The King's Fund>

Ideas that change health care

Leading for integrated care

'If you think competition is hard, you should try collaboration'

Nicholas Timmins

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Foreword

When the NHS was established in 1948, its primary purpose was to provide episodic treatment for acute illness. But the success story of our ageing population means the health and care system now needs to deliver joined-up support for growing numbers of older people and people living with long-term conditions. This requires those delivering and managing services to work – and lead – differently, breaking down silos to collaborate across organisational boundaries and giving greater priority to promoting population health. The development of integrated care systems (ICSs) is an ambitious attempt to make a reality of these ambitions.

The move towards greater integration and system leadership is not new and the path has not always been smooth. The *NHS five year forward view* began the current journey back in 2014 (**NHS England *et al* 2014**) and the NHS long-term plan built upon these foundations (**NHS England 2019a**), not least by making clear that all of England would be part of an ICS by April 2021 and, more recently, as NHS England set out a targeted set of legislative changes that would support more integrated working.

System leadership in the current health and care landscape does present challenges. It is a new direction for a system that has lived with varying degrees of organisational independence and autonomy for nearly 30 years. It is a homegrown effort across the country, not imposed from on high. While this is the right thing to do, it does place enormous onus on local leaders to find their own way. As they do so, there remain many tensions in the system that still push leaders back into their own organisational silos and away from the collaborative working needed to integrate care or to ensure that all parts of the system pull together to improve population health. Nicholas Timmins' first report on the practice of system leadership in 2015 set out many of the themes and principles that are now being applied and experienced by health and care leaders (**Timmins 2015**).

In this new report, Nicholas builds on these findings through interviews with 16 people, either leading or chairing an ICS or a sustainability and transformation partnership (STP) to explore the progress, challenges and opportunities this new

way of working presents to those tasked with taking it forward. Some of the names will be familiar to an NHS audience, as many have previously held high-profile roles in health and care or indeed still hold other, formal accountability roles in addition.

The report underlines that these local systems are still evolving. But it is important to note that the interviewees did believe that it *was* evolving: progress is being made towards a more integrated way of working. This has meant major changes for leaders, many of whom have spent their careers within a world where organisational autonomy was key and success was based on your organisation's own performance.

As it is an evolution, there is still much to do. Clearly, the approaches to accountability and transparency vary in these systems as we would expect from locally driven initiatives. This makes many commentators understandably uncomfortable. However, as there is no clear 'end state', in terms of the best form for governance and accountability, we must look to local leaders to continue to navigate the 'web of accountability' they face even if, ultimately, a greater degree of consistency will almost certainly be necessary.

It is also striking how many of these leaders are not only senior and experienced, but also towards the end of their careers, some of whom have been called back to help out sometimes troubled areas or relationships. Yet there is not an inexhaustible pipeline of the great and the good and over time the system will need to consider how it generates a sustainable supply of leaders willing and able to take on these clearly demanding roles.

We are grateful to Nicholas Timmins for undertaking this work and to the senior leaders who gave up their time to speak with him. As the leadership of the NHS and its partners continues to evolve, listening to those that live with its complexities will, I am sure, continue to provide lessons to us all as we work towards ensuring the population can benefit from healthier places and communities.

Richard Murray
November 2019

Key messages

- Progress towards integrating care better is being made. It is not easy and rarely is it fast. But progress there is.

- There is widespread agreement about the skills needed to achieve progress.

- There is much more variation in to whom the chairs and the leads of sustainability and transformation partnerships (STPs) and integrated care systems (ICSs) feel they are accountable.

- Governance of STPs and ICSs remains in a state of flux. There is considerable agreement that in time ICSs will need a statutory basis, but in a St Augustine way: 'Lord make me pure, but not yet.'

- As a very broad generalisation, relationships between the NHS and local authorities appear to be improving, with population health and its determinants featuring more strongly on the agenda.

- There is a growing issue about how 'load bearing' ICSs can or should become. How far can they, or should they, take on responsibility for quality and financial performance as opposed to planning and implementing the 'transformation' of care? In other words, what will their relationship eventually be with the centre, the region and the regulators?

- There are worries about the pipeline of future leaders of ICSs.

- There is agreement that if this essentially voluntary approach to co-ordinating care better can be achieved, then it will stick, and probably more firmly and effectively than if it was merely mandated by legislation.

Introduction

For well over a decade The King's Fund, through a mix of research, publications, courses and events, has had an interest in system leadership (Dougall *et al* 2018; Ham 2018; Gilburt 2016; Timmins 2016; Timmins 2015; The King's Fund 2011). And, quite clearly, there is no greater challenge for system leadership within the conjoined worlds of health and local government than the move to integrated care systems (ICSs).

Yet these are non-statutory arrangements; they have no direct powers. The coming together of local government and often myriad health organisations from the public, private and third sectors is essentially a voluntary exercise driven by what is perceived to be best for patients and the wider population – but with remarkably little ability to compel anyone to do anything.

Ask the chairs and leads of these organisations what authority they have and the typical response is either a loud laugh or a wry grin and the answer 'none' – which is not to say, as we shall see, that they do not have informal authority of one sort or another.

So the purpose of this piece is to explore what is involved in leading the drive to better integrated care. The discussion is based on interviews with 16 chairs and leads around the country who gave up their time to contribute. What are the skills needed? How is it being done? What are the challenges and barriers to getting there? What helps, and what stands in the way?

It is also important to state what this piece is not. It is not an attempt to assess in any detail how well the drive to integrated care is going, nationally or locally. Nor is it an attempt to assess how far advanced, or otherwise, places are on this journey. Rather, it is an attempt to explore the process: how it is being done and what is involved in doing it. And, from that, we seek to draw out not recommendations as such, but at least some understanding of what might make the process easier.

It is framed against the background of the *NHS five year forward view* of 2014, which made the case elegantly and succinctly for better integration of health

and care services (**NHS England** *et al* **2014**). That document was also arguably the first ever NHS document to say that things did not have to be done in the same way everywhere when it came to the organisation, management or procurement of services above the level of the individual unit (for example, a hospital or GP practice). The message was clear that a number of decidedly different models and approaches could emerge.

It was also equally clear that the NHS was already starting to move away from the 'choice and competition' model enshrined in the 2012 Health and Social Care Act. The tensions that the move created were neatly spelt out three years later by Matthew Swindells, then director of operations for NHS England:

> *We are trying to move the NHS from the model of the last 15 years or so with a purchaser–provider split, with transactions through contract, and with organisations asking 'What can we bill for?' and 'What can we charge for?' to a more population health management model... It is a big challenge. Because even when people do get the health system thinking going, the boards of individual organisations then say: 'Ah. But we have to balance our books.' And we are trying to say to them: 'Don't worry about that. If we can give you an overall budget for the health system, that is the one that has to balance.' But the regulation does make it difficult.*
>
> *If we had legislation, would it help? I don't know. On my more optimistic days I think that if we can pull this off it will stick better, because people will have done it themselves, rather than if we had the old, top-down approach of reorganisation, which is what legislation might give you.*

What follows is a summary of the views of some of those trying to deliver exactly that – better integrated care, through differing local models, in an approach that is essentially voluntary, and within existing legislation. And with that will come a little analysis.

Before we begin, it is worth making a brief point about the sample. We decided that if this was to be helpful – and we hope it is – it was best done quickly. Interviewing all the chairs (where they exist) and all the managerial leads of these 44 emerging systems would not have been quick. So we approached 20 of those involved. One measure of whether this might be worth doing was the large number who immediately said 'yes'.

It is important to stress, however, that while we sought an element of balance between chairs, leads, geography, etc, this is in no way a properly representative sample. It does have a reasonable gender balance. The geography is not perfect, but it is not bad. It lacks, most notably, any representation from the black, Asian and minority ethnic (BAME) community – not least because there is (to the shame of the NHS, which reflects a wider issue in itself) only one BAME leader of either a sustainability and transformation partnership (STP) or an ICS (a chair). It did not prove possible to interview Lena Samuels, independent chair of Hampshire and Isle of Wight STP, in the timescales for this work.

