

# Future systems leadership scoping project

Clinical leadership

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# About

This paper considers how to enable and facilitate multi-agency, multidisciplinary clinical leadership within integrated care systems.

The NHS Confederation is the membership body that brings together and speaks on behalf of organisations that plan, commission and provide NHS services in England, Northern Ireland and Wales. The members we represent employ 1.5 million staff, care for more than 1 million patients a day and control £150 billion of public expenditure. We promote collaboration and partnership working as the key to improving population health, delivering high-quality care and reducing health inequalities.

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# Introduction

Integrated care systems (ICS) are ‘partnerships that bring together providers and commissioners of NHS services across a geographical area with local authorities and other local partners, to plan and integrate care to meet the needs of their population’.<sup>1</sup>

The [NHS Long Term Plan](#) set out a vision for ICSs to be established across England by April 2021. Within the NHS Long Term Plan, ICSs are described as ‘a pragmatic and practical way of delivering the ‘triple integration’ of primary and specialist care, physical and mental health services, and health with social care.’<sup>2</sup> NHS England and NHS Improvement [published a document in November 2020](#) outlining options to allow ICSs to have a statutory footprint in legislation, with an aim to take effect from April 2022.<sup>3</sup> These proposals sit alongside other recommendations aimed at removing legislative barriers to integration across health bodies and with social care, to help deliver better care and outcomes for patients through collaboration and joined-up national leadership.<sup>3</sup>

The policy paper *Integration and Innovation: Working Together to Improve Health and Social Care for All* was published in January 2021.<sup>4</sup> It describes the legal framework for integrated health and care services. Each ICS will be made up of an ICS NHS body and a separate ICS health and care partnership, bringing together the NHS, local government and partners. The ICS NHS body will be responsible for the day-to-day running of the ICS, while the ICS health and care partnership will bring together systems to support integration and develop a plan to address the system’s health, public health and social care needs. ICSs will be accountable for outcomes of the health of the population.<sup>4</sup>

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# Context

Clinical and professional leadership is key to enabling the vision for ICSs, both nationally and locally, and will be critical in converting the strategy into meaningful delivery.

To be effective, it is essential that the clinical and professional leadership component within each ICS establishes a leadership triumvirate of managers/clinicians/lay. This scoping report is specifically focused on the clinical element of this triumvirate. It considers how to bring together the different facets, in order to enable and facilitate multi-agency, multidisciplinary clinical and professional leadership within a collaborative functioning unit. This unit as a standalone can provide the clinical and professional oversight to activity and governance within a system, but in combination with managerial and lay leadership, forming part of the overall multi-professional 'governing body' of the ICS. Diversity of skillset and expertise that is truly representative and understanding of local need is fundamental.

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# Aims

1. To determine challenges encountered and foreseen in ICS development and consider solutions.
2. To explore and understand best practice examples.
3. To explore and establish the structure of emerging ICS leadership models.

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# Methods

Individual virtual interviews with national leaders and system leaders predominately, but not limited to, south east England were carried out using Microsoft Teams over 2020/21. A range of leaders from different areas were consulted, including primary care, secondary care, public health, social services, nursing, pharmacy, ambulance services, children and young people (CYP), mental health and allied health professionals (AHP)s (see Appendix 1 for full list of contributors). The same questions were used for each interview to provide a basis for discussion, but the direction and content varied depending on contribution and background. The comments and discussion points were analysed and common themes drawn out.

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# Common themes

## System leadership is different

System leadership requires different skillsets from other types of leadership and requires allegiance to the system.

The ICS needs experienced people who understand the leadership process. A talent management approach with succession planning is crucial.

The ICS should empower leaders and give them accountability, responsibility, and support to follow through on plans. Celebrating small victories is good:

“Need to remember where you’ve come from and what you’ve achieved and the journey.”

“Need to spend time thinking about the system, the way the system works and how the system can be improved.”

## Culture and relationships are key

An open and inclusive culture is vital to foster strong relationships and build trust. There needs to be shared vision and values, and quality needs to be at the forefront, with the focus moved away from finances and targets.

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“Culture, behaviours and relationships trump process all day long.”

Developing and establishing relationships takes time. From this, trust develops. Consistent senior leadership and continuity of voice can help with developing relationships. Organisations must commit to shared visions and priorities and take collective ownership.

When organisational priorities differ, relationships can become strained with the risk people retreat into their organisations. Good relationships and communication are key to help overcome this.

## The working model must be efficient multidisciplinary (MDT) working

All healthcare professionals involved should work in equal partnership as part of a collaborative health and social care team. More efficient working includes:

- 1) care closer to the patient
- 2) clinicians involved in decision-making and transformation
- 3) accountability to decisions and finances.

There needs to be joined-up and holistic care: for example, health and social care and councils, and police and prisons and dentists.

“Birds flying as one, not herding sheep.”

Primary and community care leadership needs to have a voice at system level, and therefore systems need to find a way to facilitate this.

Social services and the NHS should focus their integrated efforts on areas where they overlap, understanding that this is not just

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hospital discharges. There is a need to focus both on how the NHS can help social services and how social services can help the NHS.

