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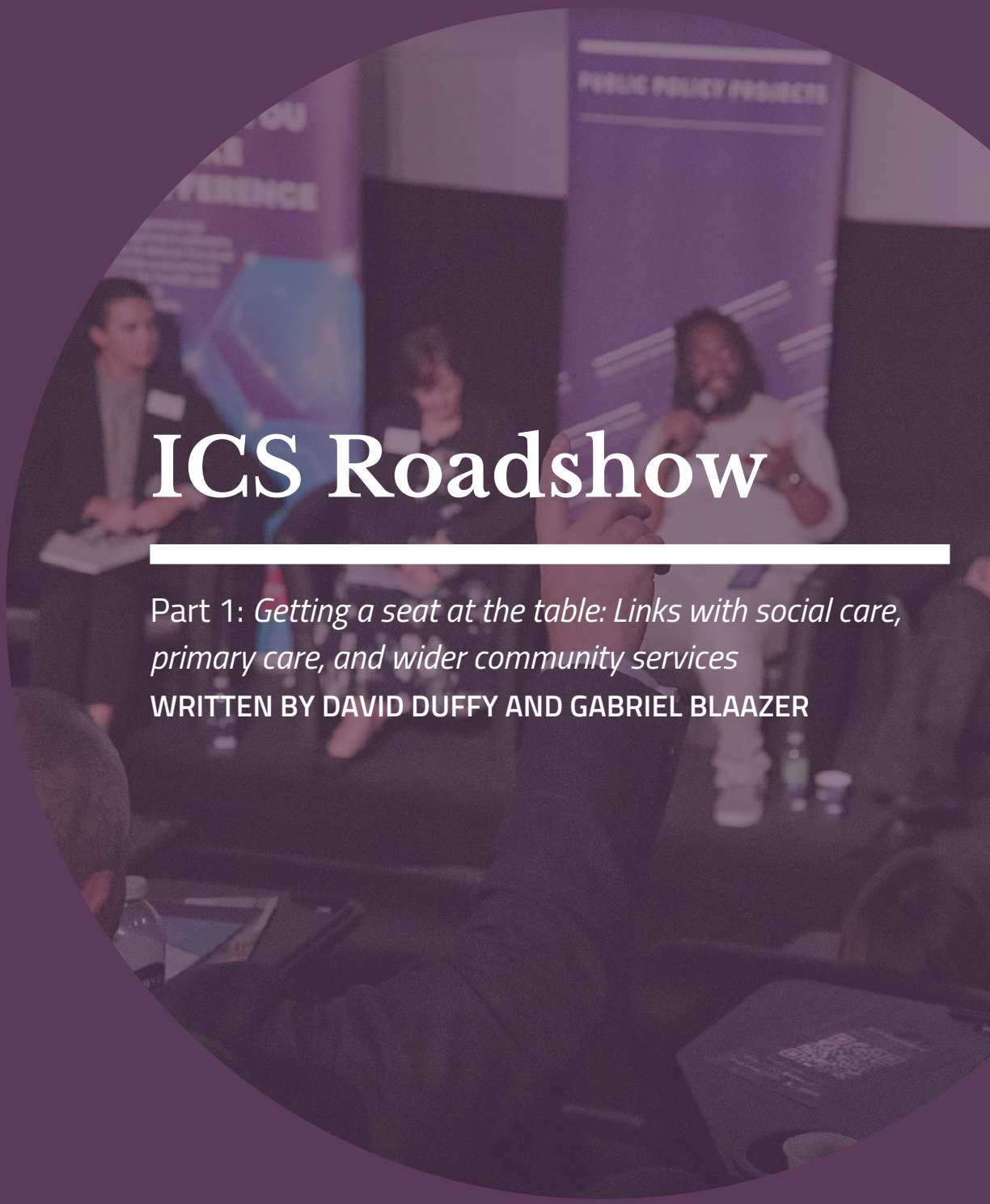

ICS Roadshow

Part 1: *Getting a seat at the table: Links with social care, primary care, and wider community services*

WRITTEN BY DAVID DUFFY AND GABRIEL BLAAZER


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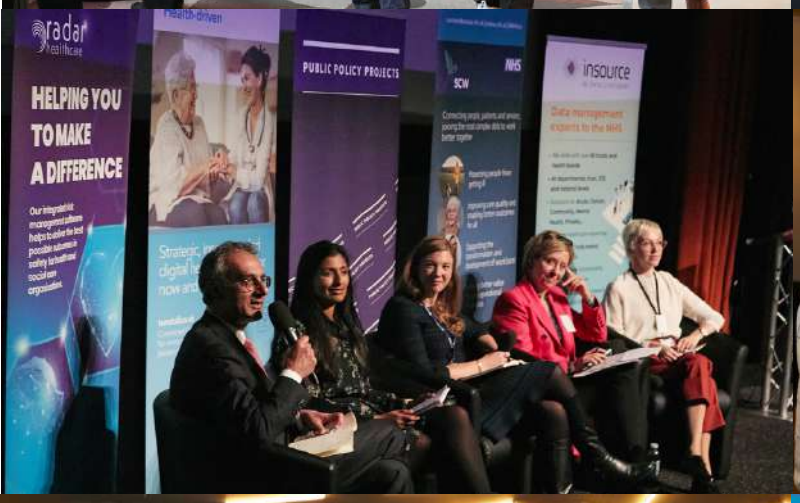
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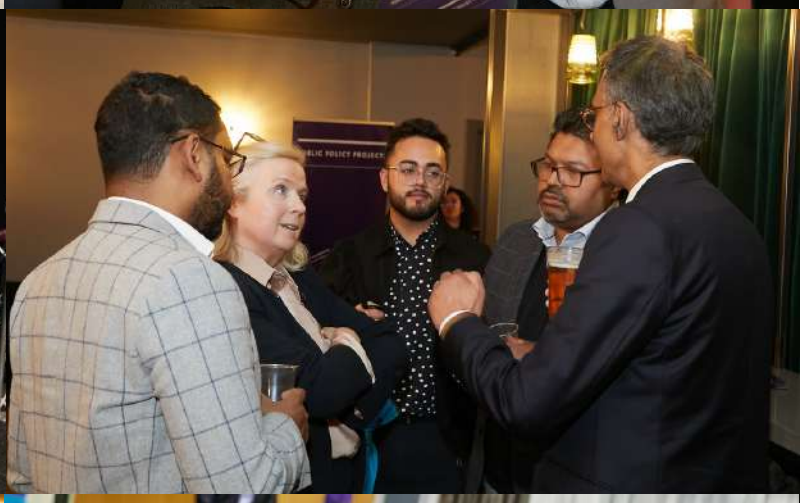


