The Integrator: Big name leaders

By Sharon Brennan

30 January 2020

LINK: ***https://www.hsj.co.uk/expert-briefings/the-integrator-big-name-leaders/7026821.article***

With sustainability and transformation partnerships needing to convert into integrated care systems in the next 15 months, *HSJ* has had another look at how the leadership of these is developing.

There are some overt signs that leadership is bedding in. All but two systems have a chair (37), or are in the process of recruiting one (three). And although a slow shift, leadership of these systems has remained stable in 74 per cent of STPs/ICSs in the last six months.

While this is only a five percentage point increase in the number of systems that had the same leader in place in July 2019, it is a big drop compared to leadership turnover of 70 per cent in the early days of STPs.

But as some of the pieces of governance fall into place, new ones emerge, especially about how integrated care partnerships fit into an ICS.

ICPs are even more nebulous entities than STPs. They are roughly defined as groups of providers working together in a local patch to redesign and deliver vertical pathways.

They are being developed in part to make the footprint of an ICS more manageable. When we surveyed ICSs/STPs we found that 23 of them are now looking to set up a total of 84 ICPs between them. Mostly they seem aligned to 'place' geography, although it is not yet clear if their population sizes will match NHS England's description of 'place' as covering 150,000 to 500,000 people.

To confuse matters, they *not* "integrated care providers" as defined by the formal contract developed by national leaders in recent years. That is proving unpopular as most areas are uninterested in going through the complexities of tendering the contract when they believe a more informal partnership approach will deliver what they are looking for.

Among those I've talked with about these informal ICPs, there seems a general consensus that their development is positive but there is very little direction from the centre as to how they should operate.

One source told me that a real barrier could be who leads them – some are mooting a person employed by a clinical commissioning group who has the commissioning experience.

However, with our recent analysis showing that an accountable officer of a CCG is currently the most popular choice for leading an ICS, that could intensify concerns about whether this new landscape is actually bringing about real change.

One senior leader in an STP/ICS warned that identifying "the CCG with the ICS by having the same leader can be seen as maintaining the provider/commissioner split, when they are meant to break down that split". This would be true twice over, if they also led the ICPs.

Alternatively, I've been told relationships between trusts could be a "barrier" for ICP development if they are to be led by a senior trust leader. It is tough for trusts to overcome the embedded instinct to compete, rather than collaborate, and this would be harder still if a lead provider model is adopted in which one trust takes on the risk and farms out parts of the contract to others.

There is also a growing risk that by encouraging partnerships between statutory organisations it becomes harder to see how to meaningfully involve the voluntary and independent sector - the latter clearly exposing the thorny issue of how to maintain patient choice in a world of agreed partnerships.

One source that has been working closely with these emergent systems also warned that if ICPs are led by trust chief execs, leadership within an ICS will end up very middle-heavy if the strategic commissioners do not attract bigger names to lead them.

However, improving leadership balance within an ICS is where we may see some real change in 2020.

To a degree, the combination of CCG role and STP leader is helping to boost the perception and glamour of the role. One person told me that the recent appointment of Wilf Williams to lead Kent and Medway's merging eight CCGs, and most likely its STP too, suggests these roles are starting to attract bigger names. "He seems well respected and I couldn't imagine him returning from Australia to head up a single CCG," I was told.

The future leaders' programme, now in its third year, is also beginning to produce a different style of provider leader – "They are no longer the big beasts, and more interested in collaboration than looking at their own organisations at any costs", the same source said.

To date most ICPs are in the very earliest stages - there is currently a commitment amongst provider organisations to work together. In the future a move to a clearer form of governance and contract negotiation will be likely, but before then getting the structure, purpose and leadership of ICPs right will be essential to their success.

The Integrator: 'Retrofitting' your five-year system plans

By Sharon Brennan

31 October 2019

Link: https://www.hsj.co.uk/commissioning/the-integrator-retrofitting-your-five-year-system-plans/7026256.article

Next month, integrated care systems, whether in established or nascent form, are expected to put their final five-year system plans before NHS England and Improvement's regional leads. The plans are expected to run from April 2020 to April 2025.

The NHSE long-term plan implementation framework, published in the summer, required these local documents to "align" with 10 principles, which included being developed "in conjunction with local authorities and with consideration of the need to integrate" with relevant council-commissioned services.

I am hearing from various senior people working in ICSs that this is presenting a significant challenge on the ground. One ICS senior manager told me councils were now involved in a "huge amount of day-to-day firefighting" because of their financial pressures. Rather than closer working, this has had the reverse effect of making the local authority "less involved" in ICS plans as it is focused on the immediate challenges ahead.

As a result, the ICS is still struggling to persuade the local council not to automatically tender services without thinking about how this affects the wider system agenda. My source said this is "unhelpful and takes work backwards" as these contracts, such as sexual health screening and school nurses, often cut across services health providers are trying to integrate.

A second issue is tension over issues which tarnished 2016 sustainability and transformation planning — council concerns the NHS is not genuinely engaging and being transparent; and NHS nervousness about sharing too much, including potentially controversial service change plans, with councillors.

Meanwhile, a leader in a different area of England asked how local authorities could develop an ICS when there is "great uncertainty" about any long-term funding solution to support growing demand for social care.