## Organisational memory

Local authorities already have health and wellbeing boards that create a strategy at place level. ICSs should have a bottom-up approach to integration and remember the work that has been done before, rather than starting from scratch.

There is a risk of change fatigue within local authorities and the case needs to be made for why working within these new arrangements is a good use of time and resources.

## The population must be at the centre

Vision and goals for the ICS must reflect the population needs and priorities and include proper patient and public involvement. Different demographics and populations across the ICS mean it can be hard to create a shared vision and can be more difficult to collaborate. Wide geography is also a barrier.

“Good leadership models fit to what the patient requires.”

The ICS must recognise the interplay and relationships between neighbourhood / place / system leadership.

“A system that doesn’t recognise that and doesn’t facilitate a way of making this work will not be as effective as one that does.”

Local authorities are run by politicians. In systems with multiple local authorities there may be different political priorities and tensions at system level. Where decisions are made at a

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system level, rather than place, there should be a clear rationale and it should not damage place.

Directors of public health (DPHs) can help give systems a population-wide view and this would be helped by senior public health representation at board level.

The voice of social services is important as they understand the needs of the citizen as part of the social model of care, embedding a strength-based approach in their practice.

## Workforce challenges including diversity and representation

There is a concern that staff feel displaced by restructuring to an ICS and that there is a lack of understanding about the role of each different ICS team member. There is also a risk that some staff in historical leadership positions may lose their roles. There is a general lack of professional pride among younger colleagues and disenchantment with the NHS, which needs addressing. The team must feel valued, and roles should ideally be filled locally where appropriate, using a local talent management approach.

“Looking after staff is key.”

Diversity and broad representation are essential. There needs to be diversity of representation at all levels which should reflect the population served, and this should be structured into the ICS model.

## Communication

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Communication is fundamental to effective clinical leadership and applies at all levels and through all vertical and horizontal components of system working.

Disconnect is most prominent in the lack of linking between primary and secondary care. However, it is important to recognise that there are a number of different multidisciplinary interfaces with potential for disconnect.

COVID-19 has provided an opportunity to respond to a mutual agenda with pace to match demand. There are examples where it has been hugely beneficial to collaboration:

“The pandemic has sparked the momentum to develop new pathways and decision-support tools at a rate and scale that would normally have taken months.”

Although remote working has facilitated communication and team working during COVID-19, there is also acknowledgement of the benefits of familiarity and a relational approach. In Portsmouth, the co-location of the clinical commissioning group, local authority, and some of the police and crime commissioner team in the same building was helpful for building this familiarity.

## Time

Clinicians find it hard to be released to commit to ICS work. Organisations are reluctant to release clinicians, therefore there is a risk of not getting the right leadership expertise or having the right leadership expertise with the wrong time allocation. This will lead to altered prioritisation and opportunity for distraction away from delivering clinical leadership. This poses a risk to the success of clinical system leaders. Leadership should feature in the work schedule / job plan and it needs to be flexible so as not to put people off.

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ICSs need to recognise resource implications of achieving true collaboration. ICSs must support and embrace clinical and professional leaders who work less than full time.

## Training and development needs

Lack of diversity and inclusivity in leaders needs addressing, by ensuring opportunities are equal and encouraged alongside training and development in the run in to taking a clinical leadership role within a system.

Integration of leadership into the curriculum at undergraduate and postgraduate level is crucial.

Leaders need relevant leadership support and development. For example, a forum for system leaders to learn from each other and develop and share new ideas. Creating a space where leaders can come together to discuss ideas is beneficial.

“Leaders need to keep improving and learning on the leadership journey.”

Leaders learn by talking with others about what others have done.

“What we got wrong is as valuable as what we got right.”

Other forms of leadership experience can complement formal training:

“Mentoring and courageous conversations and coaching are often better than a leadership course.”

Secondments and shadowing allow for wider experience and learning from different areas. It is crucial that the different ICS

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members understand each other's roles, including agendas and accountability, to facilitate collaborative working. Perhaps taking a:

“...walk in each other's shoes approach.”

Leaders need to know the nuts and bolts: demand, capacity, finance, equity, activity, performance, quality. Leaders need to be able to use data to make arguments. Population health needs should drive decision-making – this is not optional. Fresh eyes and ability to speak up and provide challenge are important. Leaders must be brave and courageous and need to believe in what they are trying to do.

“Right voice and strength of voice.”

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# ICS challenges

## General challenges

The journey towards ICS working is becoming clearer now that ICSs will have a statutory foothold in legislation.<sup>3,4</sup> However, there are still challenges with communicating to the wider workforce the rationale and benefits for moving to an ICS model.

Healthcare professionals require clarity around the differences that exist between an ICS and the current model. Many are not confident about what the powers and responsibilities of the ICS are and how the ICS will yield the power. There is a common view that there is a lack of clarity around statutory responsibilities and concerns that an ICS might be seen as a tick-box exercise.

It is likely that as legislation is formalised and systems evolve, these elements will become clearer and understanding where the responsibility lies at system, regional and national level can be identified and communicated with ICS clinical leads and all health and social care staff.