All that said, however, this does reflect a spectrum of views from those trying to do a difficult – or, as one interviewee put it (humorously) 'impossible' – job. The conversations were conducted through a mix of on and off the record, which felt important given that people were discussing relationships in real time. Thus not all are quoted either equally or attributably. But, whatever they might think of the outcome, all helped hugely in informing this piece.

At this early stage, it is also crucial to stress that there were huge variations in the answers to almost all the questions posed: whether about governance; relations with local government and the third sector; the impact of geography; style; the sense of progress; and indeed in what people perceive to be the main barriers to progress. For every question to which it might seem there was broad consensus in the answer, there was always one or more exceptions. Variation thrives.

In alphabetical order, those who made this possible are:

- Bob Alexander, Chair, Sussex Sustainability and Transformation Partnership, former Chair of the Trust Development Authority

- Paul Burstow, Chair, Hertfordshire and West Essex Sustainability and Transformation Partnership, former deputy council leader and health minister

- Sir Andrew Cash, lead, South Yorkshire and Bassetlaw Integrated Care System, former foundation trust chief executive

- Cheryl Coppell, Chair, South West London Sustainability and Transformation Partnership, former local government chief executive

- Adam Doyle, lead, Sussex Sustainability and Transformation Partnership, current Accountable Officer for the county's clinical commissioning groups

- Amanda Doyle, lead, Lancashire and South Cumbria Integrated Care System, general practitioner by background and in current part-time practice

- Fiona Edwards, lead, Frimley Health and Care Integrated Care System, current chief executive of a foundation trust

- Claire Fuller, lead, Surrey Heartlands Health and Care Integrated Care System, general practitioner by background and in current part-time practice

- Tim Goodson, lead, Dorset Integrated Care System, current Accountable Officer for Dorset Clinical Commissioning Group.

- Sir Chris Ham, Chair, Coventry and Warwickshire Sustainability and Transformation Partnership, former Chief Executive at The King's Fund

- Patricia Hewitt, Chair, Norfolk and Waveney Sustainability and Transformation Partnership, former Secretary of State for Health

- Ann James, Chief Executive, University Hospitals Plymouth NHS Trust, sometime lead for Devon Sustainability and Transformation Partnership

- Jane Milligan, lead, East London Health and Care Sustainability and Transformation Partnership, Accountable Officer for seven north-east London clinical commissioning groups

- David Pearson, Chair, Nottingham and Nottinghamshire Integrated Care System, former lead of its Sustainability and Transformation Partnership, and former council deputy chief executive and adult social care director

- Sir David Nicholson, Chair, Hereford and Worcestershire Sustainability and Transformation Partnership, former Chief Executive of the NHS

- Philippa Slinger, lead, Devon Sustainability and Transformation Partnership, former foundation trust chief executive and improvement director.

The report is split into seven sections. In Section 1, we look at the skills needed to deliver integrated care, the time taken, and what levels of authority and accountability chairs and leads feel they have. Section 2 looks at whether the

move from STPs to ICSs is helping. The third explores questions around geography and relations with local government and others. Section 4 looks at issues around governance and relationships with regions and the centre. The fifth considers how far all this can go without legislation. Section 6 considers whether there is a pipeline of future leaders. And Section 7 considers some of the challenges not addressed earlier. We finish with a tentative take on whether this essentially voluntary approach will succeed and stick.

But with that comes a big warning. Perhaps because this is about integrating care, answers and issues overlap between those broad divisions. To take just one example, the first section (on skills and experience needed) overlaps to some extent with Section 6 (on whether there is a pipeline of future leaders of ICSs).

1 Skills, authority and accountability

What are the skills needed to lead a sustainability and transformation partnership (STP) or an integrated care system (ICS)?

Entirely unsurprisingly, the 16 chairs and leads who kindly gave up time to contribute play back all the themes from *The practice of system leadership* (**Timmins 2015**), including – occasionally and wryly – its subtitle, 'being comfortable with chaos'. One or two even cited that report. The skills they highlighted include: being able to walk in other people's shoes; having a constancy of purpose while retaining flexibility; and building the evidence base for change, as a key tool for persuading the unconvinced – with persuasion the main way to get things done. Having a stable leadership team clearly also helps a lot; though, as we shall see, lack of such can be overcome. What is clear is that the quality of relationships – whether with local government, other parts of the NHS or the independent sector – is crucial. From the earlier report on system leadership there was even playback of the lines that 'you can achieve almost anything so long as you don't want to take the credit for it' and that 'you have to give away ownership'.

But there was also acknowledgement, as in the earlier piece, that system leadership is not easy, and that it takes time – often a lot of time. Indeed, frustration at the slow pace of change that is possible through this approach was a recurring theme.

Take a few quotes on the skills needed. Ann James, Chief Executive at University Hospitals Plymouth NHS Trust, who has at times been a lead for the Devon STP, says: 'You need to drink a lot of tea and use a lot of shoe leather to build the relationships, and those conversations ebb and flow to get you to a good position – to a position where things happen.' Or, as Claire Fuller, the GP who leads Surrey Heartlands Health and Care Partnership, puts it:

> *It is constantly telling the story. Painting the vision of what it could look like if we did it differently. Being able to pick up the phone to people. But also believing that people act with best intent. So when you get funny behaviour in one bit of the*

system, it is looking to understand why it is there. Normally there will be a good reason, rather than assuming that they are doing it because they don't believe in integrated care. Which of course isn't true. People come to work to improve the health of the population.

The hardest bit, probably, is keeping all of the plates spinning all of the time – and the derailment that you can get from the centre. Suddenly 'you must do this', when 'this' had not even been on your radar.

A lot of it is hard. One of the harder things is working together as a system, but then still having a construct that continually pushes you away into a commissioner–provider split. So it is trying to behave in a different way, against the confines of the legislation. That is hard. Not impossible. But it is hard.

Fiona Edwards, lead of Frimley Health and Care ICS, says:

There is something about not being ego driven and not wanting to have your name splashed on everything… Your success is determined by everyone's success. So, I talk a lot about humility and curiosity and always remembering who you're here for, and that infecting your relationships with your peers and colleagues. The exhausting bit, as a system leader, is that you are managing everyone's fear of loss of control, loss of authority and power.

Claire Fuller adds that an absolutely key attribute is 'the need to be optimistic – I'm told I'm pathologically optimistic!' And that is a view reflected by many others, including Jane Milligan, lead at East London STP, who says that 'A very optimistic view of life helps!… An unwavering ability to keep cheerful.'

Paul Burstow, who chairs Hertfordshire and West Essex STP, and who has been a deputy council leader and a health minister, says the job:

… tests the diplomat in you… It is about persuading, and finding consensus… It requires sometimes being able to push your own preference out of the equation and really try to focus on the preferences of the people you are working with. It requires a style of working which is a happy blend of being able to direct a bit where necessary, but actually quite often standing back and helping other people reach the right conclusion and make the right decision to move forward. It is a lot of soft art.

David Pearson, originally the lead and now the chair of Nottingham and Nottinghamshire ICS, says:

> *There is a phrase that the path of true love never runs straight. Well, the path of an integrated care system never runs straight! I don't know about love, but you certainly need quite a lot of affection and personal commitment to each other to work your way through the changes. And so I think the biggest challenge is sustaining all the relationships and making sure that the people who are in the tent at the beginning of the week are still there at the end of the week.*

Several interviewees point to the job being easier when people have been in post for a long, or longish, time and trust has been established. But, in certain conditions, it is possible to manage without that.

