The King's Fund> Ideas that change
health care

A year of integrated care systems

Reviewing the journey so far

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Transforming systems is ultimately about transforming relationships among people who shape those systems. Many otherwise well-intentioned change efforts fail because their leaders are unable or unwilling to embrace this simple truth.

(Senge *et al* 2015)

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Key messages

The development of integrated care systems (ICSs) represents a fundamental and far-reaching change in how the NHS works, both between different parts of the service and with external partners. The evidence reported here shows that progress is being made in most ICSs in improving health and care and developing the capability to work as a system. The challenge now is to build on the foundations that have been laid by removing the barriers we have identified and providing time and support to ICS leaders to take their work to the next stage of development. Having willed the ends, national bodies must provide the means to enable ICSs to succeed. As this happens, the understandable desire to see change happen quickly needs to be married with realism about the scale and complexity of what is being attempted.

Where are we now?

- ICSs vary widely in their size and complexity and have focused in their first year on building the foundations on which to improve health and care for their populations.

- ICSs have used the freedoms they have been given to explore what it means to work as place-based systems, both within the NHS and between the NHS and local government.

- ICS leaders have been learning about system working on the job, including the need to lead differently to deliver their ambitions.

- Much of the work of ICSs to date has involved establishing the governance, collective leadership and staffing needed to work as systems, and engaging with stakeholders such as local authorities in their communities.

- Early changes in service models include work to strengthen and integrate primary care and community services and to review how specialist services are delivered in some areas.

- ICSs also report that they are working more collaboratively to manage finances and performance across the system in a way that was not happening previously.

- Larger ICSs are working through neighbourhoods and places as well as across the whole system to improve health and care, building on the work of the new care models programme and related innovations, and emphasising the principle of subsidiarity.

- ICSs that are furthest ahead in their work are those that were already working as systems and have given priority to strengthening relationships and trust between partner organisations and their leaders.

- Some ICSs have found it more difficult than others to establish common cause among partner organisations, either because some NHS organisations have been unwilling to commit or because local authorities have yet to be fully engaged.

- Regulators and national bodies have been slow to align how they work with ICSs, and this is particularly evident in the way in which regional teams of NHS England and NHS Improvement relate to NHS commissioners and providers.

- There are continuing tensions between the statutory framework, which focuses on organisations and their roles and accountabilities, and the growing emphasis being placed on systems and partnership working.

Where next?

- Looking ahead, national bodies should ensure that ICSs are allowed time to develop and mature, and be realistic about the challenges ICSs are facing in working as systems.

- The priority for local leaders is to focus on delivering further changes in service models to improve health and care for their populations.

- ICSs should redouble their efforts to involve key stakeholders such as local authorities and to deepen the involvement of staff, voluntary and community sector organisations, patients and the public in their work to build a movement for change.

- ICSs should also continue to give priority to strengthening relationships and trust between partner organisations and their leaders; this is the fundamental foundation on which they will succeed or fail.

- Leadership in ICSs should be developed with a continuing emphasis on collective and distributed leadership, ensuring that leaders have dedicated time to fulfil their roles.

- Governance within ICSs should evolve in the light of experience to ensure that their work does not conflict with the accountabilities of local authorities and NHS organisations.

- ICSs should set aside time on a regular basis to reflect on their progress and to adapt their ways of working as part of a continuing commitment to learning by doing.

- ICSs must demonstrate the impact they are having in improving health and care for their populations to reassure those who question their ability to deliver benefits.

- National bodies should do much more to align regulation and funding with the emphasis now being placed on ICSs.

- Legislative changes will be needed at some stage to support the development of ICSs; proposals should be brought forward, drawing on the experience of leaders within the health and care system.

- The NHS long-term plan should set out a route map for all areas to progress from sustainability and transformation partnerships (STPs) to ICSs, earmark funding to support ICSs' development, and communicate simply and clearly why they are needed.

- The plan should also set realistic and measurable objectives for improving population health and hold ICSs to account for delivering these objectives at the local level.

- National bodies should work with NHS and local government leaders to further develop the support programme for current and future ICSs and to share learning based on peer-to-peer support and the spread of best practice.

- National bodies should work closely with local leaders in the further development of ICSs and should clarify where ICSs fit into the emerging architecture of the NHS in the light of plans to establish seven regional offices of NHS England and NHS Improvement, ensuring that this does not create an additional tier of bureaucracy.

- National bodies should also clarify the future size and functions of ICSs, given wide variations in the first cohort. Any move to bring smaller ICSs together should be locally led and rigorously tested to avoid destabilising relationships that are still under development. For the time being, collaboration between smaller ICSs may be a better way of enabling work to take place at the appropriate scale, rather than redrawing lines on the map.

1 Introduction

Where once the primary purpose of the health and care system was to provide episodic treatment for acute illness, it now needs to deliver joined-up and proactive support for growing numbers of older people and people living with long-term conditions and complex needs. Severe constraints on NHS and social care funding since 2010 have put the system under enormous strain, and it is clear that simply working current models of care harder is not the answer. Instead, the NHS and its partners need to work differently, breaking down barriers between services and giving greater priority to promoting population health and wellbeing.

In March 2017, NHS England set out an ambition to 'use the next several years to make the biggest national move to integrated care of any major western country' (**NHS England 2017**, p 31). This aim is now being pursued through the development of sustainability and transformation partnerships (STPs) – local 'place-based' partnerships of NHS and local authority organisations. The most advanced local partnerships have been asked to develop 'integrated care systems' (ICSs). These systems will take more control of funding and services across local areas. It is hoped that by collaborating across organisational boundaries, they will make better use of the resources available to them and improve the health and wellbeing of their populations.

Ten areas of England were selected to develop the first ICSs. Many if not all of these systems have been building partnerships to join up local services for several years, and their journeys as integrated systems can often be traced back to well before the latest national initiatives. As they work to embed and formalise these arrangements, the systems are seeking to create a different way of working in the NHS, moving away from siloed working and competition between providers, towards collaboration and a focus on places, populations and partnerships. International examples where progress has been made in creating joined-up, place-based systems of care – for example, the Canterbury system in New Zealand and the Nuka system in Alaska – highlight the improvements that can be achieved by working in this way (**Charles 2017**; **Collins 2015**; **Timmins and Ham 2013**).

Work to support integrated care and improve population health needs to happen at a number of different levels. Some of this work is taking place across systems of care, however, much of the focus is on smaller, identifiable geographies such as local towns and neighbourhoods (Ham 2018b). It will be important to establish what the role should be for these larger systems – which often have several distinct places within them – and what contribution they can make to the pursuit of integrated care.

The King's Fund strongly supports the development of ICSs. They embody the arguments we have put forward on place-based systems of care and population health and offer the best hope for the NHS and its partners to bring about improvements in health and care for their populations (Alderwick *et al* 2015; Ham and Alderwick 2015). It is early days in their development; the first systems have only been in existence for a little over a year and they have been described as 'nascent and fragile' (Ham 2018a). The challenge facing national bodies and ICS leaders is to allow time and provide support to ICSs to build on the foundations that have been laid and to remove barriers to progress.

About this research

The purpose of this qualitative study was to understand how ICSs are being developed in different parts of the country and to identify lessons for local systems and national policy-makers. The research was conducted during the ICSs' first year (between January and August 2018) and sought to capture early progress. The arrangements in each system are constantly evolving and the findings presented here reflect a particular point in time.

Our research focused on the following questions:

- What are the emerging features of ICSs, and are these common across the different systems?

- What service changes are taking place?

- How is the work of ICSs being led and governed at a local level?

- To what extent have local partners been involved in developing ICSs, including local authorities, frontline staff and the public?

- How have local areas approached the process of developing an ICS?

- How has the process been managed at a national level, and has the relationship between national bodies and local systems changed?

- What factors are helping ICSs to make progress, and what factors are making progress harder?

Given the short time that the ICSs had been in existence, we do not seek to assess their impact or draw conclusions on their success. Further work will be needed to evaluate the outcomes of the changes once the systems have been in place for a longer period.

To answer these questions, we examined progress in eight of the ten areas selected by NHS England to become 'first-wave' ICSs:

- Bedfordshire, Luton and Milton Keynes

- Berkshire West

- Buckinghamshire

- Dorset

- Frimley

- Lancashire and South Cumbria (which has grown out of the smaller Blackpool and Fylde Coast ICS)

- Nottingham and Nottinghamshire

- South Yorkshire and Bassetlaw.

Two ICS areas (Surrey Heartlands and Greater Manchester) were not included in this research due to the distinctive characteristics of the arrangements in place under their devolution deals. Taken together, the ICS areas included in this study cover a combined population of around 7.8 million – slightly more than 14 per cent of the total population of England.

We carried out interviews (n=72) with senior NHS and local government leaders in each area, as well as other local stakeholders. These enabled us to explore local experiences and perceptions of the early development and impact of ICSs from a variety of perspectives (for a detailed description of our methodology, *see* Appendix).

Structure of this report

This report consists of three parts:

- the first (section 2) describes the background and context of ICSs, including an explanation of where they came from, and why and how they were introduced

- the second (sections 3 to 9) sets out the findings from our research, capturing key themes from our interviews. They describe the structure (sections 3 to 5), process (sections 6 to 8) and outcomes (section 9) of the ICSs and their development

- the final part (sections 10 and 11) explores the emerging lessons from the development of ICSs and their implications, concluding by making recommendations for local and national leaders on the future development of integrated care.

A **supplementary online resource** contains a descriptive profile of each of the eight ICSs studied.

2 Background

Why do ICSs matter?

The development of ICSs reflects a consensus that services need to be better joined-up around the needs of local populations (**Alderwick *et al* 2015**; **Ham and Alderwick 2015**; **NHS England *et al* 2014**; **Curry and Ham 2010**). People are living longer with multiple, complex, long-term conditions and increasingly require long-term support from many different services and professionals. Fragmentation of services and a lack of co-ordination and communication between them can lead to a poor experience for people receiving care (**National Collaboration for Integrated Care and Support 2013**).

Rising demand and constraints on NHS and social care funding have put services under pressure. Many hospitals have large deficits, and key performance targets are being missed all year round (**Anandaciva *et al* 2018**). Community, primary care and mental health services are also grappling with rising gaps between demand and the resources available, and there is evidence that access to and quality of care is suffering (**Baird *et al* 2016**; **Maybin *et al* 2016**; **Gilburt 2015**). Local authorities have seen significant reductions in their budgets, resulting in cuts to social care, and public health budgets have been squeezed (**Buck 2017**; **Robertson *et al* 2017**; **Humphries *et al* 2016**).

While integrated care does not necessarily save money, it can lead to more efficient delivery of services and improve patient experience and outcomes (**National Audit Office 2017**; **Nolte and Pitchforth 2014**; **Curry and Ham 2010**). Integration has been a key policy objective for more than three decades in various national plans, including a 'shared commitment' to integrated care from the Department of Health and other national bodies in 2013, and a commitment in the 2015 Spending Review to integrate health and social care by 2020 (**HM Treasury 2015**; **National Collaboration for Integrated Care and Support 2013**). The limited impact of these initiatives is partly due to the failure to align policies on regulation, payment systems and other issues with the commitment to integrated care. If this failure is not addressed, then ICSs will not fulfil their potential.

Alongside integrated care, a further priority is to address factors beyond the health system that impact on people's health. There is a large volume of evidence to suggest that social determinants – such as housing, education, employment and social connectedness – have a greater impact on health and wellbeing than services delivered by the NHS (**Marmot *et al* 2010**). In our previous work, we have made the case for strengthening connections between the NHS and other services to create 'population health systems' to tackle these social determinants (*see* box below). ICSs offer an important opportunity to give greater priority to population health, provided that the NHS is willing to work in partnership with other agencies (**Ham 2018b**).

Population health systems – going beyond integrated care

Most approaches to integrated care in England have focused on joining up services around individuals or around defined groups of people. These approaches have an important role in improving health and care, but we have argued that they must be part of a broader focus on the prevention of ill health and improving outcomes and reducing inequalities across whole populations. It is this wider focus that characterises what we have described as **population health systems** (*see* **Alderwick *et al* 2015** for further detail).

Populations

Individuals

Unit of intervention

Integrated care models

Co-ordination of care services for defined groups of people (eg, older people and those with complex needs)

Population health systems

Improving health outcomes across whole populations, including the distribution of health outcomes
Improving population health requires multiple interventions across **systems**

Individual care management

Care for patients presenting with illness or for those at high risk of requiring care services

Active health promotion

'Making every contact count' when individuals come into contact with health and care services

Focus of intervention

Care services   **Health improvement**

Where did ICSs come from?

ICSs are the latest in a series of recent initiatives to join up local health and care services (for a list, *see* National Audit Office 2017, pp 22–23). In October 2014, NHS England and other arm's length bodies published the *NHS five year forward view* (Forward View), which set out ambitions for how health and care services needed to change to meet the needs of the population (NHS England *et al* 2014). It called for integration of services across organisational boundaries, greater emphasis on prevention, and for patients and communities to be given more control of their health. It set out several 'new care models', and 50 areas of the country were selected as 'vanguards' to lead the development of those models.

In December 2015, NHS planning guidance announced the creation of sustainability and transformation plans (STPs) as local vehicles to implement the changes set out in the Forward View (NHS England *et al* 2015). STPs brought local NHS organisations together with local authorities and other partners to develop long-term plans for the future of health and care services in their area. They were expected to outline how they would improve quality and efficiency of care and how local services would meet growing demand and achieve financial balance. In contrast to existing planning processes, these were 'place-based' plans centred on local populations rather than individual organisations. Forty-four areas of England were identified as the geographical 'footprints' for the STPs (Alderwick *et al* 2016).

The King's Fund and others identified a range of challenges with the process of developing the STP plans and some of the proposals contained in them (Boyle *et al* 2017; Ham *et al* 2017a; Ham *et al* 2017b; Quilter-Pinner 2017; Alderwick *et al* 2016; Edwards 2016). The process attracted widespread criticism for taking place behind closed doors and not involving patients and the public, NHS staff, local authorities and other stakeholders. While the plans contained welcome ambitions around strengthening primary care and community services and prevention, they often lacked detail on how this would be achieved. STPs were also required to demonstrate how the local system would achieve financial balance. As a result, many of the plans contained unrealistic assumptions around financial savings and reductions in acute bed numbers.
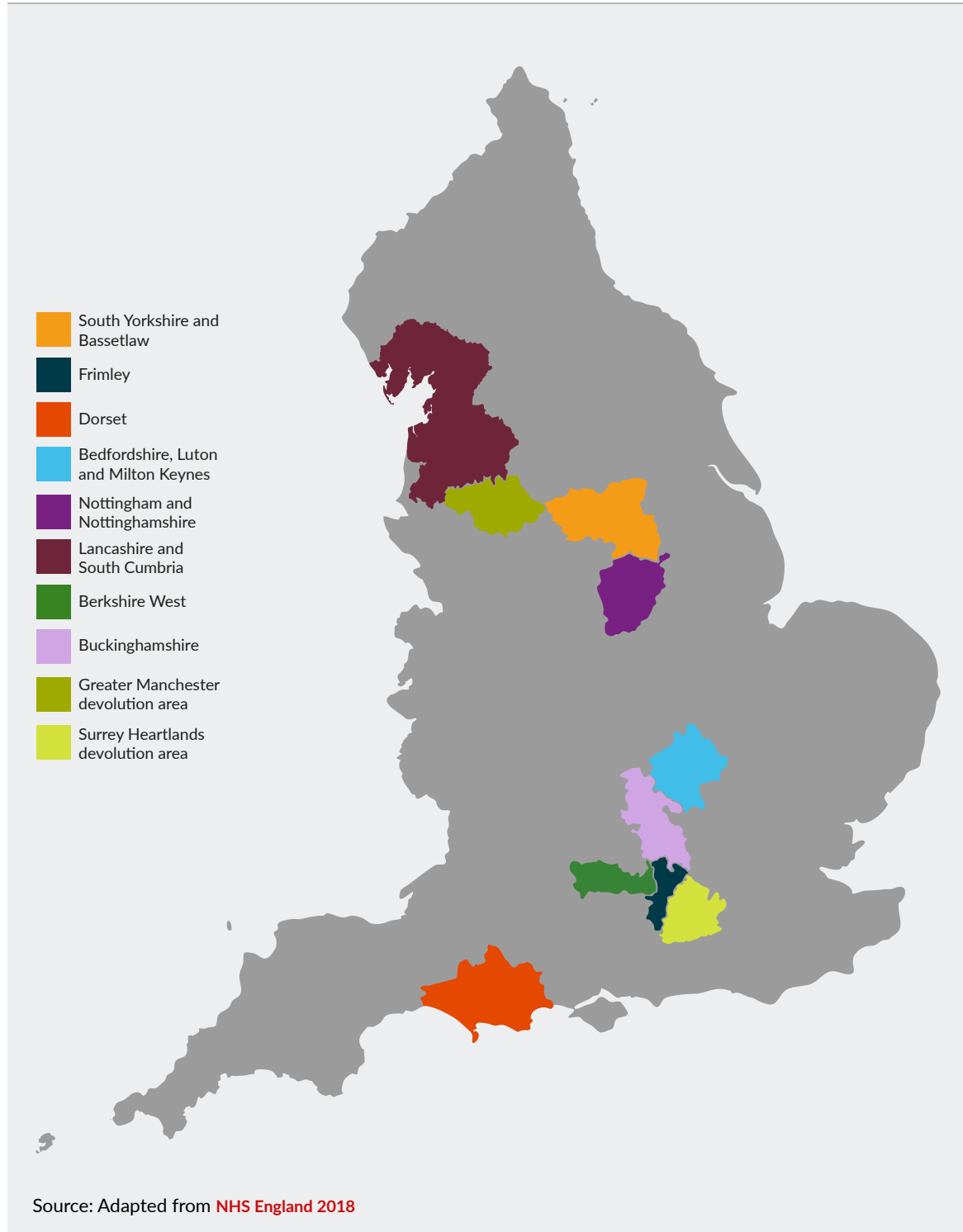
Over time, the emphasis of the STPs has shifted towards a focus on developing and strengthening local place-based partnerships. In 2017, *Next steps on the NHS five year forward view* (Next Steps) reframed STPs as 'sustainability and transformation partnerships' (**NHS England 2017**). This document also described an ambition for some STPs to evolve into 'accountable care systems' (later rebranded as ICSs). These were defined as 'evolved' versions of STPs in which 'NHS organisations (both commissioners and providers), often in partnership with local authorities, choose to take on clear collective responsibility for resources and population health' (**NHS England 2017**, p 35). These systems would be given additional powers and freedoms by national bodies to manage local resources and implement service change.