The ICS must have simple layers / structures so it can be easily used and understood. There must be clarity around what powers it has – in what areas is the ICS autonomous and which decisions the ICS can formally endorse. The ICS needs to engage with frontline workers to communicate the ICS vision and ensure buy in from the wider healthcare team.

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“It is essential that everyone working in the ICS understands and recognises the drivers and constraints of the people they are working with.”

All ICS members need to recognise the perspective of others, provide empathy and understanding, red lines, drivers and respect. It is vital to avoid structures that might hinder this, such as disabling structures.

“ICSs are not high on the agenda for trusts. We need to make it clear they are welcome around the table and that it’s relevant to them.”

There is a concern from social care that they are seen as the lesser partner to the NHS. Too often, the discourse around health and social care integration has only focused on hospital flow and discharges.

There were concerns that some of the considerable partnership working built during the pandemic may be lost, as meeting statutory requirements for ICSs becomes all-encompassing or that acute pressures on the NHS would take up all of the system’s time and resource.

Systems must not just describe issues, they also need to get organisations to change what they do and move resources to enact change.

## One size does not fit all

Leadership structures within an ICS need to take account of the differing numbers and structures of local authorities within each system.

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Unitary authorities are often very self-contained, with boundaries mapping to those of provider organisations. Large county authorities have more providers to interact with for one population, and the two-tier structure may make engagement more difficult.

It is important that district councils are involved within the system as early as possible and that leadership structures are in place for them to have their voice heard. A clear local plan is needed with the districts engaged in this.

## Local authority board representation

There is a concern that local authorities may need equivalence at board level, which the mandated two local authority members of the integrated care board would not allow.

Different systems are thinking about how to achieve this representation. Although the intention is that people are selected based on the qualities they bring to the board, rather than representation of their local authority or profession, in reality individual local authorities may perceive these board members as their representatives.

It is important that systems take a population-wide view, and public health representation at the top level would facilitate this. Structures will need to be created to allow multiple DPHs to feed into system-wide thinking.

## Individual leader challenges

Leaders may have a conflict of interest or may focus on prioritising their own clinical areas.

“Chairing feels like being a translator or a UN peacekeeper.”

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The correct leader needs to be identified, one with good negotiation skills and influence. Leaders must understand data use and make complex decisions on best available evidence, not anecdotes.

There are concerns that the leaders on the top table have often been in place a long time and there must be opportunities for new leaders with new ideas to join the top table.

“Clinical leadership should be seen as a career choice rather than an additional interest.”

## Financial challenges

Primary care providers are often challenged as individual businesses, compared with acute trusts with substantial budgets and different approaches to money. This often causes tension between primary and secondary care. A general lack of understanding around funding and historic spending models also contributes to this tension.

Managing finances between NHS and local authority at a local level may be more fluid than centralising this at a system level. There is a need to reduce bureaucracy and recreate dynamic and well-connected leadership centrally to continue with momentum so far.

How can we effectively risk share across organisations and embed this within local plans where it is of benefit to the system?

# Discipline-specific themes

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There is a desire for each sector to have a voice at the top table within the ICS. While acknowledging this aspiration, it is important for each system leadership team to construct its own board in a way that keeps it functional as well as representative. Therefore, there needs to be secure systems in place to achieve this. Each ICS will need to be flexible and the individual structure should not be too prescriptive, as this must be determined by local need.

**Pharmacy:** Involvement of pharmacists at senior leadership level is essential, including active pharmacists' networks and medicines optimisation workstreams, as well as ensuring local professional accountability.

**Public health:** The focus on population health management is really welcomed and public health has the ability to lead on population health interventions, both primary and secondary. There may be opportunity to commission section 7a services at system or place level, with this more integrated approach allowing places to make plans for populations with, for example, low screening or immunisation uptake.

In systems with multiple DPHs, it may be that not all are represented on the ICS NHS body. Although they will be expected to provide public health leadership, it is possible that they will still be seen to represent their own place, and therefore work will be needed to ensure each local authority has equivalence.

**Children and young people (CYP):** There should be a sub-system for CYP within each ICS, including an identified clinical lead for child health. This must be a broad network bringing together health, social care, psychologists and education authorities. The CYP voice is key to identifying motivations and needs of the CYP population.

The standard for children's services between places are very different but they are still under pressure to deliver. The case will need to be made for what the advantages would be in those places

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that are performing better than the wider system for why they should invest time into it, and how this will make a real difference for children's outcomes.

**Ambulance services:** Ambulance services must be integrated into the team and should have representation at a senior level within the ICS. Adequate integrative IT software is needed to access information on different platforms and across providers.

**Nursing:** There needs to be adequate senior representation of nurses on ICS boards, including both community and hospital-based nurses. Role requirements should reflect the broad diverse skillset of the nursing profession.

**Mental health:** Mental health should be a top priority at any ICS discussion. Service users and carers should be represented within the ICS.

“There is no health without mental health.”

Learning disabilities need to be included as well and are too often forgotten.

