



Department  
of Health &  
Social Care

# Government response to the recommendations of the Health and Social Care Committee's inquiry into 'Integrated care: organisations, partnerships and systems'

**Seventh report of session 2017-19**

Presented to Parliament by the Secretary of State for Health and Social Care by Command of Her Majesty

August 2018

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# Executive summary

On 11 June 2018, the House of Commons Health and Social Care Committee published its report *Integrated care: organisations, partnerships and systems*. The report included 42 conclusions and recommendations, and responses to each of these are provided here.

The Committee launched this inquiry to examine the development of the new integrated ways of planning and delivering local health and care services which have arisen out of the NHS Five Year Forward View.

As we live longer and more of us develop complex, long term medical conditions, it is increasingly important that NHS services work together with each other and social care to ensure we get the support we need to stay well.

For many years, the health and care system has been grappling with the challenge of how to bring different organisations closer together, and the 2012 Act created a range of duties, on a variety of bodies, to promote integration across health and care. Through initiatives like the Government's Better Care Fund and NHS England's Vanguard programme, there has been a major drive to build stronger partnerships between the different bodies involved in our health and care.

Sustainability and Transformation Partnerships (STPs) – and, in their more mature form, Integrated Care Systems – are ways of promoting collaboration between NHS bodies and local government and local communities across whole systems. They are also vehicles for spreading the integrated care models developed and tested through the vanguard programme.

Integrated care is centred around a person's needs; proactive in supporting wellbeing and identifying risks of health deteriorating; and coordinated so that it feels like it's provided by one service, even if it isn't. It should improve health and wellbeing for the population, enhance the quality of care from providers, and improve financial sustainability. Integrated care also involves a greater focus on population health. This will need the NHS, local authorities and the third sector to work together to enable the development of new models of care that focus on populations and their needs and, prevent ill health and unnecessary hospitalisation.

In some areas, commissioners are looking to strengthen integration by bringing together a range of health and care services under a single contract, with the provider of those services becoming an 'Integrated Care Provider' (or 'ICP' – previously referred to as an 'accountable care organisation') that is responsible for both quality of care and health outcomes for a defined population. We have changed our terminology in recognition that, as reported by the House of Commons Health and Social Care Committee, use of the term 'accountable care' has generated unwarranted misunderstanding about what is being proposed. We believe that the term 'Integrated Care Provider' better describes our proposals – to promote integrated service provision through a contract to be held by a single lead provider.

To support the NHS to deliver for patients across the country, the Government has announced a new five-year budget settlement for the NHS, which will see funding grow on average by 3.4% each year to 2023/24. This will mean the NHS budget will increase by over £20 billion compared with today. This additional funding will underpin a ten-year plan to guarantee the future of the NHS for the long term.

Ahead of the NHS plan publication in the autumn, we welcome the Committee's timely conclusion that integration is the right direction of travel. However, we agree there is more to do to communicate this in a way that is meaningful for patients, staff and other stakeholders. We expect that the current public consultation on contracting arrangements for integrated care

providers and the engagement process on the NHS long term plan will advance conversations with the public about the changes across the health and care sector.

We also welcome the Committee's recognition that integration will not lead to privatisation nor will it threaten the founding principles of the NHS – which will always remain free at the point of use.

# 1. Priorities for change

The Health and Social Care Committee recommended four priorities for change. The Department's response to each of these is set out below.

## **a) Develop a national transformation strategy backed by secure long-term funding to support local areas to accelerate progress towards more collaborative, place-based and integrated care;**

The Government has announced that the NHS will develop a ten-year plan for the future of the health service, underpinned by a five-year funding offer which will see the NHS budget grow by £20bn a year in real terms by 2023-24

This plan will set out what the NHS needs to do to make sure it continues to deliver world-class care for everyone.

Alongside the funding announcement, the Government set the NHS five key financial tests to ensure the NHS remains on a sustainable footing. The Government expects the NHS, as part of the ten-year plan, to set out clearly what transformation it thinks is necessary to meet these financial tests.

Transformation holds the key to the long-term sustainability of the NHS, and the NHS plan will set out ambitions to deliver collaborative, place-based and integrated care across the country over the next 10 years.

## **b) Commit to a dedicated, ring-fenced transformation fund;**

Dedicated funding has already enabled areas across the NHS, for example the 'vanguard' sites for new models of care, to transform the way care is provided. We expect the NHS long-term plan to set out how the NHS will use the new money announced in the funding plan to deliver this type of transformation across the country. The Government will also consider proposals from the NHS for a multi-year capital plan to support transformation.

## **c) Explain the case for change clearly and persuasively, including why it matters to join up services for the benefit of patients and the public.**

The Government welcomes the Committee's recognition that integrating care is an important goal for the NHS. We also welcome the Committee's conclusion that many of the criticisms made against STPs were wide of the mark.

We recognise the need to explain our approach to integrated care in a clear and compelling way, focusing on tangible benefits as experienced by people who use services. The responses below (at 202-205) set out existing activities and how, as part of the long-term plan, we will communicate information about complex policy change to service users, the public and their elected representatives.

The Government is committed to being open and transparent with the public. It is critical that patients and the public are involved throughout the development, planning and decision making of proposals for service changes and the Government's reconfiguration tests set out clear expectations that any significant service change must be subject to a public consultation at a local level.

**d) Alongside these changes, the Government should facilitate national bodies to work with representatives from across the health and care community, who should lead in bringing forward legislative proposals to overcome the current fragmentation and legal barriers arising out of the Health and Social Care Act 2012. These proposals should be laid before the House in draft and presented to us for pre-legislative scrutiny.**

We accept the Committee's recommendation that any legislative proposals should be led by the health and care community. As the Prime Minister made clear in her speech in June 2018, the Government must learn the lessons of the past and not try to impose change.

Therefore, the Government will consider amending the legislation where the NHS identifies a clear need to do so in order to improve services for patients including where legislation is making it harder for professionals from different parts of the NHS and different local authorities to work together to integrate care.

We remain keen to consider how to build political consensus on the case for reform and funding as part of the development of the NHS long-term plan. We welcome the involvement of Parliamentarians, as well as leaders, professionals and experts from the health and social care sector.



# Government response to conclusions and recommendations

## 2. Integrating care for patients

**12. The Department of Health and Social Care, NHS England and NHS Improvement should clearly define the outcomes the current moves towards integrated care are seeking to achieve for patients, from the patient's perspective, and the criteria they will use to measure whether those objectives have been achieved.**

2017's Next Steps on the NHS Five Year Forward View confirmed sustainability and transformation partnerships (STPs) as a pragmatic mechanism to deliver the outcomes in the Forward View's vision: improving health and wellbeing, transforming quality of care and ensuring sustainable finances.

While recognising that each area will have its own local priorities, it also set out key national priorities that STPs and integrated care systems would help to deliver in 2017-18 and 2018-19. These included: improving access to primary care, strengthening the urgent and emergency care system, and improving mental health and cancer services.

These were reiterated in NHS planning guidance published by NHS England and NHS Improvement in February 2018, along with further detail about the specific leadership role to be played by STPs and integrated care systems in making these improvements. These remain important objectives.

Further objectives and success criteria, including benefits to patients, will be set out in the 10-year plan that the NHS is developing for publication later this year.

### 3. Progress towards more integrated care

**41. More joined-up, coordinated and person-centred care can provide a better experience for patients, particularly those with multiple long-term conditions. However, progress to achieving these benefits has been slow. There is no hard evidence that integrated care, at least in the short term, saves money, since it may help to identify unmet need, although there is emerging evidence from new care models that it may help to reduce the relentless increase in long-term demand for hospital services.**

**42. More integrated care will improve patients' experience of health and care services, particularly for those with long-term conditions. However, the process of integrating care can be complex and time consuming. It is important not to over-extrapolate the benefits or the time and resources required to transition towards more integrated care.**

Across England the Government and Arm's Length Bodies have supported the NHS to move towards integrating more health and care services. This includes introducing the Better Care Fund in 2015, supporting NHS England's New Care Models programme and Integration Pioneers, which have encouraged innovation and tested new ways of working; and through STPs and integrated care systems, which involve a system-wide approach to transforming services.

NHS England's New Care Models programme has tested a range of ways of integrating care, including a 'multispecialty community provider' model that brings together general practice, community health, mental health, social care and public health services and a 'primary and acute care systems' model that also encompasses acute hospital services.

