All about ICSs

This is a summary of the discussions that took place at a DHACA Webinar on 19th November from 10am to 11.30am on Integrated Care Systems (ICSs). The event was kindly sponsored by the AHSN Network. Speakers were:

**Jenny Dodd**, Associate Director of Transformation at the Innovation Agency

**Dave Sweeney**, Executive Director at Cheshire and Merseyside Health and Care Partnership

**Mark Easton**[[1]](#footnote-1), Accountable Officer for the eight CCGs in North West London until earlier this year, and previously an STP director in South East London

**David Clayton-Smith,** Chair of Bucks, Oxfordshire & Berks (“BOB”) ICS[[2]](#footnote-2)

The NHS Long Term Plan (2019) describes the role of an ICS as:

* Bringing together local organisations to create shared leadership and action;
* Being a pragmatic and practical way of delivering more integrated care;
* Supporting providers to partner with local government and other community organisations to better integrate care;
* Supporting commissioners and providers to decide together how best to use resources, design services and improve health;
* Having streamlined strategic commissioning arrangements to enable a single set of commissioning decisions at system level.

All speakers referred to ICSs as systems: they are not single organisations. Dave Sweeney and Jenny Dodd identified them as comprising a collaboration of partnerships – the diagram overleaf shows how these are made up starting at the Primary Care Network (PCN) level, a place-based cluster of which form an Integrated Care Partnership (ICP). ICPs comprise

* Primary Care Network Leads
* Local Authority adult and children’s social services leads
* Community Health Provider
* Mental Health Provider
* Acute Provider(s)
* Public Health
* Voluntary sector
* Housing
* Police
* Education

A group of ICPs in turn collaborates to form an ICS.

Mark Easton described an ICS as a self-managing system comprised the NHS, local authority partners, voluntary service partners and any others that are relevant. ICSs vary; however, they are generally governed by a partnership board beneath which sits an executive board.

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|  | **Scale** | **Functions (examples)** |
| Neighbourhoods/  localities (PCNs) | 30-50k | * Forming PCNs, strengthening primary care, joining up primary & community care * Implementing integrated delivery models, forming MDTs * Implementing social prescribing |
| Places (ICPs) | 250-500k (Usually council/ borough level) | * Clinical care redesign (including (simplifying and standardising care pathways) * Forming provider partnerships and alliances (including GPs) to redesign and integrate services * Developing new provider models * Joining up council/hospital/community services * Closer working with local authorities and voluntary community service partners on prevention and health inequalities * Population health management |
| Systems (ICSs) | 1-3 million | * Planning for the future across a system * Develop/oversee strategies: workforce, digital, estates * Managing collective resources * Identifying and sharing best practice * Responsibility for performance and resolving challenges |

(When the NHS was formed, District Health Authorities covered all the health needs in their geographical area, so were essentially proto-ICSs, though of course there were not all the tools that exist today to manage them well.)

A theme that ran through the event is the importance of recognising that ICSs are not statutory bodies. Mark Easton stressed that ICSs are being asked to do things that are ahead of formal legislation/governance. Achievement relies on willingness to work together rather than formal power. David Clayton-Smith advised participants not to get stuck on governance as it is essentially impossible; the success or failure of an ICS is dependent on the quality of relationships that are developed in it. Relationships are hard; conflict is easy yet working in partnership needs to be a given because it is better for patients, saves money, and interfaces better with national bodies.

An ICS needs to identify practical things that will make a difference that it can do and do well. In a nutshell it is all about creating value. All were agreed that the result that all were aiming for was to improve preventive services and thereby reduce the need for people to go to hospital. There should be collective leadership and mutual accountability

In North West London (NWL) there are three focus areas:

1. Clinical strategy
2. Improving productivity and efficiency
3. A series of enabling strategies around workforce, digital and estates.

In Cheshire and Merseyside[[3]](#footnote-3) the three are:

1. Planning, managing and delivering services together to focus on need, be that a health need or a wider determinant of health need;
2. Linking education, employment and service delivery to shape the workforce and build resilience and opportunity;
3. Linking health skills and knowledge of housing and care across our neighbourhoods to support families in need or at risk of harm.

Challenges to those relationships come from many directions including:

* Place can be sovereign – although there is now a move to integrate CCGs into a single body that covers the same area as the ICS, there will still be several local authorities within that boundary;
* The NHS and local government have different cultures, financial systems, politics, in particular:
  + Local authorities are required by law to break even whereas NHS organisations can run deficits;
  + Local authority politicians need to seek re-election every four years (the “democratic mandate”), whereas many NHS organisations are run by appointed people with no need to seek democratic approval for their actions;
* It might well be that clinical services are excellent, though residents also need to be able to access them easily;
* As Jenny explained, failure to roll out successful innovation is condoning health inequality; however, variation across an ICS as that innovation is trialled, is inevitable.

