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Trust boards and systems: the key issues

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Foreword

The focus on collaboration between local NHS and care organisations and local government as the core driver of improvement within the health and care sector is now well established.

This has been an evolution. Trust chairs and local authorities were initially asked to produce strategic transformation plans to promote integration in the provision of healthcare and social care. In due course, plans became partnerships and partnerships transformed into more complex systems. This was all undertaken within the existing legislative framework that was designed for a different type of NHS, driven by competition rather than collaboration.

It was therefore inevitable, and right, that we would see new legislation to align the law with practice on the ground. We therefore have a new Bill. If it passed in its current form, the ensuing Act will create a new statutory ICS tier that will provide formal legislative underpinning for local collaboration. But, in many ways, the work local leaders are undertaking now to tackle the care backlog, reduce health inequalities, integrate services and transform care pathways will remain much the same.

Good relationships will remain central to making systems work and partnerships succeed. Good governance – leadership and direction – will remain important at ICS, place and individual organisational levels. However, we know from past experience that the good relationships that make good governance a reality need constant, hard work and real effort– they don't happen by accident.

We also know that provider organisations, including NHS trusts and NHS foundation trusts, will remain pivotal, not least because their boards remain accountable for frontline service delivery. Finally, local leaders will need to make the new pattern of system, place, provider collaboration and individual institutions work effectively to drive real improvements in patient care and health outcomes.

With thanks to colleagues at NHS Providers and Hempsons for their contributions, I hope you find this short summary of the issues at hand helpful as you develop your own collaborative arrangements.

Chris Hopson
Chief executive, NHS Providers

Introduction

As system working becomes embedded and ICSs are placed on a statutory footing, all trusts and their partners will be working together to consolidate current effective partnerships and establish new collaborations which better serve patient populations.

In this short publication aimed primarily at colleagues serving within trust boards, we have sought to highlight some of things that we believe will facilitate good system working. Since one size does not fit all we have not sought to be comprehensive or prescriptive. As trends emerge more detailed advice will become necessary, but for now we have sought to be concise and to make the case that you are already doing most of what is envisaged in the new legislation.

The Bill

The long-awaited Health and Care Bill was published in July and is now working its way through parliament. Much of what was in the Bill was, as anticipated, based on the proposals, the White Paper and NHS England's recommendations to the Government in 2019 on legislating for Integrated Care Systems. The Bill itself is wide ranging, covering a range of provisions, and legislative tweaks. Its stated intention however, and a core focus throughout, is to legislate for an NHS system that supports collaboration rather than competition.

The Bill's six parts and 16 schedules and the steadily growing collection of guidance published by the Department of Health and Social Care and NHS England will potentially have dramatic impacts on the health service. In many respects the Bill is introducing expected, and welcome, technical changes, such as allowing for wider joint decision making. These changes reflect the practice on the ground where workarounds such as committees in common have been used where joint committees were not permissible. Such technical legal changes may have little noticeable impact on how decisions are made in reality, but will simplify the legal processes of making them. Other changes, such as the replacing of competition with, build on changes that have been underway since the Five Year Forward View was published (if not before).

As was expected, the Bill will transfer commissioning functions from Clinical Commissioning Groups (CCGs) to statutory Integrated Care Boards (ICBs). There will also be some transfers from NHS England's commissioning responsibilities. ICB bodies will be responsible for their geographic region, and no two ICBs can have overlapping regions. Much like CCGs today, the ICB will be governed by a constitution, a model form having been developed.

The ICB will be a body corporate -ed by a unitary board with a constitution approved by NHS England and they will be accountable to NHS England.

ICB duties will include:

- Developing a population health plan
- All CCG functions and some NHS England direct commissioning
- Allocating resources and ensure contracts/agreements are in place with providers
- Joint work on procurement/estates
- Improvement of the quality of care
- Leading People Plan agenda.

The board of the ICB will, as a minimum, include a chair, the chief executive and members from NHS providers, general practice and local authorities and two other non-executive directors. Beyond that, ICBs will have the flexibility to determine governance arrangements in their area. This will include the ability to create committees and delegate functions to them.

Key issues

The key issues from the Bill concerning ICBs and guidance are:

- Local flexibility as to the governance of the ICB and
- The concept of subsidiarity

The Bill will make joint committees, as between commissioners and providers and between providers possible to set up. Although the final regulation on the extent of delegation of decision making from the ICB is awaited, it is clear that the intention is that there should be scope for delegation to the appropriate "level". *The Interim guidance on the functions and governance of the integrated care board* published by NHS England and NHS Improvement states that "*arrangements should be designed to facilitate decisions being taken as close to local communities as possible, and at a larger scale where there are clear benefits from collaborative approaches and economies of scale*".

