Delivering the Best Integrated Care Systems

Report of the Health Devolution Commission Roundtable, April 2022

EXECUTIVE SUMMARY

This is a summary of the opportunities, examples of best practice and challenges for Integrated Care Systems presented and discussed at the meeting of the Health Devolution Commission on 7th April 2022. Over 40 people attended the event at which presentations and contributions were made by:

- Naomi Eisenstadt, Chair ICB, Northamptonshire
- Cathy Elliot, Chair ICB, West Yorkshire
- Richard Douglas, Chair, ICB South East London
- Richard Leese, Chair ICB, Greater Manchester
- Mark Cubbon, Chief Delivery Officer, NHS England and Improvement
- Cllr Rosemary Sexton, Wellbeing Board, LGA
- Sarah Walter, ICS Network, NHS Confederation

Optimism: There is a general feeling of positivity and optimism about the potential of Integrated Care Systems (ICSs) to herald a wholly new approach to our health as a nation. It a system that is genuinely transformational and has a high level of support among local and national leaders across all sectors.

Transformation: The shift from competition to collaboration as the organising principle of the health and social care system requires a new culture of partnership working and mutual accountability for shared outcomes; new collaborative processes and structures; and a new transparency in the way decisions are made. Crucially, attention to **all** of the four primary aims of ICSs will be key to driving this new paradigm of health and wellbeing.

Shared outcomes and a place-based approach: A specific set of shared outcomes for the system to achieve may be best structured around a Life Stage approach such as 'Start Well, Stay Well, Age Well', which clearly also reflects local population health inequalities. The focus on place is at the very heart of the new system, with the aim of maximising delegation of the ICS non-hospital spend to place-based partnerships responsible for delivering the shared outcomes (as local circumstances allow).

Shared values and culture: Place-based collaboration will require partners to agree shared values for working together, build trusting relationships, develop a joint learning culture, and adopt a performance development approach to service improvement. NHS, Local Government and VCSE sector leaders should be exemplars of this new culture of collaborative behaviour.

Evidence-based decisions: The use of evidenced-based decisions that has the active support of all partners is key. This may best include robust population health and clinical data; be sufficiently granular to identify localised places or communities experiencing health inequalities; draw on professional knowledge and insights; and use real-time data that is cost-effective to gather.

Governance and structure: The relationships between the IC Board and the IC Partnership need to be clear and agreed. One approach would be for the IC partnership to have the job of holding the IC board and other partners to account for delivering the IC strategy. The IC Board Plan should be publicly assessed on whether it sufficiently meets four criteria: does it reflect the integrated care strategy; is it financially viable; is it consistent with the commitment to reducing health inequalities; and does it reflect local population priorities?

Financial flows: Five design principles for financial flows within ICSs that will reflect a collaborative approach are: remove financial disincentives to achieving the shared outcomes; create maximum funding certainty for providers; maximise financial delegation to providers; maximise flexibility in spending (but protect long-term prevention investment); and ensure full budgetary transparency.

***NHS support for broader social and economic development*:** Addressing the social determinants of ill-health is key to creating a sustainable health, social care and public health system. ICSs should recognise the causal link between health and productivity at different ages, and that work is a health outcome for many people, particularly those with mental ill-health.

Future challenges: There are significant challenges as ICSs become statutory bodies and implement the new approach. These include the pressure on acute care services; social care underfunding; shifting the centre of gravity away from the acutes and into community services; how primary care networks relate to the new structure; the role of the CQC in supporting development; different reward systems for leaders in different sectors; identifying which interventions will 'shift the curve' on population health inequalities; the impact of national economic conditions; and, coping with care workforce shortages and low pay.

Authors: Phil Hope and Steve Barwick, April 2022

The partners of the Health Devolution Commission are NHS Confederation, Local Government Association, London Councils, British Association for Counselling and Psychotherapy, Greater Manchester Health & Social Care Partnership, West Yorkshire Health and Care Partnership, Mencap and Barnardo's.

1 INTRODUCTION

This is a summary of the opportunities, examples of best practice and challenges for Integrated Care Systems presented and discussed at the meeting of the Health Devolution Commission on 7th April 2022. Over 40 people attended the event (see section 8 below) at which presentations and contributions were made by:

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During the discussion commissioners made a number of comments about best practice and identified some of the key challenges that ICSs will face in implementing the new way of working - these are summarised at the conclusion of this report.

