Institute for Public Policy Research

IPPR

SOLVING THE PUZZLE

DELIVERING ON THE PROMISE OF INTEGRATION IN HEALTH AND CARE

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Acknowledgements

SUMMARY

The government is carrying out the biggest restructure of the health and care system in almost a decade. The primary aim of the reorganisation is to drive 'integration' among different NHS services and between NHS and other public services, notably social care. Health policy has been trying to achieve integrated working between the institutions responsible for health and care for decades. In theory, the integration promises to tilt policy towards prevention and improve the quality and efficiency of services.

Previous attempts to improve integrated working have little success. In some cases, this has been because integration has been 'commanded' in an overly top-down fashion – rather than fostered from the bottom-up. In other cases, efforts at integration have clashed with 40 years of policy focused on greater competition rather than collaboration.

The government's new reforms have promise. First, they have shown a willingness to reverse key aspects of the competition-orientated Health and Social Care Act 2012. Moreover, many of the new reforms have been developed with the NHS. Integrated Care Systems, a new organisational structure on which health and care will be organised, are founded on collaboration and local determination. They have a better chance of success than previous reforms.

Ultimately, the reforms will be judged on whether they improve patient outcomes. Based on the government's stated ambitions for integration, this report presents a new integrated care index. At this stage, it gives a benchmark of where we are at the start of the reform journey. In future years, it will measure progress. Based on data from 2019 we find that Integrated Care Systems have very different starting points – differences in population health and existing service integration means each Integrated Care System will have a unique set of health priorities.

- There are almost nine times as many delayed discharges per 1,000 bed days in Norfolk and Wavey ICS compared to Sussex and East Surrey ICS.
- People with severe or complicated mental health problems in Bath and Northeast Somerset, Swindon and Wiltshire ICS are three times more likely to have a care coordinator than those in Leicester, Leicestershire and Rutland ICS.
- Patients in North London ICS are 81 per cent more likely to say they lack access to sufficient support from local health and care services compared to patients in Dorset ICS.

Closing these gaps will need more than legislative change. For all the welcome aspects of the proposed legislation, the reforms will only succeed if Integrated Care Systems have the capabilities and resources to create a develop a strong *culture of collaboration*. The government's forthcoming white paper on

health and care integration should be mindful that it is culture, not structure, that ultimately determines the quality of integration. A culture of collaboration cannot simply be bottled and shipped – but it can be shaped by policy.

1. **Leadership:** there should be broad representation of organisations on the boards of Integrated Care Systems, who should create leadership development programmes that move current and future leaders around a range of place-based institutions to foster collaboration-by-default and distributed leadership.
2. **Relationships and community assets:** place-based relationships are the essence of collaboration and flourish when regulation and commissioning encourage local institutions to work together. We propose Integrated Care Systems adopt a 'community health-building' approach and that local authorities with the starkest health inequalities are supported by a 'community health-building' fund.
3. **Devolved decisions:** the government and NHS England will need to accept that 'many roads lead to Rome' when it comes to Integrated Care System governance and should resist undermining local arrangements. They should seek to support rather than sanction and mentor rather than mandate organisations that are struggling.
4. **Resources:** it is challenging to integrate productively with an underfunded social care system and with patchy data sharing capabilities. Radical social care reform and investment in health system digital infrastructure will make integration considerably easier.

Democratic accountability in the health system needs to be strengthened to hold these reforms to account. More taxpayer money is spent on health than any other public service and past reforms have failed to deliver improvements for patients, yet only weak mechanisms exist for elected officials and citizens to hold the health service to account. However, it is not clear that proposals to give the secretary of state more directive power over national and local NHS organisations necessarily strengthens accountability. We recommend these proposals are either removed or amended to provide clarity and conditionality on why, when and how these powers would be exercised. We suggest alternative ways to make health services more accountable to citizens, local government and parliament.

INTRODUCTION

The government is moving ahead with proposals to reorganise the health service. This comes at a time when pandemic continues to create uncertainty and when one in 10 people in England are waiting for treatment they need. NHS waiting times are possibly the biggest electoral threat the government faces (Forsyth 2021). The health secretary has warned the number of people waiting for NHS treatment could rise to one in four by the time of the next general election (Stoye, Warner and Zaranko 2021). This makes the timing of the reforms a clear political gamble. But if the government gets the reforms right, there is every chance they could radically improve quality of health and care in England.

Integration has been a policy objective in England for almost half a century (Shaw, Rosen and Rumbold 2011). It is desirable because it promises to improve the quality of care for those who rely on multiple services and reduce health system costs at the same time. More recently, aspirations for integration expanded to encompass reducing health inequalities and a tangible impact on local economic development (NHS England 2021). Conceptually, this makes sense – if different parts of the health system work more closely together and toward the same goals, they are more likely to achieve them.

However, it is important to recognise how difficult it has proven in practice. Past attempts to encourage integration, such as the Better Care Fund and the Integrated Care Pioneers Programmes, have not improved patient outcomes or reduced costs (National Audit Office 2017). There are two reasons this has been difficult. First, patchwork attempts to improve integration in England have tried to command reform from the centre. This has failed to build the resources and capabilities needed for useful collaboration in localities. Second, moves to enhance integration have often clashed with policies that have looked to increase competition in the health service which has, in some instances, counterintuitively fragment it (McKee et al 2011).