**Allied health professionals (AHP):** AHPs encompass 14 professions and it is a challenge to represent all these different voices. There has been a recent national push for AHP leadership to align with medical and nursing leadership. AHPs have a lot to offer the ICS and need to have an opportunity to showcase their expertise.

## Emerging practices and approaches

These broad themes were ideas and comments gathered across a number of people who provided their expertise and insights. They

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are a dynamic reflective list that could be applicable to a number of formats and frames.

## Clinical leadership groups

- Medical and nursing directors, AHP leads, chief pharmacists, community leads, social care.
- Focus on form and the required skills/roles needed in order to deliver best care for patients. Focus away from traditional organisational leadership roles and look at need and who is best placed to fill the need.
- Advisory groups: not responsible for directly making decisions but rather focus on a range of ICS topics and feedback from individual workstreams.
- Collaborative groups making decisions: these feed into the ICS board, which feeds into the ICS clinical leadership group/s. For example, mental health collaborative, acute care collaborative, primary care and community collaborative.
- Cross-system groups: a powerful way of enabling peer learning from others and influence at the regional or national interface. For example, a pan-south-east region medical director (MD) group where MDs can share ideas and best practice.
- Allow for planning organisational development work and ensures everyone is on the same page.
- Need to know what autonomy they have and what needs formal endorsement / sign off.
- Roles and responsibilities: what roles sit at provider, place, system and region, and how they work together.

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## Enabling workstreams

- Digital
- Workforce
- Finance
- Estates
- Interface working group to improve relationships between primary, community, mental health, social and secondary care
- Public engagement

## New ways of working

- Regular online virtual team meetings to bring leaders together to share information and ideas. Created in response to COVID-19, but highly beneficial and likely to be continued in the future. For example, the Sussex, Kent, and Hampshire and Isle of Wight MD groups meet weekly.
- Some systems, prior to COVID-19, were adopting a half-day release every month where the ICS board members would meet to explore ways of working and their values.

## Webinar Wednesdays

- Webinar, open to all in the ICS to join. Each speciality / area takes it in turn to host. Discuss different topics relevant to the ICS, leads to ideas generation and develops relationships. Acts as a space for share and tell, fosters visibility and an open culture.

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## Vertical layers of clinical leadership

A multi-layer approach to leadership across the system is vital as this allows for a link between provider leadership and system clinical leadership. Furthermore, this allows for orchestration of the provider relationships.

For example, this is the case in Sussex (see Appendix 2 for details on the New Sussex Model).

## Clinical forums

A group of wise people, not a committee as such. Open, safe forum between primary, secondary, mental health and community care. Mediated so that challenges can be discussed. Take on a different topic each month that allows others to see what's going on and meaningfully feed into the ICS. Senate approach allows people to dip in and out to what is live.

## Clinical cabinets

Some areas are forming clinical cabinets. These can function as topic-specific task-and-finish groups designed to deliver to the local population. They include healthcare professionals from primary care, secondary care and the community. For example, a diabetes clinical cabinet might include an endocrinologist, a GP, a practice nurse and a podiatrist.

## Network boards

For example, in mental health, the network board includes two service users and a carer.

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ICS board fed into from different working groups:

- 1 **Clinical reference groups:** Leadership fora – discuss prioritisation and resource allocation. Multi-organisational approach rather than just commissioners. Includes admin coordination and business support. The clinical reference group then feeds into the ICS board for approval.
- 2 **People and cultures board:** AHPs, midwives
- 3 **Medicines optimisation groups:** workforce, leadership, priorities of the system.

The ICS board is made up of MDs, pharmacists, mental health nurses, social care, PCN leads. The clinical chair should be independent and remain impartial.

## MDT clinical forum

A core decision-making body on clinical issues. Considers and makes recommendations. Comprised of MDs of organisations and primary care.

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# Case study examples

## Examples of system working demonstrating effective clinical leadership in action

There are many examples of system working across England that demonstrate effective clinical leadership in action. This represents a snapshot of examples that were shared with the team writing this report.

### The Wessex model workplace exchange

The Wessex model workplace exchange was designed to allow pairs of clinicians to spend a half day shadowing each other in their respective workplaces. The model aims to build trust, develop understanding of each other's roles, and encourage appreciation and respect.<sup>5</sup> After the exchange, participants are asked to reflect on their learning and offer quality improvement ideas based on their experiences. This approach is also featured in the work in Dorset on 'walking in their shoes,' which enables professionals to build relationships through workplace shadowing.

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## Examples from London

Healthier South East London has uncovered a range of approaches outside of their geography and have learned from work in south west London. Examples that are notable from work in south west London include incorporating an ethics committee, a series of deliberately resourced and funded condition-specific networks, a clinical leadership group and a clinical senate to connect and amplify the voice of clinical and care professionals in support of system leadership. Within the south east more specifically, the Faculty of Medical Leadership and Management has been working with the South East Leadership Academy to support clinicians emerging from the COVID-19 frontline with safe-space conversations. This allows leaders to process and share the challenges and strains of leadership in this context and is reflected in Schwartz rounds which originated from the Point of Care Foundation.