2 A MAJOR OPPORTUNITY

There is a general feeling of positivity and optimism about the potential of Integrated Care Systems (ICSs) to herald a wholly new approach to our health as a nation:

- **Optimism** that the new approach of Integrated Care Systems is both genuinely transformational, builds on many years of developing a partnership way of working and has the highest level of support among leaders at national and local levels across the NHS and local government
- **Clear leadership** from NHSE to create policy frameworks that support place-based ways of working; recognise and respect all partners in the system; is as permissive as possible to allow local decision making; and supports subsidiarity and delegation of power and resources as local systems mature.

- **Clear national commitment** to focus on population health improvement, reduce health inequalities and integrate the NHS into local social and economic development to prevent ill-health and improve productivity

- **Support from NHSE** to enable local areas and systems to share learning; move resources to align with goals; and value, reward, train and recruit leaders with a system and population health approach in their roles.

3 FROM COMPETITION TO COLLABORATION

The shift from a health and care system based on competition to one based on collaboration is intended to fix the problems identified with the internal market including issues of conflicts of interest, perverse behaviours, and organisational protectionism.

An important lesson from the response to the Covid pandemic is that organisations can work together at speed when the task is clearly defined, widely shared, and local flexibility is encouraged.

Collaboration as the organising principle of the health and social care system is potentially a transformational approach, and requires new ways of working and new relationships including a new:

- culture of organisations working together, not competing
- collaboration within the NHS as much as between the NHS and local government
- belief among people in all organisations that this is the right way to provide services and to improve the health and wellbeing of the population
- structure that reflects a culture of collaboration and partnership
- process for planning, commissioning and delivering services through collaboratives
- transparency in the way decisions are made and held accountable

4 A NEW PARADIGM OF HEALTH AND WELLBEING

The 4 aims of ICSs set by NHSE are strongly welcomed and together will drive the new paradigm of health to be delivered by the Integrated care system. It is important that these are kept at the forefront of all ICS policy development and spending decisions and they are to:

I. Improve outcomes in population health and healthcare

II. Tackle inequalities in outcomes, experience and access

III. Enhance productivity and value for money

IV. Help the NHS support broader social and economic development

5 THE BEST PRACTICE THEMES AND EXAMPLES

5.1 *Shared outcomes*

Shared outcomes with a clearly defined task and a common mission for all partners are at the centre of the new system. It may be best if shared outcomes are based on a Life Stage approach, as proposed by Northamptonshire ICS, that defines a small number of key outcomes that will increase the possibility of improved health and wellbeing at the next stage of life, and reduce the likelihood of a downturn. Identifying appropriate health inequalities within this is key. For example:

- Start Well: e.g., reduction in smoking in pregnancy
- Stay Well: e.g., increase in uptake of timely cancer screening
- Age Well: e.g., reduction in falls resulting in hospital admission

When arriving at shared outcomes some important components are: the use of data on key inequalities; progress measurement that is proportional to investment; having resonance with local frontline staff and service users; and the use of effective interventions to achieve the desired outcomes.

5.2 *Focus on place*

The welcome focus on place, not organisation, is at the very heart of the new system and may represent a significant shift for some local leaders, managers and the workforce to develop place-based ways of working, and will require:

- A sustained commitment to the principle of subsidiarity so decisions are made at the lowest geographical level
- Maximising the level of delegation of power and resources to place-based structures

Although each ICS has its dual structure of an ICS Board and an ICS partnership there are also place-based partnerships within the ICS footprint that reflect the principles of maximising delegation and subsidiarity and in which a range of local partners, including those representing the voice of patients such as Healthwatch, meet formally and determine place-based priorities.

The aim is seen as social and economic development. In practical terms there may be variation between areas on the level of delegation of budgets and the extent of pooling NHS and council budgets given the maturity of the relationships in each area and how these develop over time. It also requires some 'work arounds' to make it happen given the complexities of the legislation regarding NHS finances.

The permissive approach that gives flexibility to ICSs and place-based partnerships to develop systems and processes that are best suited to their particular geography and demography will lead to variation between places. However, it will be important to be clear about variation that is desirable to reflect local differences and variation which may not be desirable or reflect under performance.