This flexibility has been broadly welcomed, but it will be for systems to determine:

- Who are the right participants on the board of the ICB (taking into account prescribed roles)
- How to manage conflicts of interest
- Where should decisions on local issues be made – place, neighbourhood or system
- What will effective and appropriate committee structures look like

Other key points of interest from the Bill

- CQC ratings for ICS were not included in the draft Bill, but we expect this to be included during the process by amendment
- As has been widely commented on, the Bill introduces a power for the Secretary of State to issue guidance on the duty of cooperation between NHS bodies
- A power for the Secretary of State to direct NHS England (which will be the legally unified body of NHS England and NHS Improvement)
- A new role for the Secretary of State to call in service reconfigurations which are "complex, a significant cause for public concern, or where Ministers can see a critical benefit to taking a particular course of action". As drafted, the legislation is not limited to the requirement to notify the Minister of such "major" transactions, as the definition covers a much broader range of changes which reduce the services available or change to how these are delivered
- New duty to meet the "Triple Aim" will require health bodies, to ensure they consider the three aims of better health and wellbeing for everyone, better quality of health services for all individuals, and sustainable use of NHS resources. In the Bill it is expressed as the "duty to have regard to wider effect of decisions". This may add a layer of additional complexity for consideration for boards when making decisions.

Other ICS Infrastructure

System split into Integrated Care Boards (ICBs) discussed above and Integrated Care Partnerships (ICPs).

The ICP will bring together NHS organisations, local government and other partners to align ambitions, purpose and strategies. It will facilitate joint action on tackling health inequalities and addressing the wider determinants of health. It will also have a specific responsibility to develop an integrated care strategy.

Provider collaboratives are two or more trusts and/or foundation trusts working across multiple places to realise benefits of mutual aid and working at scale and address unwarranted variation and inequalities. All acute, specialist and mental health trusts and foundation trusts are expected to join collaborative arrangements from April 2022, where they have not done so already. Community trusts and ambulance trusts should be part of collaboratives where this would benefit patients and makes sense for the providers and systems. In practice, we expect all trusts providing community services to be partners in multiple partnerships at different levels of populations.

Each provider collaborative will agree specific objectives with one or more ICB. They will facilitate the work of alliances and clinical networks.

Ambulance trusts and specialist trusts, but also many mental health, community and other trusts will relate to multiple ICBs which brings an added layer of complexity, so on paper at least this looks like an increasingly complex system.

Governance

We know that NHS England has released extensive guidance on system working covering the minimum requirements for each system and its component parts. It is not our intention to duplicate that guidance here or reinterpret what we already know. Rather, we have sought to highlight the governance issues that trusts and foundation trusts will need to take account of in system working. Where these issues lend themselves to generic solutions we have suggested ways forward. It is unlikely that one size will fit all, but trends will arise over time that will require detailed advice and guidance.

Key issues

- The vast majority of healthcare will continue to be provided at organisational level by primary care and by NHS trusts and foundation trusts
- Each of the partners will be responsible for delivering their part of the project in collaborative work, which means that responsibility and liability lies with the trust or foundation trust board
- The implication for boards is that their well tested governance processes of formulating strategy, overseeing the executive to manage risk and deliver strategy and setting and shaping the right culture will continue to apply

The purpose of the board

- The principles of governance between organisations will continue to apply, relying on strong relationships and tried and tested governance arrangements
- All available evidence suggests that it is the quality of relationships within the leadership of systems and their constituent organisations that will determine the scope for long term success
- It would be a mistake to imagine that good relationships will always persist or will survive a change of personnel. In the absence of proper planning care and attention, the collective leaderships of organisations and systems need to develop a strategy owned by all to foster the continuation of good relationships over time and they should not overly rely on the structural approaches envisaged in legislation
- The objective for collaborations should be the virtuous circle of respect, trust, openness, candour and the free sharing of information
- The NHS has not always been a comfortable place in which to dissent or challenge the prevailing trends and climate, but boards will need to. However, the scope for principled, but robust challenge needs to be carried from trust board into partnerships, collaboratives and systems and needs to be accepted as being absolutely essential to good decision making
- Making space to consider what constitutes solid ethical behaviour when working in collaboration and how that can be maintained as circumstances and personnel change is not always easy

Building and maintaining shared cultures so that 'how we do things here' becomes 'how we do things together' is likely to be essential to the medium-term cohesion of systems.

