Becoming an integrated (accountable) care system

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ABSTRACT

This is the second in a series of three articles that explains integrated care and explores its anticipated impact on the NHS in England. This article uncovers the concept of an integrated care system. The changing terminology is first discussed, with the aim to understand what the new terminology means in practice. Then the characteristics that will make success of an integrated care system are explored, with an emphasis on leaders shaping their environment. Building on this, the principal organisations in an integrated care system are introduced, bringing in their motivations and what they will be losing when they contribute to integrated care. The focus then moves onto the leaders of an integrated care system and how their leadership function and governance will change as the integrated care system moves to implement changes that have both short- and long-term implications. The article then concludes with the ramifications that result from the end of the internal market in this new paradigm of integrated care.

Key Words: accountable care ■ integrated care ■ leadership ■ system

Since the publication of the first article in this series, accountable care has been renamed as integrated care. The latest guidance from NHS England (2018) confirms prior speculation, so leaders are now adjusting to this new terminology. This change suggests a move away from the American healthcare model in an attempt to shape our own.

This article explores the opportunity for an integrated care system (ICS) to deliver tangible long-term change for its local population on the foundation of this shared accountability. While it has been rebranded, the imperative of collective accountability has not been lost.

In the first article in this series, the case was made for integrated care to become a new paradigm in NHS service design and delivery. Building on this, there are three themes in this second article that have significant implications for leaders of an ICS: first, integrated care brings the internal market to an end; second, the new phase of public policy we are now in, one of civic good (Turner, 2017), enables the more effective delivery of integrated care; third, it will be up to leaders to ensure that the existing legal frameworks do not get in the way of innovative approaches to care design and delivery.

These themes will be explored further, beginning with the characteristics that underpin its successful implementation.

Characteristics of a successful ICS

In an ICS, all the participating organisations share accountability for care provided to a defined population. They take collective responsibility for delivering healthcare – and ideally social care – within a capped budget. Implicit in this are common priorities, an agreed allocation of limited resources, and risk-sharing to achieve maximum results across the system. Organisations and their leaders

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therefore need to move from thinking about what is in it for their organisation to a mindset of how they can help other organisations be successful for the benefit of the system itself and the ultimate beneficiaries: patients, citizens and communities.

By unpacking the phrase 'integrated care system', we can begin to understand what is behind the terminology:

Integrated – organisations voluntarily coming together to achieve sustainable improvements in health and wellbeing

Care – encompassing health and social care not just for patients but also for citizens who will hopefully not become patients

System – the geographical boundary within which limited resources will be applied to both deliver services and change service demand.

Within an ICS there may also be a number of localities, sometimes referred to as 'integrated or local care partnerships'. These are systems in their own right and point to the transient nature of the 44 Sustainability and Transformation Partnerships (STPs) that will become ICSs. STP boundaries are largely arbitrary lines, and they will change once integrated working gains traction.

Considering what successful ICSs should become, they have a number of characteristics:

Over-arching strategy – There needs to be clarity about what is the object of the exercise. The architect Louis Sullivan (1896) famously stated that 'form follows function', but too much effort often goes into system design instead of designing what the system is for. More thinking needs to go into changing long-term demand through a focus on population health, not just treating illnesses.

Getting into the shoes of others – Even within the NHS family, there is lack of familiarity about what other family members do. This is compounded when bringing together health and social care, which have different operating models around the medical and social models of care respectively (Deffenbaugh, 2012a).

Agreed objectives – The ICS will have a set amount of resources at its disposal, so it will need to decide to which priorities these resources are allocated. Pareto analysis will show the areas of highest impact, both short- and long-term, and organisations will need to share the risk in allocating resources for the common good, not organisation benefit.

Common narrative – There needs to be one version of the truth, agreed and shared by all. This narrative will have to be effectively communicated and it will become the core mantra when leaders and staff, particularly doctors, engage with the public. This public narrative (Ganz, 2009) will need to capture the hearts, not just the minds, of those affected by system change.

Engaging citizens and communities – To work within a capitated budget, the patterns of demand will need to change. Only users can make this change sustainable. The ICS therefore needs to engage more widely and effectively with not just patients, but also citizens and the communities in which they live. This is the opportunity for public health to find its voice.