How were ICSs introduced?

The development of ICSs was described in Next Steps as a complex transition that would require a staged implementation. Unlike the STP process – where all areas of the country produced plans according to a nationally mandated timetable – the introduction of ICSs will be a gradual process, with areas only being selected when their local system is considered to be advanced enough. In June 2017, 10 areas were selected by NHS England as the 'first wave' of ICSs (*see* Figure 1). Two of these – Greater Manchester and Surrey Heartlands – are also part of the government's devolution programme.

Areas were selected based on the quality of their STPs, the strength of local leadership, and an assessment of their ability to take forward the ambitions of the Forward View (**Ham 2018b**). Not all ICSs are coterminous with STP footprints; some are built on local partnerships within an STP and are therefore smaller and less complex. This variation arose from the national bodies' desire to focus on recognising and supporting areas that were making fastest progress in improving services rather than focusing on size or structure. Over time, greater consistency in the size of ICSs is likely to emerge. National leaders envisage moving towards larger systems, covering populations of a million or more, with multiple provider partnerships at a 'place level' within these.

Figure 1 The 10 'first-wave' ICSs

South Yorkshire and Bassetlaw

Frimley

Dorset

Bedfordshire, Luton and Milton Keynes

Nottingham and Nottinghamshire

Lancashire and South Cumbria

Berkshire West

Buckinghamshire

Greater Manchester devolution area

Surrey Heartlands devolution area

Source: Adapted from NHS England 2018

Next Steps outlined expectations that ICSs would:

- agree a performance contract with NHS England and NHS Improvement to deliver faster improvements in care and shared performance goals

- manage funding for a defined population by taking on a 'system control total'

- create effective, collective decision-making and governance structures aligned with accountabilities of constituent bodies

- demonstrate how provider organisations would operate on a horizontally integrated basis (for example, through hospitals working as a clinical network)

- demonstrate how provider organisations would simultaneously operate as a vertically integrated system linking hospitals with GP and community services

- deploy rigorous and validated population health management capabilities to improve prevention, manage avoidable demand and reduce unwarranted variations

- establish clear mechanisms by which residents can exercise patient choice over where they are treated.

In return, national NHS bodies committed to offering ICSs:

- delegated decision rights for local commissioners in relation to primary care and specialised services

- a devolved transformation package from 2018, potentially bundling together funding for the General Practice Forward View, mental health and cancer

- a single 'one-stop shop' regulatory relationship with NHS England and NHS Improvement through streamlined oversight arrangements

- the ability to redeploy attributable staff and related funding from NHS England and NHS Improvement to support the work of the ICS.

Each system signed a memorandum of understanding (MoU) with NHS England and NHS Improvement that formalised these commitments and expectations. The MoU also set out requirements around national priorities and performance targets, and an expectation that ICSs would make faster progress than other parts

of the NHS in delivering these. For an example MoU *see* www.rushcliffeccg.nhs.uk/media/4374/17146-shadow-accountable-care-system-memorandum-of-understanding.pdf (Nottingham and Nottinghamshire).

During their first year, ICSs were tasked with putting in place local arrangements to take forward these new ways of working. In doing so, they worked alongside the System Transformation Group at NHS England and colleagues at NHS Improvement to co-design approaches to system-wide assurance and financial control. They also contributed to collective workstreams on priority issues such as the development of primary care networks.

National planning guidance for 2018/19 (NHS England and NHS Improvement 2018) rebranded accountable care systems (ACSs) as 'integrated care systems' in response to widespread criticism of the language of accountable care (which originated in the United States) and concerns that it indicated a move to privatisation and an 'American-style health system' (Ham 2018b). The planning guidance directed ICSs to prepare a single system operating plan across NHS commissioners and providers, aligning assumptions around income, expenditure, activity and workforce. It also outlined new financial arrangements to support them to operate a 'system control total', meaning that they would be given flexibility to vary individual organisational control totals and offset financial overperformance in one NHS organisation against financial underperformance in another. The planning guidance outlined requirements for systems to 'involve and engage with patients and the public, their democratic representatives and other community partners' (NHS England and NHS Improvement 2018, p 14).

NHS England and NHS Improvement made clear that ICSs would become increasingly important in planning services and managing resources, and confirmed that other systems would be joining the programme once they could demonstrate their readiness to do so. Four further areas – Gloucestershire, West Yorkshire and Harrogate, Suffolk and North East Essex, and West, North and East Cumbria – were announced as 'second-wave' ICSs in May 2018. In a ringing endorsement of ICSs, Simon Stevens, Chief Executive of NHS England, recently described them as 'where the health and care sector is headed' and stated that 'there is no plan B' (Stevens 2018b).

ICSs and STPs mark a major shift in health policy. Following several decades during which the emphasis has been on organisational autonomy and the separation of commissioners and providers, ICSs depend on collaboration and a focus on the needs of local populations as the driving forces for improvement. This is inherently difficult in the context of the 2012 Health and Social Care Act, which was designed primarily to promote competition between providers. ICSs have no basis in legislation, and no formal powers or accountabilities. They are workarounds whose success hinges on the willingness and commitment of organisations and leaders to work collaboratively.

There is no blueprint for developing an ICS; the changes are being designed and implemented locally within a broad national framework. This permissive context creates significant latitude for local systems to shape our understanding of what an ICS could and should look like. This report paints a picture of how ICSs are emerging and captures learning from local leaders as they write the manual for system working.

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3 What are the emerging features of ICSs?

The ICSs are united by the ambition to work together more closely as integrated systems, with organisations taking collective responsibility for resources in order to improve the health of their shared population. However, there is no single ICS model, and each area is developing differently according to local circumstances. This section describes the emerging features of the eight ICSs studied for this research and highlights key similarities and differences between them. Further detail on arrangements within each of the eight areas is provided in a **supplementary online resource**, and a summary of their key characteristics is included in Table 1.

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Table 1 **Key characteristics of the eight ICSs studied for this research**

	Bedfordshire, Luton and Milton Keynes	Berkshire West	Buckinghamshire
Population	985,000	530,000	540,000
Organisations	3 clinical commissioning groups (CCGs) 3 acute providers 3 community and mental health providers 4 unitary authorities 2 ambulance trusts 1 GP federation	1 merged CCG 1 acute provider 1 community and mental health provider 4 primary care provider alliances 3 unitary authorities, although these are not members of the ICS	1 merged CCG 1 integrated acute, community provider 1 mental health provider 1 ambulance trust 2 GP federations 1 upper-tier authority (the county council) with 4 districts
Leadership	Chief executive of one local authority	Chief officer for the merged CCG	Managing director, seconded to the ICS from the NHS England national team. Partnership board chaired by CCG accountable officer.
Relationship to STP	ICS co-terminous with the STP	ICS sits within the STP, along with the Buckinghamshire ICS	ICS sits within the STP, along with the Berkshire West ICS
Places within ICS	4 localities based on local authority areas	4 localities	7 localities based on historic GP commissioning localities
Vanguards within ICS	There are no vanguards within the ICS	There are no vanguards within the ICS (or wider STP)	There are no vanguards within the ICS (or wider STP)

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Table 1 Key characteristics of the eight ICSs studied for this research *continued*

	Dorset	Frimley	Lancashire and South Cumbria
Population	800,000	800,000	1.7 million
Organisations	1 CCG 3 acute providers 1 community and mental health provider 1 ambulance trust 1 upper-tier authority (county council) with 3 borough councils	3 CCGs (following merger) 1 acute provider 2 main community and mental health providers 3 other community and mental health providers delivering a smaller number of services 5 GP federations 2 ambulance trusts 5 upper-tier local authorities • 3 unitary authorities • 2 county councils (5 districts and boroughs)	8 CCGs 4 acute providers 1 community/mental health trust 1 ambulance trust 4 upper-tier local authorities with 13 districts
Leadership	Chief officer for the CCG	Former longstanding chief executive of acute trust	Chief officer of one of the constituent CCGs leads the ICS
Relationship to STP	ICS co-terminous with the STP	ICS co-terminous with the STP	Initially covered Blackpool and Fylde Coast area. Now co-terminous with whole STP.
Places within ICS	2 local 'health and care partnerships'	5 localities	5 'integrated care partnerships'
Vanguards within ICS	There is an acute care collaborative in the ICS area – Creating One NHS in Dorset	Primary and acute care system (PACS) vanguard model in North East Hampshire and Farnham, and new care models have also been developed in Surrey Heath	Two vanguards: • Morecombe Bay Better Care Together PACS • Fylde Coast local health economy multispecialty community provider (MCP)

Table 1 Key characteristics of the eight ICSs studied for this research *continued*

	Nottingham and Nottinghamshire	**South Yorkshire and Bassetlaw**
Population	1 million	1.5 million
Organisations	6 CCGs	5 CCGs
	2 acute providers	3 acute providers
	1 NHS community and mental health trust	2 acute/community providers
	1 social enterprise providing community health services	2 community/mental health trusts
	An independent treatment centre	1 ambulance trust
	1 ambulance trust	1 specialist hospital
	2 upper-tier local authorities • 1 unitary authority • 1 county council (7 districts and boroughs)	6 local authorities • 4 unitary authorities • 1 county council • 1 district council Involved in 'integrated care partnerships' at a place level
Leadership	Deputy CEO of county council is ICS lead. Managing director seconded from NHS England	Former longstanding CEO of acute trust
Relationship to STP	Early focus was on Greater Nottinghamshire (part of STP). Now covers whole STP	ICS co-terminous with the STP
Places within ICS	2 'transformation areas'	5 'integrated care partnerships'
Vanguards within ICS	Three vanguards: • MCP model in Rushcliffe • PACS model in Mid Notts • Enhanced health in care homes model in City	One acute care collaboration vanguard involving 7 trusts across Yorkshire and Derbyshire

Variation in the nature of ICSs

ICSs vary significantly in size, both in terms of the population covered and number of organisations involved. The South Yorkshire and Bassetlaw ICS, for example, covers a population of 1.5 million and has 23 members, while the Berkshire West ICS covers a population of approximately 500,000 and has seven members. These differences reflect NHS England's decision to initially establish some ICSs around places within larger STPs, in recognition of the progress these places have made towards integrated working.

ICSs also vary in their complexity, including the extent to which the organisations involved are co-terminous with one another, and their relationships and patient flows beyond the ICS.

> *One of the advantages of Buckinghamshire is we're a reasonably simple landscape in terms of structures.*
> (Acute provider, Buckinghamshire)

> *We have very, very messy boundaries, so every organisation apart from our acute has a multitude of significant relationships [outside the ICS]… The acute is the only bit that is co-terminous with the ICS.*
> (Commissioner, Frimley)

While most ICSs are co-terminous with a sustainability and transformation partnership, this is not always the case; for example, the Berkshire West and Buckinghamshire ICSs both sit within the Buckinghamshire, Oxfordshire and Berkshire West STP. Some ICSs consider their geography to be a 'natural' one, but in other areas it is seen as a more recent construct.

> *What we've seen is evolution from a BLMK [Bedfordshire, Luton and Milton Keynes] footprint of an artificial boundary put around the three areas into an evolution of a Bedfordshire and Luton place, and a Milton Keynes place. So the reality of the 16 organisations coming together as an ICS is very limited. What we are seeing is two health and care systems evolving within BLMK.*
> (Acute provider, Bedfordshire, Luton and Milton Keynes)

ICSs also differ in terms of the nature and extent of joint working that existed before the ICS was established. In most areas, ICSs build on existing arrangements such as the vanguards programme.

> *We developed our extensive care service as a vanguard pilot, which is an integrated community service across health and social care. On the back of that we then developed our neighbourhood models… That work's been ongoing now for a number of years. And from that then, as we start to look at what's next after vanguard, accountable care and an accountable care system.*
> (Acute provider, Lancashire and South Cumbria)

In some areas – for example, in Lancashire and South Cumbria – the relationships underpinning the ICS go back many years, whereas in other areas they are more recent. For example, in Frimley, the acquisition of Heatherwood Hospital and Wexham Park Hospital by Frimley Park Hospital in 2014 was seen by some as initiating a different way of working.

> *It was definitely that coming together of the acute patch covering 750,000 population that people were comfortable with working in that size of footprint. So people felt that they had skin in the game and that they had something in common that they could get behind. And that hadn't been the case before.*
> (Community and/or mental health provider, Frimley)

Some systems have enjoyed relative overall stability, but others are experiencing financial and/or performance challenges. These pressures are sometimes seen as providing a 'burning platform', forcing organisations to work differently; but usually, the absence of significant challenges is considered an advantage.

> *They're very, very lucky that the providers they've got are pretty darn good. Life is obviously a little bit easier… If you're working with hospitals in special measures or doing 60 per cent at A&E [accident and emergency], I'd imagine this stuff gets a lot harder.*
> (Healthwatch, Berkshire West)

Operational and financial pressures also vary between organisations within an ICS and providers involved have a range of ratings from the Care Quality Commission (CQC), from 'requires improvement' to 'outstanding'. Differences in performance between the different members of an ICS was sometimes a challenge to joint working – for example, in the context of agreeing to share financial risk.

Variations in local context and history partly explain differences in the way that ICSs have developed. Some are focused on defining the nature and role of their ICS. Others are making significant progress in managing their finances as a system.

> *I think we still lack a real sense of how we work together, what we're trying to achieve and having the capacity to deliver it. Because we just started by scrambling for deadlines to hit things, grabbing it from all bits and pieces, grabbing people, doing stuff, shoving it in... And then we sort of lost that momentum, falling back to base camp really. We almost took off like a rocket, came a little bit back down towards earth, and now we're probably in a slightly more stable orbit, but we're not moving as quick as we need to to make a difference.*
> (Acute provider, Bedfordshire, Luton and Milton Keynes)

> *We have adopted a principle of a single control total and we, as an example, have reduced our control total with NHSI [NHS Improvement] in order to allow [another provider] to increase their control total. So my understanding is that's the first time that has really happened within the NHS and it's a sign, I think, of organisations working quite differently.*
> (Acute provider, Dorset)

In most cases, ICS leadership is drawn from the NHS – including from providers and commissioners – but two are led by local authority representatives.

Activity is taking place at multiple levels

We identified activity at three main levels, which can be described as neighbourhoods, places and systems. The terminology used to describe these varies between ICSs, but there is a broad consensus around the types of activities that should happen at each.

- **Neighbourhoods** tend to cover populations of between 30,000 and 50,000. They are typically based around GP catchment areas, with practices working together in networks or federations. This is usually the level at which multidisciplinary community teams operate, recognising that they need to respond to the characteristics and needs of local populations.

- The **place** level is where most service change is taking place. The 'place' may be defined by a local authority, clinical commissioning group (CCG) or acute trust footprint, or determined by the natural geography of a town. Local authority involvement is often strongest at this level.

- The **system** level is seen as the basis for activities and functions that need to happen 'at scale'. This includes specialised commissioning, acute service reconfigurations, workforce planning, and the development of digital and estates strategies. It is also considered to be the appropriate level for population health management.