5.3 *Shared values and culture*

To be successful, place-based collaboration at and within ICSs will require partners to agree shared values and to work together to develop:

- Trust: high levels of trust between leaders, managers and the workforce
- Learning: developing a learning culture
- Performance: adopting a performance development approach

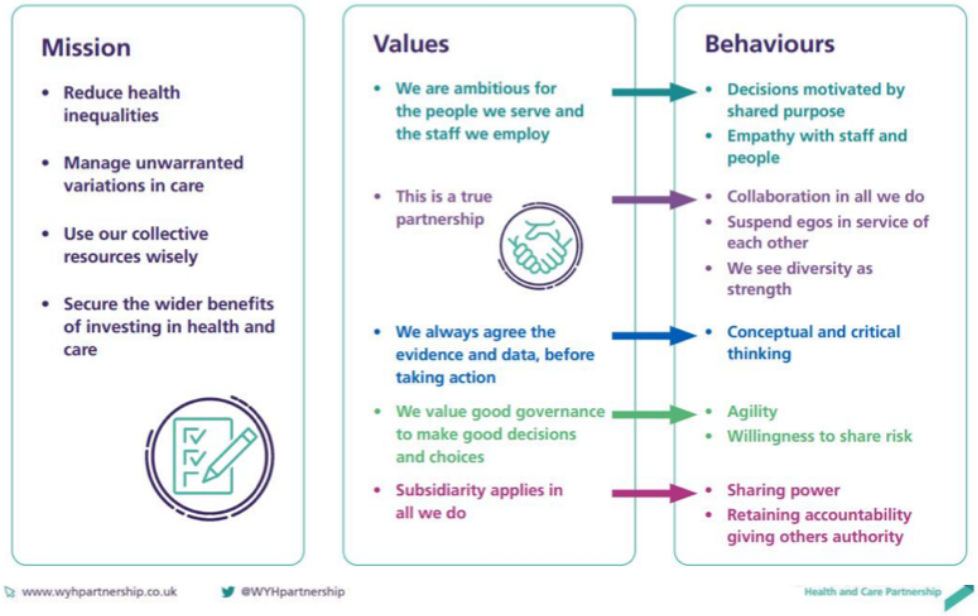
In SE London the shift in culture required to achieve this means doing all the work involved in joint teams not separate NHS and Local Government teams; the use of formal joint development programmes across all the partners for that bring together for example doctors, social workers, and nurses; and health and care leaders modelling the new culture of collaborative behaviour.

In West Yorkshire this change in culture involves having:

- a performance development culture that encompasses:
    - operational performance
    - quality and outcomes
    - service transformation

- finance
- a single framework, covering individual places, and the ICS as a whole
- a focus on making judgements about a whole place, while understanding the positions of individual organisations
- an element of peer review and mutual accountability
- improvement-focused intervention, support and capacity building.

An example of the mission, values and behaviours agreed in the West Yorkshire ICS is given below:



5.4 *Evidenced-based decision making*

The use of evidenced-based decision making is key but developing that evidence base should reflect a number of elements:

- Having robust population health and clinical data
- Having sufficient granularity of data for particular population groups or particular localities/pockets within a place experiencing high health inequalities
- Drawing on professional knowledge and insights about populations, localities, and interventions is essential
- Recognising the value of real-time data for decision making (i.e., use of formative evaluation rather than long-term summative evaluation processes)
- Ensuring data collection is done at a cost proportionate to the benefits the data analysis provides
- Having all partners signed up to the evidence-base development process and the evidence that emerges.

5.5 *Governance and structures*

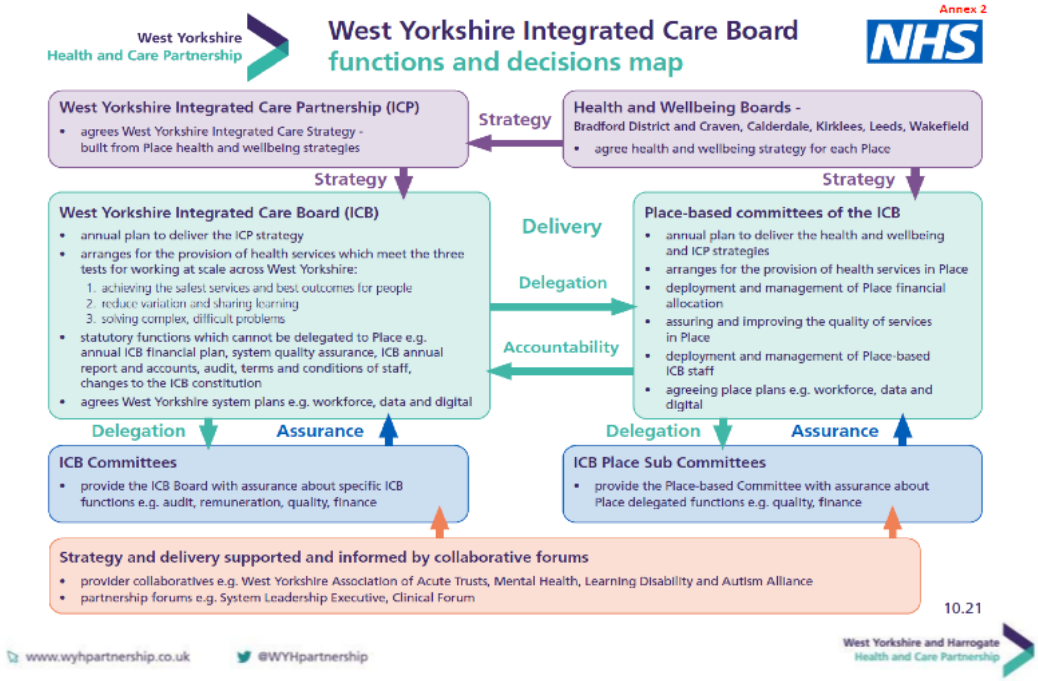
There may be 'desirable variation' in local arrangements for the way that IC Boards and IC Partnerships relate to each other; the chairing arrangements of each body; the way that accountability is ensured; and the criteria for evaluating how well the system is working.