Tim Goodson, the lead at Dorset ICS, says:

> *So much of this is knowing people, having worked with them over a number of years, having trust and respect for each other. But since we started out as a clinical commissioning group (CCG) in 2013, it is all new chairs, all new chief executives, all new council leaders, all new council chief executives. Everyone has changed apart from myself in the CCG and my chair.*

> *But the people who have come in have done so on the change agenda. They are well aware of the plans and where we have got to. You appoint people who support the change and see it as necessary, and who are on your side to do that. And we have invested a fair bit in leadership development. We ran a development programme where we challenged everyone to think outside their own box. 'Put yourself in the other person's shoes. How do you think they are going to receive what you are saying? How do you think they are going to take it?' and so on. We've spent quite a lot of time on that.*

Another interviewee said the job 'is a bit like being an elite coach. Engaging everybody's perspective and then playing it back to them.'

Several interviewees also put a strong emphasis on analytical skills. 'You need to have good analytical skills, or be able to really make sure that you are using an evidence-based approach for everything. Because if you're not doing that, whatever

change you're trying to introduce, you need to be able to feel confident that you're doing it for the right reason,' as one put it.

And in a number of places, leads and chairs say that effort has gone into getting to 'one version of the truth'. Getting away from the contract dispute conversations that too often characterised the Payment by Results part of the purchaser–provider split. As Jane Milligan, the lead at East London STP, puts it:

> *Can we at least have a single source of the truth, not just about the resource and the money but about quality improvement, and not just within the hospitals but across the whole patch? So that you are not looking at a different set of data to the one that I am looking at, and that we are actually looking at the right data.*

An additional qualification that many chairs and leads point to is the need for experience. Experience – of having been there and done that in previous jobs – brings credibility. But experience also (as we shall see when discussing the pipeline of future leaders of ICSs, in Section 6) provides a degree of insulation against the consequences of failure, should that happen.

What authority do chairs and leads have?

Ask that question and the response is almost always a hollow laugh or a wry grin, and the answer 'none'. There is nothing remotely resembling line management here. But they do of course have some authority, even if it is only soft power.

Chairs and leads do point to different sources for their authority. 'I was appointed by agreement among all the chief executives in this patch,' one lead says. 'So that does give me some soft authority.' Some chairs say that their appointment emerged in a similar way before it was approved by NHS England and NHS Improvement. Others simply point to their appointment by the centre.

For some, whatever authority they do have comes from their longstanding personal commitment to their patch. Claire Fuller puts this eloquently:

> *In terms of traditional NHS hierarchy, I have no authority. Absolutely none. The authority that I do bring is that I've grown up in Surrey, went to school in Surrey,*

I've worked in Surrey, and my family and friends all live in Surrey. So I really care about how we deliver health and care in Surrey. So it's quite personal. But I've spent most of my career as a salaried GP – without authority to tell anybody anything. So it has always been a case of getting there by persuasion. Getting there because it is the right thing to do.

Fiona Edwards, lead for Frimley Health and Care ICS, likewise says:

Well… I'm resident in this patch. There are my anchor points. It is where my daughter goes to school. It's the local hospital. It's my GP surgery. So I think about this as a resident, rather than as a clinician or a manager. In terms of authority – well, there was a moment yesterday when I felt I had absolutely zero authority. None at all. But you do have some. I'm not managing a failing organisation, and I've done a wide range of jobs. Although I went through a formal process with NHS England and NHS Improvement, I was in reality the informal nominee of my colleagues as they were asked to confirm support for me, as the one they felt they could align behind best. So there is a little bit of personal authority, and a bit of moral authority in that we are trying to do the right thing.

Chris Ham, the chair of Coventry and Warwickshire STP, says:

You have no position in any sort of hierarchy. So whatever influence you are able to have has to come from using soft skills, soft power, lots of negotiation, lots of discussion, lots of meetings. Before applying and coming here I did my due diligence, and I had lots of informal conversations. Were the leaders in organisational roles wanting to work differently and more effectively? What were they looking for? What kind of support could an independent chair provide? And what was really helpful was that I already knew most of the leaders in the system, and I was welcomed by them. So for me the authority comes from having had those conversations, and having whatever credibility you are able to bring from previous roles.

The biggest frustration, I think, is around the pace of change. This is all about finding – and then building – a coalition of the willing. So things move very slowly when you are in these sorts of roles. And you shouldn't expect it to move very quickly, otherwise you will get frustrated and probably walk away from the job.

Philippa Slinger, lead at Devon STP, says:

> *Your only authority is that given to you by the constituent organisations. That's not completely true because the regulators look to the system leads, and they push an authority on to you that you don't have with any legitimacy. It's a bit like running a membership organisation: it only works if they have faith in you.*

Amanda Doyle, the lead at Lancashire and South Cumbria ICS, says:

> *The authority that I have is really only what the [local] system has given to me. And of course, that only works if everybody wants it to work. But that does give me some levers and influence... They all laugh at me when I say the most that I can do is get really cross!*

Another STP lead who is also chief executive for its combined CCGs says:

> *There is an awful lot of carrot in what I do. But I do have two roles – the lead for the STP and chief executive for the CCGs. So I do control the money, which means there is a subtle undertone in that I can be a little more hard-edged should we need to be.*

In Dorset, Tim Goodson makes a similar point:

> *I'm just trying to keep everyone walking in the same direction towards the plan that we are trying to deliver. But I am still the CCG's chief officer. So I am still the accountable officer, and that does effectively have a huge influence on how we go about deploying the £1.2 billion of resources that we have got.*

> *But I don't really see it as a question of authority. My operating style is one of consensus – deliver together. Can we deliver it together? I'm not ordering anybody to do anything. And if people think something we are doing is not right – you've got a chief executive or senior leader really concerned about what you are saying, then that is an opportunity for you to look at it. Because if it is worrying them, it should probably be worrying you as well.*

> *We still have falling outs in the system. We still have disagreements and sparks of tension and stuff. But we try to build the relationships so that they're strong enough that we can get over those and get things done.*

It is challenging. It was Rob Webster up in Yorkshire, I think, who said: 'If you think competition is hard, you should try collaboration'. The disagreements are usually between the providers. Who is going to do what? I don't think the CCG is in a great position to constantly act as mediator or arbitrator. You've really got to get providers in the room, and get them to try to work it out for themselves.

There have been occasions when I've tried to mediate. I've said, 'Look, if you want formal arbitration or something, we could do that. But just so you're aware, my current view is this…' And I tend to tell the one I'm going to go against first, and say, 'Well I'd probably go with the other person. I think they're more right than you. I can understand what you're saying, but if push comes to shove, my decision will go that way.' That often gives enough wriggle room to actually try and get a compromise. But, we don't have a lot of that. It's quite rare really.

To whom do they feel accountable?

Here again the answers vary widely – not just between chairs and leads, which might be expected, but among them. For some the answer lies, at least in part, in their views on the previous question. Some answer instantly – 'the patients' or 'patients and the population'.

One STP lead says:

To whom am I accountable? It's a good question. In fact I get asked it quite a lot by the more political members of the public at various meetings: 'Who are you accountable to? Who can sack you?' Well, I feel accountable to the people who actually work and live in my part of the world. But who can sack me? The regional director, I suppose, or Simon Stevens [Chief Executive of NHS England]. But I'm also accountable to the CCG chairs and the members as their accountable officer. So I think they can sack me. So it's quite a mixture.

One chair answers simply:

… to the centre. I was appointed by the centre, and it is for a fairly time-limited period. So it feels difficult for me to feel accountable to the chairs of the organisations in this patch. But if you then published an ad for an independent chair then my sense is there would be more of a system input into the recruitment

of said chair. And that could bring with it a different sense of accountability, even if fundamentally, I think all the independent chairs ought to feel accountable to the centre.