Because ICSs were selected on the basis of the quality of their plans and the strength of local leadership and relationships, they are not all operating at the same level (*see* Figure 2). The South Yorkshire and Bassetlaw ICS, for example, operates at a system level, with what are termed 'integrated care partnerships' operating in the five constituent places. In contrast, the Berkshire West and Buckinghamshire ICSs have been established at a place level within a bigger STP.

Figure 2 Variations in the level at which ICSs are operating

Source: Adapted from **NHS England 2018**
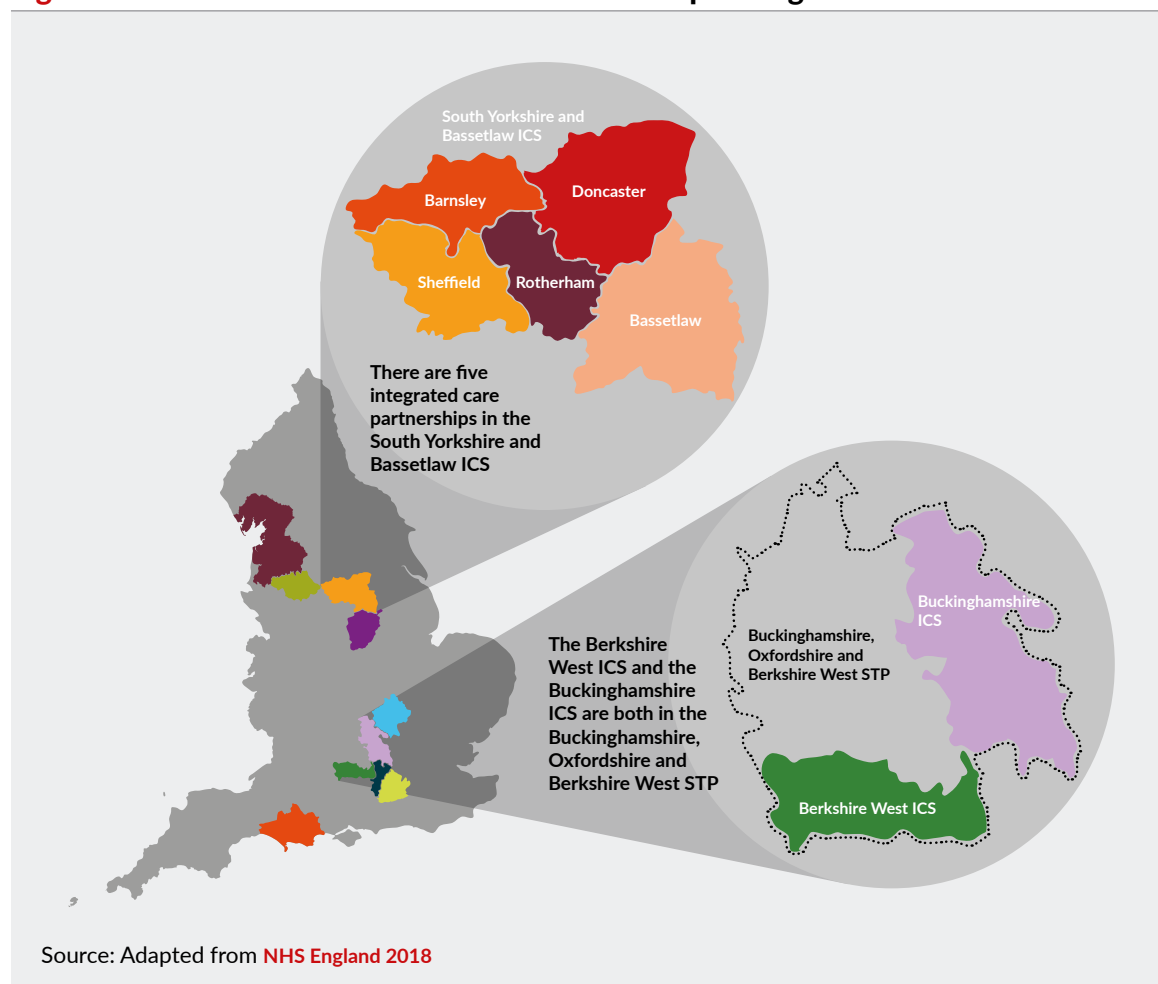
We found broad consensus on the need to cultivate activity at each of these levels to make progress on integration. There was a view that between 70 per cent and 90 per cent of the focus should be at the place and neighbourhood levels, with activity at the system level accounting for the remaining 10 per cent to 30 per cent. Work within places and neighbourhoods was often described as being more meaningful to populations and staff.

> *Places within the ICS are more around what people see as a place. I think local government boundaries and local authority boundaries and CCG boundaries are all part of that, because you can't make it real for clinicians, patients and residents unless you do that at a smaller scale.*
>
> (Local authority, Frimley)

In some cases, the allocation of functions between levels is not yet clear, and this can lead to duplication.

> *I think we've got quite a long way to go until we're all on the same page about what sits within an integrated care partnership and what sits at ICS level, particularly around roles and responsibilities and accountability and autonomy in terms of the role of the ICS, particularly in terms of what that means from a commissioning perspective; I don't think there's quite a universal view of what that means.*
> (Community and/or mental health provider, Nottingham and Nottinghamshire)

In future, ICSs are likely to evolve to take on 'system-level' functions. In doing so, one of their roles will be to support work in the places and neighbourhoods within them. This will enable ICSs to focus on functions that are best done at scale.

> *There are things where we need to come together as a collective over a wider footprint to do those. But we're not looking to transfer functions that should sit in place to the ICS just because we've created an ICS – be really clear about why we do something at an ICS level.*
> (Commissioner, South Yorkshire and Bassetlaw)

Activities at the system level

Functions that are likely to develop at a system level are as follows.

- **Planning for the future** – developing plans for improving the health and wellbeing of populations, recognising that this is 'an opportunity to genuinely think more broadly than just health', looking beyond the NHS and social care to address wider determinants of health.

- **Aligning commissioning** – rather than taking on all current commissioning functions, ICSs will focus on the 'strategic' aspects, ensuring that commissioning arrangements and decisions support system objectives – for example, ensuring that where relevant, CCGs are working together to commission across an appropriate scale, and that local authorities and NHS commissioning are aligned.

- **Integrating regulation** – over time, it is expected that some functions that currently sit within NHS England and NHS Improvement regional teams will be brought within ICSs, avoiding the creation of an additional tier of management: 'ICSs see themselves having a very clear role in having an integrated function around regulation, which is one that works with organisations, and regulation working in much more of a facilitative way rather than at arm's length.'

- **Managing performance** – ICSs will take responsibility for overseeing performance across the system, setting local standards and monitoring progress towards achieving shared goals.

- **Owning and resolving system challenges** – ICSs will manage challenges as they develop, encouraging organisations to 'come together to create solutions' by working together as a system rather than looking externally for support.

- **Providing system leadership** – moving away from the focus on individual organisations, ICSs will provide leadership across systems, supporting a shift away from individual services to a focus on places and populations.

The wide variation in size among the first cohort of ICSs means that they will not all be able to take on these 'system-level' functions, and there is some discussion of how they may evolve to address this. This might involve the footprints changing, or neighbouring ICSs collaborating or even merging. Two ICSs – Nottingham and Nottinghamshire, and Lancashire and South Cumbria – have already expanded to cover larger footprints.

Some interviewees suggested that more guidance should be provided on this nationally, and there is an expectation that national leaders will promote more consistency in the size of ICSs and encourage future ICSs to develop at a system level. However, we also heard a strong message that any move to change ICS footprints should be locally led to avoid destabilising existing relationships.

> *There's something about building upwards, rather than top-down, that's really important.*
> (Local authority, Bedfordshire, Luton and Milton Keynes)

Changes in commissioning

There are many examples of joint working between NHS commissioners, and NHS and social care commissioners, and in some ICSs there have been mergers between CCGs. For example, Berkshire West CCG was established in April 2018 following the formal merger of four CCGs, and in Frimley the number of CCGs has reduced from five to three following a merger, and two share a joint accountable officer.

In other areas, commissioning arrangements remain largely unchanged and there is less agreement around the benefits of mergers. There is also some resistance, including concerns that having larger CCGs could weaken links with local authorities and undermine working at the place level. This is a particular concern where there is coterminosity between a CCG and a local authority in the places that make up an ICS.

Our research suggests that commissioners and providers are working together more collaboratively, with providers taking more responsibility for shaping services and improving quality of care. Some are moving away from a Payment by Results (PbR) approach towards more outcomes-focused commissioning.

> *The idea is that we will end up with a single capitated budget and a joint approach to risk. And the big thing in our system is moving everybody's conversations away from pricing onto cost… The only way we'd make savings is if [commissioners] don't focus on how much [they] pay for something and [providers] don't focus on income.*
> (Commissioner, Berkshire West)

The way in which commissioning will change over the longer term is less clear, and there are different views on what future arrangements might look like.

Some interviewees made a distinction between strategic commissioning and tactical commissioning, suggesting that in future these roles would be undertaken by different organisations or at different levels. In addition, the divide between providers and commissioners may become blurred, as local integrated care partnerships take on some commissioning functions at a place level. It is likely that commissioners will make use of long-term outcomes-based contracts in future instead of the transactional approach seen in the NHS today.

For some, this raised a question about the future of CCGs.

> *We [will] move to strategic commissioning function at the ICS level, with tactical commissioning function in provider alliances at integrated care partnership level, which will probably be at the level of the two delivery units that we've currently got.*
> (Commissioner, Nottingham and Nottinghamshire)

> *We do see the cut line between commissioning and provision fundamentally changing, in that the commissioners take a step back and commission the outcomes that they would [like to] see.*
> (Commissioner, Bedfordshire, Luton and Milton Keynes)

There was agreement among interviewees that further work was needed to determine what commissioning arrangements would look like in future. This includes determining the skills that are required and ensuring that the appropriate capability is available.

4 What service changes are taking place?

All ICSs are working to improve health and care for their populations, building on STPs and other plans that had been developed before ICSs were established. Progress in implementing these plans is variable and this means that evidence of the impact of ICSs is clearer in some areas than others.

ICSs are working on many of the same changes around the country, as described below. We have included specific examples in each of the areas discussed.

Developing primary care

All ICSs described work to improve and stabilise primary care. Many are extending access to GP services, and are encouraging practices to become 'more proactive in managing a list of patients' and design new services to meet population needs.

This commonly involves primary care coming together to operate at scale through federations, alliances or networks (as well as some mergers between practices). This has enabled staff to work flexibly across practices, and to work in a more integrated way with other services. The development of networks also provides a mechanism for primary care to 'interface with the broader system' and engage with ICSs.

Primary care networks are seen as fundamental to the overall ICS architecture, and the development of robust, sustainable models of primary care were seen as key to the success of their overall ambitions.

> *Supporting primary care, building primary care resilience, recognising very, very loudly that primary care is the bedrock… unless we actually protect our primary care we can forget any concept of having enhanced community care.*
> (GP/GP commissioner, Buckinghamshire)

There are different views on the extent and speed of progress and the degree to which ICSs have been the driving force for change. In Berkshire West, for example, we heard that the ICS had 'fostered the emergence of at-scale provider organisations in primary care', whereas primary care networks were described as having been 'up and running for over four years' in Lancashire and South Cumbria.

Enhanced primary care in Bedfordshire, Luton and Milton Keynes

In Luton, building on the primary care home model, integrated teams have been developed around practice populations, with GP clusters working for patient populations of around 30,000 to 50,000. This initiative predates the ICS, having been in development for around three years.

The initial focus was on understanding the population and engaging with practices and other local partners to identify the needs of different population groups. An intensive change programme for general practice has been developed with the National Association of Primary Care, with transformation funding. There are leadership forums for networks of practices working to deliver care differently for segments of their populations. In addition, two GP clusters are leading plans for future workforce requirements. The intention is to widen this work across the ICS.

These developments are in their early stages, but benefits have already been reported. For example, some small practices that were vulnerable due to workforce and other pressures are now felt to be on a more stable footing.

Integrated community teams

Many ICSs are developing integrated community teams or community hubs, often focused around GP clusters covering populations of 30,000 to 50,000. These teams bring together a mix of health and care professionals, including GPs, community nurses, social care workers, mental health professionals, voluntary sector workers and others. Interviewees highlighted the importance of developing new ways of working and 'a shared culture' between the different staff groups.

We've established integrated community services, so some hub-based arrangements across the patch… Even in a very short period of time they are

showing that we can manage demand in a different way… It's not necessarily about additional investment, it's about integrating teams, ideally not just primary and community care but health and local authorities, including mental health, where everybody can get the best traction.

(GP/GP commissioner, Dorset)

Integrated community teams are one of a number of community-based initiatives being developed in the Frimley ICS, and these are the central focus of its work (*see* section 9, pp 75–6, for further details). These approaches aim to shift care out of hospital settings into the community, providing more proactive care and better support for people's wider needs. They include a focus on mental health services and the provision of alternative forms of care and support for people with mental health needs.

Community hubs pilot in Buckinghamshire

In April 2017, a community hubs pilot was launched in Marlow and Thame community hospitals. The objective was to test a model for delivering care closer to home, providing a single point of access to a range of services.

The model was co-designed with a range of stakeholders, including GPs, other health and care professionals, and patients and the public. It includes:

- a community assessment and treatment service (CATS), including a frailty assessment service. This provides a single point of access, enabling clinicians to refer patients to the multi-professional team

- additional diagnostic facilities

- an extended range of outpatient clinics (for example, chemotherapy and falls clinics)

- support from voluntary organisations

- links with other public services, such as library services.

The pilot has been supported by a £1 million investment in community services, and the creation of new posts in the community.

Community hubs pilot in Buckinghamshire *continued*

An evaluation of the pilot found:

- less than 1 per cent of those attending the CATS were subsequently referred to A&E

- a reduction in non-elective admissions via GP referral for people over 75

- a 60 per cent increase in outpatient appointments offered across the two pilot sites

- broad support for the model among staff, GPs, voluntary sector partners and the public.

The intention is to continue the pilot in Marlow and Thame for two years, allowing time for other, complementary elements of community service transformation to take place.

Source: **Buckinghamshire Healthcare NHS Trust 2018**

Supporting high-risk populations

Some ICSs are developing support for populations at risk of hospital admission, such as people living with frailty or long-term conditions, and frequent users of emergency services. This includes developing approaches to risk stratification and designing proactive, targeted services such as the integrated teams described above.

Extensive care service in Blackpool

The extensive care service in Blackpool and Fylde Coast was developed as part of the Fylde Coast multispecialty community provider (MCP) vanguard, so predates the ICS. It provides proactive, co-ordinated support for frail elderly people living with multiple long-term conditions in their homes and communities.

A risk tool has been developed to identify people at high risk of hospital admission. These individuals are offered an opportunity to be seen by the extensive care team, which includes geriatricians, nurse practitioners, therapists and wellbeing support

> ### Extensive care service in Blackpool *continued*
>
> workers. They remain registered with their GP, but their care is delivered and co-ordinated by the extensive care service. Care home staff can also contact the service using Skype to seek advice and patient reviews.
>
> The CCG has reported positive outcomes, including a reduction in demand for unplanned emergency care, outpatient appointments and elective procedures, and an improvement in measures of patient activation.
>
> Source: **Blackpool CCG 2018**

Information-sharing

ICSs are also working to improve information-sharing. These changes are intended to ensure that clinicians and other health and care professionals across an ICS can share information on individual patients, improving quality and safety of care and user experience. Several ICSs are developing shared care records.

> *We've got the Dorset Care Record, which has just been launched. It's taken a couple of years to get to this stage but it will be a single platform for acute community, primary care, and local authority and social care, to interface. It's seen as a key enabler to driving change. It is truly a system-wide transformation and needs more investment and more time.*
> (GP/GP commissioner, Dorset)

Some are also developing infrastructure for data analytics, bringing together information across systems to identify needs and determine service priorities – particularly in relation to population health management.

Connected care programme in Berkshire West and Frimley

Building on work initiated by the local CCGs, Berkshire West ICS and Frimley ICS have been working together to improve information-sharing across primary, acute, mental health, community and social care services. The programme brings together records from across the organisations involved – 18 health and social care organisations and 135 GP practices – into a shared care record, giving health and care professionals instant access to information about their patients drawn from across the system. It is supported by an IT system that collects and makes accessible information from the range of IT systems used.

The system went live in January 2018. A website has been created to inform patients and the public about how their information is being managed and how they can express their preferences in relation to information-sharing, and there are a range of materials on the programme available from the organisations involved.

The budget is £10.8 million over five years, and is drawn from a range of sources, including £600,000 from the Better Care Fund.

The longer-term ambition includes improving patients' access to their information through a portal, and enhanced population health analytics capability, to support priority-setting and targeted support.