In SE London, for example the IC partnership is co-chaired by the IC Board chair and a local government leader from one of the constituent boroughs, and the Partnership membership is both broad and large in number (NB the NHS Bill now also allows local councillors to be members of IC Boards). Efforts to ensure balanced membership are important but what is key is how the partnership then works in practice, is real and has teeth. This means going beyond what the legislation requires. Crucially, the IC partnership is seen as having the job of holding the IC board and other partners to account for delivering the IC strategy created by the partnership, by publicly assessing the Board plan in satisfying four key questions:

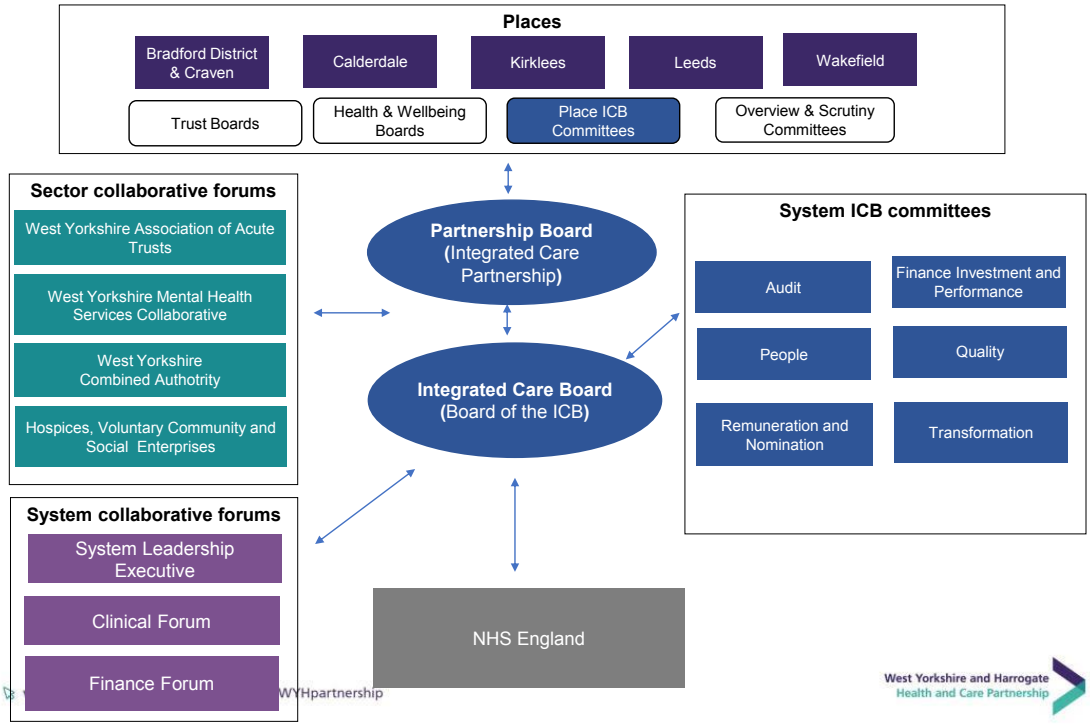
1. Does the plan reflect the integrated care strategy?
2. Is the plan financially viable?
3. Is the plan consistent with the commitment to reducing health inequalities?
4. Does the plan reflect local population priorities?

