, ICS governance and transitory board arrangements in anticipation of statutory boards probably becoming the direction of travel.

Given our wide-ranging contact with the nation's ICSs we feel in a strong position respond to this consultation. We and the majority of those with whom we work are positive about how these changes are being made. Integrated Care Systems are undoubtedly the way to go. Our work is under the Chatham House Rule and so we are at liberty to share the thinking and concerns, but not to attribute remarks to individuals. We feel this candid range of views we can present will be helpful to NHSEI as you develop your thinking and plans for implementation of what is, undoubtedly, the right policy for our NHS and the care sector

Additionally, in 2019, GGI set up the *National Commission on the Future of Governance for the Public Sector*. The National Commission has held a number of summits and round tables bringing together public sector leaders from across the country and from across a number of sectors. Recently, the National Commission convened a roundtable on 'Place', bringing together experts from policy, health, local government and the arts to discuss how system working can best utilise the know-how of all local actors. Across our work and events, we have been fortunate to collate the views of many on how they see the overall new NHS system developing and assess what have been and what will be the major obstacles to the successful development of systems and systems working.

Summary of our remarks on systems development from our work:

1. There is a varied response and degree of optimism to the NHS E/I paper

2. Most feel more power and accountability should be devolved from NHSEI to ICSs (the governance principle of subsidiarity)

3. ICS working cannot just be seen as driven by the NHS and the critical role of local government and the voluntary sector should be acknowledged and reflected as ICSs develop

4. More consideration needs to be given to the role of care homes and domiciliary services to ensure that a significant opportunity is not missed

5. Increased importance should be given to the concept 'place'. This is where real change is possible in terms of population health and more appropriate balancing of the health and social care value chain

6. The focus on place (shaped on first tier local authority boundaries) is welcomed, as is the intention for them to become the engine room for collaboration and integration at a local level.

7. The development of Provider Collaboratives are also strongly supported

8. Partnership and systems working necessitates a mind-set shift amongst some providers. There is good evidence of this shift in many places but less so in others

9. Systems will benefit from independent chair and non-executive oversight

GGI's views in more detail:

1) Variation in initial response to NHS paper:

We have seen a variation in how individuals and organisations have reacted to the paper and the two main options that have been put forward. Whilst the majority are more favourable to option 2, some still prefer option 1. To an extent we believe this is because it is universally believed to be the Centre's preferred option and will prevail. We have already seen some ICSs develop or begin to develop the initial governance frameworks and Terms of Reference for a System board, some (but not all) of which are well developed and comprise sound and competent decision-making structures and governance arrangements. Prior to the new legislation and in the transitionary period, our recommendation to clients is the establishment of a System Board in line with option 1 to which there has been general agreement. This is, to as quickly as possible, enable nascent ICSs to work towards system goals rather than remain a place where individuals stakeholders 'come to do deals'.

2) Systems feel more power should be devolved

We would encourage the centre to be locally permissive, because we have detected a degree of cynicism around an over-centralisation of the power. This negatively impacts the independence of the systems and places and the willingness of stakeholders to invest in them. The governance principle of subsidiarity will be helpful. GGI feel that systems provide the ability to balance risks across wider populations, use funding mechanisms as a tool to drive improvement and develop large-scale clinical, technical and organisational solutions, but 'Place' provides a better locus for engaging citizens, providers, local authorities, the third sector and relevant private sector organisations (e.g. care homes and domiciliary services) around local improvement and population health management. In short, the ICS will work best if it retains only those functions it is uniquely able to perform such as high-level resource distribution, the development of the outcomes framework, reporting to the Centre and overall strategy.

3) Moving beyond the NHS: ICS working cannot just be seen as driven by the NHS

Throughout much of our work, both client and non-client, we have repeatedly heard that the proposed ICSs are simply an NHS construct, with other partners as secondary. This is not helpful and the narrative needs to be established that this is the NHS looking outwards, not just in on itself. It is important to emphasise the idea that this is not the return of Strategic Health Authorities and that local authorities and the third sector are crucial for the successful development of the ICSs. Linked to this, we would recommend emphasising that this is not a 'power grab by the NHS' (we have heard this very phrase used repeatedly) but a collaborative effort. As an example, during one of our National Commission events, one local council leader said that local councils are willing to give up the power for the greater good but other system players, particularly the NHS, were not.