The reforms proposed by the government in the health and care bill have an opportunity to break with the past. The bill as it stands has two clear strengths. First, there is a willingness to move away from competition and to undo some of the fragmentation introduced in the Health and Social Care Act 2012. Moreover, there is a chance to genuinely devolve decision-making. At the heart of the proposed reorganisation are plans to create Integrated Care Systems (ICSs), a new sub-regional footprint on which health and care will be planned. Most decision-making will, in theory, be devolved to ICSs – who will have power to develop their own governance arrangements and priorities. Crucially, ICSs have been developed with NHS and local government bodies rather than dictated to them. However, the bill also contains a clear risk that could undermine the benefits devolution offers. Proposals to grant the secretary of state for health

and care new powers over NHS England and local NHS services raise concerns. It could mean that powers given away with one hand are simply taken back with the other.

While new legislation might put in place useful structures, this alone will not be enough. In 2014, Scotland created integrated joint boards requiring local authorities and NHS boards to work together to plan and deliver health and care services. Social care services in Northern Ireland have similarly been jointly commissioned and delivered with health services through a single public funded system for over 30 years. Wales coordinates all health and public health services through seven local health boards. Despite this, integration in the devolved nations has had little success in improving health and healthcare outcomes (Anderson et al 2021).

Getting integration to deliver improvement depends at least as much, if not more, on culture as it does on structure. A culture of collaboration cannot simply be bottled and shipped – but it can be shaped. As such, this paper explores how the government and NHS England can take their reform agenda one crucial step further and looks to inform the forthcoming white paper on integration. First, we explore how new structures can be combined with the capability and resource needed to create a culture of collaboration. Second, we explore ways to improve democratic accountability to ensure integration leads to improvements for patients and people. Our recommendations will help ensure legislative changes translate into better patient outcomes.

Ultimately, any health reform must be judged on whether it leads to better outcomes for patients and populations. Major health reforms of the past have failed this test. At a time when the NHS is critically stretched, it cannot afford to another restructure that does little to improve sustainability and patient outcomes. This paper is a constructive contribution to make sure this major reform achieves its potential to provide a step-change in the quality of health and care services.

WHAT DRIVES INTEGRATION?

NHS England has set out four core purposes for ICSs:

1. improve outcomes in population health and healthcare

2. tackle inequalities in outcomes, experience and access

3. enhance productivity and value for money

4. help the NHS support broader social and economic development.

These are nothing short of the grand challenges for the modern health and care system. Achieving them requires a definition of 'integration' that brings together a wide range of actors working, often in siloes, to improve health and care. ICSs that hope to deliver on these core purpose will look, at minimum, to bring together:

- **NHS services and trusts** – including primary care, community care, mental health and hospital services
- **local government services** – including social care, public health, housing, planning and other services
- **voluntary, community and social enterprise (VCSE) organisations** – both those involved directly in health and care service provision and those operating outside of health, for example in poverty alleviation
- **patients and citizens** – to improve service design, quality and accountability
- **researchers and industry** – to ensure advances and innovations in medical science and clinical care reach patients
- **other local public services** – including schools, prisons and job centres that are important determinants of health.

For the first time, NHS England has explicitly acknowledged local government, VCSE organisations and citizens as necessary and vital partners to achieve the outcomes set out above. After the NHS Long Term Plan in 2019 made alarmingly little mention of working with local government, the proposed health and care bill notes that local government should both co-lead ICS strategy and must be represented on the new ICS NHS commissioning boards. VCSE organisations are described as a "vital cornerstone of a progressive health system" by NHS England's *Integrated Care System: Design Framework* document, which also notes that patients and communities "should not just provide a mechanism for commentary on services but should be a source of genuine co-production" (NHS England 2021).

For now, though, this remains rhetoric rather than reality. In practice, ICSs will face a range of barriers to bring together different institutions involved in health

and care, including:

- lack of existing place-based relationships between institutions
- weak or poorly distributed leadership across the health system
- understaffed and overworked workforce, with considerable asymmetry between health care and social care
- differential access and entitlement to service use between health care and social care services
- funding asymmetry across with social care and public health considerably underfunded relative to hospital services
- difficulty sharing data and information with ease across the health system
- structural separation of organisations responsible for health care, social care and public health
- regulation that focuses on individual organisations rather than collaborative working between organisations
- excessive and bureaucratic central oversight and performance management.

To ensure collaborative work happens in practice, the government, NHS England and ICSs will need to break down these barriers and build a culture of collaboration.

Different starting points

The need to do more than structural reform is illustrated by the fact that ICSs have very different starting points. To highlight the levels of inequality, we have worked with the health analytics team at Carnall Farrar (CF) to develop an integrated care index.

The index is composed of a range of metrics that reflect two or more organisations working together to deliver integrated care across three major fault lines: health care and social care, mental care and physical health care, and community care and hospital care (see appendix for more detail). The index measures patient outcomes, patient experience and population health outcomes that high quality integration should lead to – rather than measuring integration as a process by assessing ICS governance. We find considerable variation in our integrated care index between ICSs before the pandemic began (figure 1).