Leaders who get along – The internal market has left a legacy of damaged relationships. An ICS needs to leave this behind; leaders need to move on. While the ICS is about organisations working collectively, the reality is that the key factor for success will be the ability of leaders to trust each other.

While it will be the leaders that work effectively together in an ICS, it is also important to understand the relationships among the principal organisations.

Principal ICS partners

The policy of NHS England and NHS Improvement towards integrated care means that the voluntary participation by NHS organisations is less about choice than it is direction. While social care can choose to participate, theirs is less about choice than it is necessity. It is only a matter of time until all STPs become ICSs with both health and social care at the core.

However, the motivations behind the partners in an ICS can potentially block effective working:

Hospitals – Since the NHS was founded, 70 years ago, hospitals have been in the ascendency. They suck in resources, attract the best staff, and garner public support when under threat. While

it has been policy to transfer resources into the community, the reality is that there has been minimal resource shift. Hospitals epitomise the NHS illness service, and the impact of an aging population with co-morbidities means that the hospital services will continue to be in high demand. The challenge for hospitals will be to work with ICS partners to help reshape future demand, while coping with current demand.

Primary care – In contrast, primary care is formed of small business entrepreneurs. General practices are primarily about providing care, not commissioning. When incentivised, it has been shown that primary care can achieve different results, for instance in meeting targets for cervical screens and immunisations. Therefore, to change patterns of demand, primary care can be engaged as business people – incentivise them, see the change, measure the impact. This will be the challenge for the ICS – to help primary care operate at scale to have this impact on demand and to allocate resources that result in tangible change. General practice income may rise, and this should be offset by the release of resources elsewhere to fund this increase.

Clinical commissioning – Clinical Commissioning Groups (CCGs) are the latest incarnation of the procurement side of the internal market equation. In a competitive environment, the task of CCGs has been to leverage change in service design and delivery via the commissioning function. In an ICS, this function is down-played. There is still a role for deciding on the allocation of resources, but in a collaborative manner. As John Kay (1993) outlined, at the time of the launch of the internal market, we need to move from classical contracting to relational contracting. ICSs will begin to operate more like the Scottish Health Boards (Scottish Office, 1997) after they moved to what was called 'single system' working.

Community and mental health – These are the 'Cinderella services', and are held back in achieving their potential as they lose out on resources, talent and policy focus to the acute sector. Yet, they have significant potential from their upstream actions to impact downstream demand, so are natural bedfellows for primary and social care. Charities have made the case (Bulman, 2017) for investing in mental health services, yet investment lags, so other services suffer the consequences. The challenge for the ICS will be to rebalance investment further upstream to avoid the impact of demand downstream.

Social care – This ICS partner has the potential to solve many NHS problems. However, social care can be a reluctant partner in integrated care: they speak a different language (social model of care versus medical model), have different professional boundaries, offer means tested services rather than free at the point of use, have different funding streams, and a different authorising environment (Moore, 1995). When the going gets tough, elected members have been heard to refer to the NHS as having a 'democratic deficit'. Within an ICS, the challenge will be for social care and health care to better understand each other and to build trust on the back of this. It is helpful that public health has a foot in both camps.

Other partners – These could be many and varied, depending on the vision and creativity of the ICS. As with social care, these partners have the ability to reshape NHS demand. Community groups, the volunteer sector, education bodies, businesses and others can all do their part, as full partners or associated with an ICS – many are already associated with health and wellbeing boards. Care is literally in the community. Pump-priming can have a multiplier impact, and the challenge for the ICS will be to find these resources and to put in place governance to ensure delivery and impact.

The internal market that emerged out of 1980's free market thinking (Enthoven, 1985) was part of a public policy epoch that is now being called into question. Whether it has been the collapse of rail franchises or outsourcing contractors, or the failure of the energy market to generate effective competition, the public is steering policy makers and politicians towards viewing the world differently. The tragedy that befell Grenfell Tower has implications wider than housing (Gapper, 2017), and could prove to be a seminal moment in this shift of public policy towards civic good instead of competition.

While organisations will comprise the ICS in this new paradigm for the NHS, it will be the maturity of their leaders that will ensure they put 'integrated' into 'care system'. Leaders will need to overcome 25 years of competitive orthodoxy, but the prize of an ICS needs to outweigh their perceived loss of control.