Chris Ham says:

I asked the question [who I was accountable to] when I was interviewed, and I didn't get a very clear answer. I'm accountable to the organisations that make up the system, who have selected me to be their independent chair. I feel accountable to the people of Coventry and Warwickshire, and the proxy for that, for me, is the two local authorities. So I make a point of keeping close to them, both the politicians and the officers. And there is a weaker sense of accountability to the region.

Philippa Slinger, the lead in Devon, says:

I feel personally accountable for trying to make a success of this. But outside that, if I'm honest, I feel accountable to the constituent chief execs. I know I'm not, because that's not how my appointment works. But I am here to serve the good of Devon, and if I can't do that, or I start to get it wrong, they're the ones that are going to tell me. And frankly if the constituent chief execs all went to the region and said 'she's a nightmare', I'd be out of here. So I do feel accountable in that way. But ultimately, of course, we are still accountable to the regulator.

Ann James, at Plymouth, neatly sums up the complexities for leads:

It's a web of accountability… I feel I'm pretty much accountable to everyone in different ways. I'm accountable to the people that I serve, I'm accountable to my staff – to make sense of it all and to create the right environment. I'm accountable to the board, clearly, but also to my colleague chief execs. And of course I'm accountable to the region when I've been the lead for the STP.

Where do chairs and leads get support from?

A wide variety of sources. Aside from the regular gatherings of chairs and leads that NHS England runs, some have personal coaches, many of them talk to each other, some have created a 'learning set', and there has been a healthy amount of 'stealing' from each other – for example, taking advice from somewhere where something

has worked on how to do it. Plus drawing on some international examples – for example, learning from the experience of integrating care in Canterbury in New Zealand, some of whose senior figures have visited several of these systems (**Timmins 2013**).

How much time does it take to lead these things?

Take the chairs first. The amount of time in their contracts varies, but most say it takes longer than they are contracted for. It is endless phone calls and meetings and emails – shoe leather, telephony and keyboard time; vision painting; making connections not just for themselves but between people, across health, across health and local government; with the third sector; soothing ruffled feathers; finding clogged wheels and oiling them; understanding why people say they have a problem; and making sure that the STP or ICS assembles the evidence for change, because evidence persuades. Trying to make sure that all this does in fact move forward from conversations to plans to (appreciably more difficult) implementation. Providing 'air cover' for their leads – a point to which we will return.

For the leads in this partial sample, it typically seems to involve about three days a week. But there is good news here – most notably as STPs move to become ICSs – which is, that leading the former and becoming the latter makes doing so less something that is *on top* of the day job but quite simply *is* the job. At least initially, leads have taken on the job in addition to their day job. As STPs mature into ICSs, the task seems to be becoming more clearly one of seeking to deliver the better integrated care that is the aim of all this. The original organisation from whence they came – whether a big provider or a CCG, or elsewhere – is itself becoming more of a part of a system that is working towards integration.

2 So does the move from an STP to – or towards – an ICS help?

Yes, is the short answer. A surprising number of interviewees volunteered the statement that STPs had become 'a toxic brand' – for reasons that have been well rehearsed. All too often the original development of STPs felt like the NHS talking to itself in secret. Local government all too frequently felt excluded. There wasn't a lot of the partnership that the title promised. Furthermore, the closed-door nature of their original development led 'Save our NHS' and others to suspect that STPs were a hidden agenda to use the 2012 Act to privatise many more services.

Indeed, in some places, systems are abandoning (or have already abandoned) the nomenclature. Bob Alexander, chair of the Sussex STP, says: 'It is such a toxic brand in our part of the world that we are dropping the acronym. We are just going to call ourselves the Sussex Health and Care Partnership.'

And nomenclature clearly matters. As David Pearson in Nottingham puts it: 'Not everybody will understand what an integrated care system is. But apart from it getting us away from what had become a toxic brand, it is closer to a description of what it is we are trying to do.'

The move towards ICSs has also helped in other ways, according to some. Paul Burstow says that the announcement in the *NHS long term plan* (**NHS England 2019a**) that all parts of the country will become an ICS by 2021 has helped:

> *I think it led to an epiphany for some leaders in the system in that it was no longer possible to say, 'well, this isn't going to happen'. So people have begun to realise that if it is going to happen then 'I want to be involved in shaping it, and to do that I have to be a constructive player rather than a silent passenger or passive resister'. I think I've noticed that quite markedly in terms of the acceleration of pace around these last few months.*

That applies, he says, not just to the leaders of NHS organisations but to local authorities: 'Some I think were uncertain whether to be on the bank or in the boat. I think more are in the boat now.'

Or as Ann James puts it somewhat more graphically in the wake of the long-term plan:

> *If you are sitting there as a hospital chief executive, and you don't see the duty to collaborate, and the way this is all going, and all the signals that your sovereignty to build your own empire, at the expense of thoroughly undermining everybody else, is going... well, you're a dinosaur.*

Andrew Cash, the lead in South Yorkshire and Bassetlaw (one of the first-wave ICSs), also says the shift has helped through greater delegation of responsibility and accountability. 'For example, in finance, when it comes to offsets for provider trusts – varying their control totals – we now do that. Previously they'd have had to apply to London – to NHS Improvement. That's now handled by the ICS.'

It should be noted, however, that some of those leading the more advanced ICSs – whose journey had often started at least in part ahead of the announcement of the STP programme – winced at the challenge facing those with a not-very-advanced STP in having to get to ICS status in a short time, a point to which we will return.

3 Geography and relations with local government and others

Does geography matter?

Yes. This is such a blinding statement of the obvious that it might seem not worth saying. But it is, quite simply, easier to do this in some places than others because of a mix of geography and local politics. Dorset, for example, has a county-wide community mental health trust, just three acute hospitals, and started out with three upper-tier councils and six district and borough councils that have just merged into two unitaries (one for Bournemouth, Christchurch and Poole covering the urban conurbation, with the county covering the rural parts). Those amalgamations may in part reflect local government's own desire for better integrated care. But it has to be appreciably easier than, for example, East London, where there are at least 18 major players, including eight local authorities, and a whole bunch of hospitals, including the behemoth that is Barts Health NHS Trust – in effect a hospital chain that includes the Royal London, Whipps Cross and Newham. Dorset must equally be easier than the Black Country and West Birmingham STP, which also has 18 organisations, or South Yorkshire and Bassetlaw ICS, with 23.

As Chris Ham puts it:

> *If you're in a big teaching hospital in London, your place is the whole of London, maybe the whole of England, and part of you is probably global. You've got less skin in the game. And perhaps, therefore, you are less committed to what's going on than if you're in a general hospital or a community service provider. So, for me, having only two acute hospital chief execs in Coventry and Warwickshire, who are very actively involved, feels really beneficial, and different from some other places.*

Geography, of course, includes local authorities. So how are relations with them?

This is a huge generalisation, but 'improving' seems to be the answer, even if there are, very clearly, exceptions. In one or two places, though not in this sample of interviews, relations still appear to be close to standoff. In Leicester and Leicestershire, for example, the councils recently complained in public that they have been 'largely excluded' and that the 'strengthening collaborative relationships and trust… has not happened here so far'.

The most negative comments from this sample included 'it hasn't got any worse – and in some parts of the patch it has got better', though better in this particular case was still a long way short of great. Or, as another interviewee put it, 'relations with local government are much better than they were a year ago, but they are still a very mixed batch. Largely, still, the local authorities around here are sort of standing back and waiting to see whether this really happens or not.' Both those comments, interestingly, came from parts of the country that are still STPs. Some of the ICS leaders were a lot more positive.

One notable feature of the interviews was how many people, off their own bat, emphasised the population health side of integrated care – the wider determinants of health such as housing, education and social deprivation. Those are issues that are critical to the longer-term success of the NHS but which can only be tackled alongside local government.