On this theme GGI believes that a significant opportunity will be missed if ICSs are seen as just reconfiguring health and social care services, with just a nod to population health management and a few nice words about the wider determinants of ill-health and inequalities. If the ICS can include local economic regeneration, citizen engagement, empowering individuals to take control of their own wellbeing and the generation of community assets much more will be achieved. If this were felt at local level to be a bona fide reaching out to others and looking to address broader goals for society legitimate and enthusiastic investment of effort will follow. Indeed, it is only through a more holistic vision and using creative solutions that care services will be sustainable.

4) Lack of understanding for care homes and domiciliary services:

As a matter of urgency, the care sector should be included in the thinking for ICS design. The sector is fragile and provides the home for many of our most vulnerable citizens. Domiciliary services enable many to maintain independent lives in their own homes. Our research towards a paper we are publishing in February shows a significant gap in understanding about this critical sector by ICS planners, and indeed the precarious financial

balancing act for keeping the sector viable. Margins are low and recruiting staff is a challenge. The potential for supporting ICS goals by care homes and domiciliary services could, however, be significant. We heard of many imaginative local arrangements to support the sector from individual CCGs and NHS providers, and ways in which care services could support NHS services, but almost no involvement of the sector in design thinking for ICSs. Our paper is available in draft for NHS E/I if that is helpful and we will be publishing the full report next month in collaboration with Care England.

5) Increased importance should be given to ICPs and 'Place'

We believe that the greatest opportunity to make ICSs most effective will be to support 'Place' and ICPs to plan and deliver care as close to the patient as possible. Whilst some decisions such as workforce or financial control totals will need to be taken at system level, there is a great opportunity for 'Place' to hold a number of decision-making abilities. Each 'Place' will have their own issues and what may be appropriate in one ICP may not be relevant in another and so some decisions should be taken independently to each ICP.

6) Composition of 'Place'

Moreover, we feel that although the paper's emphasis on population health is correct and essential to the success of ICSs, this would be best executed at ICP level, rather than ICS. Indeed, the location of ICPs was another aspect of the paper that we, and many of the systems we spoke to, felt would be best mapped around local authorities, rather than the footprints of acute trusts. A local authority spread would serve to better emphasise that systems are not merely about the NHS, or a reintroduction of old-style commissioning, rather that they are about cross-sector, *local* collaboration to achieve positive outcomes in the public health and a meaningful attack on the factors that cause ill-health and inequality. Using the local authority as a locus, or hub for this would serve to underline this point.

Also, and importantly, when CCGs are defenestrated of their GP memberships it is through PCNs operating at 'Place' level that the enthusiasm and input of primary care will make the most effect. GPs, we are sure, will need to feel that their input into planning and developing local service improvements counts and ICPs must have real 'bite'. GPs need to know that their contribution does not turn out to be bogus. We heard of concerns that ICPs could become all about servicing the local acute trust – almost a reverse syphon of resources out of community and primary care services into patching-up inevitable acute overspends. Local authorities will not be so interested in putting efforts into systems that go beyond their catchments. 'Place' defined around coterminous local authority boundaries, where possible, seems the sensible way forward to GGI. We would add that many of those we work with, however, strongly favour the opposite with the local acute trust being the centre of a vibrant system and the anchor that can quickly develop local services.

7) The development of Provider Collaboratives are also strongly supported

Provider collaborative are an important form of horizontal alignment and integration, without involving the complications of a merger and as such will require individual boards to continue operating. We would imagine over time that this would lead to a manged reduction in the number of NHS organisations, and consequently boards, although these new boards need to learn to operate at a different level. Our experience of large mergers is that board's need to reboot significantly when the size of their enterprise perhaps doubles. GGI is preparin support for provider collaboratives in the spirit of our established commitment to, and work delivering, lean governance.

Without specific thought to the governance implications of provider collaboratives they have all the ingredients of duplication, slower decision-making and loss of board line of sight to risks and service quality. GGI is committed to developing the original thinking that will enable seamless but well-governed working with provider collaboratives.

Got right, provider collaboratives will better, standardised care delivery. We do not see this, if well-managed, as a clash with local choice at 'Place' level. Well-established examples of collaborations between trusts on both back-office and clinical pathway design and delivery can be brought to the development of provider collaboratives over the coming years

8) Partnership working necessitates a mindset shift amongst providers

Even if the route to ICS board membership is through representing individual bodies, it is essential that when taking decisions as a system that these delegates adopt a different mindset. System working will be severely hamstrung if constituent organisations regard it as a vehicle for their interests. Instead, when working at system-level they must consistently recognise that all actions must be in the interests of the collective and outcomes for the population.