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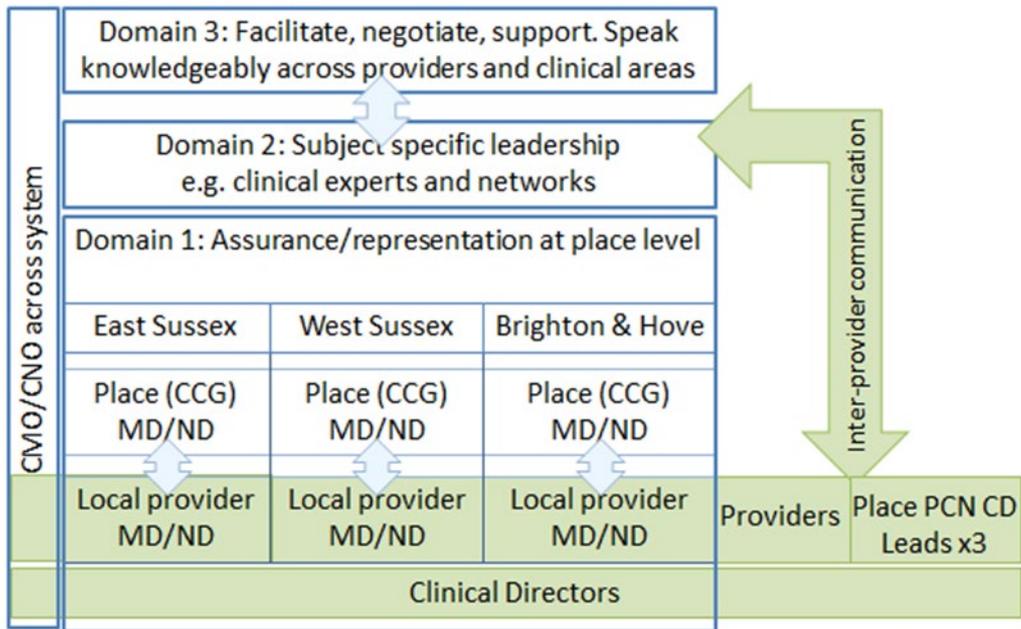
## A vision for the new Sussex model

Three domains:

- 1) Assurance / representation (at place level)
  - a. Non-executive, hold to account, represent clinicians. Not part of the system themselves. Historically GPs as CCG chairs can also be practice managers, nurses, secondary care colleagues.
  - b. Funded from governance
- 2) Subject specific (Sussex-wide level)
  - a. For example, clinical experts. Mostly consultants but also mental health nurses and AHPs. Networks, for example, cancer, respiratory, cardiovascular, diabetes. Advisory role.
  - b. Funded from ICS and networks
- 3) Facilitation / negotiating / respect (both at place level and Sussex-wide level)
  - a. Sit over the whole system, arrange deals, sell to secondary care, work with primary care, multidisciplinary. Clinically, chief medical/nursing/pharmacist/AHP officer roles  
Coach / referee all in one. Bring generic and political skills. Leadership experience through NHS leadership modules but need time to do these.
  - b. Funded from the CCG

1.6 million population across Sussex – 13 facilitators / negotiators needed. Each would work two days a week in leadership.

(See diagram below.)



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# Frimley Collaborative

## Frimley ICS partnership board

System leaders across various disciplines.

Commissioners, local authority, lay, PCN leads, MDs, chief nurses. Sets strategy / agenda / vision / tone / gives permission.

Delivery at sub-committees at place level:

- Clinical reference group. Senior medical directors. Set clinical strategy – GPs and clinical pathways.
- Reducing clinical variation workstream. Primary and secondary care.
- Health and wellbeing alliance.

The Frimley Academy is an education programme created to bring aspiring leaders together, working across multiple professions to unlock potential in local communities.

Aims / core features:

- 1 Develop culture that allows for improved patient and community health and care outcomes. Feel valued.
- 2 Leadership interventions.
- 3 Clear path to sustainable improvement.

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## Frimley Collaborative: continued

### **Frimley local patient perspectives**

Five-year strategy developed with local residents. Hundreds of residents went through 'inspiration stations' to choose the following topics to focus on in their area:

- Starting well
- Focus on health and wellbeing
- Community deal
- Focus on our people
- Culture leadership (academy)
- Value for money

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## Somerset Listening and Responding in Care Homes (LARCH) project