There is evidence that the new care models tested by vanguards have helped to improve services. The 'multispecialty community provider' and the 'primary and acute care systems' vanguards have already started to moderate growth in demand for acute services in their area. These vanguards have seen lower growth in per capita emergency admissions to hospitals than the rest of England. Indeed, some of the vanguard sites have reported absolute reductions in emergency admissions per capita.

A recent NAO report on the Vanguard programme also reported that most vanguards have helped to improve access to services or patients' experience. For example, Tower Hamlets reported that its community renal service e-clinic had helped to reduce the average wait for an appointment from 64 to five days. Connecting Care Wakefield reported that patient satisfaction with services has been improving for three years. Several vanguards have also found that their models have helped to improve staff morale by empowering and engaging staff through the new models of care. In addition, NHS England estimates that the 36 vanguards will achieve savings by 2020-21 of £2 for every £1 invested.

There are a number of similar examples of positive impact from STPs and integrated care systems. In Frimley improved access to GPs, the ability to provide more effective services in the community and to support people in their own homes, mental health services that are more accessible and oriented around people's needs, and changes in A&E that enable more patients to be treated and return home instead of admitted to hospital, mean that Frimley Health has seen falling demand for hospital care, with flat A&E attendances, and falling emergency admissions and GP referrals.

Furthermore, a 2014 meta-review of integration found beneficial effects of integration of care on several outcomes, including reduced mortality, reduced hospital admissions and re-admissions, improved adherence to treatment guidelines and better quality of life.

However, we know from international and domestic examples of integration of health and care services, that it usually takes three to five years for these programmes to fully realise their potential to improve care quality and free up resources.

Integrated care also involves a greater focus on public health, and especially population health and population health management. By its nature this will need the NHS, local authorities and the third sector to work systematically closer to enable the development of new models of care that focus on population needs with the aim of preventing illness and unnecessary hospitalisation.

**43. The Government should confirm whether it is able to meet the current target to achieve integrated health and care across the country by 2020, as well as plans for 50% of the country to be covered by new care models. These targets should be supplemented by more detailed commitments about the level of integrated care patients will experience as a result.**

Integration of health and social care is a process rather than an event. The 2020 ambition has helped to galvanize more progress on joining up health and social care.

This has been supported by the Better Care Fund, providing a mechanism for local authorities and clinical commissioning groups to pool budgets. It has helped to join up health and care services so people can manage their own health and wellbeing, and live independently in their communities for as long as possible.

The Government has already taken significant action to help reduce delayed transfers of care, including providing an additional £2 billion of funding for social care, setting expectations locally for reductions in DToC and asking the Care Quality Commission to undertake a series of local system reviews to evaluate the boundary between health and social care's functionality, the findings of which have recently been published. Since February last year, more than 1,600 beds per day have been freed up nationally by reducing NHS and social care delays. We recognize there is more to do on this and it will be a focus of NHS long-term plan and the Social Care Green Paper. As part of the NHS plan we will review the current functioning and structure of the Better Care Fund to make sure it supports integrated health and care even more.

The Department of Health and Social Care has commissioned the Social Care Institute for Excellence (SCIE) to conduct research on how progress on integration could best be measured, monitored, and shared. As part of this work, SCIE has developed an overarching framework for integration by building a logic model based on research, case study work, interviews with experts and stakeholder engagement. The logic model visually depicts how a fully integrated health and care system might be structured, how it should function, and the outcomes and benefits it should deliver for those who use services and their carers. It includes key components for integrated care, outcomes for people, service providers and the wider system and desired impacts. The model has been positively received by stakeholders as a useful tool for implementing integration.

Any changes to the model of care for patients needs to be locally-led, informed by knowledge of population need, and clinically supported on ground. It should be up to clinicians and NHS leaders in local areas, who know their populations best, to decide how to meet the needs of those populations. So deciding how new models for care will be implemented across the

country should not be mandated from the centre. Therefore, we expect the spread of these new models to be delivered through STPs and integrated care systems.

**44. We support the move towards integrated, collaborative, place-based care. To help deliver more integrated care for patients we advocate the cultivation of diverse local health and economies, comprised of mostly public, but also some non-statutory provision, in which the organising principle is centred on collaboration and quality rather than financial competition. We consider that this diversity is important for protecting patient choice and with proper oversight and collaborative working may facilitate, rather than impede, joined-up, patient-centred and co-ordinated care.**

We agree with the Committee's conclusion and welcome the support for a diversity of provision which best fits the needs of local populations.

It is our intention that people who use health and social care services are equal partners when planning, developing, monitoring and implementing their care, to make sure it meets their individual needs. When this approach is taken, we know that individual outcomes can improve and quality of life can be enhanced.

It is important therefore that organisations within local areas work together to provide the best possible range of services for local people that can help facilitate joined-up and patient-centred care.

This approach has already developed through STPs and integrated care systems, which fundamentally involve redesigning services to make it easier for individuals to access health and social care at the right time, in the right place. STPs bring NHS providers, commissioners, local authorities, and other health and care services together to agree how they, at local level, can plan and provide health and care in a more person-centred and coordinated way. STPs and integrated care systems focus on collaboration to improve quality of care and outcomes for local communities, rather than competing for resources.

The Five Year Forward View Next Steps and the NHS Planning Guidance for 2017-2019, jointly published by NHS England and NHS Improvement, has reiterated that the key task for the NHS is to implement the FYFV to drive improvements in health and care; maintain financial balance; and meet core access and quality standards.

This guidance has been built around STPs, so that the commitments and changes coming out of these plans translate fully into system-wide operational plans.

## 4. Sustainability and transformation boundaries, plans, partnerships and integrated care systems

**64. STPs got off to a poor start. The short timeframe to produce plans limited opportunities for meaningful public and staff engagement and the ability of local areas to collect robust evidence to support their proposals. Poor consultation, communication and financial constraints have fuelled concerns that STPs were secret plans and a vehicle for cuts. These negative perceptions tarnished the reputation of STPs and continue to impede progress on the ground. National bodies' initial mismanagement of the process, including misguided instructions not to be sharing plans, made it very difficult for local areas to explain the case for change.**

STPs were established as a pragmatic way for all health and care organisations in an area to identify system-wide priorities and develop practical proposals to improve care and keep people healthier for longer.

We recognise that the timeframe and funding envelopes at the time meant that to produce the first draft of local plans was stretching.

The STP process has enabled leaders from different parts of local health and care systems, including clinical staff, patient and public representatives, to begin fundamental conversations about how they could respond better collectively to local challenges.

While each area began in a different place, these initial proposals served as a valuable catalyst for the development of partnerships both between NHS bodies and between the NHS, local government and local communities. Initial proposals have been refined significantly since this time, and system-wide collaboration and trust have continued to grow.

## 5. Sustainability and transformation boundaries

**73. An STP area, or areas within it, work more effectively where they are meaningful to partners, local health professionals and most importantly the public. STPs, particularly those with more complex geographical boundaries, should be encouraged and supported to allow local areas to identify, define and develop meaningful boundaries within their patch in which local services can work together around the needs of the population.**

**74. STPs should be encouraged to adopt a principle of subsidiarity in which decisions are made at the most appropriate local level. NHS England and NHS Improvement should set out in their planning guidance for 2019/20 advice and support to achieve these recommendations.**

STPs are locally determined health systems, agreed with NHS England and NHS Improvement. We recognise that, in a small number of cases, this has produced complex geographies. We agree that STPs should encompass a number of meaningful local populations that form the basis for most service planning. For example, Buckinghamshire, Oxfordshire and Berkshire West each form recognisable populations that serve as the basis for most work on local service design, but also work together to plan some services for their combined populations. We fully support STPs working to find the most appropriate scale at which to develop different types of services.

We agree that STPs should adopt the principle of subsidiarity, with decisions being made at the most appropriate local level, and it is ultimately for local areas to determine which decisions should be made at which level.

NHS England and NHS Improvement have been working with the first cohort of integrated care systems to identify what decisions or actions are generally appropriate at which level. For example, the development of primary care networks is best considered at the level of 'neighbourhoods' at around 30,000-50,000 population, development of integrated community-based services at the 'place' level (up to around 500,000 population) and development of acute services at the 'system' level, typically covering a population of a million or more. NHS England and NHS Improvement have shared this learning with all STPs and will continue to do so throughout 2018-19.