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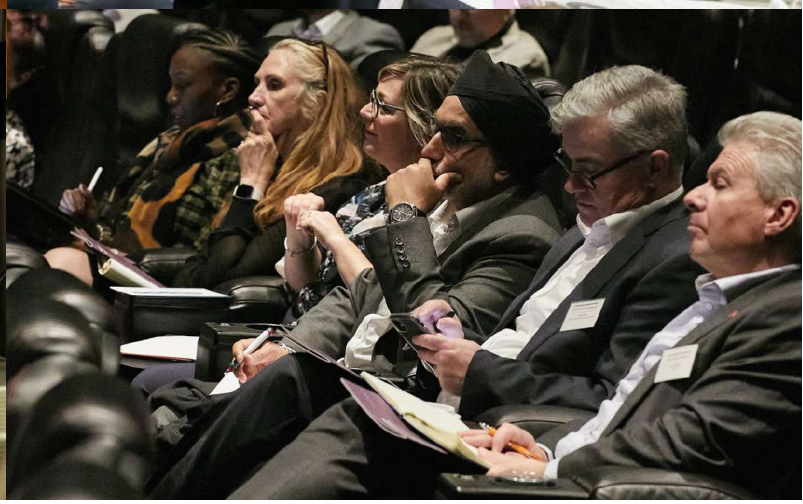


About this document

The ICS Roadshow was a series of five events, held in five different regions over the autumn of 2022. Each Roadshow event saw ICS leaders and a broad spectrum of health and care stakeholders come together for discussion and debate in five cities: Leeds, London, Birmingham, Manchester and Bristol.

The Roadshow provided a unique opportunity for health and care stakeholders to discuss the challenges and opportunities of integrated care at a localised level. The events successfully brought stakeholders together with ICS leadership and provided a platform for the next generation of health and leaders. They also allowed local people to gain an intimate understanding of what integrated care means for them.

Topics of discussion included:

- Ensuring ICSs come to represent a 'partnership of equals' between different parts of the health and care system
- Considering data sharing as a duty of care
- Prevention, early access and health inequalities
- What does 'good' look like for integrated care?

This document summarises the key insights and recommendations from the first panel: *Getting a seat at the table: Links with social care, primary care, and wider community services.*

This session considered the assets of primary care, social care local government and wider community services. The fundamental question was how ICSs can come to represent a true 'partnership of equals' with the different layers of the health and care system.

This report is not an exhaustive account of what was said at each panel, but rather a bitesize summary of key themes, and insights uncovered, with some recommendations put forward for policymakers and key health and care stakeholders to consider.

Speaking at our London Roadshow event: Emil Peters, Group CEO of Tunstall Healthcare

Speakers

We are grateful to every speaker and delegate that gave up their valuable time to contribute to these discussions and debates.

Speakers from panel 1 at each Roadshow event are listed below. Contributions for this chapter also include keynote presentations, with content from each keynote encompassing all four panel discussion topics. Insights from these keynotes will reappear in further chapters of the Roadshow Report.

LEEDS:

- Pearse Butler, Chair, **South Yorkshire ICB**
- Dr Jim Barwick, Chief Executive, **Leeds GP Confederation**
- Dr Sean Clarkson, Head of Strategic Operations, **Yorkshire and Humber Academic Health Science Network**
- Dr Indra Joshi, Strategist, **Palantir**

MANCHESTER

- Sir Richard Leese, Chair, **NHS Greater Manchester Integrated Care**
- Dr Tracey Vell MBE, Executive Lead for Primary Care, **NHS Greater Manchester Integrated Care**
- Graham Brown, Marketing Director, **Tunstall Healthcare**
- Hanif Bobat, Development Manager, **Ethnic Health Forum**

LONDON

- Daniel Casson, Managing Director, **Casson Consulting** and Digital Transformation Advisor, **Care England**
- Yousaf Ahmed, ICS Chief Pharmacist and Director of Medicines Optimisation, **NHS Frimley ICB**
- Professor Vic Rayner OBE, Chief Executive, **National Care Forum**
- Dr Khyati Bakhai, Primary Care Lead, **Tower Hamlets Primary Care**
- Dr Karen Kirkham, Chief Medical Officer, **Deloitte**
- Emil Peters, Group CEO, **Tunstall Healthcare**