Another important mind-shift, and we can see promising interest in this area, is understanding the potential for NHS organisations and local authorities to use the Anchor Organisation status to effect change. Boards need to think of their ability to address issues such as local economic regeneration and developing resilient communities through their spending, employment, citizen engagement and using the asset that is their standing, reputation and ability to influence behaviours. Indeed, the ICS should consider itself the local Anchor Organisation. There is good work going on in this area and ICSs should be at the front of developing thinking and spearheading change.

9) Systems and 'Place' will benefit from independent Chairs and non-executive oversight

Non-executive membership of ICS and ICP boards is, in our view, critical for their success, not least so that proper audit committee functions and conflicts of interest can be managed. ICSs and ICPs will need to operate proper control environments and we strongly counsel that even if ICS boards do not adopt the unitary board model, or have representative routes to board membership, the non-executive presence with the bias towards skills-based appointment is essential.

Chairs and NEDs can and are playing a critical and largely unsung role in getting systems working and reducing parochialism and provider defensiveness.

Success criteria for ICSs

The following are some qualities that we and our clients feel an ICS should have to be successful:

- All parties feel the ICS is 'theirs' and not some new level of external control within the NHS
- The ICS should work to fulfil the ambition of 'Place'
- ICS design should have the realistic prospect of turning the dial on population health by having a mission to address inequalities and the determinants of ill-health. Specifically, this should include local economic regeneration, housing, the development of community-based assets and citizen engagement
- The care value chain must be rebalanced towards care closer to home. This will benefit citizens as both patients and taxpayers
- For services and communities to be sustainable, money needs to be taken out of expensive services and invested in community assets and capacity
- Citizens of the near future will need to use services in a different way, as guardians of their own well-being and responsible users of NHS and local authority services

Governance design principles

Helping ICSs develop transitionary arrangements prior to legislated changes has been insightful in helping to develop design principles for the good governance of systems. We feel the following principles capture the core elements for successful ICS development:

i. Governance, for the purpose of an ICS or an ICP, is the ability to make a legitimate and binding decision on behalf of all organisations that not all individual parties might agree with

ii. Governance exists to facilitate the delivery of our system objectives. The ICS is the NHS, local government and the voluntary and independent sectors working for local citizens and accountable to local people and the 'Centre'
iii. System governance should reduce duplication in decision-making forums that currently is endemic. It should both simplify and hasten decision-taking
iv. The principle of subsidiarity is critical to enabling 'Place' and provider collaborative development
v. It is important to clarify the difference between forums for participation and engagement, and those tasked with taking decisions – governance
vi. The absence of an entirely clear policy landscape should not stop systems from making positive progress with integration
vii. The benefits of an Independent Chair arrangements and non-executive oversight should be designed into ICSs and ICPs
viii. Systems must be about more than NHS and Local Authority realignment

Concluding remarks

GGI congratulates NHS E/I for the move to systems working. This is long overdue and for local NHS organisations trying to be good systems players under legislation intended for a market was distracting and painful. The pandemic has proved that at the operational level so much can be achieved by NHS, local authority and other partners working together and focussed on the same aims.

We encourage NHS E/I to think big. At this moment in our national history broader and more ambitious goals need to be incorporated. We have mentioned local economic regeneration, citizen engagement and developing community assets amongst other necessary aims for public services at this time and ICSs should aspire to make progress on all these fronts as well as the important business of better care services and better outcomes for patients, citizens and taxpayers. The NHS and local authorities should use their Anchor Organisation status and the asset that is their reputation and standing in local communities, amongst other strategies, to achieve this.

In terms of implementing the new policy we believe that NHS E/I's thinking is going in the right direction and has hit an important milestone with regards to ensuring the new structures give power to the System and promote a more collaborative way of working that focuses on improving population health. The legislation route is the simpler and more effective option. However, the model must be about more than just reconfiguring the health sector and integration of social care. To improve population health outcomes, a number of actors and sectors, from education to local government, must work in harmony with a focus on people, their wellbeing, the wider influencing factors to good health and wellbeing, and to address the determinants of poor health.

The existing NHS governance arrangements will require significant change if ICSs, supported by ICPs as the delivery vehicles, are to move healthcare away from a market and towards healthcare outcomes around population health with citizen is at the centre.

GGI's response to the consultation was developed by Rory Corn, Sam Currie, Darren Grayson and Professor Andrew Corbett-Nolan.

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