MEAM:
Policy into practice series

*The **Policy into Practice** briefing series from **Making Every Adult Matter (MEAM)** explores key national policy developments, what these mean for local people and local services, and how you can get involved in shaping what happens next.*

Integrated Care Systems and Multiple Disadvantage

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What are Integrated Care Systems?

The NHS describes Integrated Care Systems (ICSs) as "new partnerships between the organisations that meet health and care needs across an area, to coordinate services and to plan in a way that improves population health and reduces inequalities between different groups."[1]

ICSs aim to better integrate acute and mental health care, primary and secondary health services and local wellbeing services. They are formed of many parts of the NHS in a local area, such as NHS trusts and Clinical Commissioning Groups (CCGs) as well as local authorities/Adult Social Care and increasingly third sector agencies.

ICSs evolved from the Sustainable Transformation Partnership (STPs) that developed from closer working between the NHS and local authorities. The first ICSs were formed in 2018 with the intention of approximately 42 to be spread across England by April 2021. Each individual ICS covers a population of between 800,000 and 3 million people.

In February 2021 the government launched new proposals to join up health and care services. As part of this, it is proposed that the NHS and local authorities will be given a duty to collaborate with each other, making Integrated Care Systems statutory bodies comprised of an ICS NHS body and a separate statutory ICS Health and Care Partnership. The ICS NHS body will commission healthcare services and be

[1] https://www.england.nhs.uk/integratedcare/what-is-integrated-care/

responsible for the day-to-day running of the ICS. The ICS Health and Care Partnership will promote partnership arrangements and develop a plan to address the health, social care and public health needs of the system, to which the ICS NHS body and local authority would have to have regard.

Why are Integrated Care Systems relevant to people experiencing multiple disadvantage?

Many ICSs have identified the reduction of health inequalities[2] as a key strategic focus for their work, hoping to improve health outcomes for groups of people who have traditionally had poor outcomes.

Increasingly important are the social and environmental determinants that lead to poor and inequitable health among certain groups. The NHS Long Term Plan identifies the development of ICSs as a way to improve those health determinants that the NHS has, in the past, had little or no control over.

This presents an opportunity to improve health outcomes for people experiencing multiple disadvantage, amongst others, through collaborative working and new ways of planning health activities.

Key issues for the development of Integrated Care Systems

Accelerated development

Local and regional health responses to COVID-19 have accelerated the timetable of ICS conversion from STPs. Increased partnership working resulting from planning and responding to the pandemic has reinforced relationships between health commissioners and local services providers, including local authorities and the third sector. All areas in England are now covered by one of 42 ICSs.

Cementing of "system," "place" and "neighbourhoods"

Making reference to different geographies is becoming an important concept in how health services are organising themselves[3]. Integrated Care Systems have relatively large geographies, with the largest, North East and North Cumbria ICS, covering several local authority areas.

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[2] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4481045/
[3] https://www.england.nhs.uk/wp-content/uploads/2019/06/designing-integrated-care-systems-i

The NHS refers to this scale of geography as a "system," covering anywhere between 800,000 and 3 million people. At this level, responsibilities will include strategic oversight, resource management and leading on large-scale change.

The next level is referred to as "place." In most areas, these structures follow local government boundaries and cover populations of 250,000 – 500,000 people. Some of the larger ICSs are developing partnerships at the "place" level, where providers have grouped into alliances that agree to collaborate rather than to compete. These may be referred to differently in local areas, for example Integrated Care Partnerships, Local Care Partnerships or Local Care Organisations. At this level, there is responsibility for changes to clinical services and public health management targets interventions to particular groups.

"Places" are complemented at an even smaller scale by "neighbourhoods," which in practice means the boundaries of the newly formed Primary Care Networks[4] (PCNs). These encompass populations of 30,000-50,000 people. At this level PCNs work to deliver co-ordinated proactive care and support, particularly for individuals with the most complex needs.

Health and Wellbeing Boards, Clinical Commissioning Groups and Integrated Care Systems

There is currently no set relationship between Health and Wellbeing Boards (HWBs) and ICSs. Some areas have developed formal agreements between the ICS and HWBs to delineate responsibility whilst other are less developed.

Under the new proposals referenced above, Health and Wellbeing Boards will remain in place and will continue to develop the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy, which both HWBs and ICSs will have to have regard to. Guidance will be issued to help HWBs and ICSs work together, complement each other's roles and share learning.