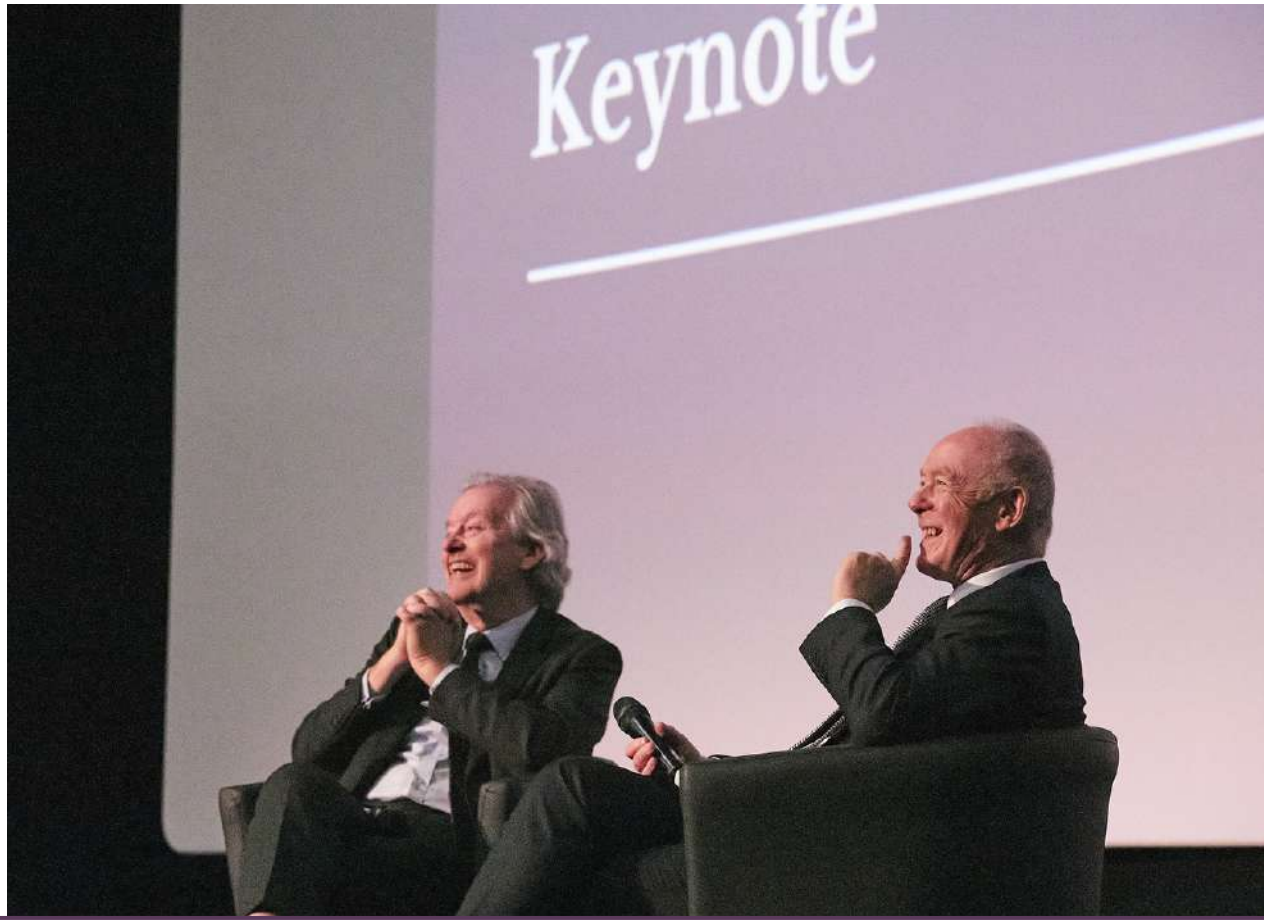
BIRMINGHAM

- Sarah Mitchell, Former Health and Care Improvement Advisor, **Local Government Association**
- Dr Justin Varney, Director of Public Health, **Birmingham City Council**
- Mubasshir Ajaz, Head of Health and Communities, **West Midlands Combined Authority**
- James Banham, Partner, **Deloitte**

BRISTOL

- Dr Jeff Farrar, Chair, Bristol, **North Somerset and South Gloucestershire ICB**
- Daniel Casson, Managing Director, **Casson Consulting**, Digital transformation advisor at **Care England**
- Tim Whittlestone, Chief Medical Officer, **North Bristol NHS Trust**
- Dr Karen Kirkham, Chief Medical Officer, **Deloitte**

Contents



Introduction

The opening panel session of the ICS Roadshow saw speakers consider how ICS governance structures can ensure a 'partnership of equals' between different layers of the health and care system, including primary and secondary care, social care, local government and the voluntary, community and social enterprise (VCSE) sector.

Integration between the NHS, primary care, social care, local government and VCSE organisations are central to achieving the core goals of ICSs around reducing health inequalities and improving population health.

People at the Heart of Care, the government's 2021 whitepaper, sets out two core forms of integration underpinned by the legislation which established ICSs; integration within the NHS to streamline clinical pathways, and integration that enhances collaboration between the NHS, local government and wider community services such as the voluntary, community and social enterprise (VCSE) sector.[1] It is the latter which recognises the fact that an estimated 80-90 per cent of health is determined outside of healthcare settings – these are the wider social determinants of health.

The two principal bodies within any ICS are the integrated care boards (ICBs), which bring together the local NHS partners, allocate resources and oversee the delivery of improved population outcomes, and integrated care partnerships (ICPs), responsible for setting strategy and working with local partners to achieve those aims.

SUMMARY POINTS

- ICSs are encouraging collaboration between new partners and bringing new organisations to the table, through both ICP and ICB structures, however the extent to which different organisations are truly represented and have a 'voice' in decision making varies.
- It will take time for different parts of the sector to become constituted with each other in system-wide decision making, with more mature ICSs presenting with more inclusive structures and going beyond statutory requirements from the centre.
- That being said, ICSs are balancing the desire for inclusivity with the need for efficiency, with levels of representation varying significantly between ICPs and ICBs across the country.
- There persist fundamental tensions within ICSs in governance, particularly between place-based decision making and aggregation and scale.
- More must be done to promote a culture of collaboration and mutual understanding between different parts of the health and care system.
- If population health is to be effectively addressed, the default primacy of one sector over the others must be eschewed in favour of creating a 'partnership of equals.

In its guidance, the government states that it has taken a "minimalist approach" to the formation of ICPs to allow for maximum local flexibility.[2] As such, the statutory framework for ICPs includes only the ICB (sometimes referred to as the 'ICS NHS body') and the local authorities within the ICS footprint.

Beyond this, each system can decide on the makeup of its ICP, but ICPs are encouraged to "take an open and inclusive approach to strategy development and leadership, involving communities and partners," with suggested partners including the local Health and Wellbeing Boards, social care providers and relevant members of the VCSE sector, as well as housing and education providers, and representatives from local transport, justice and unemployment bodies.