Source: **Maguire** *et al* **2018**

Prevention and population health

We also heard examples of work on prevention and early intervention, particularly aimed at reducing demand for acute services. Progress includes development of social prescribing models, and extended roles for community pharmacy. A further area of focus is population health management, including plans to draw on shared data, segmentation analyses and risk stratification to understand population needs.

Prevention and population health were often described as an area where both the place and system levels should play a key role. Interviewees also emphasised the need for this work to consider not only health and social care, but the wider determinants of health, such as people's housing and employment needs.

> **Cardiovascular prevention in Bedfordshire, Luton and Milton Keynes**
>
> Bedfordshire, Luton and Milton Keynes has an objective to improve cardiovascular prevention. It is estimated that across this area, 89,900 people have undiagnosed hypertension, and 7,200 have undiagnosed atrial fibrillation. Both conditions are linked to increased risk of stroke or heart attack.
>
> Bedfordshire, Luton and Milton Keynes piloted an initiative aimed at increasing the detection of undiagnosed hypertension and atrial fibrillation through screening in community pharmacies. In participating wards, adults aged 40 and over were opportunistically invited to be screened. Those diagnosed with hypertension and/or suspected atrial fibrillation were referred to a GP, and others were provided with lifestyle advice and information on preventive services. As well as improving detection of hypertension and atrial fibrillation, the pilot aimed to reduce pressure on GP services, and promote community pharmacy as a viable setting for preventive care.
>
> The pilot began in April 2018 and drew on transformational funding provided to the ICS. The first phase ended in June 2018 and, following evaluation from pharmacies and residents, a second phase will begin in September 2018 to build on uptake.

In many cases, work on prevention was spoken about as an aspiration or area requiring further focus, rather than one where concrete progress had been made. We were told that in practice, it often lost out to more immediate priorities.

> *If you don't have the right discussions around intervention and prevention then you're only ever going to work at the acute end. And if you only ever put money into acute, you're never going to address the issues that are causing some of those conditions to become acute. And that's really difficult, isn't it? But the bit around the left shift that people talk about, I don't think we're seeing evidence of that yet.*
> (Local authority, South Yorkshire and Bassetlaw)

Acute reconfigurations

There are fewer examples of acute service reconfigurations taking place within ICSs. Where changes are planned or in progress, these are often aimed at improving how hospital services are delivered across the system – for example, by centralising specialist services, or staff working more flexibly between providers. Interviewees

described a range of steps to improve collaboration between acute providers, including through shared clinical services strategies aimed at ensuring consistent standards across a system.

In Dorset and in South Yorkshire and Bassetlaw (*see* box below), major acute reconfigurations are planned. The clinical services review (CSR) in Dorset, which covers major changes to the roles of Poole Hospital and Royal Bournemouth Hospital, dates back to well before the ICS, and agreement has been reached within the NHS on how specialist services should be relocated between these hospitals to improve outcomes for the population. The Dorset reconfiguration is supported by the promise of additional capital funding based on the case for change and detailed service development work done as part of the CSR.

Hospital services review in South Yorkshire and Bassetlaw

In 2017, the South Yorkshire and Bassetlaw ICS commissioned an independent hospital services review. This included five hospitals within the ICS footprint, as well as two hospitals that are outside the ICS but send large numbers of patients to hospitals within it.

Against a background of financial pressures and challenges in quality and performance, the objective was to identify a delivery model (or models) that would secure the sustainability of five acute services across the hospitals:

- urgent and emergency care

- maternity

- care of the acutely ill child

- gastroenterology and endoscopy

- stroke.

The hospital services review's final report (May 2018) included a key recommendation that the hospitals develop 'networks of care' in each of the service areas, with a different hospital taking responsibility for each. This is intended to maximise the use of skills and expertise across the review footprint. It also recommended that the

> **Hospital services review in South Yorkshire and Bassetlaw** *continued*
>
> system should enable service transformation by providing support on workforce, reducing unwarranted variation, and promoting innovation.
>
> The review was supported by a clinical working group for each of the five services, comprising a range of health care professionals from across the providers. It also engaged with patients and the public, including through large engagement events, a telephone survey of 1,000 people, and in-depth discussions with 96 representatives of seldom-heard groups (for example, young carers).
>
> Source: **Hospital Services Review 2018**

Where acute reconfigurations are taking place, these can become a focus for the ICS.

> *The focus is more on the review of the acute trusts. And I think that's probably one of the learnings around how do we start to manage those agendas, because at the moment, the agenda is very acute driven.*
>
> (Local authority, South Yorkshire and Bassetlaw)

Other changes

Other areas of focus include work to address unwarranted variation, as well as changes in areas such as estates and workforce planning. While these were referred to less regularly during our interviews than many of the service changes detailed above, they were often described as key enablers for wider transformation within ICSs.

> *We've got a vibrant workforce development stream, which [includes] a holistic worker programme, which is a role of interface between health and social care and we developed a county-wide approach to the estates strategy, which has enabled us to be successful in some of our bids for capital.*
>
> (Local authority, Nottingham and Nottinghamshire)

Many of the service changes described – for example, primary care development and integrated community teams – are being delivered at the level of smaller place-based partnerships and neighbourhoods. Others (for example, acute reconfigurations, estates and workforce planning) are being implemented at the system level – at which most ICSs operate – due to benefits of scale. Much of the focus has been on further developing and spreading models that predate ICSs. We heard a strong message around the importance of an early emphasis on service models, in order to bring about measurable improvements in care and demonstrate the meaning and value of ICSs.

> *We've been really trying to [focus on] delivery elements where we can make more of a difference by the sum of our parts than individually, and in areas where ultimately – to the public and patients and to our staff – we can demonstrate that there's a value-added element of the ICS.*
> (Acute provider, Berkshire West)

5 What does the leadership and governance of ICSs look like?

In this section, we describe the nature of leadership within ICSs, highlighting the shift from organisational to system leadership. We also describe common features of ICS governance structures. All eight sites described their work on governance as being iterative and emergent, so we conclude by outlining how this is likely to evolve.

ICS leadership

The overall leadership comes from different organisations, including representatives from local authorities, acute providers, commissioners and clinicians. This flexibility has allowed each ICS to build on the strengths of the leadership in their local system. Most interviewees described the leadership styles of individuals as being more important than where organisational leaders come from.

There are many similarities in the nature of the leadership across ICSs. Where they are functioning well, leadership teams are taking a collegiate approach and have developed a clear sense of collective responsibility.

> *The style is collaboration, and I describe our whole ICS as a coalition of partners. We are not trying to do anything if one of the partners is really not on board, because there's nothing to keep people at the table, so unless we can agree together, if somebody decides that they're not happy and wants to effectively disengage and walk away, then that will just happen. So it's very much a coalition collaboration.*
> (Commissioner, Dorset)

Many leaders are spending an increasing proportion of their time on 'system work' compared to 'organisational work' and described how this had been a significant change to their way of working. We heard examples of individuals readjusting their focus to look at the bigger picture across their local health and care economy.

Some interviewees described developing greater insight into the motivations and challenges of other organisations. This enabled them to see problems from others' perspectives, working through challenges in partnership to come up with collective solutions, and looking beyond reactive problem-solving to take a longer-term strategic view. These features reflect capabilities that have previously been observed as central to system leadership (*see*, for example, **Hulks *et al* 2017** (below) and Senge *et al* 2015; **Timmins 2015**).

Factors that facilitate system leadership

The King's Fund has identified several key factors that can facilitate system leadership. These draw on our work with ICSs, STPs and new care models, as well as our work studying the experience of people who have occupied system leadership roles.

- **Develop a shared vision and purpose for the population you are serving**: this requires a shift from a reactive mindset to creating a positive vision of the future.

- **Have frequent personal contact**: face-to-face meetings enable leaders to build understanding and rapport and to appreciate each other's challenges.

- **Take an open-book approach to information**: transparency and honesty around finances and other issues can help build understanding and trust.

- **Surface and resolve conflicts**: this depends on leaders' ability to recognise conflicts, work them through and create the conditions in which it is safe to challenge.

- **Behave altruistically towards partners**: this involves moving away from a competitive approach to focus on the bigger picture.

- **Commit to working together for the longer term**: this requires leaders to invest time and energy in forming effective long-term relationships.

Source: Adapted from **Hulks *et al* 2017**

Changes in working styles apply not only to designated ICS leads but also to senior leaders across constituent organisations. As these leaders have increased their externally facing roles to shape and influence the system, others have sometimes stepped up to take on some of their organisational responsibilities. In one example, this had been recognised through the creation of a deputy chief executive role within a provider organisation to give the chief executive more time to focus externally.

Continuity of leadership and the presence of longstanding and respected leaders were frequently identified as key enablers of change. The perceived authenticity of these individuals – particularly their knowledge of the local system and commitment to the place and population – meant that other local leaders had confidence in them. We heard examples of individuals using their influence and experience within the system to build relationships and create a shared purpose for the ICS, as well as leading by example by ceding some of their own organisational power for the benefit of the system.

> *The most powerful person in the conversation has been [the ICS lead] because he's been seen as the big power player for the acute provider and he's basically been laying down his sword and saying: 'Look, since the creation of FTs [foundation trusts], my only role is to turn the handle and obviously make the biggest profit I can and make [my organisation] as healthy and strong as I can. I now know that's not a viable option, we all need to be more collaborative.'*
> (Acute provider, Frimley)

The role of individual leaders poses a challenge for the future development of systems, as some of these individuals are approaching the end of their career. A collective leadership model, together with leadership development at all levels, was identified as critical to ensuring sustainability and continued progress. There is also a risk in that the commitment and engagement from senior leaders in ICSs is often not reflected within their organisations.

Many interviewees highlighted the need to involve a broader range of people in the work of ICSs beyond the small groups who have led the work to date, in order to promote wider involvement and a more distributed and inclusive approach to the system's leadership. Clinical leadership was highlighted as a particularly important area for further development.

> *The transformational changes are huge and require some significant leadership at all levels – a very distributed leadership approach. But we're only really just getting into the layers to enable that distributed leadership. At the moment, it's still quite top-heavy.*
> (Commissioner, Buckinghamshire)

ICS governance

There is no single national framework for system governance, and ICSs have therefore created their own structures. This has been an iterative process and current structures are likely to evolve over time. There is no statutory basis for ICSs; they have no formal powers or accountability and rely on the willingness of individual leaders and organisations to operate in this way. As a result, governance arrangements have been built using existing legislative flexibilities such as joint committees, committees in common and memorandums of understanding.

Common features include a widely constituted partnership board made up of representatives from organisations within the system, and a senior leadership team made up of chief executives, accountable officers, senior clinical leaders and others. In all areas, these structures include NHS and local authority partners. They are generally responsible for setting the overall strategy and objectives for the ICS, and monitoring performance and progress against priority workstreams.

Other common features include sub-committees and workstreams to drive delivery of key priorities, advisory boards to guide aspects of the work, and joint committees of providers or commissioners to make collective decisions. In some areas, governance structures have been created at place and neighbourhood level as well as at the level of the ICS, as in the example of South Yorkshire and Bassetlaw. Details of the governance arrangements in Berkshire West and South Yorkshire and Bassetlaw are outlined in the boxes below.

> ### Berkshire West ICS governance
>
> There is a **leadership group** made up of the chairs and CEOs of each of the organisations involved in the ICS, led by an independent chair. It also includes the ICS's programme director, and the chair of the Berkshire West 10 integration programme (a local authority chief executive). The leadership group meets every other month and has responsibility for setting the ICS's strategy and monitoring overall progress.
>
> The structure also includes a **unified executive group**, comprising chief executives, directors of finance, other senior executives and clinicians from the clinical delivery
>
> *continued on next page*

Berkshire West ICS governance *continued*

group (*see* below). The executive group oversees the operational delivery of the ICS's work programme and has responsibility for monitoring the system's financial performance. The group meets monthly and is overseen by the leadership group.

The ICS's **clinical delivery group** includes medical and nursing directors from each of the member organisations (acute, mental health and community care), as well as the leaders of the primary care alliances. This group meets monthly, providing clinical leadership for the ICS and shaping plans for changing services. The **finance group** is made up of the finance directors from each of the constituent organisations and has responsibility for the ICS's transformation funding. The **programme boards** are responsible for delivering the ICS's work programme.

Leadership team

Unified executive team ← **Chief financial officer (CFO) group**

Clinical delivery group

ICS programme boards

- Mental health strategy board
- Long-term conditions board
- Maternity steering group
- A&E delivery board
- Primary care board

ICS clinical priority project groups

- Musculoskeletal project group
- Joint prescribing group
- Outpatients transformation group
- High-intensity users project group
- Bed-modelling project group

CFO-led projects

- Contract and finance
- Back-office project group
- Shared estates project group

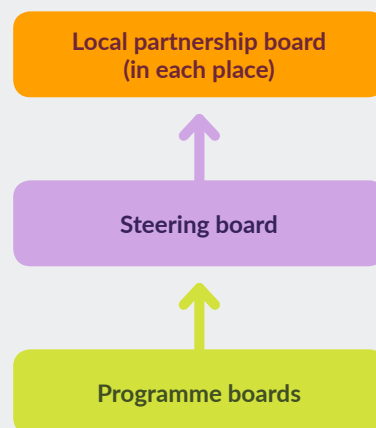## South Yorkshire and Bassetlaw (SYB) ICS governance

SYB's governance is currently being reviewed, with the revised approach expected in the Autumn 2018. The current structure includes a **collaborative partnership board**, which meets on a monthly basis. It is responsible for agreeing the ICS's strategy and monitoring performance. While the collaborative partnership board is not a statutory body, it is able to make recommendations for its members to consider formally

SYB ICS

Barnsley

Doncaster

Sheffield   Rotherham

Bassetlaw

SYB integrated care partnerships

Collaborative partnership board	Local partnership board (in each place)
↑	↑
Executive steering group	Steering board
↑	↑
Programme boards	Programme boards

Joint committee for commissioning groups

Providers' committee in common

> **South Yorkshire and Bassetlaw ICS governance** *continued*
>
> through their own governance structures. Its membership is very broad (approximately 60 people), including all ICS members, and others such as local Healthwatch groups, representatives from the voluntary and community sector, and NHS England and NHS Improvement.
>
> An **executive steering group** oversees delivery and makes recommendations to the collaborative partnership board on transformation spending. The steering group includes chief executives, accountable officers and others from the member organisations' leadership teams (such as strategy and finance directors). The **programme boards**, which report to the steering group, are responsible for delivering key priorities. Each is led by a chief executive and accountable officer. There is some scope for partners to make collective decisions through a **joint committee for commissioners** and a **providers' committee in common**. However, these two bodies cannot take joint decisions.

Formal decision-making powers and accountabilities continue to sit with statutory organisations and their sovereign boards, and system-wide governance has therefore been developed to work with and alongside these existing accountabilities and structures. Some joint committees have been established with delegated authority to make certain decisions collectively, but it is usually necessary for decisions made by an ICS executive board to be taken to the boards of its constituent organisations for discussion and formal agreement. We heard examples of this leading to duplication and making decision-making processes protracted and cumbersome.

> *It does feel a bit like walking through treacle if you're trying to get a decision made quickly... I find myself going around in fairly significant circles quite a lot of the time.*
> (Commissioner, Frimley)

We also heard examples of tensions between system objectives and organisational accountabilities, and concerns that this can lead to organisational protectionism. It is here that the boards of NHS organisations have a key role. Non-executive directors sometimes express concerns that the statutory responsibilities of their organisations will be undermined by the work of ICSs and this may act as a brake on senior leaders who are leading the work on a day-to-day basis.

Tensions have been particularly evident on finances and the development of system control totals, which may carry risks for some of the organisations involved.

We're trying to work through how the governance will work, because at the end of the day, speaking for me, I am the statutory officer for the trust. So, no matter what we do on governance, I'm still that statutory officer and I still have statutory responsibilities. And it's how we work through that.
(Acute provider, Lancashire and South Cumbria)

The non-execs on the majority of our boards are very supportive of the direction of travel, although they sometimes struggle to see how they can best reconcile their responsibilities to the survivorship of their individual organisations against the benefits of working across the system. And when that tension is created, it's mostly created not around the models of care, but more around the financial implications of those... There can be some really odd incentives that, at least in the short to medium term, seem to be encouraging people to operate individually, rather than collectively. So that puts both execs and non-execs on those provider boards in particular in rather strange positions.
(GP/GP commissioner, Frimley)

ICSs have the challenge of aligning governance with the roles and accountabilities of both NHS and local government, and with statutory bodies such as health and wellbeing boards and overview and scrutiny committees. In Buckinghamshire, the ICS partnership board reports to the health and wellbeing board as the statutory body responsible for setting the system's health and wellbeing strategy; in Frimley, a single health and wellbeing alliance board has been created to feed into the governance structure; and in Bedfordshire, Luton and Milton Keynes, the four councils have established a joint scrutiny committee.

