The New NHS: ICS Series – systems and governance in an integrated care board

Kathy McLean, Chair-designate of the Nottingham & Nottinghamshire ICB
Catherine Mountford, Director of Governance for Oxfordshire CCG

How do ICS leaders ensure that the four aims of integrated care – improving outcomes, tackling inequalities, enhancing productivity, and promoting social and economic development – are not lost in the complexity of bringing together multiple sectors, each with their own distinct agendas, to address numerous health and care challenges with limited resources?

This was the question at the heart of the discussion during the first of GGI's new series of ICS webinars on Wednesday this week. The session, on 'systems and governance in an integrated care board', focused on two ICSs – Nottingham & Nottinghamshire, and Buckinghamshire, Oxfordshire and Berkshire West (BOB).

Chair-designate of the Nottingham & Nottinghamshire ICB, Kathy McLean, said her ICS's approach was based on an inverted pyramid of priorities, with citizens at the top, provider collaboratives and place-based partnerships in the middle and the integrated care structures themselves at the bottom. She said: "It's important that the ICB becomes an enabler rather than a hierarchical part of the structure. This has governance implications and will be one of the hardest things to implement.

"The ICB is a new statutory organisation that will take on a huge number of CCG functions as well as devolved NHSE functions. And it will have new functions and duties too – such as collaboration and integration. We must have new ways of working. One of the key things will be not transferring CCG thinking into this new world. If we don't do that through collaboration, integration and shared responsibility – organisations without walls and boundaries – we will not succeed in the four aims."

One of the key principles for ICB members to grasp, she said, was that they were not there to represent their sectors. She added: "These are unitary boards so it's about the board members collectively and corporately being accountable for the system. We must make decisions as a single group and share responsibility and liability for those decisions. That's different to anything we've known working in trusts."

Catherine Mountford, Director of Governance for Oxfordshire CCG but also leading the development of governance for the BOB ICS, said this new way of working requires new levels of engagement. She said: "It's easy to draw the boxes and the lines of an ICB and start populating them but actually the discussions, the relationships – what are we trying to do with whom; how do we make it as lean and effective as possible and minimise duplication? – require engagement and discussion to bring our partners on the journey with us.

"We must listen to their views, understand what their perspective is, share our understanding of what the ICB is and what it isn't, and the role of the board in that, and how we're going to reflect on what they say to us and use it in our decision-making.

"We're using this as an opportunity to challenge our thinking about what we deliver and make sure we're defining things right. In our area we have occasionally muddled up our executive delivery and our assurance and our performance management into single groups so we're no longer sure of which hat we're wearing."

Another great challenge – and opportunity – facing ICBs is the duty they have to look beyond the traditional healthcare remit and address the wider determinants of health. One questioner asked how ICBs should set priorities for spending to diminish demand – and thus release capacity.

Kathy McLean said: "Our huge challenge is finding the bravery to move resources from one place to another. Most of our patches will have quite a few years between healthy life expectancy of various groups. Between us and local authorities we can pool budgets, do things together and have faith in really shifting things.

"One of the things I want us to focus on is our outcomes framework. I want us to be really clear about what outcomes we want to see. Some people will say it's going to take years before you see any change in life expectancy, but there are proxy measures that show if you do the following things, you will get there so I want us to be very focused on these measures.

"Some courage will be needed from somewhere to test this and see what happens – legally and in other ways – when you shift resources in an über-commissioning way but do it at place, do it at the neighbourhood level so it's very specific to populations. It's an interesting area and in a way it's why we're there."

Catherine agreed, adding: "We must also understand the inequalities beneath the outcomes. It's good to address this at a very local neighbourhood level with local authorities to figure out who the people are who most need support and work with partners on the best way to provide it. Let's not increase average life expectancy by helping the healthy to get healthier, let's target those who need it the most. We can only do that by working together."

The months ahead are filled with challenges, but with possibility too. As Catherine said: "All of this is happening before we've established statutory organisations – we're working with a chair and chief executive-designate but not a full board so everything we're doing is subject to legislation and change.

"These are very interesting times full of great opportunities. The flexibility we need is both enabling and a bit frightening. I think it's always important to go back to the objectives of what we're trying to do. If it's not supporting integration and reducing inequalities, then we're not doing it properly."

The next webinar in the New NHS: ICS Series on 16 February will focus on a case study 'Surrey Heartlands: An established ICS adapting to change'. We will explore the distinct function between an ICB and an ICP and sustaining and maintaining momentum as timelines change. Find out more on our events pages.

Here to help

Negotiating this immediate period of set-up, challenge and change calls for the sort of expert support that the Good Governance Institute is providing in systems already. With more systems on board, we can help share best practice and learning and improve delivery.

We have contributed to the national conversation on integration and can see its potential and understand how it can be achieved. We bring extensive experience of working with non-NHS partners in integrated care systems: education, third sector, local government, hospices, and the private sector. And no one understands core NHS governance better than us.

We are independent, thoughtful, ethical and practical. This is what is needed to work through the foundations of system success. We understand where we can enhance and complement what you are already doing, and where it is best to leave things up to you.

We can add real value at a time when it is needed. And we are ready to help.