The Partnership has a 'stop the clock mechanism' if it is not satisfied that the Board plan meets these criteria and the plan can be re-assessed and amended accordingly. It will also have direct oversight of 3 or 4 priority programmes within the partnership strategy.

The example from West Yorkshire Integrated Care System shown below is firstly, a functions and decisions map of their dual structure ICB/ICP, and secondly the governance and accountability for all the partners and structures in the system:



Governance and accountability



5.6 *Provider collaboratives*

The purpose, structure, funding and role of provider collaboratives within and between Integrated Care Systems requires further discussion and development. Examples of types of provider collaboratives, that in some cases act as provider forums, include:

- Population-based collaboratives: e.g., Children and young people
- Condition-based collaboratives: e.g., Mental health, learning disability and autism
- Sector-based collaboratives: e.g., Voluntary, Community and Social Enterprise sector
- System-challenge collaboratives: e.g., Acute care admissions and discharge

5.7 *Financial flows*

Five design principles drawn from experience on what works and could be used by ICSs to underpin the design of local financial processes are:

I. Avoid a reliance on financial incentives for achieving change as these lose their impact over time; and focus instead on removing financial disincentives to allow change to take place in line with the new aims
II. Create as much funding certainty as possible for as long as possible to support providers to plan their work/investments
III. Maximise the level of financial delegation to providers who now how to deliver
IV. Maximise the financial flexibility for providers and minimise ring-fencing whilst protecting long-term investment in up-stream prevention interventions (a relatively small amount compared to acute care spend)
V. Ensure the fullest possible transparency about where money goes, why and how so that leaders (not just chief finance officers) fully understand their budgets

5.8 *NHS support for broader social and economic development*

It is widely recognised and agreed that addressing the social determinants of ill-health is key to creating a sustainable health, social care and public health system. This is now a fourth purpose of an ICS - to support broader social and economic development in their area in different ways. This means ICSs recognising and responding actively to the causal link between health and productivity at different ages; and the importance of having work as a health outcome for people.

Key areas highlighted were:

- **Health and wealth**: A new report by Professor Michael Marmot 'The Business of Health Equity' says that 'The pandemic has taught us all that wealth and health are not in competition with each other, but have to be mutually supporting' and highlights the key idea of a minimum wage for healthy living. A strong economy requires people of working age in good health – and vice-versa.

- **Work as a health outcome**: The Greater Manchester Independent Prosperity Review explores is great detail the relationship between health and productivity that most labour productivity models ignore. However, the impact of losing a job on people's health is now widely recognised – the longer people are out of work the more their health, particularly mental health - deteriorates. The productivity gap between the north and the rest of the UK average could be reduced by 30% if participation in the workforce was raised by addressing ill-health.

- **Investing in early years**: Other reports on what will help local economic development have highlighted the importance of investing in early years as the cognitive development before birth up to three years is so crucial to a child's future development. This suggests that a focus on the health of babies and children by ICSs will have wide ranging benefits to individuals, families and communities and local economies in the long term. The 8-stage Early Years New Delivery Model developed in Greater Manchester includes a shared outcomes framework and a whole family common assessment pathway. This is now showing real benefits such as increases in school readiness, and improvements in school performance and outcomes among those local authorities who have implemented this approach.

- **Public service reform:** Experience in reform of public services to troubled families in need of most support has seen a move to asset-based approaches (not a deficit model), trusted assessors to tell your story once, whole family and whole community approaches, and co-design and co-production with families.

- **Over 50s:** Unemployment, low numeracy/literacy skills and poor health among older people is significant and ICSs create an opportunity to take a holistic approach to improving the health and wellbeing of a population that is often overlooked.

- **Housing**: Lack of suitable housing for low-income areas is a problem but we need to be building healthy places to live and work not just building houses.