Most areas have taken the view that 'form should follow function', with work on service change coming first and formal governance structures following to underpin this. A strong message from this research was the importance of building collaborative relationships alongside governance.

We've done it, I won't say on the fly, but we've done it where we've come up with an idea or come up with a service change or initiative and then worked out, with colleagues, how the governance or decision-making sits. That always takes longer,

but I think we probably iron out more bumps in the road as we go along… All the governance structures and technical things in the world are great, but if people don't have an aspirational intent to work together, it doesn't really matter what you write down.

(Commissioner, Frimley)

Next steps on governance

We heard examples of system-wide governance structures supporting difficult decisions to be made. However, we were also told that in many ways, governance of ICSs has not yet been put to the test. Arrangements are still developing, and none of the sites we spoke to viewed their current arrangements as the 'end-state' for their system's governance.

Intellectually we all understand that decisions will have to be made to enable the best use of the public purse across the system and that will have organisational impacts, but I don't think we're quite there yet on saying: 'Right, we're going to do that anyway because it's the right thing to do and then we'll collectively deal with the consequences'.

(Other stakeholder, Nottingham and Nottinghamshire)

So far, most decisions have been made by consensus, reflecting the fact that participation in ICSs is voluntary and they have no formal decision-making powers. Many areas have managed to reach consensus on challenging issues – for example, around signing up to system control totals, proposals for acute service reconfigurations, and changing payment systems. However, reaching consensus often requires a lengthy process of discussion and negotiation, and agreement will not always be possible.

Our research highlights the need for further development of governance arrangements to support delivery and enable decisions to be taken in the interests of the system.

If you've got to take on more statutory responsibility – responsibility for system control totals and financial management – then the governance that's needed for that has to be much more robust and real and stick, so we are having to look at that now.

(Other stakeholder, South Yorkshire and Bassetlaw)

If they are to take responsibility for the allocation of large amounts of public spending, then ICSs will need to develop a legitimacy to make those decisions that goes beyond agreement between executive leaders. Robust mechanisms that provide scrutiny and can hold the leadership to account will be essential. Some ICSs are beginning to address this by bringing elected members, non-executive directors and lay people more directly into their governance.

A further priority for future development is to improve the balance between different partners within the governance arrangements, as although a range of organisations are represented, it was often perceived to be an unequal partnership with an inherent NHS focus. We also heard about ambitions to streamline and simplify current arrangements.

> *There's been a bit of duplication and double running, definitely, and that's caused a bit of frustration in some ranks. Going forward, I think what we're trying to do is streamline the whole process, acknowledging that ultimately we still have individual statutory responsibility as organisations… So I think it is still a work in progress.*
> (GP/GP commissioner, Berkshire West)

The extent to which local systems can transfer decision-making powers and accountabilities to an ICS is limited by the current legislative framework and its focus on organisations. This was highlighted by many as a fundamental barrier to system governance, which will need to be addressed in due course.

While effective governance is important to support system-wide decision-making and accountability, several leaders cautioned against ICSs focusing too heavily on this, emphasising that they 'need to see action and movement, rather than just talking', and that too much focus on governance and structures can distract from efforts to bring about meaningful change in services and behaviours.

> *[Governance] is a means to an end, it's not the end in itself… It needs to have its proper place – it is a servant, it's not the master of all this. It's a very important servant, but that's its right role.*
> (Community/mental health provider, Buckinghamshire)

6 How has the process been managed by local areas?

Significant amounts of time and energy have gone into the development of ICSs during their first year. Each ICS has approached this in its own way, but there are common areas of focus. In this section, we describe how ICSs have built collaborative relationships across organisations, how they have been resourced and managed, and how they have tackled system-wide financial management. We also describe the overall change process and how this has been experienced.

Developing collaborative relationships

Developing relationships was frequently identified as the most important element of the work done so far. One leader told us that 'a really effective system is all about building relationships, trust, knowledge and confidence in one another' and another described their system as 'proceeding at the pace of trust'. In most cases this builds on existing relationships and a history of collaborative working that predates the ICS.

ICS leadership teams are tasked with making collective decisions for the benefit of their local population. This may lead to conflicts and disagreements, requiring conditions in which it is safe to challenge and time and space to work through these disagreements (Hulks *et al* 2017). In our research, we heard examples of leadership teams working together to reach agreement on challenging issues – for example, in relation to arrangements for system control totals.

The development of a shared vision and clear objectives setting out the changes needed are important in bringing organisations together. One leader described how 'the thing that's bound us together has been the vision around what we're trying to achieve', while another told us that this is 'a bedrock and it really needs to be there at the outset'. Many felt that insufficient time had been spent on developing and articulating a shared purpose and narrative for their ICS and identified this as a priority for further work.

A number of strategies had been used to develop ICS leadership teams, including spending time together as a group and holding meetings more frequently than in the past and face-to-face wherever possible. Relationships have also been strengthened through open and honest discussions and collectively working through difficult issues. Recognising the value of being able to express disagreements openly and constructively has been an important part of the learning in some areas. Some ICSs had drawn on external facilitation and development support, using a range of different organisational development methodologies.

> *The relationships have got better the harder the challenges are, because they have to bring tricky conversations to the table.*
> (Healthwatch, Nottingham and Nottinghamshire)

> *We've done some of it by working collectively together, and we've done some of it deliberately using leadership development techniques to bring people together. So it's been a mix of having conversations about what we're trying to do, having lots of face-to-face time together to talk about our collective problems and how we want to collectively solve them, and doing some explicit leadership development that helps us do the softer stuff.*
> (Acute provider, Frimley)

We heard examples of how mutual understanding between different organisations and sectors had improved as a result.

> *Relationships already did exist, but I think that this has really sharpened minds and people have got together a whole lot more and relationships are that much more developed now than they were... We understand why there are problems, not just that we know each other personally but we understand what the problems are.*
> (Local authority, South Yorkshire and Bassetlaw)

> *I've learnt more about how local authorities work in the past 18 months than I've done in the previous 42 years. So I think we've got more of a genuine partnership than we've ever contemplated beforehand and that seems to be working... It's been spending time with one another and understanding one another's problems and issues.*
> (Other stakeholder, Frimley)

Directing people and resources to ICSs

There has been very little in the way of dedicated resource and capacity to manage the work of ICSs. Most capacity has come from staff working in partner organisations, and individuals are usually managing the work of the ICS alongside their existing responsibilities. This is placing significant demands on their time.

> *I find it incredibly challenging at the moment with that statutory accountability that I have for this organisation and my role and responsibilities in terms of the system space as well. I have to say I'm finding it incredibly challenging. I don't think I'm alone in that. Just in terms of where my effort and focus needs to be, should be, can be. I do feel like I could do with being cloned!*
> (Community/mental health provider, Nottingham and Nottinghamshire)

The pressures are particularly acute when leaders are also dealing with immediate operational or financial challenges.

> *We're a little bit behind where we would want to be, but I think some of that is a symptom of the winter we've just experienced in terms of the demand on all of us really in terms of our own capacity and just trying to cope with the demands.*
> (Community/mental health provider, Lancashire and South Cumbria)

To address this, some systems had put a dedicated project management office in place and were releasing staff from other duties to resource it. In some cases, this was possible because existing functions had been consolidated through CCGs merging, and in other cases, organisations had adjusted their own management structures to accommodate the time their leaders are spending on the ICS. A small number of the systems – including Buckinghamshire and Nottingham and Nottinghamshire – had additional capacity through secondment of staff from NHS England.

Despite the additional pressure placed on their time, leaders viewed system working as a critically important part of their role, and some stressed that this should increasingly be seen as a core responsibility for staff at all levels.

> *We rely very heavily on people developing this way of working alongside their current responsibilities, but also increasingly as part of current responsibilities.*

Because one of the things that we need to do is embed this system approach in the way that we work. So it's not something that's developmental any more, it is actually our core business and something that everybody does day-to-day.
(Other stakeholder, South Yorkshire and Bassetlaw)

Workforce shortages in frontline services are making it more difficult to release clinical staff to work on transformation and service redesign, and to recruit staff to deliver new service models.

ICSs received some transformation funding to support their work, but in most cases only small amounts. This was sometimes used to backfill people's time to work on the ICS or to pump-prime the development of new service models such as integrated care hubs. A smaller number had used transformation funding to pay for external support – for example, around data and analytics and from management consultants.

Managing system finances

Although ICSs were not formally operating system control totals in 2017/18, several were already working to manage their finances collectively. Progress in the Frimley system had been accelerated by the appointment of a joint finance director across the East Berkshire CCGs and the acute trust.

We've had a system control total in shadow form this year, and we have exercised some of the opportunities that's given us. What it's certainly allowed us to do is have really good transparency across all financial partners... Achieving balance this year has involved using some of the financial surplus that exists within the system to ensure that all partners achieve balance at the end of the year, individually and collectively.
(Acute provider, Frimley)

Most of the systems have now signed up to the ICS incentive scheme for 2018/19, where an agreed proportion of provider and commissioner sustainability funding is linked to meeting a system control total. The scheme offers a number of options, allowing a system to determine the proportion of sustainability funding that is linked to it depending on the level of shared risk the organisations involved are

willing or able to take. Systems have spent significant time and effort negotiating how they can manage this, particularly where there are organisations with unachievable individual control totals.

This issue came to the fore following the publication of the 2018/19 planning guidance, which set out initial national proposals around system control totals. There was very little flexibility in these proposals, creating an 'all or nothing' scenario that was felt to be too high risk for systems with challenging organisational control totals. After much debate and hard work on the part of ICSs and the national bodies, proposals were revisited, resulting in the more flexible arrangements that have now been agreed. System control totals relate to NHS finances across providers and commissioners, but do not include local authority spending (for example, on public health or social care).

Managing the change process

The development of ICSs requires a move away from autonomous organisations working in silos, towards collaboration and partnership working across systems. This shift requires many organisations and individuals to change their priorities and behaviours. The scale and complexity of this change should not be underestimated and progress is unlikely to be linear.

> *Some days I think there's real movement in thinking, and discussions and plans. And then other days I think we haven't made much progress. And that's probably what you'd expect because it's step forward, step back, step forward, step back... And it's not a process is it? It's a bit messy.*
> (Commissioner, Nottingham and Nottinghamshire)

The emergent nature of the reforms has required local systems and leaders within them to cope with high-level ambiguity – not least regarding the changes to their own roles and how to reconcile organisational and system responsibilities.

> *People will sometimes have to wear two hats, but actually most of us are wearing two hats and therefore you need a degree of maturity to be able to handle the two hats and some of the ambiguity of this. But I think that's what this change requires.*
> (Local authority, Nottingham and Nottinghamshire)

A strong message from our research was that it takes time to develop collaborative working. Collaboration had often taken longer to develop than expected, but many interviewees felt that this was inevitable given the scale and complexity of the change.

> *We can't do any of this quickly. This is very big change for a lot of people across the system. I think that to do it any quicker we would have just fallen over. I think we need to give ourselves a very realistic timeframe going forward… and give ourselves, as a system, the opportunity to realise those goals.*
>
> (GP/GP commissioner, Dorset)

7 Who has been involved in developing ICSs?

There is evidence that ICSs have enabled closer collaboration between local organisations, enhancing existing relationships and helping to build new ones. As the STP experience demonstrates, it is critical that the work of ICSs involves not only a handful of local leaders, but staff, patients and the public more widely. The role of local authorities is also key in bringing about change. In this section we consider how these groups have been involved in the development of ICSs, highlighting some of the challenges to meaningful engagement.

Local authority involvement

The nature and extent of local authority involvement in ICSs varies. In most cases they are part of the ICS board and/or other parts of the governance structure, and in Nottingham and Nottinghamshire and Bedfordshire, Luton and Milton Keynes the ICS lead is a local authority representative. However, in some areas, local authorities have been involved in the ICS as a partner, rather than as a full member.

Local authority involvement in ICSs often builds on a history of joint working between health and social care – for example, through joint commissioning arrangements (although the footprint for these historic relationships is not always the same as the ICS geography). We also heard that in some places working together through an ICS had strengthened relationships and supported new ways of working.

Health and wellbeing boards and overview and scrutiny committees are often the key mechanisms for engaging elected members in ICSs.

Challenges to local authority involvement

There are several common factors that can make full local authority involvement in ICSs difficult. These include different accountabilities and decision-making structures: while local NHS organisations are accountable to national government and NHS bodies, local government is accountable to the public. There are also many cultural differences between the NHS and local government, which leaders need to be able to navigate and work through to make ICSs a success. We heard examples of organisations 'using the same language… but actually mean[ing] different things'.

Reductions in local authority budgets and service provision have been much more significant than those in the NHS and are seen as significant obstacles to delivering integrated care. Different funding arrangements could also affect the approach to managing finances across a system, as local authorities have a duty to spend funding on their own residents.

Another key challenge was the perception that ICSs are NHS-focused, and that local government involvement had not been treated as integral to plans from the start. This has not been helped by the focus and tone of national guidance, or by the legacy of the STP process, although this appears to have become less of an issue over time.

> *I think one of the issues is that the ICSs do start from an NHS lens, so to assist what you do locally you have to sometimes fight against the… you have to get over the hurdle that this is, to a degree, an NHS thing. However, we have got over that and we have really assisted each other.*
> (Local authority, Dorset)

Politics was also identified as a barrier to local authority involvement. Party-political opposition to STPs and ICSs, and media stories suggesting a link between ICSs and the privatisation and 'Americanisation' of health services, have meant that some local authorities feel unable to formally participate in ICSs.

> *They are very politically opposed to ICSs on principle, actually when you talk quietly to the members on a one-to-one they think it's a really good idea. They'd never say that in the public domain, so they will oppose it politically. It's quite challenging.*
> (Commissioner, Berkshire West)

Local geography also influences the nature of local authority engagement – for example, in Frimley, this has been made more difficult by the complex geography, as some local authorities span multiple STPs and ICSs. The extent to which an ICS's footprint is considered as 'natural' varies, and NHS and local government organisations can have different perspectives on this; a footprint that is meaningful to the NHS may not appear the same way to local government, and vice versa.

Benefits of local authority involvement

Despite these challenges, interviewees agreed that there are clear benefits to local authority involvement, including the opportunity to work more closely with a range of local services, particularly social care and public health. Local authorities also support a focus on wider determinants of health through services such as housing and leisure – although in general this was described as a future opportunity, rather than an area where significant progress had already been made.

> *We are having different conversations around the wider determinants of health, and going forward, there is an opportunity to maybe take some differential decisions that will support our populations living with more independence and being healthier. So there's actually a really broad range of conversations with our local authority elected members that is important.*
> (Acute provider, Frimley)

Local authority involvement was seen as strengthening ICSs' connections with their local communities by providing a democratic link and supporting public engagement. They were also seen to help with navigating local politics and engaging elected members.

> *Because local government is required to be much more transparent at a local level with the public, I think I pushed for greater levels of openness.*
> (Local authority, Nottingham and Nottinghamshire)

> *As a key partner, being able to see what's going on at least diminishes some of their fear and suspicion at what's happening nationally with STPs, where people thought they were up to all sorts of nasty things. It really has dealt with that.*
> (Community and/or mental health provider, Frimley)

Although ICSs are typically built on existing arrangements, the ICS model was seen as supporting a different type of relationship between the NHS and local government, helping those involved to better understand one another's roles and perspectives. Our research suggested that one advantage of this new relationship was the ability of local government to provide scrutiny by looking at NHS plans with 'fresh eyes'.

> *I think [local authority officers] understand better how, as a place, we sit in a wider system. So the complexity of the NHS – which I think is quite difficult for people who don't work in the NHS, and I include local government in that – I think the understanding is better now because they're also involved in the ICS work.*
> (Commissioner, South Yorkshire and Bassetlaw)

Involvement of clinicians and other frontline staff

Evidence shows that the benefits of integrated care arise largely from bringing together clinical teams and services, rather than from integrating organisations (**Curry and Ham 2010**). For ICSs, this highlights the importance of involving clinicians and other frontline staff in the development of new models of care, ensuring that changes do not just create new organisational arrangements but result in genuine improvements in health and care for local people.

In some ICSs, influential clinical leaders have been central to progress, and there are examples of clinical leadership being included formally within governance arrangements. The Lancashire and South Cumbria ICS's governance structure, for example, includes the Lancashire and South Cumbria care professionals board, which brings together a wide range of clinical professions from across acute, community and primary care, as well as public health.

Our research suggests that primary care is key to the development of ICSs, and that the coming together of primary care at scale can support this engagement. There are examples of influential GP leaders within ICSs, as well as specific activities aimed at involving practices, but in many areas this is still seen as a work in progress.