The integrated care system in South Yorkshire and Bassetlaw, for example, has developed area-wide partnership with a defined leadership role for five constituent 'places' coterminous with local authority boundaries. Similar models have been developed in areas such as Greater Manchester and West Yorkshire and Harrogate. We agree that 'place' is an important building block for integrated care systems, usually coterminous with borough or district local government boundaries, and acting as the locus for integrating GP, hospital, mental health and local government services.

Clinical evidence shows that some services should be considered across a wider geographical footprint. Again, in South Yorkshire and Bassetlaw, the acute services review (which considers how hospitals can best share resources in areas such as hyper acute stroke and lower gastrointestinal services) is looking at services across the whole of its geography, as well as how to align services with those offered in neighbouring areas such as Nottinghamshire and West Yorkshire and Harrogate.



## 6. Sustainability and transformation partnerships

**91. Sustainability and transformation partnerships provide a useful forum through which local bodies can come together in difficult circumstances to manage finite resources. However, they are not on their own the solution to the funding and workforce pressures on the system. We are concerned that these pressures, if not adequately addressed, may threaten the ability of local leaders to meet their statutory obligations let alone transform services. Overwhelming and unrealistic financial pressure drives them to retreat back to organisational silos. This would seriously undermine the progress local leaders have made in already difficult circumstances.**

We agree with the Committee's view that STPs and integrated care systems cannot alone solve every challenge facing local systems.

The additional funding announced in five-year settlement for the NHS represents a significant increase in NHS resources. The NHS will set out later this year how this additional funding will be deployed, together with a long-term workforce plan.

**93. We recommend that the national bodies, including the Department, NHS England, NHS Improvement, Health Education England, Public Health England and CQC, develop a joint national transformation strategy. This strategy should set out clearly how national bodies will support sustainability and transformation partnerships, at different stages of development, to progress to achieve integrated care system status. This strategy must not lose sight of patients. National bodies in this strategy should:**

- a) set out how national bodies plan to support local areas to cultivate strong relationships;**
- b) strengthen the programme infrastructure of STPs;**
- c) consider whether, and if so how, support, resources and flexibilities currently available to integrated care systems could be rolled out to other areas to help them manage pressures facing their local areas;**
- d) develop a more sophisticated approach to assess the performance of STPs and their readiness to progress to integrated care status. This should include an assessment of local community engagement, the strength of local relationships and the progress towards preventative and integrated care. An assessment of prevention should encompass a broader definition than preventing demands on hospitals and integration should focus on how to improve patients' experience of and outcomes from services.**

The NHS long-term plan commissioned by the Prime Minister is an opportunity to develop a transformation strategy along the lines suggested by the Committee. This plan will build on existing work the NHS has undertaken to develop STPs and integrated care systems. Below we set out what support national bodies are already providing and how the NHS plan will build on these. Including:

### **a) Developing strong relationships**

At 301 we set out how NHS England and NHS Improvement are supporting STPs to develop system leadership, governance and infrastructure. Local workforce action boards (LWABs) are also in place, bringing local STP providers and commissioners together to identify workforce



challenges at a local and national level, and to work with stakeholders to provide solutions to these.

**b) and c) Supporting STPs and ICS**

Below (at 107) we set out how national bodies will help STPs to develop into integrated care systems.

**d) Measuring STP progress**

As set out above (at 12) NHS England and NHS Improvement have already set out key national priorities that STPs and integrated care systems will help to deliver and how the STP dashboard will measure progress on these areas.

## 7. Integrated care systems

**105. We support the development of integrated care systems, including plans to give greater autonomy to local areas as part of their ICS status. We are encouraged by the positive progress the first 10 integrated care systems have made in the face of challenges on the systems. However, like STPs more generally, we are concerned that funding and workforce pressures on these local areas may exacerbate tensions between their members and undermine the prospect of them achieving their aims for patients.**

Our answers to paragraph 91 and paragraph 233 highlight the plans on funding and workforce.

In addition, one of the defining features of integrated care systems is the commitment on the part of local NHS organisations to manage their resources collectively. This will enable them to use financial resources – and deploy their local workforce – more efficiently and effectively to improve quality of care and health outcomes. Many are developing their own workforce strategies to enable them to take a collaborative approach to recruiting, retaining and developing staff.

**106. NHS England and NHS Improvement should systematically capture and share learning from areas that are furthest ahead, including their governance arrangements and service models, to accelerate progress in other areas and also to provide clarity about what is permissible within the current legal framework.**

NHS Improvement has produced a review of governance models which will be updated this year. As the Committee suggests, NHS England and NHS Improvement will also collect good practice from leading systems and make these available through published documents, an online platform (accessible to all vanguards and STPs) and regular learning events.

We are keen to see rapid progress, and will continue to support the STPs where they are clinically led and locally supported. To accelerate the development of integrated care, NHS England and NHS Improvement announced the first cohort of shadow integrated care systems in June 2017. NHS England and NHS Improvement have worked closely alongside the first cohort of these systems to support their development. This includes hands-on support in solving problems common to all systems and regular learning events for system leaders including clinical leaders.

**107. We recommend, as part of a joint national transformation strategy, that national bodies clarify:**

- a) how they will judge whether an area is ready to be an ICS;**
- b) how they will support STP areas to become ICSs;**
- c) what they will do in areas that fail to meet the criteria;**
- d) how they will monitor the performance of existing ICS areas and provide support including the necessary funding to ensure they continue to make progress; and**
- e) how they will address serious performance problems in ICS areas.**

The NHS long-term plan commissioned by the Prime Minister is an opportunity to develop a transformation strategy along the lines suggested by the Committee. This will set out the timeframe over which we expect most systems to become integrated care systems and the help national bodies will give them to develop in this direction.

NHS England and NHS Improvement are offering targeted support to less advanced STPs. We have also backed strong STPs with over £2.8bn of capital.

The NHS has selected the existing integrated care systems on the following criteria:

| Criteria   | Key measures   |
|--|--|
| <b>Effective leadership and relationships, capacity &amp; capability</b> | Strong leadership, with mature relationships including with local government.<br>Clear shared vision and credible strategy.<br>Effective collective decision-making.<br>Effective ways of involving clinicians and staff, service users/public, and community partners.<br>Ability to carry out decisions that are made, with the capability to execute on priorities            |
| <b>Track record of delivery</b>  | Tangible progress towards delivering the NHS Five Year Forward View priorities (redesigned urgent and emergency care services, better access to primary care, improved mental health and cancer services)<br>Progress in improving performance (relative to rest of country) against NHS Constitution standards (or sustaining performance where those standards are being met). |
| <b>Strong financial management</b>                                       | Strong financial management, with a collective commitment from CCGs and trusts to system planning and shared financial risk management, supported by system control total and system operating plan.   |
| <b>Focused on care redesign</b>  | Compelling plans to integrate primary care, mental health, social care and hospital services, and collaborate horizontally (between hospitals).<br>Starting to use population health approaches to redesign care around people at risk of becoming acutely unwell.<br>Starting to develop primary care networks.   |
| <b>Coherent and defined population</b>                                   | A meaningful geographic footprint that respects patient flows.<br>Contiguous with local authority boundaries, or – where not practicable – clear arrangements for working across local authority boundaries.<br>Covers one or more existing STPs, generally with a population of ~1m or more or with plans to expand to a population of this size.                               |

In addition to the integrated care system development programme, NHS England and NHS Improvement will work more closely with other systems aspiring to become integrated care systems in 2019-20. Our intention is to help all STPs become integrated care systems.

Each year the NHS will publish the ‘STP progress dashboard’ which assesses the performance of all STPs. We will continue to refine the metrics this includes in 2018-19, as well aligning it with NHS England’s CCG Improvement and Assessment Framework and NHS Improvement’s Single Oversight Framework for trusts.

More broadly, system partners will continue to work to align the data they collect around a shared view of quality, as set out by the National Quality Board’s Shared Commitment to Quality (for health care) and Quality Matters (for social care). This commitment is also reflected in CQC’s strategy, which identifies a strategic priority to promote a single shared view of quality across the health and social care system.