Through the summer and beyond, there have been warnings councils cannot continue to offer the services they do unless the funding crisis is resolved, as various interests seek to encourage the new administration in Whitehall to act. In May, the County Council Network, the umbrella group for county councils, warned local authorities will resort to providing the "bare minimum" of services. Research it had commissioned from PwC found councils faced a £52bn funding black hole over the next six years — roughly the period these system plans are expected to cover.

Meanwhile, the Health Foundation has noted, in the absence of additional funding, the money available for adult social care will rise at an average rate of 1.4 per cent a year in real terms — much lower than the 3.4 per cent a year the government has committed to the NHS and far below rising demand of 3.6 per cent a year. It has also confirmed the NHS is effectively poaching staff from social care providers, as NHS wages are slowly beginning to rise while those in social care stagnate. These disparities are likely to make integration trickier as staffing and funding gaps widen.

One source involved in the local long-term plan process explained that — as is familiar with such exercises — they were seen by many councils as "just an NHS plan that the local areas have to get over the line". The source added: "Unlike the NHS, councils wouldn't just write any number [they cannot realistically achieve] in a plan as we would lose our jobs over that."

With Britain now heading to the polls on 12 December and Brexit delayed — again — until next year, the arrival of firm proposals for social care funding reform seems no closer. Although the Conservative Queen's Speech promised to "bring forward substantive proposals [including] setting out legislative requirements", any detail of these has been glaringly absent.

Meanwhile, a Labour election victory would require a major reworking of the policy, the party having recently promised free personal care to older people (notably not solving the problems working-age disabled people face accessing domestic care).

Without any national direction on the funding available for social care, ICS planners face a conundrum that seems to necessitate a fudging of their local implementation plans. One leader told me: "Things could get fixed to meet [NHSE/I's] timeline nationally and then retrofitted later to fit in social care after [plans are approved]." So expect the final plans to be widely variant on social care integration.

Some areas will have local authorities much more willingly engaged in developing ICS policy, even if they don't yet know what funding they can commit. Others will have councils stepping back from engagement as day-to-day demands overwhelm them.

What is clear is the longer social care funding policy remains unresolved, the harder it will be for systems to continue to drive down delayed discharges of care, let alone try and turnaround rising accident and emergency attendance and emergency admissions by pushing the prevention agenda — for which councils have a lot of the responsibility, and which is so important to the NHS staying within its own financial envelope.

The dearth of system leaders

By Sharon Brennan

28 November 2019

LINK: https://www.hsj.co.uk/integration/the-dearth-of-system-leaders/7026462.article

HSJ has reported on several stories in the last few weeks about top tier sustainability and transformation partnership and integrated care system leaders stepping down.

The biggest of these departures is Jon Rouse from Greater Manchester. On the same day his resignation was announced, so was Louise Patten's, who is leaving her role as joint leader of Buckinghamshire and Oxfordshire CCGs. Though not an STP or ICS leader, she played a big role in the old Bucks ICS and now expanded ICS in the Thames Valley. These were followed this week by the news the Hertfordshire and West Essex STP is seeking its fifth leader in four years.

These stories indicate how hard it is to find, and then retain, good leaders capable of taking on the challenges of bringing together organisations.

A new Nick Timmins King's Fund report finds that, while there is a concerted push to get the whole of England to meet the national April 2021 deadline to become an ICS, there has been less focus on what happens beyond that date.

Mr Timmins talked to 16 STP/ICS leaders and found that, while heading up these systems is a challenge that experienced leaders are prepared to step up to, there is little consistent planning to develop a pipeline of new leaders to replace those who will inevitably choose to retire or move on at some point.

His work showed that — as *The Integrator* has previously observed — many of the current system leadership roles are currently taken by people at the end of their careers, who feel they have less to lose in terms of career progression. Combined with that is the concern that people who have only worked within the silos of providers or commissioners, rather than across both, may not have the breadth of experience needed to gain the confidence of an STP/ICS board.

Just as importantly, there is still a dearth of BME leadership at the top levels of STPs/ICS. *HSJ* analysis in the summer revealed just one system chair or executive lead was from a BME background. Owen Williams, Calderdale and Huddersfield Foundation Trust chief executive, said at the King's Fund's annual conference this week: "It's damn right we need to have a conversation about [BME] leaders at ICS level… it does matter." He cited the fact that ethnic minorities consistently have worse health outcomes as just one reason why it's important ICS boards reflect the diversity of the population they serve.

The issue of where these leaders are to come from is exacerbated by the fact ICS roles are not ones which are attracting 40-something aspirant chief executives. As Philippa Slinger, the lead in Devon, puts it: "There's no legal entity, there's no job security, there's not even a clarity of cross-party government policy."

Some of these issues may be eased through the legislation proposed by NHS England and supported by the Conservatives — but if and when this might come into effect is uncertain, as is whether it would really solve the problem.

Some systems, such as Surrey Heartlands and Dorset, are investing in system leadership and development to help generate their own local pipeline, but these two regions are already recognised as exemplary ICS. Where will the more challenged systems find their recruits?

NHS England and NHS Improvement need to start thinking now of what happens past 2021, as they manage their senior leadership talent. Leadership programmes should adapt quickly to ensure those coming through are diverse both in experience and in gender/ethnicity to ensure they can cope with system challenges. When the old guard leaves it is not clear who will be able — let alone willing — to step up.