Engagement within ICS member organisations is strongest at a senior level; most staff at less senior levels have limited awareness of the ICS's objectives.

> *The one thing we're struggling with is getting that message permeating down to the troops on the ground.*
> (GP/GP commissioner, Berkshire West)

It was noted that the changes taking place within ICSs created uncertainty around the future of commissioning, which can leave those working within CCGs uneasy about them.

> *They see that the CCG's on a trajectory to wind down, and actually if they're not close enough to it, they don't necessarily see what the next stage is.*
> (GP/GP commissioner, Buckinghamshire)

A number of challenges to engaging staff were highlighted, including changing terminology, and the difficulty of getting clinicians to think about systems rather than their immediate clinical teams. We heard views on the need for ICSs to do more to communicate their objectives and demonstrate benefits in a way that clinical staff can engage with. There was clear agreement that engaging clinicians and staff in the development of ICSs is essential, and that this should receive greater attention.

> *One of the areas I think we haven't done brilliantly is being as clear as we could be with both our population and our staff on the elevator pitch. We haven't got one that's really clear for our ICS. We get quite wordy, we get quite service based. But what everyone would want to have is one really clear narrative that we share.*
> (Commissioner, Frimley)

The 2020 place-based Leadership Programme in Frimley

The 2020 place-based Leadership Programme has been running across the Frimley ICS since January 2017. The programme involves a range of clinicians and other professionals working at all levels across health, social care and public health. The intention is to move away from traditional hierarchies, and to promote collaboration between organisations across the system.

One of the objectives of the programme is to improve the connection between those working in health and care, and the communities they work in. It is intended to help clinicians and managers understand the needs of their population, while also providing local people with the opportunity to influence services in their area.

The programme encourages the clinicians and other professionals to lead service changes, working across organisational boundaries and making use of co-production tools, with each participant developing a 'change initiative'. One example includes changes to the stroke pathway, led by a consultant stroke physician and geriatrician.

Patient and public involvement

ICSs have undertaken a range of activities to engage patients and the public, including running public meetings and events, and providing information through newsletters and online. In some areas, the local Healthwatch is playing a key role in engagement activities, but in others there is a sense that it could be more involved. The activities being carried out in each area are described in more detail as part of the site profiles in the **supplementary online resource** to this report.

The nature and level of engagement varies across the sites, and almost all interviewees felt that there was more to do to embed public and patient involvement within the ICS. Some of the ICSs are receiving external support in this area. For example, Frimley is currently working with NHS England and The King's Fund to develop their understanding of frailty. This has included looking at what they know already from existing local and national sources, and thinking through how they collect more insight from this group of people to inform how care is delivered.

Our research emphasised the importance of genuine engagement with patients and local people, from all groups, and of involving them in the design of ICSs, rather than just consulting or informing them.

There's more we can do to enlist the public to make this work. At the moment, we only engage them in a sense of they need to know, or we need to ask them what isn't working, or we need to make sure they understand so they don't get upset or frightened or worried. But I don't think we've got to the stage of asking them, actually, 'Can you help us to make this happen?'
(Acute provider, Bedfordshire, Luton and Milton Keynes)

Public engagement on the clinical services review in Dorset

The Dorset ICS is building on the approach to engagement adopted for the clinical services review, launched by Dorset CCG in October 2014.

Before carrying out a formal public consultation, and building on the 'Big Ask' in 2013 (which gathered feedback from the public and was used as part of the decision-making process that led to the clinical services review), the CCG undertook a series of public engagement events. This comprised 9 events in total, involving 339 people, to inform the review's proposals. These were followed by two further engagement events for those with a special interest in community services, and a roadshow involving staff to reach out to communities across Dorset. Other public engagement events were also carried out with hard-to-reach groups, youth groups, local-interest groups and local stakeholders. The CCG also hosted informal discussions with local groups.

A formal public consultation was launched at the end of 2016, lasting three months. This included inviting people to complete questionnaires and provide written statements, as well as drop-in events, focus groups and a telephone survey. In total, approximately 18,500 people provided their views. The results were analysed and written up by an independent provider of specialist consultation analysis.

The feedback from the engagement process led to alterations in the review's proposals, including those for the community hospitals, although the preferred option in relation to the roles of Poole and Royal Bournemouth hospitals did not change.

Following the governing body decisions in September 2017 the engagement work continues with a wide range of activities including working with local politicians, MPs, community groups, local health and wellbeing groups and the local health information network.

Source: **Dorset Clinical Commissioning Group 2017**

Challenges in engaging patients and the public

We heard about the challenges of engaging patients and the public in structural changes or the 'nebulous' concept of an ICS. Many interviewees felt that ICSs needed to do more to explain and communicate their objectives to the public. In practice, patient and public engagement has taken place primarily at a 'place' level, which can be more 'meaningful' for local people, and has focused on specific service changes rather than the ICS itself.

> *If you want to bring it home to what actually the ICS means for individuals, then the focus will always be on service change. Because there aren't that many people who are going to be interested in focusing on the conceptual issues.*
> (Healthwatch, Buckinghamshire)

> *One of our big challenges over the past year or 18 months and going forward is how do we make the ICS real to people in a form or a language or an experience that speaks to more of the public and more of our staff?*
> (Acute provider, Berkshire West)

We were told that the legacy of STPs had made engagement harder, and that changes in terminology had caused confusion. In some areas, there has been some local resistance to the work of the ICS. For example, in Nottingham and Nottinghamshire, there has been some opposition to the involvement of Centene, a private provider of data analysis and IT software.

Involvement of other key stakeholders

We heard that non-executive directors, lay members and elected councillors are not as involved in ICSs as they should be. Some areas are starting to address this within their governance structures and through engagement events.

There is also limited evidence of involvement of the voluntary and community sector. There were some examples of the sector being represented within ICS governance arrangements, and a sense from some that engagement was improving; however, this was often stronger at the level of local places than the wider ICS. In most cases, much more needs to be done to fully engage groups from this sector.

8 How has the process been managed by national NHS bodies?

National NHS bodies were responsible for selecting the 'first-wave' ICSs and have had an important role in overseeing and supporting their development. While local leaders were generally positive about the support they had received from national teams, their views on the approach of the regional teams were much more mixed. In this section we describe how the ICS process has been managed and supported at a national level and explore the experiences of local leaders in dealing with central and regional teams from the national bodies. We also describe views on how ICSs should be regulated in future.

National support for ICSs

Interviewees were typically supportive of the approach taken by the national teams leading the development of ICSs. Each area has a named senior sponsor within the central team at NHS England and regular meetings are held between ICS leads and senior leaders from NHS England and NHS Improvement. These provided a forum for discussion and allowed issues to be raised.

Most interviewees felt that having direct access to senior national leaders had helped them to make progress. We were told that the national team had provided valuable advice and had helped local leaders to overcome barriers. External support was also made available to ICSs – for example, around leadership development and population health analytics.

> *The access that we're now getting to effectively the very top leadership team has been excellent. And I think the relationship with that team has been one of, 'We want to make it work, tell us what we can do to make it work'. They're very open to ideas, they're very open to trying to support and if there's a blockage,*

they will try their damnedest, I would say, to actually unblock that and come up with a solution.
(Commissioner, Dorset)

The overall approach to the development of ICSs was felt to be relatively permissive, with flexibility for local areas to put in place arrangements that work for them. The national team at NHS England had emphasised to local leaders that their aim was to work alongside them to co-produce the changes, rather than to impose a strict blueprint. Interviewees were particularly positive about regular opportunities to meet with leaders from other ICSs, enabling them to share knowledge and experience, work through common challenges and collectively raise concerns with national bodies.

I think the most useful thing has been the sessions that have been arranged for the accelerating sites... the honest discussions about the wicked issues and how they can best be navigated. And that has felt, to me, like a breath of fresh air actually and incredibly helpful... You can't just impose a blueprint from Skipton House or Whitehall. This has to be more iterative and co-produced.
(Local authority, Nottingham and Nottinghamshire)

However, some aspects of the national programme were viewed less positively. Interviewees were critical of initial proposals for the system control total financial incentive scheme, as they felt these created a disproportionate risk that all sustainability funding across a system could be lost if one organisation missed its control total. While most ICS leaders were supportive of the principle of taking collective financial risk, many were unwilling to do so on this basis. In response, the national bodies revisited proposals in consultation with ICS leaders. The revised scheme offered greater flexibility on the proportion of sustainability funding that is linked to the system control total, and most ICSs have signed up to it.

The memorandum of understanding (MoU) between ICSs and national bodies was also criticised. Deliverables in the MoU – which largely brought together existing national performance targets – were viewed as unachievable for many systems due to financial and performance challenges. We were told that the MoU had 'missed the point' of ICSs and should have contained more focus on transformation and population health. A further concern related to it being 'health centric', with little

mention of the role of local authorities. Leaders also described a lack of clarity over the implications of failing to deliver against the expectations set out in the MoU and whether they would be held to account over this.

> *It's not realistic. In fact, we signed up to it on the basis that anybody who delivers all of this will be extraordinary. We know we have to deliver these things, but there's not a chance that any system anywhere I know of was going to deliver all of those targets.*
> (Other stakeholder, Nottingham and Nottinghamshire)

> *What I think of the MoU is it isn't worth the paper it's written on, if I'm honest. The reality is, it doesn't describe at all the work or the intention behind any of the ICSs.*
> (Acute provider, Dorset)

National bodies responded to this by changing their approach when developing MoUs for the second year. The content of these MoUs is being developed in partnership with local areas, and each MoU will include a section setting out local priorities.

Regional support and co-ordination with the national teams

In contrast to the broadly positive attitudes on the approach of the national teams, ICSs were more critical of the approach taken by the regional teams. Some systems gave examples of the approach beginning to change, including joint assurance meetings with NHS England and NHS Improvement and system-based assurance meetings replacing those for individual organisations. One interviewee told us that this had led to 'a different set of conversations'.

But despite some examples of progress, most felt that the regulators still had a long way to go at regional level. While they had been told that ICS status would mean a 'one-stop shop' regulatory relationship, local leaders often felt that day-to-day interactions are largely unchanged and remain focused on managing the performance of individual organisations, which is still the regulators' core priority. This was also raised as an issue in relation to the CQC's focus on organisations. These findings are in keeping with the conclusions of the CQC's recent local

system reviews (reviews of how health and social care services for older people are working together in 20 areas of England), which highlighted the 'significant' role of regulators in driving behaviours that run counter to collaboration (**Care Quality Commission 2018**).

> *While we want to operate as a system, there have been quite numerous occasions when my colleagues within the system tell me that one regulator or another has simply reminded them, 'That's all very fine, but just remember that you will be held to account for the performance of your individual organisation'.*
> (Local authority, Bedfordshire, Luton and Milton Keynes)

> *It's a major challenge for the ICSs that we've got two regulators giving two different messages... I think it's ironic that the national leaders are encouraging us to work in an integrated manner and in reality they struggle to do so themselves.*
> (Other stakeholder, Nottingham and Nottinghamshire)

> *A lot of the demands from the centre, around things like workforce plans, delivery plans, and reporting requirements, are happening in the new world, but we've also still got the old-world reporting. We're finding lots of duplication... It feels, at the moment, like the new world and the old world seem to operate slightly siloed.*
> (Community/mental health provider, Frimley)

NHS England was generally felt to be further ahead than NHS Improvement in adjusting its approach to work with systems. There was also a sense that the views of the most senior individuals in the national bodies are not aligned with those further down the organisations.

> *NHS England certainly are putting their money where their mouth is around aligning their staff to work with the ICS... NHSI [NHS Improvement] are finding it much, much more difficult to break with existing ways of working.*
> (GP/GP commissioner, Lancashire and South Cumbria)

> *When we have a dialogue in London it's a completely different attitude, they're listening, they're saying, 'What would it take, what do you think the answers are, what can we do to help?' Whereas I would say regionally, we're getting the same old really.*
> (GP/GP commissioner, Bedfordshire, Luton and Milton Keynes)

Some felt that this was due to a lack of communication and understanding, while others suggested there was active resistance to the changes, highlighting that 'We mustn't lose sight of the fact that this does encroach on their roles, their careers'.

> *There are some people who are very steeped in the way the NHS has worked for a very long period who are finding it very difficult to think in any other way. And I don't think we should underestimate that there needs to be some space created for people to unlearn behaviours that they've learned over a very long time.*
> (Local authority, Bedfordshire, Luton and Milton Keynes)

Future regulation

It was widely felt that national bodies need to change the way they work with ICSs in the future, and people were positive about their willingness to do so. During the period in which we carried out our interviews, NHS England and NHS Improvement announced commitments to work together, including integrating regional teams and appointing single regional directors for the seven new regions. The announcement was welcomed by many ICS leaders as a clear national commitment to align regulation with system working. The CQC has indicated similar willingness, calling for new powers to regulate local systems (building on their recent local system reviews) and nationally agreed metrics for system performance (**Care Quality Commission 2018**). We also heard some evidence of a commitment to change among the regulators at a regional level.

> *There is a genuine attempt of dialogue going on, to be fair to them, which is to say, 'How can we get this right?' So, they do want to get it right and they recognise that they're not at the moment.*
> (Community/mental health provider, Frimley)

In terms of future regulation, some interviewees described an ambition for more assurance and regulatory activity to be done within or alongside local systems, rather than at arm's length from them. This was particularly the case for large systems such as South Yorkshire and Bassetlaw. It is expected that, over time, this will involve the transfer of people and resources from regional teams into ICSs.

There is a lack of clarity over how the seven regions will relate to ICSs, and some interviewees questioned what the function and value of the regions will be if

regulation and assurance is increasingly managed within ICSs. However, we heard that most systems are currently some way off having the capacity and capability to 'self-regulate'. There is still work to be done to determine how this could work, and to ensure that this does not add another layer of bureaucracy to the system architecture.

9 Are ICSs making a difference?

In this section we consider the areas where the impact of ICSs has been most visible. Recognising that ICSs are still developing and have been in operation for only a year, we also highlight areas where they would like to see more progress in future. The examples we report show where improvements are emerging and demonstrate that these are more evident in some ICSs than others, as might be expected at such an early stage in their development.

Bringing about service change

All ICSs reported that there was considerable work under way, with some early indications of progress – for example, work on primary care transformation, integrated community teams, information-sharing and acute pathway changes and reconfigurations.

However, there was also a sense that, so far, evidence of measurable change is limited. We heard a mixed picture regarding progress; some ICSs (such as Frimley) pointed to evidence that they have begun to moderate increasing demand for acute care, while others suggested that the changes have not yet had a measurable impact.

> *We have got some really good change impact starting and we perhaps have experienced more observable impact as a proxy on hospital-based activity than we might have expected to achieve at this stage.*
> (Acute provider, Frimley)

> *I think given our starting position nine months ago, my personal sense is we could be making more progress than we are... We could have advanced faster than we have and further than we have with the transformation elements of community services.*
> (Acute provider, Dorset)

Unlike the vanguards programme which went before it, there is no agreed approach to evaluation built into the national ICS programme. This may lead to challenges in tracking progress.

There was recognition that delivering substantial change – and being able to demonstrate its impact – takes time. We heard views on the importance of planning over an appropriate timeframe and setting goals that are achievable.

> *So my thing now is look, let's set a realistic target. If it's not a one-year programme, fine, I want to see a three-year programme. I want to see it phased over three years and let's not judge it at the end of nine months and have a report and say 'well, actually, we haven't delivered' because nothing happens in a year.*
> (GP/GP commissioner, Berkshire West)

ICSs were intended to provide a vehicle for spreading best practice within their area, and this continues to be a key aim of many systems. We heard some examples of progress, but also many examples of the challenges involved in spreading models across a broader system footprint.

> *The pockets of work at a locality level, which are integrated care in its truest sense, with broader partnerships other than the statutory bodies, I think has delivered and is working. I think trying to roll that out remains difficult because of the complexity.*
> (Healthwatch, Nottingham and Nottinghamshire)

The role of ICSs in driving change

Where there was evidence of tangible change, our research suggested that these changes were not fully attributable to ICSs. In practice, the main focus of delivery is commonly at the place or neighbourhood level, although ICSs have sometimes played an important role in supporting these local changes.

We also heard that much of what is now coming to fruition builds on work that has been under way for some time. This includes existing work on developing new models of community-based care in many of the sites, and longstanding work on acute reconfigurations in Dorset and South Yorkshire and Bassetlaw.

I think you can try and make the ICS too instrumental in this. The fact that Buckinghamshire put itself forward for an ICS was because it was doing these kinds of things and saw the ICS as the right kind of framework to help support doing them.
(Community/mental health provider, Buckinghamshire)

Many ICSs are building on the work of vanguards within their areas (*see* boxes below), as these provide a foundation on which to further develop service models and relationships. Even in areas without vanguards, interviewees often referred to a history of relationships and collaboration within their systems that predated the ICS.