FIGURE 1

Variation in integrated care outcomes between ICSs
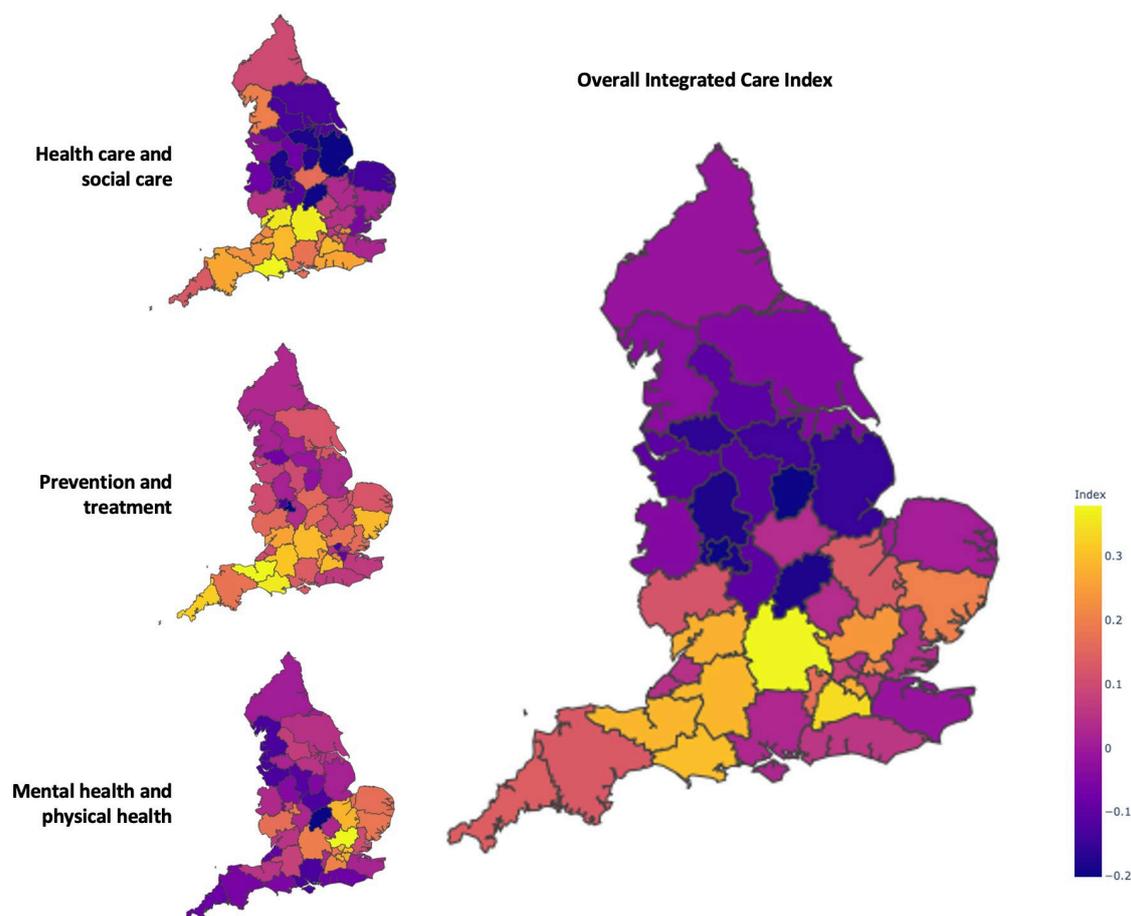
Source: CF 2021

Notes: value above 0 indicates integrated care index is above national average, value below 0 indicates integrated care index below national average. Based on data from March 2019 to March 2020 – see appendix for methodology.

Figure 1 illustrates that every ICS is starting from a different point. The scale of variation highlights the importance of allowing ICSs to set their own local policy priorities.

- There are almost nine times as many delayed discharges per 1,000 bed days in Norfolk and Wavey ICS compared to Sussex and East Surrey ICS.

- The rate of maternal deaths is 16 times higher in the Sussex and East Surrey ICS than it is in the Suffolk and North East Essex ICS.

- People with severe or complicated mental health problems in Bath and Northeast Somerset, Swindon and Wiltshire ICS are three times more

likely to have a care coordinator than those in Leicester, Leicestershire and Rutland ICS.

- Children with a mental health emergency in Birmingham and Solihull ICS are 80 per cent more likely to be seen by a mental health specialist within four weeks compared to children in Gloucestershire ICS.

- Patients in North London ICS are 81 per cent more likely to say they lack access to sufficient support from local health and care services compared to patients in Dorset ICS.

- The rate of foot amputations for every person with type two diabetes is 2.6 times higher in the in Northamptonshire ICS than it is in the Lincolnshire ICS.

If the current reforms are successful, each ICS should show an improvement in our integrated care index. That will only happen if the government matches its reforms with a plan to provide ICSs with the resources and capabilities they need to deliver improvement. Indeed, ICSs who are starting furthest behind are more likely to be places with the greatest population health inequalities and where austerity had the greatest impacts. But this is as much an opportunity as it is a challenge. If each ICS eventually matches the outcomes already seen in the top 25 per cent of ICSs, we estimate the potential national benefits could include 42,600 bed days saved in hospitals due to fewer delayed discharges and 63,300 more patients with severe or complicated mental health illnesses having to a care plan.

A framework for integration

If the government and NHS England are to get these reforms rights, they need a clear understanding of what drives integration. To that end, we have developed conceptual framework, based on over 30 interviews with local and national health and care leaders, that proposes a 'culture of collaboration' is seen as the ultimate determinant of integration in the health system (figure 2). We hope this framework provides a useful guide to the government's forthcoming white paper on health and care integration.

The factors in the outer-circle – which shape and influence the 'culture of collaboration' – are amenable to policy. They are not intended to be exhaustive but represent leading themes identified during our interviews. In the next chapter, we make recommendations to move these levers to help ICSs create a 'culture of collaboration' and deliver high quality integration. In the final chapter, we explore how the reforms can be held to account.