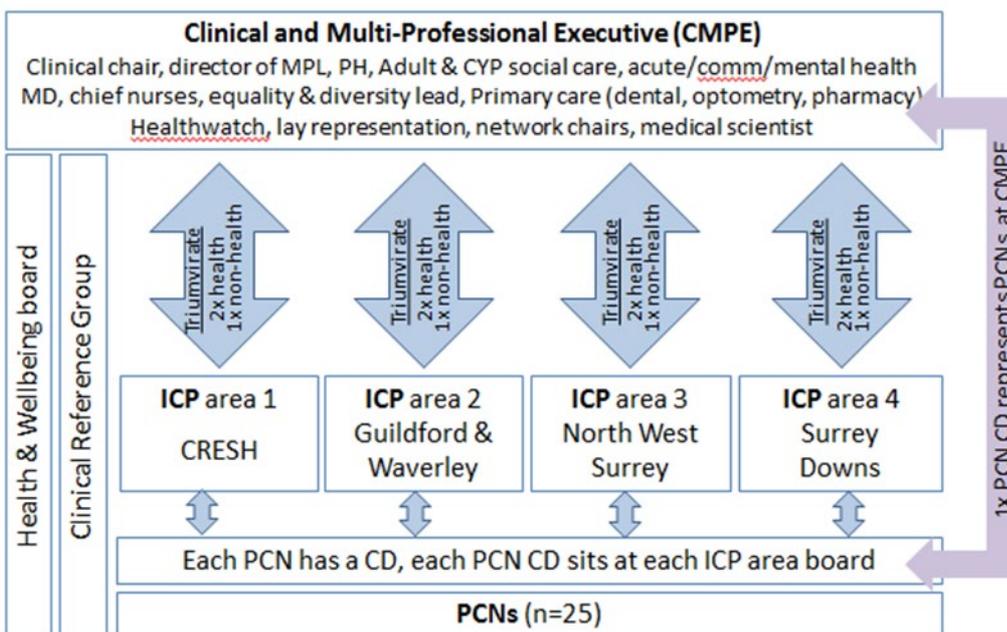
County care home team established to good effect.

- Wanted treatment escalation plans.
- Led to confidence and competence in care homes, reduced admissions by 28 per cent.
- Work included medication reviews, de-prescribing and oral hydration training.
- Collective leadership, shared decision-making and co-creating, collaborating and communicating.
- Included occupational therapists, paramedics.
- During COVID-19 everyone was recruited, connected to 200+ care homes.
- Accountable to one person, but collective leadership with trust and shared vision.
- Resource for system to support problem-solving in care homes.

# Surrey Heartlands ICS

Within Surrey Heartlands ICS there are 25 PCNs. Each PCN has a clinical director (CD) that sits at each integrated care partnership (ICP) area board. There are four ICP areas within the ICS. Each ICP has a triumvirate representation at the clinical and multi-professional executive (CMPE). The triumvirate is composed of two health and one non-health representative. One PCN CD also sits at the CMPE. The health and wellbeing board and the clinical reference group sit vertically across the ICS. The CPME has overall governance and accountability, although various functions and roles are devolved to place level, allowing time-appropriate decision-making that relates to the local population. The CMPE is a diverse multi-professional group with broad representation across the system.

(See diagram below.)



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## Nottingham and Nottinghamshire ICS

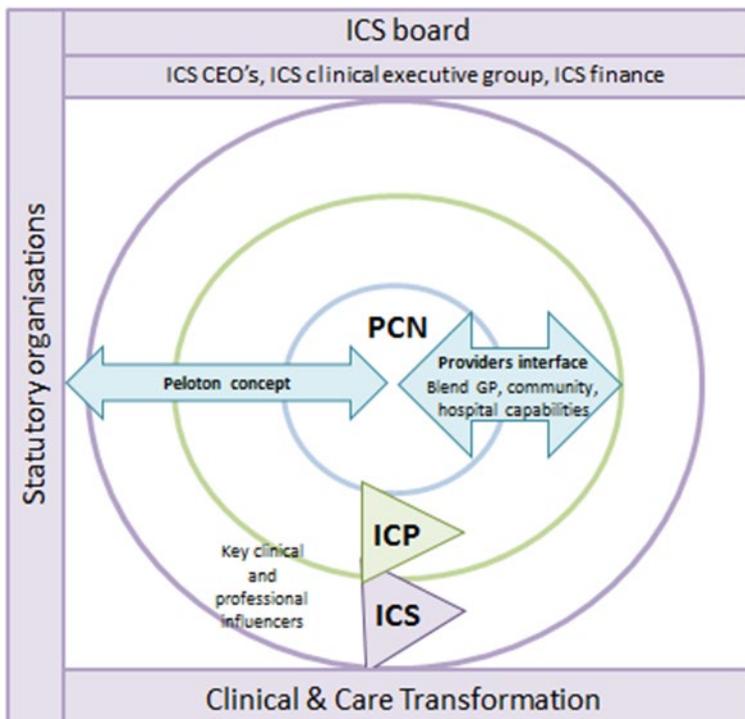
The Nottingham and Nottinghamshire ICS is built around an ICS board that has a system prioritisation model which provides the overall ambition for a collaborative structured approach to how planning and prioritisation is managed. The ICS board is composed of a number of clinical leadership groups, including the clinical executive group (responsible for determining priorities and ensuring optimal clinical population value from the available resources), the ICS CEOs and the finance group. The interface between providers and commissioners is a blend of GP, community and hospital capabilities. There are a number of key clinical and professional influencers at every level within the ICS.

The ICS refers to the concept of 'peloton'. In a cycling road race, a peloton is the main group of leading riders and teams travelling as an integrated unit whose very complex, cooperative and competitive interactions produce enormous mutual energy savings. Although the interactions between individual cyclists are in principle very simple, with each rider making slight adjustments in response to their adjacent riders, the collective behaviours of the peloton are very complex. Peloton is central to the ICS's emergence as a truly integrated healthcare delivery system and its future as a pre-eminent accountable care system.