Andrew Cash, in South Yorkshire and Bassetlaw, says:

> *What's getting people fired up locally is the health and the wealth debate. What do we do about the 18–24-year-olds coming through who are not in education, training or employment of some sort? Because we know about the long-term effect on their health. What are our housing issues? That is the stuff we're really interested in.*

Ann James, in Devon, says: 'It has been good to get back to the agenda of population health, which many of us had before the 2012 Act' – with the implication that the 2012 Act has proved a distinct distraction from that. But there remain many challenges to achieving a relationship across local government and the NHS that genuinely ties both local authorities and the NHS into tackling those wider determinants.

One interesting feature is that relations seem to be a bit easier – though again not a universal truth – where there has been direct local government involvement in the leadership of an STP or ICS. At the start, just four of the 44 STP leads came from local government. Since 2016, as personnel have changed and as chairs have been added (some systems are only now acquiring an independent chair), there has been more direct local government involvement in other places as well.

David Pearson in Nottingham was one of the four STP leads with such a background:

> *I was a deputy chief executive at the council, so I think we had engagement from the beginning. That didn't mean that some of the national narrative about STPs being really an NHS construct did not rub off on us. But we did have engagement. And, after some significant bumps in the road, the city council chief executive is now the lead for one of our integrated care partnerships.*

Other leads say that having a local authority chair has been a big help, both in building bridges and in understanding how local government thinks.

Not that it all thinks the same way. One (at first sight) counter-intuitive conclusion from the interviews is that having different political parties in control of the local authorities in any given area does not necessarily, as one might expect, make things harder. Conversely, having the same political control does not necessarily make them easier. Political tensions *within* parties can, on occasion, be more obstructive than political tensions *between* them.

So, for example, Labour-controlled Coventry and Conservative-controlled Warwickshire have brought their health and wellbeing boards together in a joint forum. A meeting where, Chris Ham says, 'they discuss issues of common concern around how they're tackling health inequalities, how they're developing their strategies. There's a real meeting of minds, despite the political differences.'

In other parts of the country there have been discussions between councils of different political colours about forming a single health and wellbeing board between them. And in Lancashire and South Cumbria, an area with differing political control of councils, Amanda Doyle says:

> *The local authority geography around here is really quite complex. But we have got some really good leaders among the local authorities. And despite there being*

differing political control, and political things on which they will never agree, on the things that matter to us – how does social care work, how do hospital discharges work, how do we take decisions that improve health outcomes – they're not politically contested. They are not stuff that anyone is disagreeing about. And we have some local authority leaders who really get that, and want to get to a way of working that will help tackle some of the real deprivation that we have got, the poor health outcomes, and the widening health inequalities. It is really important for the economic environment that we improve the health of the population, and vice versa. So the local authorities are really quite keen to work with us. What we are perhaps not so good at yet saying is 'so therefore what, and how?'

Contrast that degree of co-operation with someone who has a number of councils with the same political control on their patch:

They don't naturally work together. People talk about the local authorities as if they are one humongous mass who all think as one. They don't. There have been times when they actively don't get on, and there are political factions within them. That does not make any of this easier.

So at what level does engagement with local government happen?

Precisely which members of local government are involved in the top-level boards of STPs and ICSs varies enormously. Whether it is the council leader or cabinet member for health, for example, or the chief executive, or the director of adult social services.

Some of this is affected by geography. The STP that Paul Burstow chairs, for example, crosses the county boundaries of Hertfordshire and Essex:

I feel rather sorry for Essex, because they are stretched across three – two STPs and an ICS. They want to maintain some policy integrity and consistency about approach to the issues that matter to them, and they feel very stretched in terms of their capacity to be properly on the ball when it comes to everything that's going on in all three. It's just not possible, for example, for the council leader or chief executive to be on all three.

It has to be the case that where the council leader has decided this is an important part of his or her agenda, things have to get at least a little easier. But the level of

engagement – political or officer-led or both – does not lie within the choice of the NHS. As one chair says:

> *The chief executives of our local authorities really don't like it if we ever reach out directly to the political leaders. And I think that probably is a function of the political machinations that go on in each of the local authorities. The level of officer engagement is good in one, improving in the other, but much trickier in another because there is a very difficult political environment, and my impression is that the officers there are less empowered than in the others. But it is still the officers who we mainly have to go through.*

Another says: 'I've heard the lead for another ICS say that the person they talk to most is the council chief executive. I'd say our relations with our local authorities are good. But we are nowhere near that. We are making progress, but it is still very NHS driven [rather than council-led].'

It is also worth observing that while local government has long complained about repeated NHS reorganisations – build a good relationship only for it to be organised out of existence – the NHS can find the same frustration with local government. For example, as one lead says, 'We had one council withdraw from the partnership, not because there was a change of party control but because there was change of control within the same party. They've since come back. But we had to overcome that.' In another, a county and city had created a joint overview and scrutiny committee, but a change of party leader in one of the two saw that broken up. In another case, a county had signed up to a big hospital reconfiguration only to change its mind and support appeals against it.

But against all that, where relations are good, leads say the NHS has much to learn from the way local government operates. As one put it: 'There really are things that we can learn from local authorities. They tend to be much better at public engagement than we have been.'

It is also clear, though the sample size is too small to say much about this, that in places where relations are good, health and wellbeing boards are being reinvigorated (**Humphries 2019**), providing a clearer element of at least partial democratic oversight of changes. Indeed, one or two interviewees speculated, tentatively, that in places they might eventually evolve into the partnership board for an ICS.

4 Governance, reorganisation and relations with the centre

Governance

Governance is so varied, and has gone through (and is still going through) so many iterations locally, as to be almost indescribable. STPs and ICSs both have boards, but what they are called, who sits on them, and how large they are varies considerably, as do the structures beneath them. Many have revised their membership repeatedly – one sign of the challenge in getting the right people from the right sectors in the right place to ensure that integrated care is driven forwards. And, perhaps unsurprisingly, the first thing most new chairs do is launch a governance review.

Boards invariably include the big NHS providers and commissioners. But, as already noted, just who is represented on them from local government, at what level of seniority, and whether that representation is political or officer-led, varies. Some have sought to bring – and/or are seeking to bring – the voluntary sector in health and social care on to the boards as part of the partnership. But that is often difficult because the voluntary sector is not one voice but instead a collection of charities, social enterprises, community groups and other non-profits who often guard their independence and their voice jealously. They cannot all be on the board, but it is genuinely difficult, as one ICS lead put it, for a cancer charity locally to agree that the Alzheimer's charity locally should be the voice for the whole of the voluntary sector. The private sector seems to be absent from the boards – still essentially seen as a contractor in an NHS world where the purchaser–provider split remains.

The role of the chair also varies. All chair the main board, but some do not chair the varied structures that exist beneath that – the more executive part of seeking to deliver integrated care so to speak, rather than the vision and planning part of the endeavour. Some who do chair such structures – for example, a board of chief executives charged with pushing the changes forward – wonder how progress gets made without the STP/ICS chair being on them.

Until very recently, none of the STPs or ICSs have met in public, though in time many chairs and leads recognise that they will have to. There are now websites that set out what is happening, although in widely varying degrees of detail. Some have Healthwatch represented on the main board, which provides an element of public scrutiny. But, as interviewees pointed out repeatedly, neither STPs nor ICSs are executive bodies. Decisions about the changes of service that go with better integrated care are for the statutory organisations that do exist; they publish the papers and minutes that go with that and, almost invariably, they meet in public.

Since April 2019, the Nottingham and Nottinghamshire ICS board has met in public. Why? 'Well, we thought we ought to,' says David Pearson (now chair at the ICS):

> As the stewards of £3.3 billion worth of public expenditure we thought we ought to be transparent about our deliberations. It is a sign of maturity, and the level of our responsibility for something for which we need to be accountable to others, including the public. And if you don't meet in public then people say it is secretive, and the next leap in that analysis is to say 'it's secretive, and therefore it is a conspiracy'. To be fair, until this year we didn't really have the level of maturity about what we were doing, or the infrastructure. I think meeting in public is a good thing, although not everyone agrees absolutely with that.