6 FUTURE CHALLENGES

Whilst there is much to be optimistic about in both the policy direction of travel and the examples of best practice on the ground, there remain significant challenges to be acknowledged and addressed as ICSs become statutory bodies and implement the new ways of working:

- **Pressure on services:** Short-term pressure to meet NHS acute care targets – unplanned and elective – crowding out other priorities and undermining long-term population health improvement and reducing health inequalities
- **Social care underfunding**: Financial pressures and low pay putting at risk the viability and continuation of residential and domiciliary social care services, and in particular the impact of the current proposals for implementing a Fair Cost of Care regime.
- **Shifting the centre of gravity:** supporting NHS leaders to focus their efforts on the ICS system goals and shared outcomes rather than just those of the acute care services
- **Development of Primary Care Networks**: how they relate to place-based partnerships and ICSs
- **Behaviour of the regulator**: how the role and behaviour of CQC and other provider/system regulators support the new way of working
- **Reward systems for leaders in different sectors**: NHS leaders rewarded for delivering NHS priorities in conflict with local government leaders rewarded for meeting local needs. Need for leadership career development and recruitment to reflect new paradigm of collaboration.
- **Identifying priorities that 'shift the curve':** Identifying and focusing on priorities that 'shift the curve' on improving population health and reducing health inequalities
- **National economic conditions:** Poverty is a key driver of ill-health and, whilst some action can be taken to address it at a local level, addressing this is fundamentally a national issue with poverty levels growing substantially in the short-term
- **Workforce issues:** Coping with staff shortages in both the NHS and social care, and minimum wage pay and conditions in social care (one ICS led a successful large-scale joint recruitment event by health and social care commissioners and providers).

7 NEXT STEPS

Three further meetings of the Health Devolution Commission are planned in 2022.

On Wednesday June 8th from 330 to 530 pm an online meeting will look in more detail at the potential for ICS best practice in reducing health inequalities and will look in detail at case studies regarding children's health and well-being and regarding learning disabilities. Professor Michael Marmot will speak as well as senior representatives of the Shelford Group, Barnardo's, BACP and Mencap. The Minister and a senior representative of the ADCS has also been invited.

On Wednesday September 14th again from 330 to 530 a further online meeting will look at a number of the "wicked" issues highlighted in section six above. Speakers are yet to be identified.

On **Tuesday December 6th from 3 to 5pm** in the Attlee Suite of Portcullis House the Commission will launch its final report.

Please contact the Secretariat – steve@devoconnect.co.uk - if you would like to receive an invitation

8 ATTENDEES

COMMISSIONERS		**PARTNERS**	
Andy Burnham	Co-Chair	Cllr Rosemary Sexton	LGA
Norman Lamb	Co-Chair	Steve Mulligan	BACP
Naomi Eisenstadt	Northamptonshire ICS	Jackie O'Sullivan	Mencap
Nadra Ahmed	National Care Association	Rob Webster	WYH&CP
Phil Hope	Former Minister	Alyson Morley	LGA
Imelda Redmond	Former HealthWatch Chair	Rukshana Kapasi	Barnardo's
Cedi Frederick	Chair, Kent and Medway ICB	Ed Jones	NHS Confed
Peter Hay	Former ADASS President	William Pett	NHS Confed
Linda Patterson	Former RCP Vice President	Sarah Walter	NHS Confed
Suzi Leather	Former ICS Chair	Sarah Price	GMH&SCP
Cllr Izzi Seccombe	Leader Warwick CC and WMCA Wellbeing Portfolio Holder	Ian Holmes	WYH&CP
GUESTS		**SPEAKERS**	
Nigel Edwards	Nuffield	Naomi Eisenstadt	Northamptonshire ICS
Mark Dayan	Nuffield	Cathy Elliott	West Yorkshire ICS
Hannah Davies	NHSA	Richard Leese	Greater Manchester ICS
Hannah Shah	Norfolk ICP	Richard Douglas	South East London ICS
Laura Churchill	NHSE, London ICSs	Mark Cubbon	NHSE Chief Delivery Officer
Jon Restell	Managers in Partnership	Sarah Walters	NHS Confed
Amanda Sullivan, Hazel Buchanan and Lucy Dadge	CEX, Nottingham and Nottinghamshire ICS	Cllr Rosemary Sexton	Wellbeing Board LGA
Jonathan Blay	RCGP		
Isobel Laing	Office of Karin Smyth MP	**GUESTS (CONT'D)**	
Rachel Newton	Chartered Society of Physiotherapy	Pavi Brar	National Voices
Cheryl Davenport	EELGA	Leo Ewbank	King's Fund
Dr Rima Makarem	Chair, Bedfordshire, Luton and Milton Keynes ICS	Stephanie Elsy and Sue Harriman	Chair and CEX, Bath, Swindon, NE Somerset and Wiltshire
Sir Neil McKay	Chair, Shropshire, Telford and Wrekin ICS	Stephen Eames	CEX, Humber, Coast and Vale ICS
Mark Axcell	CEX, Black Country ICS	Karen Brown	Northern Housing Consortium
Jen Crisp		Zoe Russell	