Relationships are clearly vital to overcoming those challenges – one way of working out how to make them work is by looking for hooks to draw people in and to get them to see that it is in their own best interest to cooperate.

Jenny Dodd suggested that the people who can best bridge the various organisation are residents, using technology – the more technology that we can put in their hands, the more information they have access to, the more they are likely to pressure professionals to cooperate.

As David Clayton-Smith put it: The challenge is to get the organisation upside down – ICSs are there to serve the residents and not preserve long term organisational structures, so the people should come at the top. This is Jenny Dodd and Dave Sweeney’s diagram that describes how they have worked together to get innovation into Cheshire and Merseyside at an ICS level:

A specific example of the challenges being tackled by the NWL ICS is the huge inequality of hospitals in the area covered. It has some of the best teaching hospitals in the world and some of the not-so-good. The plan therefore, now being activated, is for the teaching hospitals to lever up the quality of the not-so-good. In digital this is done via a single digital board.

Another example is that the community beds had different admission criteria and different lengths of stay - some people were in hospitals who should not be. Their rapid response teams had different service specifications and response times varying from two hours to 24 hours. Moving towards standardised services meant that hospitals knew what to expect from community services, so they cut long stay patients by something like 50%.

A further challenge which proved harder than at first sight was unifying the back-end services to create a single HR, finance, and procurement unit. There is lots of behavioural change that needs supporting.

In answer to a question of how industry can get involved, the suggestion was made by Dave Sweeney that companies should aim for a social value award. By stressing how their product or service will improve society, it shifts the language to a much more constructive conversation.

# Appendix

# How BOB ICS works

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| **Places i.e. Bucks, Oxon, Berks West and 45 PCNs** | **ICS** |
| **Ensure the delivery of high-quality care, closer to home for all local residents**   * Urgent and emergency care, primary care, community care, children’s services, community mental health and learning disabilities * Greater collaboration and integration: providers, local authorities, voluntary and 3rd sector | **Support the development of three strong places**   * Work with partners in a more integrated way to better serve our communities * Develop the CCG resources: focus on building new ways of working and capabilities |
| **Strengthen the activities aimed at reducing inequalities and improve outcomes**   * Support a greater focus on prevention and the wider determinants of health | **Set the strategic direction and high-level plan for the system**   * Much is set by the NHS Long Term Plan, but a number of strategic choices remain, and we need to live within our means |
| **Engage with the local population**   * Increase people’s confidence to manage their own care and use new digital channels where appropriate * Ensure patient and public engagement and co-design of change | **Encourage the collective management and improvement of performance**   * Shared resource strategies: e.g. workforce, estates * Support the major projects – particularly those across providers |

It is a partnership between:

* 45 Primary Care Networks (175 GP practices)
* 3 Clinical Commissioning Groups
* 6 NHS Hospital Trusts
* 5 Unitary/County Councils
* 1 Academic Health Science Network

…serving a total of 1.8 million people

# Cheshire and Merseyside Health & Care Partnership

Cheshire and Merseyside Health & Care Partnership is one of the largest ICSs. The objective of the ICS is to build on existing integration of health and care services. Place is sovereign. Bringing together local NHS providers and commissioners, local authority, and other local partners to collectively plan and integrate care to meet the needs of their population.

## Vision

We want everyone in Cheshire and Merseyside to have a great start in life and get the support they need to stay healthy and live longer.

## Mission

We will tackle health inequalities and improve the lives of our poorest fastest. We believe we can do this best by working in partnership.

## Aims

1. Improve the health and wellbeing of local people
2. Shift from an illness focus to a health & wellbeing model
3. Provide better joined up care, closer to home

The view in this ICS, which has some of the most respected hospitals in the country on its patch, is that there is relatively little need to engage these: the hospitals run themselves well and fix people well. The area covered by the ICS still has health inequalities though – ICS is all about stopping people needing to go to hospital

1. Mark Easton’s communications channel proved very unstable so whilst this summary had access to his notes, the recording on the website misses some of this detail. [↑](#footnote-ref-1)
2. The organisations that form BOB ICS are shown in the appendix. [↑](#footnote-ref-2)
3. More details of the Cheshire & Merseyside ICS are in the appendix. [↑](#footnote-ref-3)