Amanda Doyle, in the north west, reflects the view of a number of other interviewees when she says:

> We do a lot of public engagement. And the joint committee of CCGs meets in public. And the ICS produces papers that go out to the constituent organisations, which put them to their boards, so we are not doing secret stuff. But, yes, the plan is that ultimately the board will meet in public. The difficulty we have got is that we are not really an organisation at the moment.

One governance challenge – or perhaps more accurately a communication one – is with the non-executive directors of NHS organisations. In an already crowded landscape, there are an awful lot of them. Paul Burstow says:

> I've heard non-executive directors from across the country saying 'I barely hear anything about what's going on in the STP, it's this remote other thing over there'. I think we have a cadre of chief executives and chairs and a few others who are

increasingly intimately involved in all of this, and a larger group of lay members of CCGs and non-executives and governors, for that matter, of trusts, who know it's happening, but not necessarily are fully read-in. And I wouldn't say that's just exclusively about the Hertfordshire and West Essex system that I chair.

To tackle that, in a number of places more effort has started to go into engagement with non-executive directors. Methods vary, but include holding meetings, sending briefings and addressing boards. And that matters, because to get to better integrated care, non-executive directors as well as executive ones will have to make decisions about where services sit (**Humphries 2018**).

Are STPs and ICSs becoming more executive?

Clearly not formally, because they have no statutory powers. But in places they have started to make system-wide appointments. Finance chiefs are now common in order to handle the system control totals that are being handed down. In some places, including in some STPs as they prepare to become ICSs, there are also programme directors, transformation directors, clinical leads and chief operating officers being appointed. None of these (almost needless to say) have any executive power, but their presence makes the various systems look a little more like an organisation working on delivery – 'acquiring some firepower', as one chair put it – rather than being just a debating and planning shop. All such appointments are in practice secondees from somewhere, as STPs and ICSs cannot employ anyone directly. Many of the appointments are part-time (two or three days a week) but their numbers are growing and some are now full-time.

But views differ about how much 'firepower' ICSs will eventually need or seek. Some see them as being relatively 'thin' structures sat over the statutory bodies, doing only what needs to be done at system level. Much of the real action in delivering better integrated care for those with long-term conditions, mental health and disability will, after all, take place much more locally – in neighbourhoods and in the places where the links between GPs, community teams, social care and the hospital are key. Others see ICSs as eventually becoming something more substantial, with stronger decision-making powers – something more like a health authority (though most interviewees baulk at using the word because of its connotations with the past).

Which raises the question of how load-bearing can STPs and ICSs be? How much of the regulatory and assurance load can they take?

As the new regions are coming into existence, systems seem increasingly being asked not just to be planning and implementation bodies, but to take on an assurance role. In other words, when things go amiss, the system will handle that.

Some interviewees were in favour of that. Andrew Cash says: 'What you are doing with an advanced ICS is putting together provision, commissioning and regulation. The latter, regulation, is delegated from NHS England and NHS Improvement. An integrated care system does try to do the lot, and that is good because we've got much more local knowledge than anyone else.'

But some have reservations, particularly when this is applied to STPs. Chris Ham says:

> Regions, I think, have a view that STPs are not just about planning and transformation, but also increasingly about managing performance in their system. Now, I don't think those two are incompatible. But there needs to be clarity about the balance between the two. If it's going to be substantially about managing performance as well as planning and implementation, that's a different set of issues. It requires new ways of working among the partners, taking collective responsibility for a system control total, for hitting targets and standards. And I don't think we are yet ready to do that, because I don't think we've yet got the maturity of relationships, or understanding of what it would need to work in that way. We don't, as a system, yet have the means to act on and intervene, when money or performance is going off.

> The more advanced systems are beginning to develop that capability on a voluntary basis. But you are going to have to have some really tough discussions about the bigger systems. I'm thinking of the big metropolitan ones, where money or performance goes off badly in a big acute trust. What does it mean for the system to own that problem? What does it mean for the system then to intervene and support that organisation and improve? That is a different approach to calling in the management consultants or parachuting in a transformation director from NHS Improvement, it's about the system being in that role. And I think there are questions about how easy that will be to handle.

The chair of another STP says:

> *We are in the early days of thinking about this. Can we develop a small assurance capability as we move to become an ICS? It is easy to describe it, but it is not straightforward to do. I'm pretty relaxed about an assurance system, where I, with the region, hold my health places to account for their plans, for governance arrangements, for the money, for performance, for clinical standards and safety, and all that stuff.*
>
> *But I am under no illusion that if, out of the blue, one of our foundation trusts, currently rated outstanding, had clinical disasters coming out of their ears, or someone suddenly opens a drawer and finds a £30 million deficit, I've absolutely no doubt that there would be significant intervention from the regulatory bodies. Because under the law there would have to be. Or else, when Simon Stevens sits in front of the Public Accounts Committee and gets asked for the 78th time, 'so who's in charge then?' it's very difficult to say, 'well actually, I've got a group of people who sit around a table down there and hold themselves to account'. I am not sure that us saying 'well, we're being developmental, and we've put a quality improvement programme in place' will crack it. I don't see that. I'd love to be proved spectacularly wrong.*

In other words, does autonomy exist only for as long as the sun shines?

Which raises broader issues about relations with the regions and the centre

The interviews for this piece were mainly conducted during August and September 2019. So it was very early days for the seven new regions that have been formed out of the *de facto* though not yet legal merger of NHS England and NHS Improvement. Most judgements were therefore tentative.

One of the biggest complaints about the two separate bodies over the years has been that however clearly those at the top of those organisations have been saying they want to stop sending mixed messages into the system, it had yet to feel like that on the ground. And those messages at times clashed not just *between* the two organisations, but *within* them. One lead lamented that as their CCGs were brought

together, the finance officer now responsible for all of them formally asked if that meant their budgets could now be treated as one. 'Yes,' came the answer – only for another edict to come down six months later stating that the allocation for each individual CCG had been made on the basis of its population, so it still had to be spent and accounted for separately. In another system, the lead says that last year all the providers hit their control totals, some of the commissioners were in deficit, but the system as a whole balanced. 'Even so, the deficit commissioners were given quite a hard time. And if we are meant to be a system, that doesn't feel right.'

Given that the regions are so new, those interviewed were reluctant to go on the record. A fair number said the jury was still out, while others said that the early signs felt encouraging. One lead said: 'I feel better able to draw on improvement capacity, and there is a shortage of that here.'

A few interviewees raised issues about continuity at the top – given that that has also changed alongside the new regional structure. If system leadership is helped hugely by stable relationships, some worry about the departure of key players at the centre who have been closely involved in the development of STPs and ICSs so far, such as Michael Macdonnell and Matthew Swindells. Will the centre's view remain consistent about what ICSs are meant to be, or meant to become? How varied can they be? What freedoms and responsibilities will they ultimately have? How far will they be standardised?

And, even though it is early days, it already seems clear that different regions are taking different approaches in terms of how hands-on (or hands-off) they are, and how far they want to shape the structures of the systems below them, regardless of whether these are STPs or ICSs.

One ICS lead says:

> I look at the regional directors, and some of them are from the old school. They only know one way to manage. So when trouble comes they will react in the old way, rather than trusting us, as ICSs, to do our job and sort it out and make this work. I worry about the level of management competence at the centre to allow people to work differently.

Another says that the next 12 months are critical:

If the ICS lead is going to be made managerially responsible to a regional director, people like me will just leave. If this is all about direct line management from a region, ultimately leading to Simon Stevens, then we've got it all wrong. There's a big argument going on about that right now, and we're back into sort of 'bedpans being dropped in Tredegar' territory. I and a lot of my colleagues feel very strongly about this.

So, the critical point is that you want your best leaders in as devolved a place as possible, as close to the front line as possible. That's where the foundation trust movement was so good.