FIGURE 2

Determinants of integration in the health system – a framework
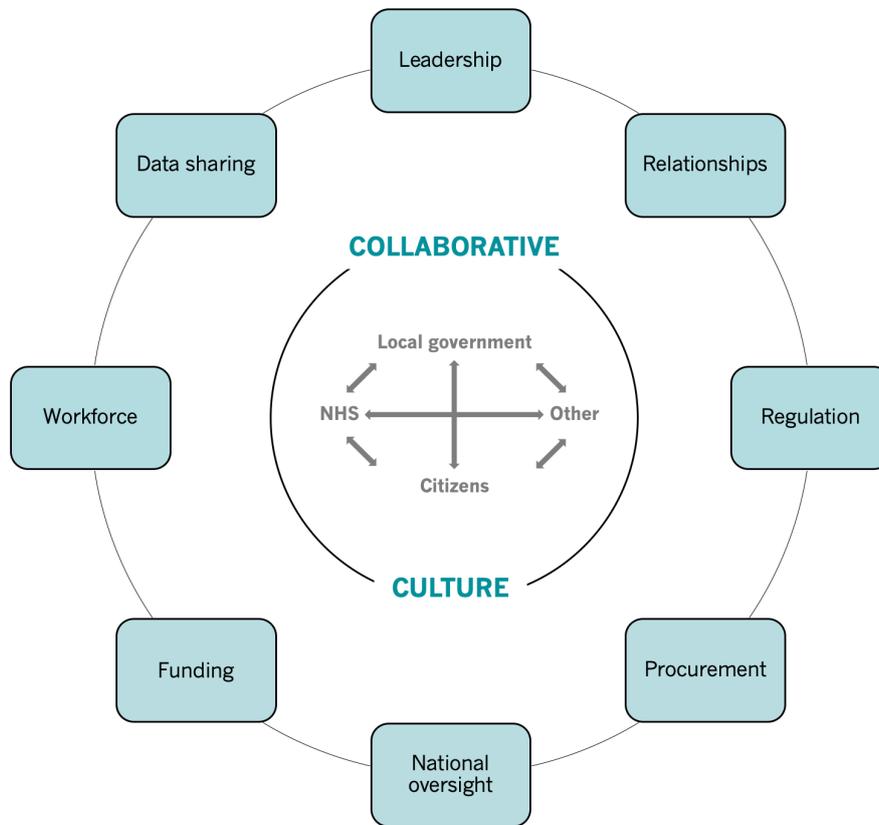
Source: IPPR 2021

BUILDING A CULTURE OF COLLABORATION

According to Raymond Williams, culture is "one of the two or three most complicated words in the English language". But it is not created in a vacuum. Indeed, it is entirely possible for the government and NHS England to impact and change culture in the health and care system. If ICSs are to deliver on the core purposes they have been set by NHS England, they will need to have the resource, powers and capabilities needed to create a strong a culture of collaboration.

1. Distributed leadership

Leaders at every level of the health system – PCN directors, Trust executives, council executives and ICS board members to name a few – are among the most influential shapers of a culture of collaboration. Successful integration relies on leadership being well distributed across the health and care system, rather than concentrated in any one part. Too often it is acute hospital trust executives that yield greater power than those in primary care, community care and local government.

ICSs should signal a move away from this power dynamic. Better distributed leadership will allow ICSs to better meet local health priorities – for example seeking to reduce local obesity levels not just by commissioning weight loss classes but by considering how urban planning and local transport policy can encourage heathier diets and exercise.

Equally as important as distribution of power is the concept of a common mission and common responsibility (Quilter-Pinner and Antink, 2017). The West Yorkshire and Harrogate ICS is a good example of this principle in practice. It is a principle that should now govern the relationship between the two boards of an ICS. If the commissioning board and strategy board are not aligned in their mission or feel a shared sense of responsibility, the ICS reforms will amount to little more than a rearrangement of the deck chairs.

Distributed leadership cannot be commanded from the centre. Indeed, it would be actively detrimental to mandate or recommend specific governance arrangements within an ICS. But policy can help evolve the right leaders over time and better distribute power within ICSs.

We recommend the following.
- **ICSs create their own leadership development programmes**. There are simply not enough leaders who 'think in systems' in the health sector. National NHS leadership development programmes have proliferated in recent years, but they overlook the importance of local geography and institutions beyond the NHS. Most programmes offered by the NHS Leadership Academy and the Faculty of Medical Leadership and

Management do not incorporate formal routes of exchange between the NHS and local government. ICSs should create their own leadership development programmes that move current and future leaders through the health, housing, education, police, community and voluntary sectors to develop a deep and local understanding of what makes integration work. This kind of knowledge exchange not only develops leadership but also builds the foundations for relationships that define integrated working.

- **ICS members should have the power to democratically remove their chair**. Appointment and removal of integrated care board chairs can only be performed by NHS England and requires secretary of state approval. There is no process for members of the integrated care board themselves to initiate a process to remove their chair. This is clearly problematic and goes against the concept of distributed leadership. Members of the integrated care board should be able to initiate a process to democratically remove their chair.

2. Local relationships and community health-building

Place-based relationships are essential to a culture of collaboration. They take time to develop and are stronger in places that have been working together for longer. Relationships at the ICS footprint level, however, are relatively new across the country.

Regulation of health and care service regulation is one factor that sets the conditions for relationship building. Regulating only individual organisations can re-enforce rather than repair fragmentations in the health system (Edwards, 2016). Approaches to regulating a group of place-based organisations, and therefore regulating integrated working, have been piloted for years but have not yet become the main focus of regulatory activities. The shift of ICSs should come with a shift in the regulatory system if collaboration and co-ordination are to succeed.

One of the most promising opportunities from the change in procurement rules is the potential to take an asset-based approach to commissioning, which actively seeks to build up the human, social and physical capital of local communities (Local Government Association, 2020). ICSs can learn from councils such as Preston City, Wigan and Newham that have been pioneering 'community wealth building' – using their commissioning powers and budgets to not just commission services but to ensure they also create high quality local jobs, support community organisations and local businesses, and drive local economic growth. If ICSs take a similar 'community health-building' approach, they will improve the wealth and health of their localities and strengthen place-based relationships.