## 8. Integrated care providers

**140. Given the controversy surrounding the introduction of accountable care organisations in the English NHS, we believe piloting these models before roll-out is advisable. There should be an incremental approach to the introduction of ACOs in the English NHS, with any areas choosing to go down this route being carefully evaluated.**

There are no organisations currently providing services under an ICP Contract. Following the successful outcome of High Court judicial review proceedings\*, NHS England has commenced a public consultation on the contracting arrangements for ICPs. The consultation will provide an opportunity for NHS England to take into account patient and public feedback before deciding whether, and if so how, to further develop the draft ICP Contract. The ICP Contract will not be used before public consultation is concluded.

If, following consultation, the decision is made to support the ICP Contract, NHS England would adopt an incremental and controlled approach to its introduction to ensure that insight from evaluation and experience of the forerunner sites is used to inform the plans of other areas, the contract itself and the controls in place to ensure its appropriate use.

Any decision to use the draft ICP contract (following and subject to the outcome of the consultation), remains one for local commissioners who have their own duties to engage the public, patients and providers. Should a local commissioner decide, following engagement, to propose use of the ICP contract, its award would be subject to successful completion of the Integrated Support and Assurance Process run by NHS England and NHS Improvement. This is an additional safeguard around the award of a complex contract and an opportunity to ensure that learning from early sites has been incorporated into the process.

Before the contract is used, the Department intends to consult on new draft Directions, which are needed to allow the ICP to deliver primary medical services. No site can use the ICP contract without these new draft Directions.

If NHS England introduces the ICP contract for use following its consultation, the directions will initially be made on a case-by-case basis to allow specific local areas to use the ICP contract, after they are signed off through Integrated Support and Assurance Process, satisfying national scrutiny requirements. This will, again, help ensure ICPs are implemented where they represent a good solution in the interests of patients and the public.

\* 'NHS England successfully defended the R (oao Jennifer Shepherd) v NHS England [2018] EWHC 1067 (Admin) judicial review claim. Note, however, that the applicants have been granted leave to appeal. NHS England and the Department of Health were also successful in defending the R (oao Hutchinson & others) v SSHSC and NHS England [2018] EWHC 1698 (Admin) claim for judicial review. The applicants in that case have not sought leave to appeal.

**141. The evaluation of ACOs should seek to assess:**

- **the benefits and any unintended consequences of these structures compared with improving joint working through integrated care partnerships.**
- **The implications of the scope of the ACO contract, particularly whether hospital services, GP practices and social care should be incorporated, either in a partially integrated or fully integrated capacity.**

- **the impact of ACOs on decision-making processes, objectives and incentives for staff and the resilience of services outside of hospitals.**
- **the impact on patient choice.**

**We do not believe it is in the best interests of patients to return to a system devoid of choice.**

We agree that evaluation is important to assess the impact of ICPs.

We do not yet have any ICPs in place in England. However, subject to the outcomes of NHS England's consultation, we plan to study the effects of the first ICP Contracts that come into being and share learning with others that may follow.

Dudley, the first area that might use the draft ICP Contract, has a programme of evaluation underway.

Subject to consultation, we will work with the first systems using the draft ICP Contract to ensure that:

- in the near term we capture the lessons around how to improve the local processes for designing and establishing the ICP model, including how amending national rules could aid this; and
- in the longer term there is ongoing evaluation of any improvement in population health outcomes and other measures of performance in areas served by an ICP relative to others and how these were achieved.

We would expect local areas that implement an ICP Contract to evaluate outcomes and impact against local measures.

We support the Committee's recommendation around choice for patients, and NHS England will ensure that any ICP contract preserves and, where possible, enhances choice for patients.

**155. We recognise the concern expressed by those who worry that ACOs could be taken over by private companies managing a very large budget, but we heard a clear message that this is unlikely to happen in practice. Rather than leading to increasing privatisation and charges for healthcare, we heard that using an ACO contract to form large integrated care organisations would be more likely to lead to less competition and a diminution of the internal market and private sector involvement.**

We welcome the recognition that ICPs are not about privatisation or undermining the fundamental principles that the NHS is free at the point of use.

We consider it likely that statutory organisations will hold the ICP Contract, but for example ICPs based on primary and community services (similar to the multispecialty community provider concept) could be a GP-led organisation. It is for would-be providers to decide the organisational form which they believe will be best suited to deliver the ICP Contract which the commissioner wishes to award, and for the commissioner to assess the suitability of that organisation against its advertised criteria.

The draft ICP Contract is not intended to, and does not, promote or encourage privatisation of NHS services or outsourcing of NHS services to private sector organisations. Indeed, to do so would be unlawful.

The emerging bid for Dudley, the first area that might use the draft ICP contract, is led by NHS bodies and has the support of local GPs.

**156. We recommend that ACOs, if a decision is made to introduce them more widely, should be established in primary legislation as NHS bodies. This will require a fundamental revisiting of the Health and Social Care Act 2012 and other legislation. Whilst we see ACOs as a mechanism to strengthen integration and to roll back the internal market, these organisations should have the freedom to involve, and contract with, non-statutory bodies where that is in the best interests of patients.**

We welcome the Committee's conclusion that ICPs are part of the solution to delivering integrated care.

However, DHSC, NHSE and NHSI will work together collectively to consider whether there is a clear case for further legislation to promote service integration at the heart of the health system. This work will be led initially by NHSE and NHSI.

In the short term, a range of secondary legislation will be needed to enable these ICP contracts, but it is clear, as the judicial review proceedings have confirmed, that ICPs can be implemented in the NHS without needing primary legislation.

Subject to these secondary legislative changes and the introduction of the proposed Directions to enable an ICP to deliver primary medical services, it will be possible for commissioners to award an ICP contract, with that organisation then becoming accountable for providing integrated care and improving health outcomes for a defined population.

**167. These mechanisms are no substitute for effective solutions to funding and workforce pressures, but if well designed and implemented they can represent a better way to manage resources in the short-term, including using the skills of staff more effectively on behalf of patients.**

The NHS long-term plan, underpinned by additional funding and a new workforce strategy, will set out how the NHS will be supported to design and implement these models in ways that provide the best services for patients and the best value for money for the taxpayer.

## 9. Making the case for change to the public

**181. STPs, ICSs and ICPs currently have to work within the constraints of existing legislation and manage rising pressures with limited resources. This context limits progress towards integrating care for patients.**

The first cohort of integrated care systems have shown how much progress can be made within the existing legislative framework. Where aspects of the current legislation if amended would accelerate progress or enable us to move things that are otherwise harder, the Government will consider supporting NHS proposals.

**182. Some campaigns against privatisation confuse issues around integration. Concerns expressed about the ‘Americanisation’ of the NHS are misleading. This has not been helped by poor communication of the STP process and the language of accountable care, neither of which have been adequately or meaningfully co-designed or consulted on with the public or their local representatives.**

We welcome the Committee’s recognition that these criticisms were wide of the mark and we agree that everything possible must be done to ensure that the public fully understand our objective to improve services through integrated care.

To this end, NHS England recently published a plain English summary of integrated care, explaining why it is taking place and what it means for local services. This drew on independent deliberative research about the most effective ways to communicate information about complex policy change to service users, the public and their elected representatives. It was tested with, and incorporated feedback from, service users and key national stakeholders, including representatives of local patient groups, local councils and NHS staff. This can be seen at: [www.england.nhs.uk/publication/breaking-down-barriers-to-better-health-and-care](http://www.england.nhs.uk/publication/breaking-down-barriers-to-better-health-and-care).

The Department also published a “Brief Guide” to Accountable Care Organisations (as they were then known), which set out, in plain English, what they are, what they might mean for patients and staff and how they could be implemented in the NHS.

As noted above, NHS England has commenced a public consultation on the contracting arrangements for Integrated Care Providers (ICPs). This is an opportunity to test our proposals with patients and the public, and provide more detail about how the proposed ICP Contract would underpin integration between services, how it differs from existing NHS contracts, and how ICPs fit into the broader commissioning system.

**183. We recommend that the efforts to engage and communicate with the public on integrated care which we refer to above should tackle head-on the concerns about privatisation, including a clear explanation to the public that moves towards integrated care will not result in them paying for services.**

We recognise the great public support for the founding principle of an NHS free at the point of use. Independent research shows that patients and the public understand that a health and care system founded in a different era must adapt in order to meet changing needs.