The discussions of the ICS Roadshow were brought into a sharp and timely context by commencement of the Hewitt Review, which is currently considering "how the oversight and governance of ICSs can best enable them to succeed, balancing greater autonomy and robust accountability." [3]

RECOMMENDATIONS

- Government should consider broadening the statutory framework of ICPs to ensure a minimum level of representation to tackle the wider social determinants of health.
- ICSs should consider the implementation of formal, cross-sector leadership training, to ensure that all parts of the system are aware of the capabilities and limitations of the others.
- Government should consider mandating the formation of provider collaboratives who can provide an elected chair to sit on ICPs.
- The upcoming Hewitt review should examine CQC's ability and capacity to regulate cultural changes, as well as encourage greater scrutiny of how ICSs ability to represent a 'partnership of equals'.

Why is representation important?

> ***I don't think an ICB can be remotely successful unless there's really good partnership arrangements with its local authority and its voluntary sector.***

Pearse Butler, Chair, South Yorkshire Integrated Care Board

Given the degree to which population health is influenced by wider social determinants, it is arguable that achieving the population health objectives set out in Core20PLUS5 will be near impossible for ICSs without a broad spectrum of perspectives represented at the top levels of the system. [4]

The importance of supporting and maintaining strong links between the traditional pillars of healthcare (NHS and primary care) and community health services was acutely summarised by Pearse Butler, Chair of the South Yorkshire ICB, who stated: "I don't think an ICB can be remotely successful unless there's really good partnership arrangements with its local authority and its voluntary sector."

Fulfilling their statutory obligation of improving population health and reducing health inequalities will require ICSs to engage with sectors that have traditionally rested outside of healthcare's sphere of influence, including housing, transport, unemployment, and community-based support organisations. Failure to do so would constitute a failure to truly appreciate and account for the impacts that these factors have on population health.

Although panellists noted the tensions inherent in undertaking such a consequential reorganisation of the health system while keeping existing services running, it was agreed that the formation of ICSs is an opportunity that must be taken to transform the ways in which care is provided, accessed and regulated.

Left: Jim Barwick, CEO, Leeds GP Confederation
Right: Pearse Butler, Chair, South Yorkshire Integrated Care Board

In addition, improving the representation of the different parts of the health and care system (and improving the connectivity between them) are core aspects of the Fuller Stocktake, which recommends that more effort must be made to connect primary care with social care providers and the voluntary sector.[5]

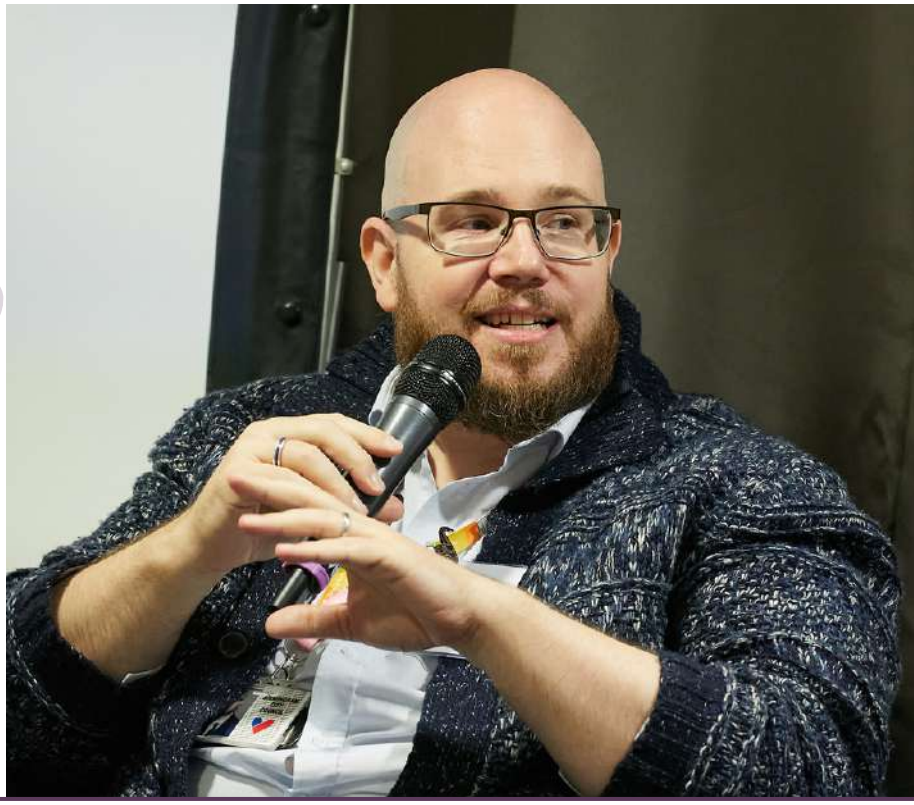
Speaking in Birmingham was Dr Justin Varney, who, in his role as Director of Public Health for Birmingham for Birmingham City Council, played a key role in first drawing up ICS strategy for the Birmingham and Solihull ICS.

He made the case for the inclusion and representation of the housing sector within ICSs as a means of tackling population health outside of healthcare settings, saying: "When I think about brownfield regeneration, it tends to be designed for young people, able bodied, and for economic growth.

Rarely do we see these developments actually think about supported housing or think about disabled accessible housing as part of the development plan. If all we do is create new houses for able bodied young people, we're furthering the exclusion and the marginalisation."

The Fuller report likewise recommends the system level involvement of the education, unemployment and transportation sectors (also wider social determinants of health) within ICSs.