We recommend the following.

- **The Care Quality Commission regulates ICSs and takes a less burdensome approach to individual providers.** Following a recommendation for the Health and Social Care Select Committee, it likely an amendment to the health and care bill will provide the Care Quality Commission (CQC) with powers to regulate ICSs. This is welcome and may nudge better collaborative working. It should not come at the expense of regulating individual organisations, which is vital to ensure patient safety, but should come with a rebalancing of where the CQC focusses its resources to drive quality improvement and breed excellence rather than compliance. We recommend regulation of individual providers becomes less burdensome, for example with fewer on-the-ground inspections, to ensure the new system of regulation does not simple simply insert an additional level of bureaucracy.

- **ICSs take a 'community health-building' approach to commissioning**. The sizeable commissioning budgets ICSs will be in control of gives them considerable influence over social and economic development in their localities. They should consider spending this in a way that improves the wider determinants of health – both directly, for example organisations involved in adult education, and indirectly, for example by contracting organisations that would create high quality local jobs. In this way, both community wealth and health can be improved. The first step will be for ICS strategy boards to map out the health-creating assets in their footprint, which should include organisations that have both direct and indirect impacts on health. The ICS commissioning board should use this local 'asset' map when making commissioning decisions.

- **The government creates a 'community health-building' fund for local authorities**. Some places have richer 'assets' than others – for example thriving community organisations and strong local public services. Indeed, places with fewer 'assets' often also have greater population health inequalities and experienced the greatest cuts in council funding (Thomas, Round and Longlands 2020; Johns et al 2020). If this is ignored, regional health inequalities could continue to grow, with well-off places benefitting most from ICS reforms. To help develop health-promoting community 'assets', the government should create a 'community health-building' fund for local authorities with the starkest health inequalities. This could be seen as an investment in social infrastructure and a partner to the physical infrastructure focussed Levelling Up Fund.

3. Devolved governance

Every ICS will have different governance structures, priorities and strategy. This is not only to be expected, but to be desired. There is no one-size-fits-all

approach to integration. Considerable variation exists in population demographics and health needs, local politics, provider make-up between ICSs.

At the heart of the integrated care system reforms is the acknowledgement that improving population health requires place-based decision-making. ICSs will, for example, be able to set their own constitution and make decisions around staff pay. This is welcome – decentralising health policy is associated with better patient outcomes and a culture of collaboration flourishes when intervention from the centre is kept to a minimum (Dougherty et al 2019).

Although ICSs will be granted most decision-making powers, NHS England will retain its powers to intervene at both the ICS and provider level, and the bill proposes to give the executive government new powers of direction over national and local health policy. This means NHS England and government both risk undermining the benefits of genuine devolution. Signs of this are already emerging. NHS England have tried to prescribe 10 mandatory members for ICS commissioning boards (this was rightly rejected). If the ICS reforms are to be successful, NHS England and the executive government will need to accept many roads lead to Rome.

We recommend the following.
- **NHS England supports, rather than bypasses, struggling ICSs - exercising its powers of intervention only as a last resort**. NHS England's *System Oversight Framework* is right to incorporate ICSs in its oversight system, but should go further to make ICSs the default first port of call for struggling Trusts, rather than NHS England itself. The *System Oversight Framework* provides little detail on what NHS England's 'Recovery Support Programme' for underperforming ICSs and Trusts would entail. Traditionally, the approach to 'laggards' has been one of sanctions and external management by NHS England. If ICSs are to become sustainable institutions in themselves, it would be better to make more use 'more carrot and less stick'. This could include better use of mentorship programmes. A good example of successful mentorship is the London Challenge, a school improvement programme launched in 2003 and credited explicitly with significant improvements in the London education system (Kidson and Norris 2015). In their evaluation, Ofsted noted the London Challenge "continued to improve outcomes for pupils in London's primary and secondary schools at a faster rate than nationally" (Ofsted 2007), a finding repeated in a more recent evaluation (CfBT Education Trust 2014). The programme worked by pairing high performing schools with others, with a remit to provide mentorship. The focus was not on shaming poor performance but building capability to improve outcomes. NHS England should look to develop better mentorship

schemes, which could be adopted by trusts within a provider collaborative,[1] and perhaps even between ICSs.

- **Limiting legislative proposals to give the secretary of state greater powers of direction over NHS England and local service reconfigurations**. These proposals create opportunity for the national political pressures in Westminster to bypass local health priorities (see Chapter 4). We recommend clause 38 and schedule 6, which relate to new powers over local service reconfigurations, are removed from the health and care bill. We also recommend that clause 37, which relates to new powers over NHS England, is either removed or amended to provide clarity and conditionality on when, why, and how the government would direct NHS England.

4. Resource to integrate productively

There are stark funding, workforce and data-sharing asymmetries between health care and social care. The pattern is the same: resources are thin in the NHS and considerably thinner in local authorities. Attempting to integrate under-resourced public services will not improve outcomes for patients and populations, nor will it improve productivity.

Austerity starved the NHS but fell hardest on local government budgets. The pandemic has widened this inequality: the NHS has been relatively well supported through special funding arrangements with HM Treasury but local councils are facing financial ruin and several have gone bankrupt (Ogden and Phillips 2020). That access to health care is free at the point of use for all but social care is means tested is another formidable hurdle to integration. Hypothecated integration funding, such as the Better Care Fund, can help but only papers over the cracks – to be capable of genuinely productive integration, local authority financing needs more radical reform.