# Nottingham and Nottinghamshire ICS: continued

Peloton is dedicated to supporting the ICS health and care providers: primary care, general practice, community services, allied healthcare professionals, specialist clinicians and hospitals, covering the entire care continuum, who have agreed to work together and accept collective responsibility to improve the quality of care delivered to patients within the resources allocated. Peloton will work with and for, the network of clinicians and support colleagues who provide care to more than 1,100,000 individuals in Nottingham and Nottinghamshire ICS.

(See diagram below.)



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## South Yorkshire and Bassetlaw ICS

South Yorkshire and Bassetlaw (SYB) ICS serves a population of 1.5 million, in five local places (Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield). The system includes 72,000 members of staff, 208 GP practices, 36 neighbourhoods, six acute hospital and community trusts, six local authorities, five clinical commissioning groups and four care/ mental health trusts.

SYB ICS identified that they had a higher than national suicide rate among men aged 30-50 years. They used system working and organisational integration to identify local need, quantify the problem, allocate resource (£555,000 allocated to mental health services in May 2018 in order to help fight against suicide) and identify key stakeholders required to deliver and coordinate services. They have established key approaches, included training staff, improved communication between organisations, a large-scale campaign on emotional wellbeing, real-time surveillance, bereavement support, work alongside the media and a retrospective coroner's audit.

This really is everyone's business and demonstrates why it is important for partnerships with the voluntary and community sector, football clubs, prisons, workplaces and increasing community capacity to reach out to those who are potentially having mental health difficulties. No one should have no one. Reducing loneliness and isolation and reducing the stigma around mental health difficulties should be everyone's responsibility as part of their own wellbeing and that of others.

The main aim of suicide prevention work is to reduce the number of suicides in South Yorkshire and Bassetlaw by 10 per cent.

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## Greater Manchester Health and Social Care Partnership

Manchester is an HM Government devolution area and it has chronologically led the way in the journey of ICSs. This undoubtedly lends itself to opportunities to learn about structure and form, but also more broadly into other aspects of integrating care. A lot of the learning from Manchester has been echoed in other case studies provided. In addition, Manchester offers a different example in a system approach to supporting an acute trust following a CQC report that highlighted need for improvement.

Traditionally, external expertise and support for an organisation would be instigated, to aim to deliver improvements in care. Instead, collective system action, drawing on local resource enabled by joint commissioner and regulator expertise is used to address challenges. A system approach will help identify and address challenges outside the organisation that are key influencers, as well as provide a coordinated approach. This points to a future in which provider failure may be seen as a responsibility of the system, rather than the responsibility of an organisation.

## Leicester, Leicestershire and Rutland ICS

Leicester, Leicestershire and Rutland (LLR) ICS is focusing on developing a culture of clinical leadership with emphasis on clinical leadership with management support. It has identified four pillars of clinical leadership:



To support this vision, the COVID-19 pandemic has provided additional challenges and unique opportunities for clinical leadership to lead system response and transformation. The clinical community identified ways of working that will drive all parts of future clinical leadership culture. The result is ten system expectations developed by the clinical leadership group and has been supported by all partner organisations. This buy-in from all stakeholders is essential for engagement and delivery of systems working.

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# Appendix 1:

## Contributors

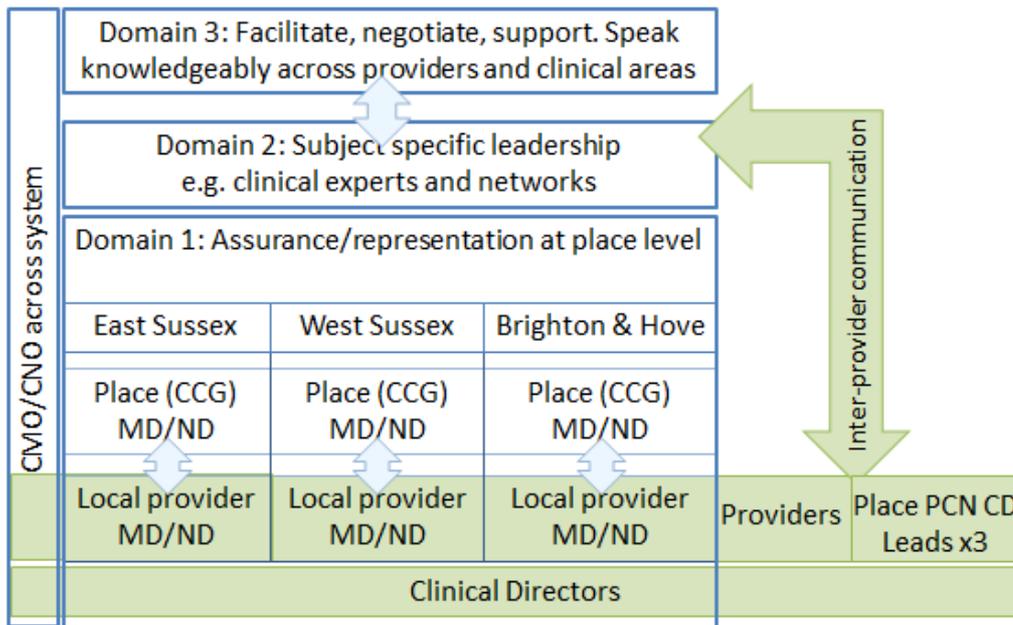
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Graham Jackson	GP Chair NHS Clinical Commissioners Senior Clinical Adviser NHS Confederation
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Navin Kumta	GP Clinical Chair, Kent and Medway CCG
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Ursula Montgomery	GP and CCAS Clinical Auditor Senior Clinical Advisor, Primary Care Provider Transformation
Carolyn Morrice	Former Chief Nurse at Brighton and Sussex University Hospitals NHS Trust
Crystal Oldman	Chief Executive, The Queen’s Nursing Institute