Clinical Commissioning Groups currently commission clinical services on behalf of the NHS in a local area. Since the advent of CCGs in 2013, many have merged

[4] PCNs are collections of GP practices which work with a range of local providers, including across primary care, community services, social care and the voluntary sector, to offer more personalised, coordinated health and social care to their local populations

together in order to benefit from greater economies of scale or to match ICS footprints.

Under the government's proposals the ICS NHS Body will take on the commissioning functions of the Clinical Commissioning Groups (CCGs) and some of the commissioning responsibilities of NHS England within its boundaries.

Opportunities for Integrated Care Systems to address multiple disadvantage

Many ICSs are focused on reducing health inequalities for vulnerable populations. Individuals facing multiple disadvantage are often among the most vulnerable in local communities experiencing very poor health and therefore improving their health outcomes should be seen as a priority.

Involvement of lived experience in local healthcare planning

Most ICSs have put in place engagement leads. These roles seek to better engage the public with the work of the ICS and to include people with lived experience in NHS decision-making processes. This could be, for example, to better connect communities with PCNs or to consult populations with historically poorer health outcomes about specialist commissioned services. Local areas should ensure that they know who their engagement lead is and offer opportunities for them to engage directly with people facing multiple disadvantage.

Opportunities for voluntary organisations

Third-sector organisations are being invited to join ICS partnerships, bringing important perspectives and neighbourhood connections to populations that have poorer health outcomes. This presents an important opportunity to ensure that voluntary sector expertise is embedded into wider health structures, enable community involvement in health planning and commissioning, as well as agreeing local responsibilities around health and wellbeing between the voluntary and statutory sectors.[5]

An example of this is the rollout of the Community Mental Health Framework for Adults and Older Adults. This is actively engaging voluntary organisations in

[5] Rethink mental illness have published a guide for ICSs and STPs to better engage the voluntary sector and community. While focussed on mental health concerns, it is a useful framework to consider regarding other health issues and interventions.

developing local models of care in 12 early implementation sites, which are all STP or ICS areas. It is expected that all ICS areas will have adopted this framework by 2023/24.

Development of data sources

As the use of health algorithms increases to predict future poor health and to plan future activity, it will be vital that groups that have been excluded from or underrepresented in traditional data sets measuring health outcomes, such as people experiencing multiple disadvantage, are better included.

Encouraging the development of new data sets that allow for the incorporation of more qualitative data is important; as is sharing knowledge from local services with those who are monitoring the performance of health systems. Developing relationships with ICS data teams will be important to ensure there is a better understanding of the needs of people facing multiple disadvantage within local areas.

The production of additional health audits, such as Homeless Health Needs Audits[6] or those relating to people newly released from prison, will continue to be useful tools to gather data and could help influence and encourage greater involvement and focus on people facing multiple disadvantage from ICSs in the future.

Primary Care (Network) Navigators and Social Prescribers

Also of interest, are the primary healthcare workforce who are delivering different aspects of the NHS Long Term Plan. This includes the emergence and increasing numbers of primary care navigators and social prescribers.

While not a new phenomenon, primary care navigator roles are designed to offer signposting through to appropriate primary care services, reduce the workload of GPs and help people play a more active role in managing their own health. Local areas should seek to make contact and form links with primary care navigators wherever possible

[6] https://www.homeless.org.uk/our-work/resources/homeless-health-needs-audit

Related to this is the increasing importance placed on social prescribers. Their purpose is to connect patients to community activities that may have beneficial effects on their health[7].

Joint Strategic Needs Assessments

Joint Strategic Needs Assessments (JSNAs) are carried out to understand the health needs in a local area. They often provide a rich source of health data for a local area to consider and provide evidence on which services should be commissioned. As noted above, JSNAs will remain the responsibility of Health and Wellbeing Boards, and ICSs will have to have regard to them. Local areas should continue to engage with any future opportunities to feed into JSNAs highlighting the specific needs of people experiencing multiple disadvantage.

Conclusion

The development of Integrated Care Systems marks a new opportunity for areas to have a greater say in the way healthcare is delivered locally. While there is still a significant amount of change to come, this is an opportune time for local areas to build new or reinvigorate already existing relationships with ICSs and wider health partners. Many ICSs have identified tackling health inequalities as a focus and this presents new opportunities for areas to influence and improve local health systems supporting people experiencing multiple disadvantage.

[7] MEAM produced a briefing on social prescribing earlier this year, read it here.