



NIHR POLICY RESEARCH UNIT IN HEALTH AND SOCIAL  
CARE SYSTEMS AND COMMISSIONING

**Integrated Care Systems: What can current reforms learn from past  
research on regional co-ordination of health and care in England?**

A literature review – Executive summary

November 2019

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**Disclaimer:** This research is funded by the Department of Health and Social Care via the Policy Research Programme. The views expressed are those of the researchers and not necessarily those of the Department of Health and Social Care.

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## **EXECUTIVE SUMMARY**

### **Introduction**

This report is part of the research of the Policy Research Unit in Health and Social Care Systems and Commissioning (PRUComm) on the developing architecture of system management in the English NHS – including Sustainability and Transformation Partnerships, Integrated Care Systems or their successors – commissioned by the Department of Health and Social Care.

Five years since the publication of the *Five Year Forward View* (NHS, 2014), the integration of health and social care at a ‘system’ level remains a central NHS policy priority in England. The *NHS Long Term Plan* (NHS, 2019a) further set out how organisations are to continue to work together collaboratively across bounded geographic territories with the aim of improving co-ordination of local health and care services to encourage the better use of resources and through managing population health. Without change to legislation, encouraging system-wide collaboration marks a major shift in policy direction away from the primacy of quasi-market competition.

Forty-four non-statutory Sustainability and Transformation Partnerships (STPs) of NHS commissioners and providers, local authorities, and in some cases, voluntary and private sector organisations have been formed across England. Fourteen of the more ‘mature’ partnerships have since been designated Integrated Care Systems (ICSs) to be granted increased autonomy, providing greater freedom over how they manage resources collectively. There are usually three spatial levels of organisation within each STP/ICS: ‘neighbourhoods’ covering a population of roughly 30,000 – 50,000; ‘place’ between 250,000-500,000 people and STP/ICS ‘system’ level between 1 million – 3 million. In addition, seven new regional teams bring together NHS England and NHS Improvement at a regional level, intended to harmonise their operations for system-wide working.

Despite undergoing continuous reinvention, an intermediate tier has existed for most of the history of the English NHS, with statutory authorities (at times, several layers of authorities) responsible variously for long-term strategic planning, allocating resources, acting as market umpires, and overseeing delivery of local health services. The latest reforms mark a return of an intermediate tier, filling a vacuum left behind by the abolition of Strategic Health Authorities (SHAs) in 2013. However, unlike previous health authorities, STPs and ICSs are not statutory bodies, but instead exist as non-statutory voluntary partnerships despite being effectively mandated by NHS England.

This report presents the findings of a review of literature on previous intermediate tiers in the NHS. Drawing on peer-reviewed academic research, historical analysis and commentary from academic and policy sources, it examines their functions and responsibilities, how they operated in practice and their interaction with local government. Putting current reforms in their geographical and historical context, we draw out lessons for the challenges and opportunities STPs and ICSs may encounter in the years ahead.

## **Summary of our findings**

Our review of literature reveals there has not been extensive, systematic research into intermediate tiers of the health service in England over the last seven decades. During this time, regions have continuously been a target for reform. There is no consensus among policy makers or commentators over where functions and responsibilities should be located. Differing views appear to have been shaped by different political strategies and policy trends. Organisational change has accelerated in recent years. Broadly speaking, operating within intractable tensions facing the health service, regions have progressively declined in their influence. Once responsible for the allocation of resources, their reduced role coincides with new forms of performance and financial management. Nevertheless, our review shows that longer-term strategic planning has usually occurred at an intermediate level. Through situating current changes in their historical and geographical context, a series of key themes and their implications for policy can be identified.

## **Implications of the literature for current policy**

### ***System-wide co-ordination and oversight***

There are certain benefits in an intermediate tier planning and overseeing services, as well as mediating centre-local relations. Previous intermediate tiers operated with planning functions across wider geographic areas, as well as having capacity for dispute resolution and managing finances. Ongoing mergers of Clinical Commissioning Groups (CCGs) appear to be a recognition of the benefits of co-ordinating certain functions over larger geographies than that of the existing CCGs, although disputes over where functions and responsibilities are best located will likely prove a recurrent issue. Hierarchy in the NHS remains strong and the ability for STPs and ICSs to provide a counter balance to national bodies appears weak. It is not yet clear what the role and mechanisms available to the new regional teams of NHS England/Improvement will be, but it is likely that they will act as agents of central control. Unless ICSs were to become statutory bodies with clear authority and stronger mechanisms to sustain agreements, given the inevitable conflicts embedded within the existing organisational landscape, current reforms at both 'system' and 'regional' level do not resemble a 'return to health authorities', even if certain functions of SHAs are being recreated.

### ***Between system working and organisational autonomy***

In the absence of changes to the individual regulation of NHS organisations, system-wide collaboration between organisations will remain challenging. Thus, having an intermediate body to facilitate closer working has benefits. Yet in the absence of any primary legislative changes, the current policy will require STPs and ICSs to operate with further 'workarounds' to support closer working in a regulatory landscape established to promote competition. The complexity of governance arrangements required to undertake decisions across the different geographies within (and beyond) STPs/ICSs may well impede local service changes at the pace demanded. Partnerships will likely be tested by individual organisational risks, contentious decisions and response to crises.

### ***Appropriate scale***

There is no 'perfect scale' for integrated commissioning or planning. Establishing where is 'best' also depends on the particular service or function under question. How proposed primary care-led models of care fit together across neighbourhood, place and system levels will demand careful attention. Fine-grained oversight of the delivery of local services such as primary and community care requires detailed local knowledge and strong relationships across a territory with a meaningful identity among those involved, including staff and the public. Yet how this intersects with the commissioning, monitoring and regulation of the wider geographies associated with acute and specialised sectors, and potentially politically contentious decisions remains unclear. It will therefore be particularly important to define carefully the scope, role and responsibilities of 'places'.

### ***Place matters***

Tensions aligning *national* health with *local* government have been in existence since the NHS was created. These will not be resolved by the latest policies. Different attempts have been made over the years to align or integrate health and social care services at the intermediate tier. Coterminality of boundaries may help co-ordinate health and social care, although NHS commissioners, Trusts, and local authorities now operate across different geographies. Caution must be exercised in assuming aligning boundaries and establishing partnership arrangements will necessarily lead to 'integrated care' for patients. Pooled budgets and co-commissioning have been increasingly used in recent years, however the associated political and technical difficulties are unlikely to be overcome under the current arrangements. STPs and ICSs will not operate uniformly across the country. With local government facing major financial pressures, aligning local priorities and decisions will be important, if challenging. Expected 'participation' remains unclear, however the role of Health and Wellbeing Boards may prove significant. How voluntary and private sector organisations are embedded within the new partnerships also remains uncertain. Health and well-being is influenced by more than health services alone, however, concerns policy-making is NHS-centric are by no means unprecedented. Both local and national politics will impact reform, not least given uncertainties over social care as well as questions over accountability and involvement of the public.

### ***Reform takes time***

Top-down reorganisation has been pursued at remarkable pace in recent decades. Policy churn is now a widely recognised phenomenon. Legislation alone does not determine how systems function. However, using 'workarounds' to circumvent existing legislation is problematic given the absence of political scrutiny and reflection. It takes time before the effects of reform become apparent, yet reorganisation now occurs without time to generate sufficient evidence or to learn lessons from previous failures. As debates over the future of the purchaser/provider split continue, policymakers should not expect the current changes to solve the complex challenges facing health and social care in England. Yet nor should urgency to reform provide sufficient justification to move onto the next reorganisation if expected outcomes are not achieved rapidly.