A well balanced and motivated health and care workforce, and an ability to share data between organisations, are prerequisite to good integration. But working in an understaffed health system leads to burnout, moral injury and mental health problems (Patel and Thomas 2021), making integrated care challenging under the constraints. For example, ensuring a patient's social care package workforce is ready for a timely and safe discharge This is made even harder by the lack of occupational mobility within the health and care. Moving data between organisations can be almost as difficult. IT interoperability and capabilities to share data within and between health and care institutions is incredibly poor.

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[1] Provider collaboratives are two or more NHS trusts working together to join up services in a place or ICS. They are an important part of the ICS reforms and every trust in England is expected to part of a provider collaborative by April 2022.

This makes providing integrated care, joining up services and planning in systems cumbersome at best and impossible at worst.

We recommend the following.

- **A 'Long Term Plan' to overhaul the quality of social care.** The government's 'cap and floor' proposals resemble progress and will help thousands of families avoid catastrophic care costs. However, pressing questions around the quality of social care and its workforce remain unanswered. A funding boost of £5.4bn over the next three years for social care falls far short of the £7bn a year the service needs (Patel, Thomas and Quilter-Pinner 2021). Better integration with the NHS will remain challenging without improving the employment conditions of care workers and without improving the quality of social care providers. A 'Long Term Plan' for social care should be high on the government's list of priorities if it remains committed to "fix the crisis in social care".

- **A multi-year capital budget to upgrade digital infrastructure across the health system.** The main barrier to data sharing within and between health care and social care organisations is technical rather than regulatory. ICSs should make IT interoperability a priority – it will lead to better health and healthcare outcomes, reduce inequalities and improve productivity (Wachter 2016). They will require considerable investment to upgrade digital infrastructure, which should come from the Department of Health and Social Care's capital budget rather than squeezed from day-to-day NHS budgets. A four-year digital transformation capital budget should be announced at the comprehensive spending review. NHS England have estimated a total £8.1 billion is required to fund the digital transformation, although the Commons Public Accounts Committee suspects this is an underestimate (Public Accounts Committee, 2020). Crucially, this funding should be transferred to ICSs rather than controlled by NHS England to avoid repeating the mistakes of failed IT programmes of the past.

HOLDING THE HEALTH SYSTEM TO ACCOUNT

Health is the largest single item of day-to-day government expenditure, rising from 27 per cent in the 1990s to 42 per cent in 2019/20 (Stoye and Zaranko 2019). The funding settlement announced in September 2021 will push this to 44 per cent of day-to-day public spending by 2024/25 (Zaranko 2021). Despite this, mechanisms to hold the health service to account are weak.

In recognition of this, the *Integration and innovation* white paper included a section titled "improving accountability and enhancing public confidence" (Department of Health and Social Care 2021). This is welcome and necessary; greater accountability is key to ensuring integration succeeds in improving the health of patients and populations, and vital to the NHS's sustainability (Guerin, McCrae and Shepheard 2018).

Table 1 summarises of the main institutions with accountability for health care in England. There is a clear power imbalance between elected and unelected officials: decision-making overwhelming lies with experts and trained professionals. There is good reason for this – planning and delivery of health and care services requires specialist knowledge and skills, and independence from politicians ensures a single-focus on patients. But a governance system poorly reactive to public demand is undemocratic – the role of elected officials and citizens in health and care should be strengthened.

This chapter explores how political accountability can be strengthened. We outline a refined role for greater ministerial powers, as well as a much more pronounced role for local government and citizens. We believe this offers a more nuanced take on one of the more controversial aspects of the government's NHS bill.

TABLE 1

Distribution of accountability for health care in England

NHS footprint	Political accountability (elected officials) and citizens	Administrative accountability (unelected officials)
National	Executive government parliament	NHSE CQC
System	Mayors	ICS
Place	Local councils	Trusts
Neighbourhood	Citizens	General practice

Source: IPPR 2021

New political powers

The health and care bill includes several proposes to expand the powers of the secretary of state such that the executive government is more able to direct NHS England and other "arm's length bodies", ICSs and local service reconfigurations.

- **NHS England**: clause 37 of the Bill provides the secretary of state a new general power of direction over NHSE. These powers are not defined any further. It would create a second channel, outside of the NHS Mandate (which will no longer be set annually), for the executive government to direct NHSE.
- **Integrated care systems**: appointment and removal of integrated care board chairs require secretary of state approval and can only be initiated by NHS England. There is no process for members of the integrated care board themselves to initiate a process to remove their chair
- **Local service reconfigurations**: clause 38 and schedule 6 of the bill allows the secretary of state to intervene at any stage of any local service reconfiguration. Health care service changes are often divisive – for example reconfiguring London's stroke care services was contested at the time but has proven highly successful at improving survival. Allowing the executive government to interfere in service changes, usually driven by quality improvement, means electoral motivations could interfere patient outcomes and public health.
- **Arm's Length Bodies**: clauses 86–92 of the bill allow the secretary of state to transfer functions between, and abolish, certain ALBs including Health Education England, NHS Digital and NHS England.

Taken together, these proposals mean health and care policy is likely to become more political and less predictable – potentially at harm to patients and public health. Figure 3 illustrates how the proposals for new executive government powers can bypass existing governance and decision-making processes in health care.