- There is a need to ensure that those who take decisions in systems will be responsible for the outcomes so that decision making is linked to accountability
- Individuals and organisations should not be unduly pressurised to sign up to things that they do not believe they can achieve within a given timescale
- There is a plethora of evidence that cognitive bias is ubiquitous, and we need to guard against this to ensure decision making is as good as circumstances allow
- Challenge is part and parcel of guarding against flawed decisions so systems need to find a way of involving independent non-executive directors at the point of decision making at all levels from ICB down to relatively small collaborations, with proper assurance that risk is being manged being the outcome

There should be no taboo subjects that remain unaddressed and nothing should be exempt from constructive challenge.

Workforce

In terms of managing the workforce challenges the "HR framework for developing integrated care boards" document and the "Building strong integrated care systems everywhere: guidance on the ICS people function" have a few core themes:

- Collaborative working at all levels
- A more flexible workforce ("one workforce")
- Minimising disruption in managing the change from CCGs to ICBs
- Recognising that senior CCG leaders will be displaced
- Retaining talent
- Managing the transition in accordance with the People Plan and the People Promise

Staff will transfer under a transfer scheme and will be in line with the obligations under the Transfer of Undertakings (Protection of Employment) Regulations 2006 ("TUPE") and the Cabinet Office Statement of Practice ("COSOP").

There is an employment commitment to "lift and shift" CCG staff below board level which is intended to limit the amount of organisational change required.

Whilst the emphasis is upon maintaining continuity and causing a minimal amount of workforce disruption, it is inevitable that there will be significant change required to make the new structures work.

The People Plan sets out the desire to have a flexible workforce that can easily move across organisations. The level of integration associated with the new structures will require this as well as a degree of cultural change.

Key issues

The key issues in relation to workforce are:

- Implementation of the "one workforce" approach and finding ways to reduce obstacles to working across organisations. This is likely to require clear and effective contractual arrangements
- Retain talent and ensure that key staff are not lost in the displacement
- The application of the principle of subsidiarity is likely to mean that, subject to national guidance and requirements, the workforce structure will vary from ICS to ICS
- A focus on ensuring the change is conducted in accordance with the People Plan

Conclusions

As we stated earlier, good relationships will be at the heart of making systems work. This implies inclusion, listening and seeking to reach consensus. It also implies an acceptance of challenge as a positive input, rather than a threat with a place for well-reasoned dissent at every level of each system. Good relationships don't happen by accident, they take planning and work to maintain them. They also require mutual respect, acknowledgement of roles and responsibilities and an understanding that the buck will stop with providers and their boards when it comes to service delivery.

Complexity may be necessary, but simplicity is nearly always preferable and should be the objective in developing the strong working relationships and the governance arrangements that will make systems work.

Perhaps most importantly, we need to remember, that as Bill Moyes, the former executive chair of Monitor, said back in 2004: "there is no such thing as a perfect organisation. The best we can ever hope for is that an organisation is self-aware, recognises its issues, and deals with them effectively". The same is true of systems.

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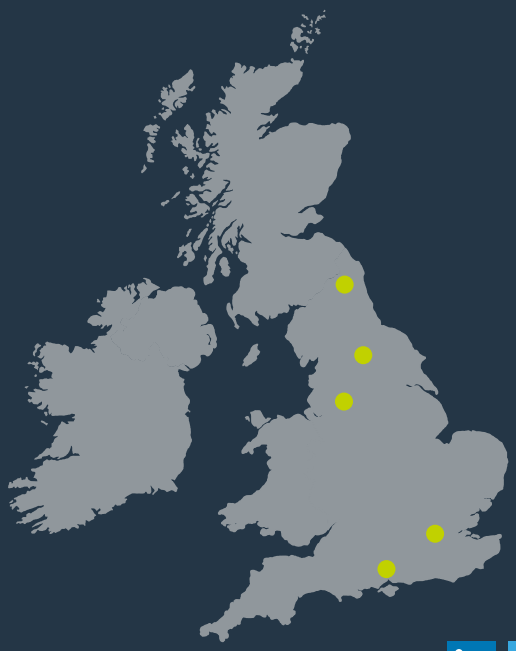

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