> ***If all we do is create new houses for able bodied young people, we're furthering the exclusion and the marginalisation.***
>
> **Dr Justin Varney, Director of Public Health, Birmingham City Council**



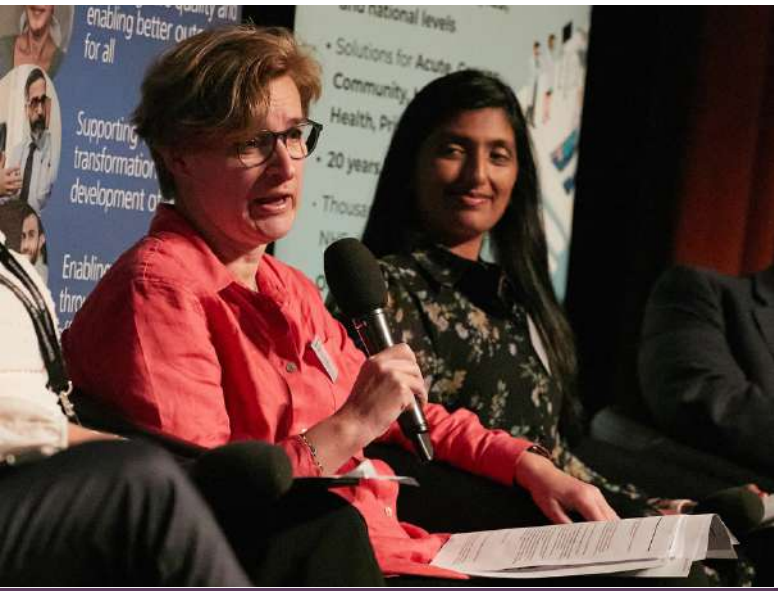
Frameworks for representation

> ***Many systems are grappling with interconnectivity between integrated care partnerships and the board and provider collaboratives, and these dynamics have yet to be formalised in a way that works for systems.***

Yousaf Ahmed, Chief Pharmacist and Director of Medicines Optimisation, Frimley Integrated Care Board

When asked how ICSs can ensure the representation of social care and the VCSE sector at the top table, panellists discussed some of the approaches that have been taken by systems across the country. It was clear that in large part, the dynamics between social care, the NHS and primary care are yet to be formally established. How these relationships develop will vary across the country according to the needs of each system, but many approaches will be replicable across different ICSs.

Speaking in London, Yousaf Ahmed, ICS Chief Pharmacist and Director of Medicines Optimisation at NHS Frimley ICB, said: "Many systems are grappling with interconnectivity between integrated care partnerships and the board and provider collaboratives, and these dynamics have yet to be formalised in a way that works for systems. The paradigm will be markedly different depending on the system."



At this nascent stage of ICS development, and resulting from the government's minimalist approach to statutory frameworks, there is already significant divergence in who is represented at the top level of England's 42 ICSs.

Professor Vic Rayner OBE, Chief Executive of the National Care Forum (NCF), explained that despite being told "that local systems will do the right thing and bring in social care provision… most ICSs that the NCF has been working with our membership around don't have proper social care representation within those ICPs or ICBs. They may have local authority representation, but they aren't the ones who are providing, developing and delivering social care."

According to Professor Rayner, "a proper partnership going forward has to have a more structural framework that requires both the voice of the people who are providing services, and indeed, the voice of people who are receiving those services."

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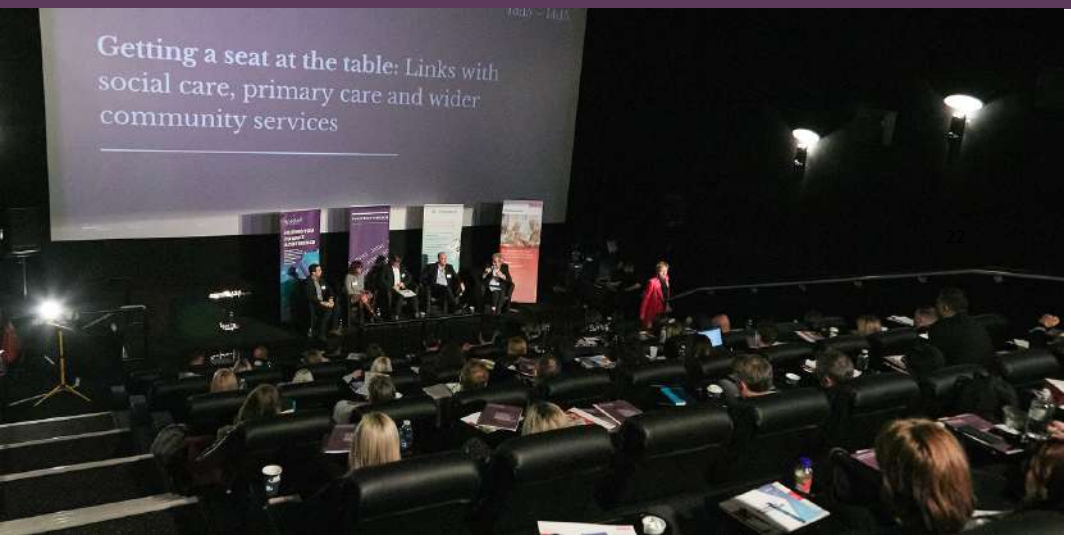
Professor Vic Rayner OBE, Chief Executive, National Care Forum



We are trying to incorporate VCSEs at all levels

Dr Jeff Farrar, Chair of Bristol, North Somerset and South Gloucestershire ICB

In Bristol, Chair of the Bristol, North Somerset and South Gloucestershire ICB, Dr Jeff Farrar, explained how his team had worked to establish "inclusive structures" that ensure that as many parts of the system as possible are represented at the top level; "We've got a large integrated care board, and we've also got a large integrated care partnership", said Dr Farrar.

"We are trying to incorporate VCSEs at all levels", Dr Farrar continued, and with eight out of 29 seats on the ICP reserved for the voluntary sector, the ICP's composition goes beyond the statutory requirements imposed upon it by the centre. In addition, the ICB, chaired by Dr Farrar, includes representation from the Chief Executives of all providers working within the ICS – something that Dr Farrar conceded was "quite fortunate" and could not necessarily be replicated across every ICS.

However, this approach will not work for every system. As expressed by Deloitte Partner, James Banham, having too many partners around the top table can create a structure which is "unwieldy and utterly unmanageable".