FIGURE 3

Powers of direction in health care institutions in England

Current powers of direction (top diagram) and powers of direction under new proposals (bottom diagram)
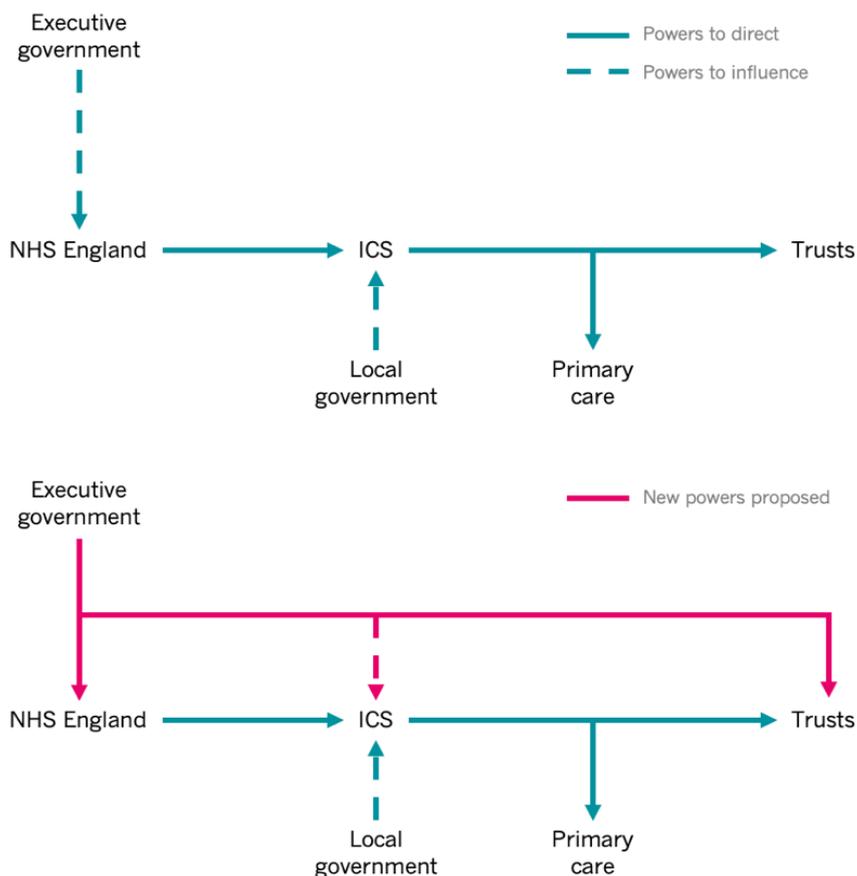
Source: IPPR 2021

It stands to reason that such moves may allow the government to implement policy more effectively. But fewer checks and balances on the executive government can pose problems – it is easy to see how greater government powers may lead to national politicians interfering with local ICS priorities for electoral advantages. There is also a question about efficacy and performance. Analysis of OECD countries found decentralising health policy decision-making, at least to an intermediate level of government, is associated with lower costs and increased life expectancy (Dougherty et al 2019).

We recommend against clause 38 and schedule 6 in the health and care bill, which provide the government with new powers over local service reconfigurations. There is already a robust and independent review process for these service reconfigurations. The secretary of state does not have the local expertise or adequate time to add value to this process. The result would likely

be more arbitrary, or politically bias, decisions about local health service reconfigurations. We also recommend against clause 37 in its current form, which provide the government with 'general powers of direction' over NHS England. It is clear that in some cases the government may want to direct NHS England such that it is better aligned to its broader policy goals, for example on climate change. However, clause 37 in is broad, ambiguous and compromises the independence of NHS England, which exists to safeguard patients from political expediency. The government should either remove clause 37 from the bill or propose an amendment that includes conditions for when, why and how it will direct NHS England.

Other ways to enhance democratic accountability

Parliament

Parliament is well placed to provide democratic accountability at the national level. There are two main mechanisms. The first is through the NHS Mandate, which the secretary of state sets for the NHS and can, in theory, be debated in parliament if the NHS believes it is being set unreasonable objectives (in reality, the NHS Mandate has never been debated in parliament). The second is through the House of Commons Health and Social Care Select Committee which plays a critical role in scrutinising the government and NHS England. It has already played a pivotal role analysing the current ICS reforms, with many of its recommendations taken up by the government.

We recommend the following.
- **The NHS Mandate is debated and approved by parliament.** We propose *The Health and Care Bill* switches the NHS Mandate from negative resolution regulations to affirmative resolution regulations. This would mean the NHS Mandate would require positive endorsement from both houses of parliament. It is particularly important given the Mandate will no longer by set on an annual basis.

Local government

Local government is central to health system integration. It is also democratically elected. We welcome that local government will be represented on both the ICS NHS commissioning board and the ICS strategy board. But each ICS will encompasses multiple councils and often politicians of different stripes. Working more closely with local politicians in itself strengthens democratic accountability. Local authorities are also well placed to examine links between local public services and hold integrated working to account.

We recommend the following.

- **Health and wellbeing boards scrutinize the integration of local public services**. Their remit should be broader than just health care and social care services and examine how, for example, policing and health care services are working together. Health and wellbeing boards are well placed to scrutinize the state of integration among local public services, including NHS and social care services, and identify opportunities for closer integration to improve outcomes and productivity.
- **ICSs should work with local politicians when making commissioning decisions that affect their locality**. ICSs will be responsible for a considerable amount of spending that will affect local communities directly, through what health services are commissioned, and indirectly, through the impact they have on local social and economic development. Local government, by virtue of being members of both ICS commissioning and strategy boards, will influence commissioning decisions. But not all councils within an ICS will be board members. ICSs should go further to meaningfully engage with the full breadth of councils they overlap with when making commissioning decisions that affect their local populations.