These carriers of messages at regional level and above can just put a dead hand on everything. They are doing a regulatory role, not a commissioning or provision one. So the staff at those regions should come into the integrated care systems so that we create a flexible but fleet of foot-type organisation that the membership locally is very much bought into. It's based on improvement, not on the traditional regulation. And I am really worried we could lose that.

5 So how far can this go without legislation?

The answers vary. And it depends on what legislation one is talking about. Chris Ham reflects the view of many interviewees when he says that it can go 'quite a long way'.

> *I don't think there's anything fundamental stopping us doing what we want to do, if the willingness that exists continues, and the move to working in partnership becomes more real as we're evolving with the local authorities. It is not the case in my part of the world, but I do think sometimes the legislation card is held up almost as an excuse not to make progress.*

Likewise, David Nicholson, the chair for Hereford and Worcestershire, says: 'I haven't seen anything yet, that we want to do, that needs legislative change.'
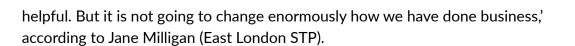
That is not to say that among this sample there is not broad support for the legislation that NHS England and NHS Improvement have proposed – namely the removal of many of the market-like requirements that the 2012 Act introduced, along with measures to make it easier for NHS organisations, including foundation trusts, to have committees in common that can make decisions (**NHS England 2019b**).

Amanda Doyle says the proposed legislation:

> *... does include a lot of the enablers to make collaborative working really easy, rather than really difficult. And that's important. We need to remove some of the things that make it difficult. At the moment, we're working around things, which is just adding to the complexity and the difficulty of it all.*

But while there was a general view that the legislative proposals would help, there were differing views on quite how much it would. 'I think it would be to some extent

helpful. But it is not going to change enormously how we have done business,' according to Jane Milligan (East London STP).

The tougher questions are whether ICSs will, in time, need the formal authority they currently lack in order to make things happen, and whether they should themselves become statutory organisations.

Philippa Slinger, the lead in Devon, says:

> I think we can get a long way without legislation. We can go as far as our constituent organisations will let us go. And I think the test of that will be the first time we have to do something difficult that hurts one of those constituent organisations… when somebody has to suffer, be it immediately, or for a year or two, or when somebody has to give up something they've really wanted to hold on to. That will be the test of whether without legislation you can keep people at the table or they walk away.

It is also the case that ICSs will increasingly shape the way billions of pounds of public money is spent, and many will find it odd if they do not become statutory bodies. As the Commons Health and Social Care Committee recently observed: 'There is a broad consensus that governance and accountability of STPs and ICSs is far from ideal and that the law will need to change eventually to establish ICSs as separate legal entities' (**House of Commons 2019**).

So the pressure for them to have accountable officers and have some statutory shape, including perhaps more directive powers, will grow. Many chairs and leads agreed with the first part of that, but had reservations over the second.

There was, however, no desire among those who took part in this research for any of that to happen fast – not least because ICSs remain a work in progress. Paul Burstow again (the chair in Hertfordshire and West Essex):

> I think the beauty of what's happening at the moment is that there is a degree of experimentation going on around the country about the precise form of integrated care systems – from fairly muscular organisational structures to fairly light, ecosystem-type structures, and I don't think we should feel the need to legislate to impose any one of those at this stage.

And there were other reservations, chief among which was that legislation is far from guaranteed to change behaviour. As the history of the 2012 Act shows, behaviour often trumps legislation (**Timmins 2018**). Fiona Edwards says:

> I oscillate over whether statutory change would actually make this any better. The organisation I work for [the Surrey and Borders Partnership, which is a mental health and disability foundation trust] is the product of a three-way merger [back in 2005]. We've been pretty successful. But while we have worked consistently hard from the earliest days to join up all the work we do, we still have traces of the three old organisations at play – despite the statutory instrument that created us.
>
> And those of us who have done other mergers know that it doesn't work in terms of getting the right outcome for our residents in short order. What will work is us being able to deploy our staff together and give permission to them to work together in whatever form, whether it's crossing the commissioning–provider divide or the provider-to-provider divide. Allowing people to take the initiative, rather than telling them.

David Pearson in Nottingham says:

> I think eventually you will have to have a statutory entity called an ICS. But I would not want it to come in a way that completely scuppers the flexibilities and the place-based planning that we have. There will be some requirement for some authority and accountability. But it must not come in a way that undoes the fundamental premise that people build sustainable change because they're committed to a common cause, not because they're told to do something. As Joel Klein, the American educationalist says, 'you can't mandate greatness, you have to unleash it'.

Andrew Cash's view, from South Yorkshire and Bassetlaw, is:

> The current position is that everyone will get to be an ICS by 2021, but the missing bit is 'how will the governance work?' Different ways of governing are emerging in different places – and that's a good thing. This is not a one-size-fits-all exercise. In my opinion this is about building governance up from neighbourhoods, then places, and then what cannot be carried out at neighbourhood or place level should be carried out at system level.

How these are governed has to be worked through. One model that has emerged is the mayoral one [Manchester], but that doesn't suit everybody. Within a couple of years I suspect there will be three or four models that can satisfy public democracy as well as being a vehicle to run a good system which the partner organisations are all happy with. I'd have no problem then with legislation being worked up, once we have worked out what those new models are.

6 Is there a pipeline of future ICS leaders?

There are concerns about that. Without wishing to insult anybody, the independent chairs and some (though far from all) of the leads are by and large people nearer the end of their careers than the beginning. They are almost all very experienced, having worked across many parts of the NHS or parts of local government (most notably social care) that have interacted with the service.

They bring many skills – including, as several leads put it, providing 'air cover'. If a former NHS chief executive, or health minister, or other very senior figure is telling the centre that something can't be done – or can't be done yet – that carries weight.

But there is a perception that the purchaser–provider split in general, and the 2012 Act in particular, has tended to push people towards working only in one silo – in an acute trust, or community trust, or on the commissioning side, or in general practice – with fewer people having worked much more widely. That broader experience, even if it was some years back, does bring an understanding of the issues facing others in the system. Being able to walk in other people's shoes is a key enabler of system leadership.

Philippa Slinger, the lead in Devon, puts it like this:

> These leadership jobs right now are not anything that I think you're going to get the 40-something aspirant chief exec or leader leaping into, for lots of reasons – some of them being very obvious ones. There's no legal entity, there's no job security, there's not even a clarity of cross-party government policy. So you don't even know, if things change at a general election, whether this policy will continue or not.
>
> So actually, you're not getting those people coming in. What you are getting if you look around the country are people like me, toward the end of our careers.

And actually, maybe that's quite a good thing. Because maybe as a group we do bring that experience. And we can try and get it to something that feels safe for the 40-somethings to leap into, and the legislation will catch up.

But I do ask myself, 'who is going to be the next me?' Is there somebody now in the system that I can start to identify, that I can start thinking about 'right, how do we get them?' And I can't see who the leaders of these things are as they stand, can you? I am in the position – at the stage of my career – where there is no personal risk to me in doing this.

Ann James underlines the point:

You haven't got a legal basis. So you have to be very confident about your ability to influence, shape and guide people into doing whatever it is that needs to be done. So you do need the experience – and maybe it helps, at this formative stage of ICSs, that people will need to do this for three to five years and many of them are not trying to build careers for themselves. They've done that – got the t-shirt and the badge. But we will need the next generation.

She adds that for the next generation of management trainees in Devon, the intention is to broaden their experience. They will spend time in a social enterprise and a homeless charity – 'because they need to start seeing life from the totality of health and care, from a person's perspective, not just an institution's. That is something we want to recreate – seeing the full range of health and wellbeing, which requires some different decisions to the ones we have been making.'