We have been clear that the long-term plan should reflect a shared vision for the next ten years of the NHS, which means that we will be working with staff and patients over the coming months to discuss and develop ambitious but realistic policies which will deliver better care and health outcomes across England.



**184. We recommend that national bodies take proactive steps to dispel misleading assertions about the privatisation and Americanisation of NHS. The Department should publish an annual assessment of the extent of private sector in the NHS, including the value, number and percentage of contracts awarded to NHS, private providers, charities, social enterprises and community interest companies. This should include an analysis of historic trends in the extent of private sector involvement over a 5–10-year period.**

NHS England and DHSC already collect and report to Parliament information on the limited role of non-NHS providers. DHSC's annual accounts provide detail on the value of the years spend (along with a comparator for the previous year) in the four categories of i) independent sector, ii) voluntary sector, iii) local authorities and iv) devolved administrations. All of this data comes from the information that NHS England collects in their turn from CCGs' accounts.

In response to Parliamentary Questions and Freedom of Information requests, the Department has used this data to provide ten-year trend information. This information, which is already in the public domain, shows that the rising trend of spend in the first few years has plateaued out more recently.

Such data can only be coded for and collected prospectively, and it is not possible therefore to derive information about new or amended categories of expenditure from previous years' accounts. However, we could extend the number of categories of spend going forward, and this could add greater transparency to our financial reporting. For that reason, DHSC and NHS England have therefore agreed to explore with NHS bodies the feasibility of collecting data in a manner that provides a more detailed breakdown of the spend, as well as establishing how soon processes could be implemented to make the changes. As a starting point, we are looking at including a further breakdown of the 'voluntary sector' category to show community interest companies and social enterprises; and exploring whether the 'independent sector' category can show acute and mental health providers from within the private sector separately from GP, NHS joint venture or other public sector type contractors. Getting the definitions right will be key to being able to provide meaningful data.

It is highly unlikely that we will be able to highlight work that NHS providers sub-contract to the independent sector, or that the independent sector subcontracts to the NHS.

The likelihood is that, if feasible, this might occur from the financial year 2018/19 (or 2019/20) onwards, subject to consultation with CCGs and providers. We will update the Committee with the results of these discussions later in the year.

**202. There has not been a sufficiently clear and compelling explanation of the direction of travel and the benefits of integration to patients and the public. National and local leaders need to do better in making the case for change and how these new reforms are relevant to those who rely on services. The language of integrated care is like acronym soup: full of jargon, unintelligible acronyms and poorly explained.**

We recognise the need to explain our approach to integrated care in a clear and compelling way, focusing on tangible benefits as experienced by people who use services.

In May 2013, a national collaboration on integrated health and social care published "Integrated care and support: our shared commitment," a framework document which sets out how local areas can make further steps towards integration, using existing structures like Health and Wellbeing Boards. It includes a narrative for person-centred coordinated care developed by National Voices and Think Local Act Personal (TLAP), working with service users, carers, charities, commissioners and professionals. The narrative offers a detailed understanding of



what good integrated care and support looks and feels like for individuals by describing a person's experience of joined-up care using a series of generic "I" statements – for example, "I tell my story once." The "I" statements help clarify what integrated care actually means for people across the health and care systems.

To supplement the plain English summary mentioned in our response above (at section 182), NHS England have developed a wide range of accessible material in different media. This includes:

- a series of videos showing how service users are experiencing better care and better day-to-day health because of local partnership;
- infographics and other digital resources setting out what we mean by integration, the reasons for change and the risk of doing nothing; and
- case studies that show examples of successful integration, including in the 50 'vanguard' sites that developed new models of care from 2015 to 2018, and grass roots partnerships between local councils and the NHS.

These are regularly and widely shared for use in, and adaptation by, local systems. We are actively supporting local systems to develop material tailored to make sense of their own work to local audiences, and to do this in a way that is cogent and widely accessible.

Most importantly we are encouraging systems to focus on setting out tangible benefits for local people. It's these improvements we should communicate rather than the 'plumbing' behind the scenes.

**203. The Department of Health and Social Care and national bodies should clearly and persuasively explain the direction of travel and the benefits of these reforms to patients and the public. We recommend the Department and national bodies develop a narrative in collaboration with representatives of communities, NHS bodies, local government, national charities and patient groups. The messaging should be tested with a representative sample of the public. A clear patient-centred explanation, including more accessible, jargon-free, language, is an essential resource for local health and social care bodies in making the case for change to their patients and wider communities.**

Our emphasis is on supporting local systems to develop jargon-free patient-focused explanations about the benefits of integration to people in their areas.

A good example of this is the West Yorkshire and Harrogate STP (now a shadow integrated care system), whose leader has recorded a short video explaining their goals to the public in plain English, supplemented by weekly newsletters, social media and online information-sharing. The wider leadership team produce regular, accessible progress updates, answering questions and gathering feedback from local residents: [www.wyhpartnership.co.uk/next-steps](http://www.wyhpartnership.co.uk/next-steps)

Lancashire and South Cumbria STP has produced easy-read versions of its case for change and other key documents, to help ensure that its plans are accessible to different groups of its local population. Like many partnerships, they have drawn on nationally produced materials and supplemented them with local information and updates, an approach we are encouraging nationally: [www.healthierlsc.co.uk/about/stp](http://www.healthierlsc.co.uk/about/stp)

South West London STP has developed a 'You said, we are doing' feedback approach for local people, with accessible information on how they are responding to issues raised during an extensive programme of public outreach meetings carried out on their behalf by their local Healthwatch:

**204. Making the transition to more integrated care is a complex communications challenge covering a range of different services and patient populations. The case for change must be made in a way that is meaningful to patients and local communities. In addition to providing a clear narrative, in accessible language at a national level, the Department of Health and Social Care, NHS England and NHS Improvement should explain how they plan to support efforts to engage and communicate with the public.**

NHS England and NHS Improvement work with local systems to strengthen communication and engagement on integrated care, including sharing examples of good practice through collaborative workspaces, network events, webinars, publications, e-bulletins and social media, with advice tailored to individual areas. A recent national network event for system engagement and communications leads included sessions on developing a clear narrative, using social media proactively, and actively involving primary care clinicians.

The Government wants to do more to strengthen the patient voice in different ways, for example by enabling community co-production of local proposals and by improving the transparency of decision-making. The 2018-19 planning guidance emphasised the particular importance of involving democratic representatives.

NHS England produced national guidance in 2016 (refreshed in 2017) for those developing local partnerships. This included a summary of relevant statutory duties, guidance and evidence of good practice and engagement principles from both NHS and independent sources. Supplementary material for frontline practitioners was widely circulated, promoting good emerging local practice as set out in recent written evidence to the Health and Social Care Committee. This included briefings on involving voluntary and community partners (March 2017), Healthwatch groups (jointly produced with Healthwatch England, May 2017) and elected representatives (July 2017).

We remain committed to amplifying patient and community voices in 2018-19 and will support local systems to strengthen engagement. Measures will include updated guidance and evidence (including new work with the Local Government Association on involving local government), targeted funding, training and advice, and building engagement into assessment and development programmes for local systems.

During autumn 2018, NHS England will be supporting localities at STP/ integrated care system level to facilitate conversations with local people about their priorities for the service's future. This information will be captured and considered as the NHS draws up its forthcoming long-term plan.

**205. NHS England and NHS Improvement should make clear that they actively support local areas in communicating and co-designing service changes with local communities and elected representatives.**

The NHS England Involvement Hub has a wide range of guidance on involving communities in service change, including a co-production model. Most recently NHS England has produced a detailed resource to support public engagement on major service change, pulling together learning from areas such as Dorset and Cumbria which have recently carried out well regarded consultations about high profile changes to local service configurations.

NHS England has also shared good practice around new approaches to prevention and care in Surrey Heartlands (cardiovascular services), Buckinghamshire (integrated community hubs) and East London (diabetes prevention).