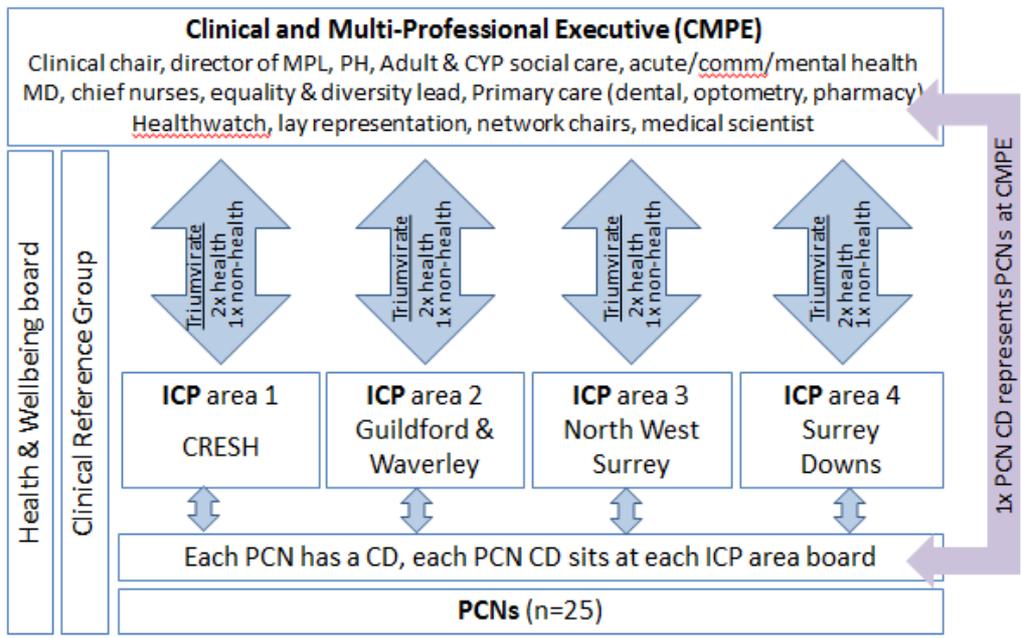
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James Williams	Director of Public Health Medway Council
Jane Youde	Clinical Director, Audit and Accreditation Care Quality Improvement Department Royal College of Physicians

# Appendix 2: Emerging leadership models

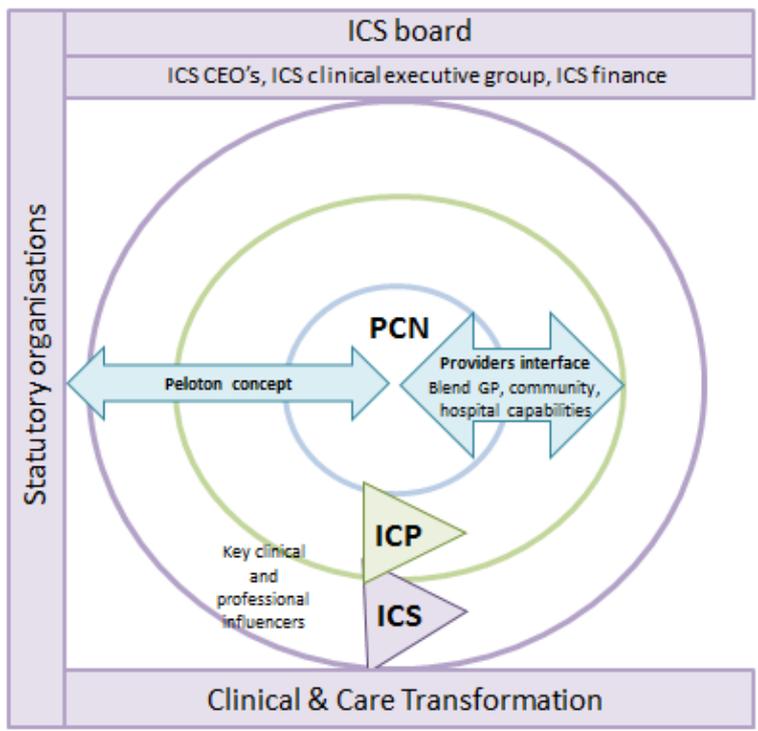
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