However, Banham was keen to warn against an overreliance on former CCG leads filling positions in ICBs and called for ICSs to be "brave and bold" in securing even representation.

Panellists agreed that it would be unrealistic and undesirable to have each individual care provider sitting at the top table, and instead shared examples of frameworks which can facilitate sectoral representation without sacrificing the ability to reach consensus decisions.

Offering another perspective, Professor Vic Rayner added: "I'm not advocating having 17 social care providers round the table – there are structural ways to do this. Local support organisations are one of those, local care associations are another. ICSs will have to follow these organisations to support that representation."

Whether this representation should be imposed from the centre can be debated, however, a key recommendation of PPP's *ICS Futures* report published in 2022 was that government should mandate the involvement of social care providers on ICPs, rather than giving this responsibility solely to local authorities.[6]

At the London ICS Roadshow event, Dr Khyati Bakhai, Primary Care Lead at Tower Hamlets Primary Care, discussed the work of the Tower Hamlets Together Board, a structure that had been in place for several years before ICSs, came into existence. Dr Bahkai explained that the Board, which reports directly to the Northeast London ICB, "has grown from partnership and collaboration with various local stakeholders", and now features "representation on the board from secondary care, the local mental health trust and community health services, from public health, primary care, social care and more."

This proxy representation at the top table of the ICS has allowed Tower Hamlets to respond to local concerns with coherent, integrated strategies and Dr Bakhai explained that "through this collaboration, we were able to bring together other stakeholders, including housing authorities and public health" to help address the wider determinants of ill health in the borough.

Following the tragic and much-publicised death of a young child with asthma in Tower Hamlets, the partnership was able to reduce the number of emergency admissions for asthma in the borough by 15 per cent within 12 months; "We were able to look at asthma in various ways, such as looking at the impact of air quality, looking at the impact of housing on the condition, looking at the emotional wellbeing aspects around asthma, and looking at improving undiagnosed asthma so that we're not seeing the first presentation when [people] attend A&E in a crisis. And this absolutely would not have been possible without an integrated care team looking at this."

Similarly, Jim Barwick described how Leeds' Local care partnerships have expanded on the remit of Primary Care Networks to work at neighbourhood level (covering roughly 30-50,000 people), collaborating with local pharmacies, the third sector, mental health bodies and all of the local statutory organisations as one.

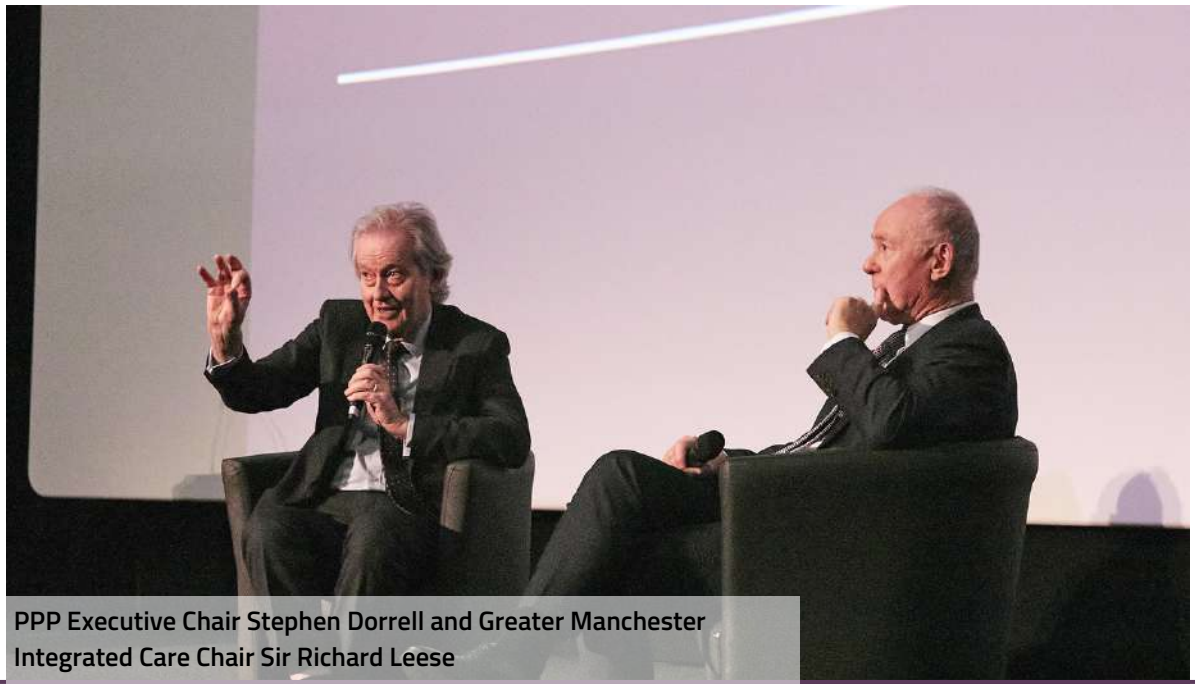
> ***Half of Greater Manchester now has wholly integrated adult care with primary care operating on a neighbourhood basis, the key ingredient has been bottom-up locality, place-based decision making, not top down.***
>
> **Sir Richard Leese, Chair, NHS Greater Manchester Integrated Care**

Speaking in Manchester, Sir Richard Leese, Chair of NHS Manchester Integrated Care, shared some of the outcomes stemming from the devolution of powers to Greater Manchester in 2015, often referred to as 'Devo Manc'.

This was designed to position health as part of a broader public sector reform package, although it does not include the acute sector.

Devo Manc allowed Greater Manchester to integrate many of its health and adult social care services even before the national rollout of ICSs. "Half of Greater Manchester now has wholly integrated adult care with primary care operating on a neighborhood basis. The key ingredient has been bottom-up locality, place-based decision making, not top down" , Sir Richard said.

Just three years after devolution, "life expectancy in Greater Manchester had improved by 0.196 years compared to what would have been anticipated… [and in] the more deprived parts of Greater Manchester, life expectancy improved above what was expected, by 0.369 years – twice the national average."