**207. Bringing local health and social care services together through STPs and ICSs to plan and organise care within their footprints is a much better way to manage constrained resources than the siloed, autonomous and competitive arrangements imposed by the Health and Social Care Act 2012. Our view is that STPs and ICSs are a pragmatic response to the current pressures on the system, rather than a smokescreen for cuts, but that these mechanisms are not a substitute for adequate funding of the system. Funding them properly, including access to ring-fenced transformation money, is necessary and would allow a far better assessment of their potential.**

We welcome the Committee's support for the approach the NHS is taking. We agree that one of the opportunities arising from system-based approaches to integrated care is the ability to better manage collective resources. In light of this, NHS England is developing tools, examples and templates to help STPs make better use of their collective resources, drawing on the experiences of the first integrated care systems, the vanguard sites and other recognised good practice. We also agree that STPs cannot be a substitute for adequate NHS funding overall. The five-year funding settlement recently announced by the Prime Minister will make a material difference in this respect.

## 10. Funding and workforce challenges

**231. The NHS and local government have not been given adequate investment, support and time to embark on the scale of transformation envisaged. Transformation depends not only on having sufficient staff to maintain day-to-day running of services, but in the capacity and capability of staff to redesign services, engage in dialogue and consultation and develop new skills. Transformation also requires funding the staff costs associated with double-running new services, while old models are safely decommissioned.**

**232. The Government's long-term funding settlement should include dedicated, ring-fenced funding for service transformation and prevention. We recommend that the Government commit to providing dedicated transformation funding when it announces its long-term funding settlement this summer.**

**233. The task of determining the scale of funding and the most appropriate ways to allocate and manage such resources is a complex challenge. To inform this work we recommend:**

- **Building on experience from the new care models programme and Greater Manchester, national and local bodies should form an estimate of the transformation funding they require to transition to new models of care at scale. This should include an estimate of funding required in each area to provide staff with the capacity to engage in transformation, develop new skills and facilitate the double running of services.**
- **Government and national bodies should develop clear proposals on how to allocate and manage this resource to ensure the best value for money.**

To support the NHS to deliver for patients across the country, the Government has announced a new five-year budget settlement for the NHS, which will see funding grow on average by 3.4% each year to 2023/24. This will mean the NHS budget will increase by over £20 billion compared with today. This additional funding will underpin a ten-year plan to guarantee the future of the NHS for the long term

It is critical to the success of the plan that the whole NHS:

- improves productivity and efficiency;
- eliminates provider deficits;
- reduces unwarranted variation in the system so that people get the consistently high standards of care wherever they live;
- gets better at managing demand effectively; and
- makes more effective use of capital investment.

These are the five key financial tests that the Government has set the NHS to put the service onto a more sustainable footing and deliver value for money. The Government expects the NHS to give this work the utmost priority.

As part of the ten-year plan, the Government expects the NHS will clearly set out what transformation is necessary to meet these financial tests.

We expect this plan to build on the learning from across the NHS, including the vanguard sites and in Greater Manchester, to set out how it will allocate the new money announced in the funding plan to enable transformation in services and patient care to be delivered across the

country. As part of this the Government will consider proposals from the NHS for a multi-year capital plan to support transformation.

As part of this long-term plan, the NHS will produce a workforce plan which is our opportunity to support more joined up working in the health and social care systems to ensure we have the capacity and capability to successfully respond to the ever increasing, and complex, needs of the population through new integrated models of care. By developing this workforce plan as part of the NHS long-term plan we can ensure the NHS has the right numbers and skills to deliver the care of the future.

# 11.National oversight

**242. To assess whether the commitments by NHS England and NHS Improvement to align priorities and incentives at national level have made a tangible difference to those on the frontline, we encourage those organisations to conduct a joint survey one year after their announcement on 27 March 2018. The real test will be whether this makes a positive difference at local level**

The Government agrees that it is crucial to involve frontline staff in designing and implementing integrated care – they are the NHS’s most important asset and its most effective agents and advocates of change. In 2017, NHS England commissioned independent researchers to undertake deliberative research with frontline staff, and has acted on its recommendations for involving them in, and educating them about, new approaches to designing care.

NHS England are also in continual dialogue with representatives of different clinical and staff groups, including doctors, nurses and allied health professionals. NHS England have developed support networks across these groups and are partnering with organisations such as the Academy of Medical Royal Colleges and the Royal College of Nursing to improve staff awareness and to hear their views.

NHS England will consider the Committee’s suggestion in light of the data we already gather as part of the Staff Survey and the additional cost of conducting a separate survey.

**265. Local bodies’ experience of their national counterparts is one of competing priorities that perpetuate existing divides between services and encourage organisations to retreat into individual silos. While this appears to be improving, we have not heard clear and compelling evidence that the interventions of national bodies reinforce and enable more integrated, place-based care. Incoherence in the approach of national bodies is a key factor holding back progress.**

NHS England and NHS Improvement recognise the need to evolve and adapt, and to change the way they work to provide single system leadership that supports and facilitates integrated care.

While respecting the need for the NHS England and NHS Improvement boards to maintain separate oversight of their distinct legal responsibilities, both organisations will over the next few months formalise new joint working arrangements that will enable them to provide much more integrated and streamlined support for local health systems. These changes will include single regional teams acting on behalf of both organisations and the establishment of a new NHS Executive Group co-chaired by the organisations’ respective chief executives.

Further detail is available at [www.england.nhs.uk/wp-content/uploads/2018/05/01-meeting-in-common-nhs-england-nhs-improvement-next-steps-aligning-the-work.pdf](http://www.england.nhs.uk/wp-content/uploads/2018/05/01-meeting-in-common-nhs-england-nhs-improvement-next-steps-aligning-the-work.pdf).

**266. We heard, and saw, outstanding examples of great care that frontline services have been able to build, implement and maintain even in periods of constrained resources. We also heard of promising results from the new care models programme. However, how national bodies plan to scale up and spread best practice and accelerate transformation across the system remains unclear.**

STPs have been designed with the express purpose of spreading new care models. As set out in a paper submitted to the May 2018 meeting in common of the NHS England and NHS

Improvement boards: “The national new care models programme captured learning from the vanguards and distributed this through a range of channels and published products. The programme demonstrated that the vanguards that made the most progress demonstrated qualities such as strong leadership (clinical and managerial), trusting relationships, cooperative behaviours and a collective willingness to work to address system-wide problems. This learning has been carried forward into NHS England and NHS Improvement’s joint programme to develop integrated care systems, which is scaling the learning from vanguards through Sustainability and Transformation Partnerships (STPs) to broaden and deepen care redesign across England.”

NHS England and NHS Improvement have made it clear that all integrated care systems are expected to have “compelling plans to integrate primary care, mental health, social care and hospital services using population health approaches to redesign care around people at risk of becoming acutely unwell” – and they are supporting local systems in developing these plans.

The Memorandum of Understanding agreed with the first cohort of shadow integrated care systems made clear that these systems should “spread existing ‘vanguards’ where they exist and copy their most successful models in areas that have not yet been part of the new care models programme”.

NHS England and NHS Improvement are also supporting a good practice and learning programme in 2018-19 and beyond that aims to spread the ‘active ingredients’ of the most successful new care models. This programme includes:

- regular national learning days at individual vanguard sites for others developing integrated care;
- networks of practice between vanguards and those working in sustainability and transformation partnerships and integrated care systems;
- a widely accessed online platform used by vanguards and integrated care systems;
- a wide range of published products from the vanguards including implementation guidelines and local evaluations;
- regularly showcasing vanguards’ experiences at conferences and other events;
- working with the NHS Confederation, NHS Providers and the Local Government Association to promote vanguards’ new ways of working and experiences to their members across the country, through case studies, blog posts and other written material;
- a series of video case studies.

**267. We recommend that the Department of Health and Social Care and national bodies, particularly NHS England, NHS Improvement, Health Education England and the Care Quality Commission, clearly describe as part of a national transformation strategy how each of the bodies will work together to support transformation.**

The NHS long-term plan will be an opportunity to set out how all national bodies will support transformation across the country.

The Department will work with its Arm’s Length Bodies, the NHS and other partners to develop and implement this plan.



**268. We request a joint response from the Department of Health and Social Care, NHS England, NHS Improvement, Health Education England and CQC setting out, against each of the following headings, how their roles, responsibilities, functions and policies support the following factors that are critical to transformation and integrated care.**

- **Skills and capacity of frontline staff;**
- **NHS leadership;**
- **Financial incentives;**
- **Infrastructure, particularly digital infrastructure; and**
- **Coherent oversight and regulation.**

**The response should include details of plans the national bodies have over the next year to make progress on each of these areas.**

The NHS long-term plan, to be published in the autumn, will include details about how the national bodies will make progress on the above areas over the next year and beyond.