Citizens

Almost two decades ago the Wanless review of the NHS envisaged that higher levels of public engagement would be fundamental to improve quality of care and health outcomes (Wanless 2002). To this day, there remains only weak mechanisms of direct accountability of health and care services to patients and citizens. There is not single 'correct method' of better involving citizens in decision-making, and ICSs should use a range of quantitative (eg surveys) and qualitative (eg citizen panels) approaches. Building citizens into the decision-making process will only grow in importance as variation in service provision in an inevitable aspect of devolving powers to ICSs.

We recommend the following.
- **Local citizen panels are used to resolve difficult trade-offs and conflicts in ICSs**. In the context of the pandemic and special financing, ICSs have not yet faced difficult resourcing decisions and trade-offs. It is inevitable that difficult decisions will have to be made around service commissioning and strategic prioritisations. This is likely to lead to a new footprint for 'postcode lottery' in health and care. The best solution to this is to deliberate trade-off decisions with citizens such that they are democratic. Deliberation, rather than engagement, implies that people and communities are seen as active decision makers rather than merely informed of decisions the ICS board has already made.
- **Patients are represented on ICSs NHS commissioning board**. While we believe it is important to not overprescribe membership of ICS boards, it is imperative that an institution that represents patients sits on this board. While it should not be assumed this body represented the view of

all patients and amounts to sufficient patient engagement, ensuring a patient organisation is involved in ICS decision-making will be of considerable value. We recommend this is added to minimum integrated care board membership requirements in the health and care bill.

APPENDIX

Integrated care index methodology

The index was developed by Carnall Farrar and IPPR to analyse outcomes associated with integrated care across ICSs in England. We decided to consider only metrics that related to patient outcomes, population health outcomes and patient experience – rather than attempting to measure the process of service integration itself. Carnall Farrar and IPPR worked to identify a set of variables that measured integrated care across three major faultlines in the health system:

1. health care and social care
2. community care and hospital care
3. mental health and physical health care.

Carnall Farrar sought to identify which of these variables had publicly accessible data sources, collected data and developed the index.

Data sources

- Hospital Episode Statistics via NHS Digital Data Access Request Service.
- Emergency Care Data Set via NHS Digital Data Access Request Service.
- Maternity Services Data Set via NHS Digital Data Access Request Service.
- Public Health England Fingertips.
- GP Patient Survey.

Data collection

- Data was collected from March 2019 to March 2020.
- Data granularity varied by data sources, including CCG and ICS levels. Data from CCG levels was mapped onto ICS levels. Where data was not available at either these levels (e.g. only available at local authority level), we were not able to use that metric in the index, as there is not a clear mapping between local authorities and ICS areas.
- Where the data is at CCG level, some data sources used the '2019' CCG list, when there were 191 CCGs, and others the '2020' CCG list, when there were 135 CCGs left after some mergers. This has not impacted the roll-up of CCG to ICS level.

Variables

A total of 23 variables compose the current version of the integrated care index.

Physical and mental health	Per cent of children and young people presenting to emergency services for mental health reasons and seen by specialist mental health services within four weeks
	Hospital admissions as a result of self-harm
	Mental health service users on the Care Programme Approach (CPA)
	Adults subject to Mental Health Act
	Hospital admissions due to substance misuse
	Proportion of people with severe or complicated mental health problems with a crisis plan
	Rate of accident and emergency department presentations for mental health related conditions
	Years of life lost due to suicide (age standardised, 15-74 years)
Community care and hospital care	Percentage of people with type 2 diabetes who were offered and attended Structured Education within 12 months of diagnosis
	Record of offer of support and treatment to smokers
	Proportion meeting two months wait target from GP referral to first treatment for cancer
	Maternal mortality rate
	Diabetic foot amputation rate
	Deaths from causes considered preventable (under 75 years, standardised mortality ratio)
	Patient-reported sufficient support from local services to manage condition
	Patient-report oxford hip score
Health care and social care	Rate of accident and emergency department presentations for people who are homeless
	Rate of hospital admissions related to social problems such as pressure sores and safeguarding concerns
	Ambulance calls from residential or nursing home
	Rate of delayed discharges
	Patient-reported sufficient social care support during cancer illness

Indexing methodology

- Data has been assigned a polarity, to determine whether an increase in the metric is seen as a positive indication of integrated, or a negative indication of integrated care.
- The overall index equally weights the three categories (health care and social care; community care and hospital care; mental health and physical heath) at 33.3 per cent. Within a category, each variable has been weighted equally.
- Where required, data has been adjusted to account for differences in population size and prevalence.
- Adjusted data has been converted into an appendix using a 'z-score' approach, looking at how many standard deviations each data point is away from the national average. The 'Tanh' function has then been applied to this data. This will reduce the impact of extreme outliers on every other data point, and brings every data point between -1 and 1.
- For each metric, an index of +1 shows the most integrated ICS areas, and an index of -1 shows the least integrated ICS areas, relative to the national average.
- When using this approach to calculate the index for future years, the same approach should be used, but when calculating the 'z-scores' for each metric, the baseline (2019/20) median and standard deviation should be taken. This will demonstrate how things are moving nationally over time.

Limitations

There are several limitations to our index, most notably that it is not exhaustive measure of integrated care. This is both because integrated care is broadly defined and because data access is limited. We hope to iteratively develop the index over time and add to the variables the variables that compose it. Despite this, we believe the current version of the index provides a helpful snapshot of the variation between ICSs before the reforms have kicked off and the different starting points. This will allow monitoring of progress over time per ICS.

We also made the decision to measure only health care outcomes, population health outcomes and patient experience outcomes. This is what we think ultimately the reforms should be judged on. We have not looked at financial data or attempted to evaluate governance arrangements.

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