PPP Executive Chair Stephen Dorrell and Greater Manchester Integrated Care Chair Sir Richard Leese

Bringing the right partners together

Ensuring the representation of other, traditionally non-health related sectors was a common topic of conversation, and largely focused on the necessary inclusion of housing in decisions around population health. Answering a question from an audience member in Birmingham on what role the supported housing sector could play within an ICS, Dr Justin Varney explained: "Birmingham is a city of 1.2 million people, and the issue is that there are many providers that don't work across the whole of Birmingham, so its size excludes some of the smaller providers; they can't get a seat round the table."

In Birmingham and Solihull ICS, the inclusion of these sectors is achieved through the collaboration between the Health and Wellbeing Board (responsible for upstream thinking on the wider determinants of health across the wider system) and the Place Boards (responsible for the integration of delivery in their locality).

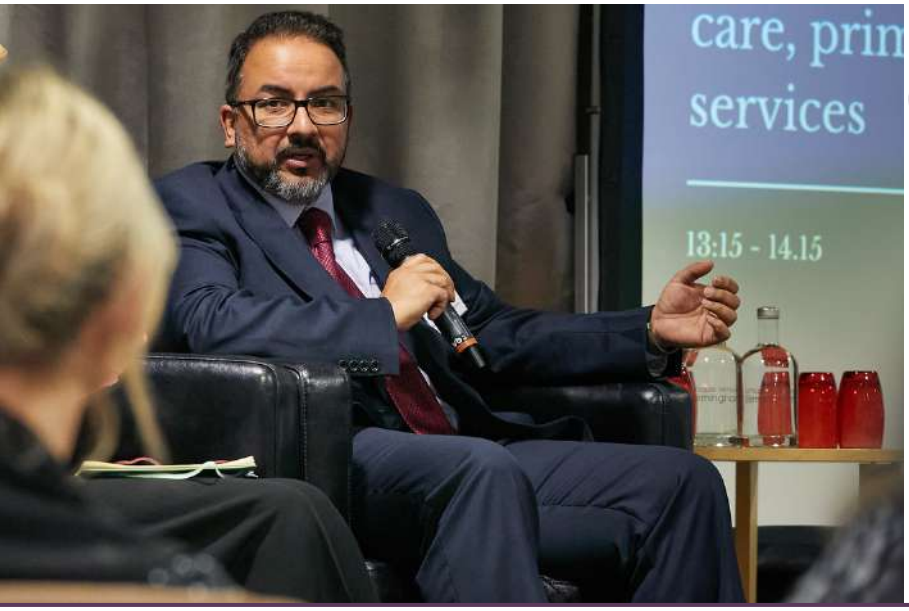
Dr Varney explained that "the Place Board is where the connection with supported housing providers and the voluntary sector happens".

Their close connection with the Health and Wellbeing Board ensures that local concerns can be addressed at the top level and that all providers, regardless of size, are represented, at least indirectly, at system level.

Also speaking in Birmingham was Dr Mubasshir Ajaz, Head of Health and Communities at West Midlands Combined Authority. He explained why it is essential for ICSs and local authorities to be closely aligned in the fight against health inequalities, emphasising the maxim that "in order to have a thriving economy, you need to have a thriving community, and vice-versa."

As a "hyperlocal activity", he argued that it is right for discussions around housing to go through the locality and place-based boards in place. However, "where there are bigger issues that are shared across the region, that is exactly where the combined authority can play a supporting role", provided there is close collaboration between the authority and its local ICS.

Dr Ajaz cited the valuable support of Andy Street, the Metro Mayor of Birmingham, who chairs the West Midlands Combined Authority as a "dynamic and recognisable" figure. Through this influence, issues such as housing, employment or transportation can be taken up at a political level, making it more likely that they will have a voice in discussions around population health.



> ***In order to have a thriving economy, you need to have a thriving community, and vice-versa.***
>
> **Dr Mubasshir Ajaz, Head of Health and Communities, West Midlands Combined Authority**

Self-organisation

As vital as a seat at the top table is, many panellists and audience members agreed that a seat without a strong voice is little better than having no seat at all. "I've sat on many boards, but as a token gesture," explained Dr Tracey Vell MBE, Executive Lead for Primary Care at NHS Greater Manchester Integrated Care. "I know many of the voluntary sector feel that they are [there] as a token gesture, and that seat may give you a voice, but the voice is drowned out by others in the room."

A frequent topic of discussion, therefore, was how individual sectors can have louder and stronger voices once at the top table. To this end, panellists overwhelmingly agreed that provider sectors must organise themselves, create a unified voice, and use this influence to push for meaningful change at the top levels. In Yousaf Ahmed's words, that means creating a "voice [that] represents not your organisation, but your profession."

In Birmingham, Dr Justin Varney noted that "in the creation of ICSs, there was a requirement to have the representation of an NHS provider collaborative", but no such obligation was put in place for the social care sector. According to one audience member who works for a care provider, this has led to poor communication from their local ICB, who have been unable to say who would represent social care at system level, other than the local authority.

In his keynote speech, Sir Richard Leese attributed much of Greater Manchester's success to the fact that "the voluntary sector in Greater Manchester has organised itself. It has a leadership group that went through a competitive appointment process to appoint the partner member on the board of the ICB."

> ***How brave are ICSs prepared to be in really empowering ICPs and place based partnerships to go beyond even all the great work they've already done, and perhaps hold even more resources, hold more budget and make more decisions.***

James Banham, Partner, Deloitte

This colloboration between systems and providers is a particularly important aspect for both parties to consider. One audience member in Birmingham, himself a CQC inspector, reminded the panel that the CQC "will certainly want to see evidence of social care providers interacting with their ICS."

While this will require some initiative on the part of both providers and systems, the incentives in terms of adhering to regulations and the benefits to population health should not be understated; self-organisation should therefore be considered essential.