### **Skills and capacity of frontline staff**

National oversight for training and development is provided by the Department of Health and Social Care (DHSC) in its role of enabling health and social care bodies deliver services according to national priorities and works with other parts of government to achieve this. It sets objectives and budgets, and holds the system to account on behalf of the Secretary of State. The Department is looking at the skills mix required to meet the new integrated models of care and working with the wider system to understand how to approach integrated training models.

NHS England (NHSE) implements the priorities and direction of the Department when commissioning services in predominately the health sector, although its remit covers some specialised social care services. Local Authorities (LAs) are responsible for commissioning the majority of publicly funded social care services. NHSE and LAs play an important role in shaping the workforce's skills and capacity through this commissioning function.

National funding is provided through Health Education England (HEE) to support the development of the NHS workforce equipping them with the right skills to meet the needs of patients. HEE invests up to £300m a year on supporting individuals in NHS employment reach registered qualifications. It also provides funding for Continuing Professional Development (CPD) which is used for different training and development activities for the purposes of professional practice in the NHS. Skills for Care, an independent charity, work as a delivery partner of DHSC to support workforce development in adult social care.

The health system is supported by NHS Improvement (NHS I) to give patients safe, high quality, compassionate care within local health systems that are financially sustainable. It does this by providing a range of support mechanisms, including publishing guidance for trusts to build their capacity and capability. It has developed a national framework to improve skill, capability building, leadership development and talent management for people in NHS-funded roles in England.

The interests of patients and the wider public are safeguarded through the Care Quality Commission (CQC). By monitoring, inspecting and regulating health and social care services, CQC ensures services meet fundamental standards. These standards include ensuring staff have the right qualifications, competence, skill and experience to keep patients safe. Where providers fall short of this, CQC takes action to ensure the services are improved to meet acceptable standards of care.



Each individual employer in the health and social care sector is responsible for supporting its staff with core courses to fulfil their duties in the workforce, for example health and safety, and information governance. It is for the employer to consider what is appropriate, depending on the requirement of the workforce.

The forthcoming national workforce strategy will support the health and social care system to ensure we have the capacity and capability to successfully respond to the ever increasing, and complex, needs of the population through new integrated models of care.

## **NHS leadership**

Leaders exist at every level of the health and care system. Individual employers and the boards of health and care organisations are responsible for the development and management of their leaders; at a national level, the NHS Leadership Academy and Skills for Care provides development training and support to leaders across the sector. NHS Improvement, working in partnership with the Leadership Academy, is responsible for managing NHS leadership talent.

Through the NHS Leadership Academy HEE delivers a range of inclusive, high quality leadership development programmes for staff working at all levels in the health and care system. These programmes support staff to gain the skills, knowledge and behaviours required to lead people.

## **Financial incentives**

STPs and integrated care systems have all produced sustainability and transformation plans for the communities they serve. The Department works closely with ALBs to ensure that funding is used effectively and distributed fairly across the country to meet service needs.

## **Infrastructure, particularly digital infrastructure**

Innovation has been a key driver of quality improvement in the past and will continue to be in the future. Many of the most important innovations in the coming years are likely to be around technology, including digital infrastructure. Better use of data and technology has the power to improve health, transform quality and increase efficiency in the delivery of health and care services. It can also reduce the administrative burden for care professionals.

National bodies have a range of responsibilities for fostering digital infrastructure in the NHS.

NHS Digital is the national information partner for the health and care system. Its role includes maintaining the infrastructure services that are critical to effective healthcare and working closely with the fast-growing market in healthcare technology to nurture innovation. NHS Digital are also responsible for ensuring that the public's health and care information is kept securely, used appropriately and made available to patients themselves so they can manage their own health and care.

The CQC's strategy for 2016-2021 identifies encouraging innovation as a strategic priority. It is working with providers and innovators to understand how it can do this most effectively, within its role as a regulator of quality and safety. It has also published updated inspection frameworks with key lines of enquiry on assessing cyber-security arrangements. This includes what leaders should do to ensure their organisation is cyber-secure. The CQC is working more closely with NHS Digital to make regulatory activity around cyber security more effective.

Technology is also key to enhancing training and learning across the health and social care workforce. HEE works with partners to support care professionals to make the best use of data and technology. As part of the draft workforce strategy published in December 2017, Secretary of State commissioned Dr Eric Topol to undertake an independent technology review to consider how we best prepare the healthcare workforce to deliver the digital future. Dr Topol will publish an interim report in Summer 2018 and a final report in early 2019.

National bodies are supporting the NHS to develop the digital infrastructure needed to support integrated care. For example:

- Local Health and Care Records will help the NHS to understand patterns of illness and preventative measures, allowing the NHS to deliver services effectively and flexibly to meet the needs of their local patients. 5 initial areas have been chosen to become Local Health and Care Record Exemplars, covering 23.5 million people in total - Greater Manchester, Wessex, One London, Yorkshire and Humber and Thames Valley and Surrey
- We have established 16 acute health, 7 mental health and 3 ambulance Trust Global Digital Exemplars (GDEs). These are grounding innovation in local realities and developing practical approaches for the rest of the system to follow. Each acute and mental health GDE is working with a 'fast follower' trust to work out how best practice can be shared beyond specific local realities and be developed into blueprints for the whole system.
- The NHS Apps library launched in April 2017 and now hosts 70 apps that have been assessed and approved. We are also developing an NHS App which will give patients access to records, GP appointments, NHS 111 and preference setting via their mobile phone, underpinned by strong individual verification. A private beta will be available in September and a public beta in December, with full roll out in 2019.
- NHS Digital unveiled the 'beta' version of NHS.UK website in 2017 and it has already received more than 26 million visits. NHS Choices, the precursor to NHS.UK continues to be immensely popular registering 525 million visits in 2017, of which about 330 million were from people using their mobile phones
- The Summary Care Record is now available in 98% of community pharmacies. This provides pharmacists with access (with patient consent) to information about the patient's medication, allergies and adverse reactions, avoiding time-consuming calls to GPs

## **Coherent oversight and regulation**

NHS England and NHS Improvement will, over the next few months, formalise new joint working arrangements that will enable us to provide much more integrated and streamlined support for local health systems.

CQC is taking a number of steps to make oversight and regulation more coherent across health and care systems and to support the move to integrated care.

- CQC is making changes to its regulatory approach to respond to the emergence of new and complex providers, which work in an integrated way across multiple sectors. These changes, which will ensure CQC can hold to account those who are ultimately responsible for the quality of care, include identifying a single relationship holder for each of these providers, developing additional guidance for inspectors, and moving towards assessing leadership at the provider level, rather than separately for each service. These changes will help CQC to make more

accurate assessment of quality and provide the clarity that providers need to move towards integrated care.

- In 2017, CQC consulted on a new set of criteria that identify the legal entity that is directing or controlling a system of care. This clarity is particularly important for organisations that are developing new and integrated ways of working.
- CQC is committed to working with and learning alongside new ICPs as they emerge. CQC is currently considering its approach to ICPs, and other new, integrated models of care. Within its existing legal powers, CQC will be able to register an organisation holding an ICP Contract where it is established as a separate legal entity. This will enable CQC to regulate the ICP overall, as well as its constituent regulated services.
- Although its regulatory activity focuses on providers, CQC is working to develop an approach to regulation that takes greater account of the systems within which providers operate. In 2017 and 2018, CQC has reviewed health and social care systems in 20 local authority areas to find out how services are working together to support and care for people aged 65 and older. The reviews focused on how each local system works within and across three key areas: maintaining the wellbeing of a person in their usual place of residence; care and support in a crisis (admission to hospital or alternative) and; step down (return to usual residence or admission to new residence). As well as publishing a report on each system, CQC published an interim report in December 2017 and a final report, with key learning and recommendations drawn from all 20 reviews, in July 2018.
- In 2018, two test sites will be established (in Frimley and Greater Manchester) where CQC will work with system leaders to understand how we can modify our approach to regulation to be more effective in ICSs.