Fiona Edwards, the lead of Frimley Health and Care ICS, says:

I see myself at the latter stages of my formal chief exec career. So your resilience is built up. It is not going to be the end of the world if I upset somebody. So there is a personal confidence, and nothing can replace experience and maturity in my view. I didn't grow up in the NHS. I've worked in the private sector, and I know the voluntary sector from non-executive and other roles which I have held. I currently lead mental health and learning disability services, so for the people we serve, that is all about complex relationships to get the focus of your staff right, and the system right – and that includes local authority services.

I do wonder how, if you come from a commissioning-only background, or a hospital-only background, and you don't have breadth added to your experience, how you can really have credibility with everyone sat around the table.

Another lead says:

People say the NHS is denuded of up-and-coming talent and leadership because everyone is scared of stepping up to more senior roles for fear of having their legs chopped off. I am one of the younger leads. But they could take a risk on me because I've got a hugely experienced chair – who acts as my umbrella and mentor. And it has helped no end, having a very senior person to work with. These very senior people do exist, just not in the more traditional roles any more. And we do need to invest in potential talent, but with these very senior people there to provide comfort.

There is a question mark, however, over how many of these 'very senior people' want such roles. A couple of the chairs said they had taken on the task because it was exciting and important, but also because they suspected 'that nobody else was willing'. And, aside from the NHS pipeline, and given that a small number of the STPs were led by experienced people from local government, there remains a question about how far younger people in local government will see leading an ICS as an attractive career option.

7 So what are the challenges still to come?

Most of those have been outlined or hinted at earlier in the report. But a key one, clearly, is the pace of change. Our interviews did not seek to define rates of progress in different areas, although it is clear that some good things are happening pretty much everywhere. People cited, for example, significant changes to stroke services, or local authority staff being sited alongside NHS staff in joint community teams, with joint appointments and with GP support, to really reshape mental health and/or community and disability services – precisely the sort of better integrated service that this whole endeavour is meant to deliver.

And if structural change is a mark of progress, then there is a fair amount of that happening, in both the NHS and local government. In some places, for example, there are now joint overview and scrutiny committees, or joint health and wellbeing boards, while in the NHS there are the new joint regional offices that NHS Improvement and NHS England have created, which is no small change in itself.

In addition, there is the progressive bringing together of CCGs. These range from the appointment of a single accountable officer across several, with the individual CCGs remaining intact, to full-blown merger – with the one often preceding the other. The 2012 Act originally resulted in some 212 CCGs. Their number now looks to be heading down closer to 80 and perhaps even fewer if the presumption in the long-term plan of one CCG per ICS becomes the reality.

And there are other changes that point to more joined-up working. In a few places, the chief executive of the CCG and the director of adult social services is one and the same person. A limited number of smaller hospitals now share a chief executive with a bigger one. As one lead says, of one of those arrangements, 'two years ago hell would have frozen over before they would have shared a chief executive. Now everything you hear back is that people feel it is better-run and managed, and their services are better integrated.' In places, the chair of one hospital is also becoming the chair of nearby ones. For example, the chair of St George's in London will also

chair the Epsom and St Helier University Hospitals NHS Trust, to help align their strategies. And in one of the more spectacular appointments, the chief executive of Croydon's big hospital is also to head the local CCG as they seek to build a single executive team across the two. The mantra may still be 'no more top-down reorganisations' – whatever that may mean – but a fair amount of reorganisation is going on under the hood.

But when asked how fast systems are genuinely making progress towards better integrated care, the response of many was 'slowly', while 'glacial' was the description from one STP lead. Another lead says: 'It took a year for the CCGs to even contemplate having a single accountable officer, and then another year for us to agree to have a single finance director.'

But there is optimism in places that the pace is speeding up and will continue to do so. Patricia Hewitt, the chair of Norfolk and Waveney STP, says:

> It took some 18 months to agree that there would be a single accountable officer and a single management team for the CCGs. But once we'd done that, and once the long-term plan had pointed to a single CCG for each system, we then quite rapidly got to agreement to merge them properly. So you can get momentum.

In Hereford and Worcestershire, David Nicholson, the STP chair, says progress has been 'slow, it has been organic,' and there remains a risk that people will end up 'back in their bunkers,' as he puts it. 'But it could accelerate. There is all the potential to move much faster. But we are not there yet.'

ICS leads, because their systems are further ahead, were among those who were more optimistic about the pace of change. One says:

> It is still not the case that everybody is sure what an ICS is. The people who want to do it, who see the benefits, are moving quite quickly and are relishing the opportunity to see if we can actually change the way we deliver. But there are always going to be people who don't want change, don't like change, feel threatened by it. And for those people, there is still a statutory framework that allows people to resist if they want to. Though I have to add – and please don't quote me – that resistance is futile!

So questions do remain about how to get those who are reluctant (for whatever reason) to participate in this 'transformation'. One way, as already noted and as increasingly being adopted, is to get to an agreed single set of data – on finance, performance, workforce, or other measures – so that the facts (what needs to change) start to speak for themselves. That produces both understanding and a degree of peer pressure. And there are other pressures that are forcing closer working, other than the simple desire to deliver better integrated care. As one lead puts it: 'If you look only at the workforce issues, it is clear that individual organisations cannot solve that all on their own. They and we have to collaborate.'

On the pace of change, Andrew Cash, from South Yorkshire and Bassetlaw (one of the more advanced ICSs), says:

> *You go initially at the pace of the slowest, don't you? Otherwise you lose the way. So this sort of matrix management is very complex, very behavioural, because it is very reliant on all the partners agreeing. So it is harder and less dynamic at the start, until you get a drumbeat going. Then it becomes easier because the peer group start doing it for you. People can see the problems and they can see what needs sorting, and the peer group starts to work on people so that we get to an agreement. And the agreement can include who gets the capital first, or who changes what first – and so on. Prior to this, in competition, nobody gave a fig about the problems of others, as they were understandably consumed by their own. But it does take time. It can easily take two or three years to get to that position.*

Which leads to a worry among some ICS leaders about the timetable that is being demanded of the less-advanced STPs. One says:

> *We started on bits of this – seeking to integrate care better – well ahead of the announcement of STPs. So we have been at this, or parts of it, for four years and more. And we have made progress – quite a lot. But we are still not there. How they are meant to get there in two years is beyond me.*

And, at the extreme, the pace of change can be agonising. The original merger of Bournemouth and Poole hospitals, for example, was blocked by the Competition Commission back in 2013. The proposal has since gone through legal challenges

and the Independent Reconfiguration Panel. At the time of writing, it was with the Secretary of State. If it is agreed, it will have been a dozen or so years between the original proposition and the changed services actually starting to operate.

And finally...

If all this can be pulled off without, or ahead of, structural legislation, will it, as some believe, stick better because people will have done it themselves? There was widespread support for that view. 'If it is home grown, then we've really done it,' as one ICS lead put it.

One STP lead says:

> I agree with that view. If you look at our area, we chose to merge the CCGs, we chose, successfully, to re-invite local government back into the fray, we chose to have a population health check written by the clinicians, and then we chose to write a strategy on the back of that. No one made us do any of it. But I have to say it could all fall apart quite quickly. It will stick if our providers take a leap of faith that lets us get to the next level of management and clinical leadership that means we really do work together.
>
> So will this work, and will it stick? I think in systems where they have got a coalition who are all behind it, it will. In systems that have got hatred, and where they haven't got on with each other for years... well, probably not.

And despite the qualified optimism expressed by many of our interviewees, the acid tests have yet to come. As one ICS lead says:

> We genuinely are making progress. But I do fear that we create something that looks beautiful and is collaborative – and it is all there. But actually still we haven't reduced the inequalities, or we haven't actually had any impact on the population, which is fundamentally what we're trying to do.

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Nicholas is also the author of *The five giants: a biography of the welfare state*, of *Glaziers and window breakers: the role of the Secretary of State for Health, in their own words*, and co-authored *A short history of NICE*.

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