> ***The CQC will certainly want to see evidence of social care providers interacting with their ICS.***
>
> **Audience member in Birmingham**

Creating a culture of collaboration

Another frequent point of discussion was the need for cultural change among the constituent parts of ICSs, to facilitate the effective integration of each player in the health and care system. If population health is to be effectively addressed, the default primacy of one sector over the others must be eschewed in favour of creating a 'partnership of equals'. In Leeds, Pearse Butler stressed the need to "break with old habits", saying: "We've spent the last 30 years competing with each other; it doesn't always feel like one system."

In Bristol, Dr Jeff Farrar echoed this sentiment, reflecting that: "If only I'd spent more time early on in my career…with other organisations, to get a better grasp of what people do." Panellists frequently noted that if the system understands what each of its constituent parts is able to do, they can be harnessed more effectively, and conversely, their limits better understood.

Professor Vic Rayner explained that during the pandemic, "care home nursing staff were not allowed to vaccinate for Covid", even though many would have been eminently capable of doing so, "and care homes received no funding whatsoever to enable the vaccine programme to happen at speed." She argued that "a proper integrated system would see these as joint community health objectives and enable the funding to flow."

In addition to the CQC's desire to see evidence of care providers engaging with ICSs, Dr Justin Varney added: "I would hope regulators will start to focus on whether the cultural shifts are still being made, [and ask] 'have you got integrated leadership training'? For years we've had the Nye Bevan programmes supporting leadership in the NHS, but they've been purely for NHS staff."

> ***People around the boardroom must better understand what other sectors are, what they can do, and what restrictions they operate under.***
>
> **Dr Tracey Vell MBE, Executive Lead for Primary Care, NHS Greater Manchester Integrated Care.**

> ***A shift towards collaboration would also help to promote a culture of collective responsibility, in which each sector understands that they have a role to play in combatting health inequalities and is invested in doing so***

Accordingly, panellists agreed that creating a culture of collaboration should see ICSs implementing integrated, cross-sectoral leadership training. According to Dr Tracey Vell, this would "make people around the boardroom understand what [other sectors] are and what they can do, and the restrictions" on them, facilitating better decision making and resource allocation.

In their efforts to deliver a range of perspectives among the leadership, Dr Farrar explained that the chairing of the Bristol, North Somerset and South Gloucestershire ICP is done on a rotational basis. The ICP is "chaired this year by the Chair of the Health and Wellbeing Board in North Somerset, and [the chair] will pass to the Bristol Council next year and then to South Gloucestershire Council."

A shift towards collaboration would also help to promote a culture of collective responsibility, in which each sector understands that they have a role to play in combatting health inequalities and is invested in doing so. James Banham spoke on his vision of arriving at "a situation where if there is a problem on the table, everybody around that table genuinely feels like it is their problem, and they have a contribution to make to help solve it."

This was echoed by Tunstall's Graham Brown, who argued that "genuinely shared and committed outcomes…across the entire organisations involved, are absolutely vital." As explained by Palantir Strategist, Indra Joshi, "people will be willing to change if they know others have got their back when they make those changes. Hopefully the structure of ICBs allows people the confidence that the budget, the data infrastructure and the workforce infrastructure has allowed them the air cover to make that change so they may be less hesitant."

Conclusion: Representation is through having a voice, not a seat

Fundamentally, an integrated care system that is geared towards tackling population health would see each part knowing its role and having appropriate powers vested to them to achieve those ends.

The title of this session, 'Getting a seat at the table', was designed to frame a debate about structure, of place-based decision making against aggregation and scale. While there are still fundamental tensions around these issues that run across ICSs in the country, the recurring theme that come from each of the five panels was the importance of having a 'voice', rather than simply a seat.

These structures are mandated to reflect a broader range of service provision but is this true representation? Is this a collaborative partnership? Are each of these partners truly empowered to achieve system-wide population health objectives? And is the ICS coming to represent, in Sir Richard Leese's words, a "coalition of the willing" as well as a 'partnership of equals'?

Dr Tracey Vell was quick to dispel the importance of "seats and tables" in favour of something more fundamental. "This issue is much deeper than just having a seat, this is about bringing the voice of all colleagues in primary care, in the voluntary sector and in local government to unite and to actually connect the frontline to strategy. As a token gesture, a seat is useless if it your voice is drowned out by others and does not come with inclusivity and parity."

> ***ICSs can only have true impact when they get down to place and neighbourhood level and start examining specific problems***
>
> **Graham Brown, Marketing Director, Tunstall Healthcare**

This issue is much deeper than just having a seat, this is about bringing the voice of all colleagues in primary care, in the voluntary sector and in local government to unite and to actually connect the frontline to strategy. As a token gesture, a seat is useless if your voice is drowned out by others and does not come with inclusivity and parity.

Dr Tracey Vell MBE, Executive Lead for Primary Care, NHS Greater Manchester Integrated Care.

Ensuring each partner has an equal 'voice' means ensuring that they are included in discussions outside of the board room, that they are truly involved in a co-production process rather than hearing about proposals at the high table where they are already outvoted.

ICSs must be brave to ensure the right voices are being positioned correctly. As stated previously, an estimated 80-90 per cent of health is not driven by health care, but wider, external factors. As such, it is vital that the upcoming Hewitt Review recommends broader representation of traditionally non-healthcare related sectors within ICSs, while encouraging mechanisms to improve care delivery extending beyond nationally mandated targets (which tend to prioritise secondary care).

The extent to which ICSs are able to create a true 'partnership of equals' will be dependent on how much freedom they have to deviate from the centre. What was encouraging throughout the Roadshow was the different ways in which ICSs are looking to bring different sectors together, but there remains fundamental obstacles and constant tendencies to create ICSs as, in Dr Justin Varney's words, "different shades of NHS blue".

Left to right: David Duffy, Head of Content, Public Policy Projects, Dr Tracey Vell MBE, Executive Lead for Primary Care, Greater Manchester Integrated Care, Graham Brown, Marketing Director, Tunstall Healthcare

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