**269. NHS England and NHS Improvement should systematically capture, distil and disseminate key lessons from the local areas that are furthest ahead, including the governance arrangements and service models used in these areas. Careful attention should be played to striking a balance between learning from the frontrunners and not overburdening these areas. We recommend that NHS England and NHS Improvement undertake a review of the first cohort of integrated care systems starting in April 2019, and make the key findings available to all STP areas. That should include the level of financial support underpinning transformation.**

To accelerate the development of integrated care, NHS England and NHS Improvement announced the first cohort of shadow integrated care systems in June 2017. They have worked closely alongside the first cohort of these systems to support their development. This includes hands-on support in solving problems common to all systems and regular learning events for system leaders including clinical leaders.

NHS Improvement has produced a review of governance models which will be updated this year. As the Committee suggests, NHS England and NHS Improvement will also collect good practice from leading systems and make these available through published documents, their online platform (accessible to all vanguards and STPs) and regular learning events.

This network support is supported by a programme of targeted support led by NHS England for aspiring integrated care systems, and regional support for all systems facilitated by the NHS Confederation, Local Government Association and others. NHS England and NHS Improvement regularly review different aspects of integrated care system operation and management, in areas that include service design, governance and staff and public involvement.

## 12. Governance and legislation

**295. Positive progress has been made within the constraints of the current legislative framework but sometimes requiring cumbersome workarounds. Our view is that national and local leaders have had little room for manoeuvre in which to transform care. We are concerned that many local areas are operating with significant risks in terms of their governance and decision-making.**

**297. The law will need to change. We recommend that Parliamentarians across the political spectrum work together to support the legislative changes to facilitate evolutionary change in the best interests of those who rely on services.**

**298. The Department and national bodies should adopt an evolutionary, transparent and consultative approach to determining the future shape of health and care. The Department and NHS England should establish an advisory group, or groups, comprised of local leaders from across the country, including areas that are more advanced and those further behind, and representatives from the health and care community, to lead on and formulate legislative proposals to remove barriers to integrated care. The proposals should be laid before the House in draft and presented to us to carry-out pre-legislative scrutiny.**

**299. The purpose of legislative change should be to address problems which have been identified at a local level which act as barriers to integration in the best interest of patients. We wish to stress again that proposals should be led by the health and care community.**

The Government will work with the NHS and other partners to develop and implement the long-term plan. The Government will consider updating the legislation where the NHS identifies a clear need to do so in order to improve services for patients including where legislation is making it harder for different parts of the NHS to work together.

As the Prime Minister made clear in her speech in June, the Government must learn the lessons of the past and not try to design or impose change. We accept the Committee's recommendation that any legislative proposals should be led by the health and care community.

The Government remains keen to consider how to build political consensus on the case for reform and funding as part of the development of this long-term plan. We welcome the involvement of Parliamentarians, as well as leaders, professionals and experts from the health and social care sector.

**300. Evidence we have heard from representatives from NHS and local government has identified the following legislative areas that may need to be considered:**

- **A statutory basis for system-wide partnerships between local organisations;**
- **Potential to designate ACOs as NHS bodies, if they are introduced more widely;**
- **Changes to legislation covering procurement and competition;**
- **Merger of NHS England and NHS Improvement; and**
- **CQC's regulatory powers.**

**Where barriers are identified and can be removed with secondary legislation, this may represent a less complex way forward.**

We will ensure that the NHS considers these and other areas in bringing forward proposals for legislative changes that would help improve quality of care for patients.

### **A statutory basis for system-wide partnerships between local organisations;**

DHSC, NHS England and NHS Improvement will work collectively to consider whether there is a clear case for further legislation to promote service integration at the heart of the health system. This work will initially be led by NHS England and NHS Improvement.

### **Potential to designate ACOs as NHS bodies, if they are introduced more widely;**

Subject to the outcome of the current NHS England consultation and the Department's consultation on the Directions, it will be possible for commissioners to award an ICP contract with that organisation then becoming accountable for providing integrated care and improving health outcomes for a defined population.

The emerging bid in Dudley, the first area that might use the draft ICP contract, is led by NHS bodies and has the support of local GPs.

As part of wider discussions on the legislative framework, the Government will consider whether any change is required in this area.

### **Changes to legislation covering procurement and competition;**

The Department has previously written to the Committee setting out the details of the current legislation covering procurement in the NHS. This legislation currently provides that Clinical Commissioning Groups (CCGs) must select an appropriate provider of clinical services by means of a fair and transparent process, but that this need not necessarily involve a full competitive tendering exercise. The current guidance to commissioners provides information on where and how the flexibilities offered by the current procurement regime can be exercised.

It is timely and helpful for the Committee to have made their report, giving us the opportunity to reiterate the message that the procurement regime is designed to benefit the NHS, its staff and its patients, not suppliers. Procurement can be an effective enabler in protecting patient choice, and, ensures public money is used transparently and in the best interests of patients. We therefore intend to work with NHSE and NHSI to explore with the NHS what possible changes they would like to see in how the procurement requirements work, or are described and explained. We will report back to the Committee on progress later this year

### **Merger of NHS England and NHS Improvement;**

As set out under the 2012 Act and the NHS Act 2006 (as amended by the 2012 Act), NHS England, Monitor and the Secretary of State have different statutory functions and accountabilities, including in relation to monitoring and supporting of trusts and CCGs. NHS Improvement is the operational name for the organisation that brings together Monitor and the NHS Trust Development Authority (TDA), the latter exercising functions on behalf of the Secretary of State.

Within this legal framework, NHS England and NHS Improvement have already taken some steps to exercise their functions in a more streamlined and joined-up way. This includes appointment of shared, associate non-executive directors to chair a joint finance group that oversees an integrated approach to managing the NHS's financial resources. NHS England and

NHS Improvement recently announced the intention to initiate from September further integration and alignment of national programmes and activities, and to establish seven integrated regional teams.

These changes will enable NHS England and NHS Improvement to work even more effectively to support increasingly integrated local health systems and make best use of collective resources. The Government welcomes these steps to deliver more joined-up leadership of the NHS.

### **CQC's regulatory powers.**

CQC supports the transformation and integration of care through working with system partners to provide coherent oversight and regulation.

As populations age, more people are living with complex needs and using multiple parts of the health and social care system. This means that quality of care and health outcomes depend increasingly on the effectiveness of system-wide collaboration. CQC is responding to this by developing approaches that take greater account of system-level quality.

As we see more providers operating across multiple sectors CQC will adapt its approach to inspection and rating to include a greater focus on leadership, partnership working and integration.

Much can be done within the existing legislative framework, but the Government will continue to work with the CQC on local systems reviews, and will consider proposals for legislative change where these are shown to benefit peoples' care.

**301. Until legislation is introduced, national bodies should support local areas to develop transparent and effective governance arrangements that allow them to make progress within the current framework. National bodies should also provide greater clarity over what is permissible within current procurement law and develop support for local areas in working through these issues. National bodies should set out the steps they plan to take to provide clarity, guidance and support to local areas on these matters in response to this report.**

Effective governance will be key to ensuring STPs and integrated care systems are able to make progress and NHS Improvement has produced a review of governance models, which has been disseminated to all STPs and will be published later this year.

In addition, NHS England and NHS Improvement provide practical hands-on support to local systems, often through their regional teams. These teams help develop system leadership, governance and infrastructure.

As well as regularly convening system leaders to explore shared challenges and to learn from each other, NHS England funds development support from The King's Fund for integrated care system leaders and their teams (continuing a programme that was well received in 2017-18). Much of this support is focused on developing the relationships and governance necessary to support effective collective decision-making.

The Department worked closely with NHS Improvement (then Monitor) and NHS England to support commissioners with guidance for commissioners, published in October 2016, on the Public Contracts Regulations 2015. This explains that NHS commissioners need not go through a competitive tendering exercise if it is defensibly obvious that there are no realistic alternatives

available, for instance because the services can only be provided by an established local hospital.

## 13. Conclusion

We welcome the Committee's report and their broad support for the principle of integrating services for patients. The publication of the NHS long term plan in the Autumn will set out the practical next steps the NHS will make to deliver this type of transformation across the country. This plan will also begin conversations with the wider public about why integrating services is important to ensuring the NHS continues to offer the highest quality services fit for the 21st century.

We look forward to working with the Committee to ensure the NHS continues to deliver the best outcomes for people and the health and care system as a whole.



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