Primary and acute care system (PACS) vanguard in North East Hampshire and Farnham, Frimley

The PACS vanguard in North East Hampshire and Farnham introduced a range of measures to join up services and enhance community support, including:

- five integrated care teams to support individuals with complex care needs in their own homes. These teams include community nurses, occupational therapists, physiotherapists, social workers, paramedics, pharmacists, mental health practitioners, geriatricians, GPs and voluntary sector workers

- schemes to prevent ill health and support self-care, including support for carers, training for pharmacists and other professionals to give self-care and wellbeing advice, and a social prescribing scheme to link people to local services and support

- improved access to primary care through extended opening hours and an online tool that allows patients to consult with a GP without having to visit the surgery

- a wider variety of health care professionals in primary care, with direct access to physiotherapists and clinical pharmacists, and a paramedic home visiting service

- a range of initiatives to improve the connections between hospital and out-of-hospital services – for example, GPs working in A&E and on hospital wards to facilitate discharge

- better mental health crisis support through the introduction of Safe Havens, as well as expansion of the Recovery College to improve the health and wellbeing of people living with, or recovering from, chronic mental or physical health conditions.

Primary and acute care system (PACS) vanguard in North East Hampshire and Farnham, Frimley *continued*

The local system has reported evidence on the positive impact of these models, including:

- year-on-year reductions of 2 per cent for emergency hospital admissions and 10 per cent for avoidable admissions, as well as a 4 per cent reduction in GP referrals

- a plateau in A&E attendances compared to increases for demographically similar CCGs

- reductions in mental health-related hospital attendances and admissions since the introduction of the Safe Havens.

Sources: **North East Hampshire and Farnham CCG 2018**; **Naylor and Charles 2018**

Enhanced support for care homes in Rushcliffe, Nottinghamshire

As part of the Principia MCP vanguard, a package of enhanced support was introduced for older people living in care homes across Rushcliffe. The model involves:

- aligning care homes with practices

- regular visits from a named GP, including proactive review of residents' medications and care plans, reviews of new residents within five days of moving to the care home and comprehensive geriatric assessments within two weeks

- improved support from community nurses, who accompany GPs on regular visits and support care home nurses through peer-to-peer support, training courses and signposting to specialist community services

- independent advocacy and support delivered by Age UK

- support for care home managers, including a care home managers' network and regular meetings with the CCG.

Analysis indicates that the package led to lower use of emergency care for residents: A&E attendances were 29 per cent lower for residents of the care homes than for a matched comparison group, and there were 23 per cent fewer emergency hospital admissions for this group. It did not find any impact on hospital length of stay, or the number of elective admissions or outpatient attendances.

Source: **Lloyd *et al* 2017**

Building on existing work was often seen as positive, because it created a sense of local ownership of the changes.

> *We're really clear we are using it as a way of scaling up what we've learned... People like to have done their own thing, so it isn't a lift and shift, but we've had some real success particularly in our out-of-hospital integrated care services.*
> (Commissioner, Frimley)

Our research highlighted a range of ways in which being part of an ICS had 'added value'; this included the 'permission' that came from being part of the national programme, improved working relationships, and having the decision-making structures in place to support delivery.

> *I'm very clear in my mind – we would have got nowhere near it unless we had the ICS framework to operate within. People wouldn't have had the relationships, there wouldn't have been the understanding that you could think differently about how we might tackle the problems that were presenting themselves. So I think it is, undoubtedly in my mind, attributable to the STP–ICS movement in some way.*
> (Local authority, Bedfordshire, Luton and Milton Keynes)

Changing ways of working

The impact of ICSs is visible in ways of working between partner organisations and their leaders. We heard about changes in the nature of conversations between leaders and the way that organisations are working together, and about the development of a sense of 'mutual accountability' for performance. Interviewees described a more collaborative and less competitive approach, moving away from the purchaser–provider split that has existed for more than three decades.

> *I think we're transforming away from that internal market economy that we were all exposed to, and I think it was a travesty in terms of setting us in competition against each other as providers, when it's the same pot of money that we're all fighting for. And actually it's been so refreshing to be able to try and park that and to think differently about how can we work collaboratively... I think the travesty with competition is that people don't share those good models of practice that they are developing.*
> (Community or mental health provider, Frimley)

Areas also described a more transparent and open-book way of working, especially on financial matters, resulting in more honest conversations. The appointment of a shared finance director between the acute provider and commissioners in Frimley illustrates how far some systems have come in breaking down transactional approaches and overcoming organisational protectionism.

In some cases, this change in approach has had a tangible impact on the way that funding flows within the system. Both the Frimley and Dorset ICSs, for example, have moved money between organisations in order to achieve financial balance and to maximise the benefits to the system of additional funding through the Sustainability and Transformation Fund. In Dorset, there has been a move away from a Payment by Results (PbR) approach for the acute trust, releasing funding for investment in community and primary care services (*see* box below).

Managing system finances in Dorset

Within Dorset there has been a fundamental change in the financial system underpinning the ICS. This is based on the view that it is not sustainable to have individual organisations with separate budgets competing against each other. All organisations in the system have agreed that working with a combined budget is the way to achieve the best outcomes for the population of Dorset.

Building on the CCG's analysis of the current and future financial position for the system, a two-year financial collaboration deal in Dorset has been formally agreed. All organisations are open with their financial information and decisions are taken to ensure that the combined budget is spent in the most effective way for the population.

In practical terms, Payment by Results (PbR) has been effectively suspended, removing the incentive for providers to 'trade their way out of financial difficulties'. While each statutory organisation retains its own financial position and responsibilities, the collaborative approach means that funding decisions are taken collectively to maximise access to national resources such as the Sustainability and Transformation Fund. This has involved the movement of money between partners to ensure that they all achieved their control total to benefit the whole system. The system has also moved spending from acute care to enable investment in community and primary care services.

There is evidence that organisations and their leaders are finding ways of behaving altruistically towards each other, in line with work showing that this is one of the most important ways of creating trust and building collaborative relationships (**Hulks et al 2017**). However, this is taking time and some ICSs have made less progress than others.

Our research suggested that, by working together through ICSs, different organisations and parts of the system had a better understanding of one another's priorities and viewpoints. They are finding ways of 'walking in each other's shoes' and in this way are adding a system understanding to their organisational perspectives.

> *There's a lot more understanding of the mutual accountability and the interdependencies. So if you think about if the ICS wasn't here, or we didn't have that kind of joint working, each of the places and the providers and commissioners within there just worry about their own boundaries... What the ICS enables us to do is to have that much bigger lens of actually what's happening and how might that impact detrimentally or positively on each of those five places? But also, what does it do to the system overall?*
>
> (Commissioner, South Yorkshire and Bassetlaw)

These changes in relationships are being reflected in increased collaboration between providers – for example, through the creation of provider alliances, and similarly between commissioners through joint committees, committees in common, CCG mergers, joint appointments, and other changes. We also heard examples of increased collaboration between providers and commissioners, and between the NHS, local authorities and other local partners.

> *I think one of the things about our ICS, it's not unique, it's certainly a strength, and it's the provider collaborative... [it] has given us a real strength in shifting from a clinical commissioning-led conversation around models of care to one where the providers are in the room taking responsibility for improving the models of care and reducing that cost.*
>
> (Acute provider, Buckinghamshire)

> *Collaboration is the real change... We're not there yet entirely, but there has been a shift within the room to a more equal partnership. And I think from a voluntary*

sector point of view, we're starting to feel that at that level (although within our place we feel embedded), at that level, we are now being respected as an equal partner round the table.

(Other stakeholder, South Yorkshire and Bassetlaw)

Next steps

The delivery of tangible service change and measurable improvements in outcomes is a key priority for all ICSs. Many interviewees highlighted the need to demonstrate improved services for patients to increase the credibility of and confidence in ICSs. Identifying some 'quick wins' to show progress was suggested as one way to build this confidence.

I think we've got to invest in the top three priorities to do something. We've got to make a difference. If we don't do something this year on preventing older people coming to hospital and keeping them at home and things, if we don't achieve it this year, we won't have any confidence that we can ever achieve it, because we've talked and talked.

(Acute provider, Bedfordshire, Luton and Milton Keynes)

I think next steps are actually to demonstrate quick wins... People are already starting to buy into the concept more... but there's also a big hearts and minds thing to do.

(GP/GP commissioner, Buckinghamshire)

There has been limited progress to date in terms of scaling up improvements across ICSs. This challenge is not limited to ICSs; there are well-known challenges to widespread adoption of innovation (**Collins 2018**). This highlights the importance of ICSs developing systematic, evidence-based plans for spreading good practice.

From our perspective, there may be pockets of [good practice on integration], but what we are not aware of, and don't seem to be able to find is, well, how are you going to make that happen in the rest of the county? How's that going to be rolled out? There must be a plan for that.

(Healthwatch, Dorset)

While there is still much to be done, our research found clear support for the ICS model among those involved in implementing it. There was broad consensus that the model has great potential to bring about change, and the principles underpinning ICSs were seen as critical to placing health and care services on a sustainable footing.

> *This is the only game in town at the minute. That – until such time as something changes – is the only way in which we can deliver safe and sustainable services. We can't deliver competing with each other. We can't deliver by taking an isolationist stance. We can't deliver by reinforcing the borders. We can only deliver by recognising what the challenges we've all got are and working together to try and solve them.*
>
> (Local authority, South Yorkshire and Bassetlaw)

> *I'm really positive about the whole programme. By the way, if I bump into Simon Stevens tomorrow in the corridor and I had 10 seconds to say anything to him, I would say 'Please keep going with this and don't let it drift or let someone convince you it's the wrong thing to do, because it's not'. This is absolutely the right thing to be doing for the NHS and I'm really proud that we're at the vanguard of it.*
>
> (Commissioner, Berkshire West)

10 Emerging lessons from ICSs

Drawing on the views and experiences of interviewees from the eight ICSs included in this study, we have identified key factors that are supporting or holding back progress within local systems.

What factors are helping progress?

Collaborative relationships

ICSs rest first and foremost on the willingness of partner organisations and leaders to work together and their ability to trust one another to share risk and responsibility across organisational boundaries. ICS areas that are furthest ahead often have a history of positive working relationships and continuity of senior leaders in the system. Regular face-to-face meetings and focused development work have helped to build and strengthen these relationships.

Shared vision and purpose

Having a collective understanding of what the ICS is for and how it will improve the health and wellbeing of the local population is essential to align priorities and goals across organisations. Agreeing a shared vision and purpose early and in an inclusive way is a prerequisite in the development of effective system working and enables ICSs to determine collective priorities for action. This in turn allows common objectives to be set.

System leadership

Leaders in ICSs have adapted their behaviours to lead differently, using a facilitative and enabling approach instead of the pacesetting style that has predominated in the NHS in the past. Many ICSs have benefited from the influence of respected local leaders who have earned the trust of their peers over time through their actions and achievements. In some cases, new leaders have enabled progress by bringing new skills and capabilities, as in the case of ICS leaders drawn from local government.

Clinical leadership and engagement

Clinical leadership is a key factor behind the implementation of successful service changes within ICSs such as those developed through the vanguards programme and related innovations like the primary care home programme. A wider group of clinical leaders will be needed to realise the full potential of ICSs as they move to the next stage, recognising that the benefits of integration arise first and foremost from clinical and service integration rather than organisational integration. These leaders need to be drawn from a wide range of professions and roles.

Partnerships with local authorities

Local authority partnerships have brought several benefits, including: a stronger connection between ICSs and elected members; better engagement and involvement of local people; closer working across health and social care; and opportunities to address wider determinants of health through connections to wider public services such as housing and leisure services. Local authority leaders have shared their experience of leading across systems with NHS leaders, who have traditionally been more focused on their organisations and on looking up rather than out.

A meaningful local identity

A shared understanding of the area with which a system is aligned helps in building a commitment to collaborative working. What defines the area varies; for some systems, a local authority boundary has provided a natural footprint, while in others it has been defined by the patient flows around an acute provider. It has been harder to develop partnerships in systems where there is no sense of place to unite around. This is sometimes the case where areas within an ICS have a strong identity and the footprints covered by systems are seen as artificial constructs.

Established models of integrated working

A track record of successful service improvement can act as a catalyst for further change. Pre-existing work provides foundations on which to build both in terms of clinical delivery models and collaborative working arrangements. Tangible examples of changes and evidence of their impact breeds confidence and supports clinical and public buy-in to the work.

Stability of local finances and performance

Where partner organisations were meeting core targets and achieving financial balance, systems were generally able to make faster progress on the development of the ICS. This was partly due to local leaders having more time to spend on transformation work rather than dealing with operational pressures. Other factors included these systems experiencing less intervention from the regulators and fewer obstacles to taking on shared financial risk across organisations.

Funding to support transformation

ICSs have received some additional funding to support their development and this has helped to backfill the time of managers and clinicians to work on the ICS and to pump-prime the development of new service models. Some ICSs have benefited from the allocation of capital monies to fund investment in community services and planned changes in specialist services. The sums involved have not been large but they have helped in enabling ICSs to show what they can achieve.

A permissive and supportive national programme

ICSs have been given freedom to develop arrangements to suit their local context rather than being required to follow a national blueprint. They have also received support from national bodies in regular meetings that have enabled two-way communication on how the programme is developing. Difficult issues such as the introduction of system control totals have been debated openly and national bodies have shown a willingness to work with ICSs, individually and collectively, to find solutions.

What factors are making progress harder?

The legislative context does not support system working

The current NHS architecture is designed around organisations working relatively autonomously rather than as collaborative systems. There is a limit to how far systems can shift functions and decision-making as ICSs have no legal basis, and system objectives may conflict with statutory accountabilities. The financial system may incentivise organisations to act in ways that run counter to system interests

and layering system control totals onto the current regime does not address the fundamental tensions and perverse incentives at play. Some elements of competition law also run counter to the ethos of collaboration.

A legacy of competitive behaviours

Years of transactional relationships have created challenging relationships between many NHS organisations and their leaders. Collaboration requires different behaviours and new relationships to be built from the bottom up and cannot be mandated by regulators or others. Scepticism on the part of some organisations and their leaders about the concept of ICSs and their ability to lead change is also a factor, resulting in a focus on organisational priorities rather than a commitment to system working. Not all organisational leaders are yet persuaded that system working will bring benefits, and this is acting as a brake on progress.

Regulation and oversight is not aligned behind ICSs

Regional regulation and oversight is focused mainly on the performance of organisations rather than systems. This risks undermining the work that local systems are doing and makes it harder for partner organisations and their leaders to shift their focus to the interests of the overall system. ICSs may receive conflicting messages from national bodies and from the central and regional teams within them. Recent commitments to bring together the work of NHS England and NHS Improvement and local system reviews by the CQC are both steps in the right direction (**Care Quality Commission 2018**).

Frequently changing language and the lack of a clear narrative

STPs have left a legacy of mistrust in some areas that systems have had to work hard to overcome. The use of the term 'accountable care systems' to describe ICSs in their first months fuelled concern in some quarters around the association with the US health system and privatisation. At both national and local levels, insufficient attention has been given to communicating the purpose of ICSs and how changes are expected to benefit local populations and staff. The absence of a clear narrative has made it harder to secure buy-in from staff, communities and local politicians.

Leaders face competing demands

ICSs currently rely on people doing the work on top of their day jobs. Leaders face many competing demands on their time and priorities and sometimes struggle to devote the time needed to the work of ICSs. This is not sustainable in the long run, and if ICSs are to take on greater responsibility, they will need dedicated capacity and resourcing to match.

Funding pressures can both help and hinder progress

The challenging financial position of some organisations has made it harder for local systems to take collective responsibility for resources, due to concerns about sharing financial risk with organisations in deficit. However, we also heard that current pressures have been a key driver of change in making the status quo unsustainable. In this sense, financial and operational pressures have created a 'burning platform', uniting organisations behind the case for change.

⑪ Where next?

Building on our findings, we now set out our recommendations on what needs to happen to consolidate progress and realise the full potential of ICSs.

Our recommendations reiterate many arguments we have previously made about what is required to develop integrated care at scale and pace (**Ham *et al* 2016**; **Ham and Murray 2015**; **Ham and Walsh 2013**). The lack of progress in aligning funding mechanisms and regulation with the direction of travel since we made these recommendations represents a chronic failure on the part of national policy-makers to remove barriers to integration. If this continues, ICSs will end up as another worthy idea that did not deliver on its promise.

Recommendations for local systems and leaders

Invest in building collaborative relationships at all levels of the system

A system can only really be transformed by transforming relationships between the people within it (Senge *et al* 2015). ICSs should therefore continue to give priority to strengthening trust and relationships between partner organisations and their leaders. This must be done locally and will take time and commitment. It requires leaders and staff from different organisations to spend time together face-to-face, to work through challenges and create a shared purpose and objectives. It also involves leaders developing an understanding of each other's organisations by 'walking in each other's shoes' (**Timmins 2015**). Regular dialogue and exercises such as peer-to-peer shadowing can facilitate this.

Promote and value system leadership

Leadership in ICSs demands a collective and distributed approach spanning organisational and sectoral boundaries. This involves different skills and behaviours from organisational leadership and requires leaders to shift their mindsets and behaviours from pacesetting to facilitative and enabling styles (**West *et al* 2014**). Core capabilities identified by Senge *et al* (2015) include: an ability to see the larger

system; fostering reflection and generative conversations; and a collective shift in focus from reactive problem-solving to co-creating the future. Our research suggests that the ICSs that are most advanced are working to develop these capabilities and others need to learn from their experience.

Integrate at different levels of the system, building up from places and neighbourhoods

ICSs should continue to support work in places and neighbourhoods in line with the principle of subsidiarity. They should set the overall vision and provide leadership across the system, undertaking functions that are best performed at scale, such as work on specialist services, workforce, use of the estate and IT. Where appropriate, ICSs should collaborate with each other to address issues that are best tackled across bigger footprints, as is already happening in many areas.

Draw on the skills and leadership of frontline staff

Improvements in service delivery depend on the leadership and involvement of the frontline staff who will be putting them into practice. Their involvement should be front and centre of plans to redesign services and should be underpinned by clear, focused workstreams and clinical leadership. Resources must be found to release clinicians and frontline staff from some of their current responsibilities to enable them to lead innovations in care.

Build governance in an evolutionary way to support delivery

Further work is needed to put in place governance to support decision-making and accountability. This should be iterative and locally led, recognising the need for arrangements to evolve as systems mature. Oversight and scrutiny should be built in to ensure that ICS leadership teams can be held to account. Arrangements must work alongside the current statutory framework and organisational accountabilities until the law is changed.

Develop system-wide capabilities to gather, share and act on public insights

ICSs must take active steps to listen to and work with the public on an ongoing basis. This means much more than informing them of plans or carrying out consultation exercises. It means finding ways to listen to and act on what the public says and bringing their insights into decision-making. A useful starting point is to identify specific objectives in relation to public engagement and the methods that can be used to meet those objectives. ICSs should also agree on how to bring together dispersed elements within the system, mapping out existing patient insight and feedback data, identifying gaps, and bringing together data gathered by different organisations (**Wellings and Evans 2018**).

Develop active strategies to facilitate wider adoption of new care models

All ICSs have ambitions to spread models of care from pockets within their systems across the whole area, but this is challenging (**Collins 2018**). Research on large-scale change highlights the need to take an active approach (rather than relying on passive diffusion of good practice), and to balance fidelity to a model with adaptability to local context. Peer-to-peer learning and networks are generally more effective in driving adoption than central edicts (**Albury *et al* 2018**; **McCannon *et al* 2016**; McCannon *et al* 2007).
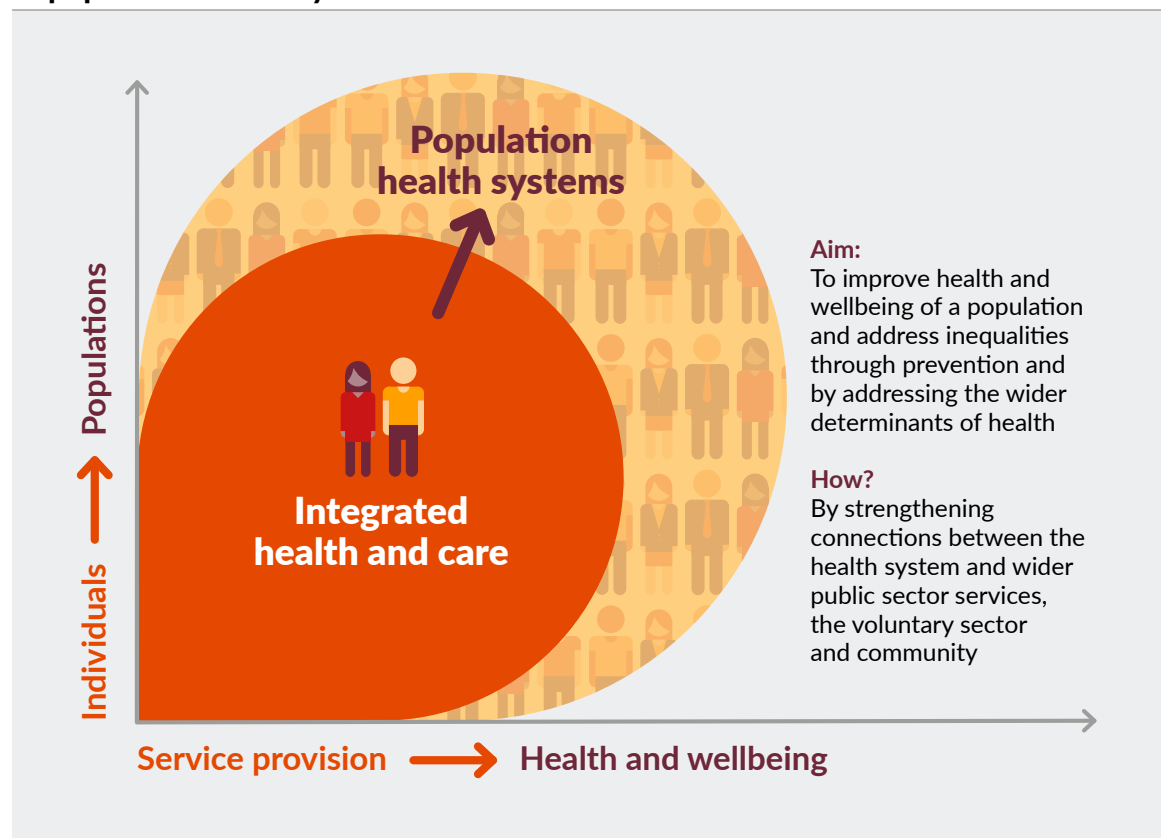
Build robust evaluation into the ICS programme that supports learning and improvement and measures progress

Objective-setting and evaluation should build on learning from the new care models programme (**National Audit Office 2018**). Metrics should reflect the breadth of ICSs' priorities, capturing improvements in population health and avoiding a narrow focus on hospital activity. Realism is key; much of the impact is likely to emerge in the long term rather than the short or medium term, and a range of measures should be selected to track progress at different points in time. ICSs should consider how they can evidence early improvements and progress towards longer-term objectives.

Look beyond the health and care system to improve population health

Traditionally, health and care services have often been provided in a fragmented way, and joining up services to address this is an important objective of ICSs. But the bigger prize is to create broader partnerships that can lead to greater improvements in population health and inequalities through acting on wider determinants (*see* Figure 3). This requires local authorities' involvement to go deeper than the links between health and social care, recognising their roles in public health, leisure and other services that shape health and wellbeing. It also requires ICSs to work much more closely with the voluntary and community sector, independent sector organisations and communities. ICSs should look to learn from systems that have made progress, including the devolution areas of Greater Manchester and Surrey Heartlands, and areas such as Wigan that have adopted asset-based approaches (for other examples *see* Buck *et al* forthcoming; **Alderwick *et al* 2015**).

Figure 3 **What does it mean to move from integrated care to population health systems?**

Aim:
To improve health and wellbeing of a population and address inequalities through prevention and by addressing the wider determinants of health

How?
By strengthening connections between the health system and wider public sector services, the voluntary sector and community

Recommendations for national leaders

Back locally led change, while also offering central guidance and support

National bodies must hold their nerve in supporting locally led change, learning from the failure of previous top-down approaches to NHS reform. ICSs are writing the manual for system working, and it is important that the learning is systematically captured and shared so that others can benefit from their insights. National bodies should also offer support to areas that are further behind in their maturity as integrated systems to avoid a situation where assistance is only available to help the best get better. The emphasis should be on facilitating all areas to share learning through peer-to-peer support, and co-designing how the programme evolves, with the full involvement of local leaders.

Clarify the future size of ICSs without destabilising existing systems

Smaller ICSs will need to find ways to manage 'system-level' functions. This should be considered in the selection of future ICSs. Any move to bring smaller ICSs together should be locally led and rigorously tested to avoid destabilising relationships that are still under development. In the short term, it may be better for smaller ICSs to collaborate – as is happening in some areas – rather than to attempt to redefine boundaries.

Make a long-term national commitment to ICSs backed by dedicated funding

National bodies should ensure that ICSs are allowed time to develop and mature, and be realistic about the challenges they face. A national commitment to ICSs should be reflected by their future role being embedded in the NHS long-term plan, which should communicate clearly and simply why they are needed and set out a route map for all areas to progress from STPs to ICSs. This should be accompanied by dedicated funding to support their development. Some of the additional NHS funding recently announced by government should be earmarked for this purpose (Ham and Murray 2018) and ICSs should be able to determine how it is spent.

Make population health the centrepiece of plans to transform services

The NHS long-term plan should set realistic and measurable objectives for improving population health, and ICSs should be held to account for delivering these locally. National bodies should also consider what more could be done to create alignment at a national level with other government departments and bodies – for example, in relation to housing and education. The experience of areas that are further ahead in giving priority to population health should be documented and shared, and their leaders should be freed up to support areas that are further behind.

Reform regulation to align with local systems

Regulators must look at how they can measure and support the ability of whole systems to meet the needs of local populations, building on learning from the CQC's local system reviews (Care Quality Commission 2018). This requires a shift in mindsets and behaviours among individuals working in regulatory organisations, particularly at a regional level, and staff need to be supported through this change to avoid a situation where national ambitions are not reflected by actions on the ground.

Work with local leaders to clarify how ICSs fit into the regional architecture

As NHS England and NHS Improvement take forward commitments to come together, they should work with local systems to set out how relationships will evolve as systems mature. There are still significant questions over how the seven regions will relate to ICSs and these must be worked through to prevent duplication. The starting point should be to clarify the functions of the seven regions and how these relate to the functions of ICSs, as we have distilled them in this report. The risk of adding another tier of bureaucracy should be avoided at all costs.

Model collective leadership, and create a supportive regulatory environment

Mirroring the change in leadership styles taking place within the ICSs, national and regional leaders in NHS England and NHS Improvement should demonstrate a commitment to the collective, compassionate style of leadership set out in the *Developing people – improving care* framework (National Improvement and Leadership Development Board 2016). This means creating a supportive and proportionate

approach to regulation and modelling different behaviours and leadership styles in the regional teams to give local leaders the time and space they need to develop their own improvement capabilities.

Redesign the financial architecture to incentivise integration

Current financial rules must be changed to better support the aspiration to deliver more integrated care. The financial controls introduced in recent years have created a cluttered and complex finance regime, which is in urgent need of reform. System control totals are a step in the right direction and more significant change is needed to create a simpler, fairer and more effective system (**Anandaciva *et al* 2018**). The way that commissioners pay providers also needs to change, with the emphasis on capitated budgets, risk-sharing, and outcomes-based contracts rather than Payment by Results.

Bring forward proposals for legislative change drawing on the experience of leaders within the health and care system

Changes will be needed to align the statutory framework with ICSs. Leaders should focus on identifying the most essential amendments and/or regulatory changes that could support progress in the short term, while formulating proposals for more significant changes in the longer term. Proposals should be based on the experience of leaders within the health and care system to avoid another damaging top-down reorganisation (**Health and Social Care Committee 2018**; **Stevens 2018a**). Key areas for consideration include: requirements on commissioners to use competitive procurements; barriers to the merger of NHS England and NHS Improvement; and changes to the Care Quality Commission's regulatory powers. Finally, options should be explored for a statutory basis for ICSs to appropriately reflect their growing role through formal powers and accountabilities.

Top tips from the ICSs

We asked local leaders what advice they would give to other systems starting out on the journey to developing an ICS. The pieces of advice most frequently offered were as follows.

Spend time developing trusting relationships. They saw strong, open relationships between ICS partners as key to effective joint working. These relationships were described as more important than new structures.

> *I will pinch from somebody else, who effectively said that the ICSs will move at the speed of trust. So that would probably be my advice – this is really about relationships and trust among the partners.*
>
> (Commissioner, Dorset)

Establish and articulate a shared vision. Interviewees highlighted the importance of this being based on a common view of the 'case for change' and the need for ICS leaders to be united behind it. Engaging staff and the public was also seen as critical.

> *Have a strong narrative, and in a language that people can understand and that would include your patients and public, and believe in it. Believe you're doing the right thing.*
>
> (GP/GP commissioner, Dorset)

Don't underestimate the time it takes to bring about change. Local leaders urged realism about the time and resources required to bring about complex change.

> *If you try and race towards the perfect end point, you'll probably never get there, and that can be demoralising, and it can damage relationships... Systems ought to establish, 'What is it that we're going to actually achieve in the next few months and does that take us broadly in the direction that we want to go in?'*
>
> (Commissioner, South Yorkshire and Bassetlaw)

Drawing on the lessons from their own experience, the overriding message from the people we interviewed was that **the ICS model has great potential**.

> *Go for it. It's uncomfortable, it's challenging. But the rewards throughout that journey are actually going home and feeling that you are starting to provide grass-roots clinicians with a different opportunity and different ways of working. And break the rules!*
>
> (Commissioner, Berkshire West)

Appendix: Methodology

This study examined progress in eight of the ten areas selected by NHS England to become 'first-wave' ICSs:

- Bedfordshire, Luton and Milton Keynes

- Berkshire West

- Buckinghamshire

- Dorset

- Frimley

- Lancashire and South Cumbria

- Nottingham and Nottinghamshire

- South Yorkshire and Bassetlaw.

In each area, we carried out interviews with senior NHS and local government leaders involved in the work of the ICS, as well as other key stakeholders. Interviews took place between February and May 2018 and enabled us to explore local experiences and perceptions of the early development and impact of ICSs from a variety of perspectives.

We identified between seven and eleven senior leaders from each area, using criteria to ensure that the sample was representative of a range of views from across each system. We conducted a total of 72 semi-structured interviews across the eight ICSs (*see* Table A1). Interviews were audio-recorded and professionally transcribed, and the data was subjected to a thematic analysis. All interviews were conducted on a confidential basis, and the anonymity of participants has been protected throughout this report.

Table A1 **Breakdown of interviews**

Role	Number (across all ICSs)
Acute providers	14
Community and/or mental health providers	7
GPs and GP commissioners	9
Local authorities	11
Clinical commissioning groups	18
Local Healthwatch organisations	6
Other stakeholder	7

'Other stakeholder' includes individuals employed directly by ICSs and local groups representing people who use services. The ICS leader was interviewed in all sites.

For each area, we also reviewed documents detailing the ICS's strategy, governance arrangements, and plans and progress in implementing service change. This included published materials and additional documents provided to us directly by the ICSs. Together with information gathered during interviews, information from the document review was used to write a descriptive summary outlining key features of current arrangements and plans in each area. These summaries can be found in the **supplementary online resource** to this report.

At the same time as this research was taking place, The King's Fund was working on-site with ICS areas to deliver leadership and organisational development support commissioned by NHS England. No information from the support work has been used in this research project. However, it provided useful contextual background for the project team in understanding how ICSs are operating in practice. This report has been independently designed, conducted and funded by The King's Fund.

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Chris researches and writes on all aspects of health reform and is a sought-after speaker. He was awarded a CBE in 2004 for his services to the NHS and an honorary doctorate by the University of Kent in 2012.

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The King's Fund is an independent charity working to improve health and care in England. We help to shape policy and practice through research and analysis; develop individuals, teams and organisations; promote understanding of the health and social care system; and bring people together to learn, share knowledge and debate. Our vision is that the best possible health and care is available to all.

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The King's Fund> Ideas that change health care

Integrated care systems (ICSs) have been proposed as the future model for the health and care system in England – a way to meet the needs of the growing numbers of older people and people living with long-term conditions. ICSs represent a fundamental and far-reaching change in how the NHS works across different services and with external partners.

A year of integrated care systems: reviewing the journey so far is based on interviews with eight of the 'first wave' ICSs to understand how they are developing and to identify lessons for local systems and national policy-makers.

ICSs' development has been locally led and there is no national blueprint. The systems vary widely in their size and complexity. Larger ICSs are working to improve health and care through neighbourhoods and places as well as across whole systems, emphasising the principle of subsidiarity.

The authors found early signs of organisations working more collaboratively as systems, including in managing finances and performance. There are also signs of progress on delivering service changes, for example in relation to strengthening primary care and developing integrated care teams.

The report concludes that is early days for these systems, and more time is needed to embed changes and determine their impact. The research found broad consensus that the ICS model has real potential to bring about improvements in health and care. The challenge now is to build on the foundations that have been laid by removing barriers and providing time and support to ICS leaders to take their work to the next stage of development.