Leadership and governance

System leadership is harder than organisational leadership – in an organisation, leaders have greater control and authority to exercise influence and achieve things, while in a system compromises cut across significant vested interests and conflicting performance measures. Different capabilities are therefore needed for system leadership: seeing the larger picture; fostering reflection and more generative conversations; shifting the collective focus from reactive problem solving to co-creating the future (Senge et al, 2015).

ICS leaders will need to grapple with a number of issues as they change their mindsets and acquire these core capabilities:

Understanding the motivations of partners – Motivational Needs Theory (McClelland, 1961) points to leaders having a combination of needs: achievement, affiliation and power. Leaders will have to understand their own motivations and those of others to operate effectively in a collaborative integrated care environment. The internal market might have satisfied the need for power, but if this motivation still dominates behaviour in an ICS, then serious relationship problems will quickly emerge.

Unconditional commitment – In moving from a competitive to a collaborative mindset, there is a danger that system leaders will put conditions on their commitment to integrated care. Such a mindset at the outset means that the new venture will fail. There is no space for a prenuptial agreement. Yet it takes courage to change this mindset, and leaders will need to support each other through this change process.

Collective ownership – The same can be said for the collective ownership of resources. No longer is there a CCG deficit or a provider deficit – it is now the ICS deficit. There will no longer be earned income, tariff or 'my money'. Open book accounting will put all the resources on the table, and ICS leaders will need to maximise the public sector pound.

Networking across the system – NHS leaders are being challenged in an ICS to have their 'eyes up' to be an effective system partner in addition to 'eyes down' into their own organisation. They need to look in both directions. Leaders also need to build networks among the integrated care partners, and encourage their staff to also do cross-organisation networking. Stanley McChrystal (2017) refers to this as building a 'team of teams'. In these circumstances, leaders will need to control their power motivation and focus on affiliation and achievement through the work of others.

Maintaining choice – The demise of the internal market does not mean the end of patient choice. The ICS needs to be dynamic, with opportunities for new partners to enter if they offer better services or quality, and for underperforming partners to make way if they have not responded to opportunities to improve. There are obvious limitations on the ability to exercise this system dynamism, but the ICS should not be regarded as the fiefdom of existing players. A strong relational approach to problem solving, instead of using the levers of contracting, will go a long way towards increasing system effectiveness.

Leading the ICS – The STP started as a plan, then became a partnership, and is now a system providing integrated care. There is no basis in law for this new structure, so existing legislation will need to be worked around. What leaders can fall back on is the need to do the right thing for civic good in place of organisational good, and to be guided by the NHS Constitution (Department of Health and Social Care, 2015). ICS leaders will wear three hats (Deffenbaugh, 2012b) – individual, organisation and system – and it is the system hat that trumps the others. There will be times when they will conflict, of course, and it will be up to their ICS colleagues to work through these conflicts.

Making this happen

A number of stars must align to enable successful implementation of ICSs.

First, regulators need to push in the same direction. NHS Improvement is pushing providers to earn income at the expense of CCGs. NHS England is doing the opposite with CCGs. With the end of the internal market, it is time to end this artificial divide and take an integrated approach to an integrated system. It is only a matter of time before NHS Improvement and NHS England become one.

Second, an ICS offers the opportunity to adopt a new model of care provision: GPs operating at scale and incentivised to influence demand; hospitals working hand-in-hand with primary care and community services to push services closer to the patient; investment in upstream activity to reshape downstream demand; integration of health and social care so that patients cannot tell the difference. This could take over a decade to see significant results, so health and social care partners will need to hold their nerve to maintain this long-term perspective.

Third, since there will be no more resources and, as the ICS budget is capped, resources will need to be created. The new health and social care model will need investment in many areas as discussed earlier. Within the ICS there are resources that can be freed up: services can be rationalised; referral protocols tightened; variation reduced; standardisation increased; overheads reduced; and primary care incentivised to do more outside the hospital setting. Some of this may require 'invest to save', so if government does pump-prime, then there will be close monitoring of implementation. This will particularly be the case if a social impact bond outcome-based approach is adopted.

Fourth, there will be a heavy burden on the shoulders of ICS leaders. Their role will change to become facilitators of change, empowering others to make it happen, and working collectively for the good of the system (Collins, 2014). This is a significant change in mindset for leaders brought up to be competitors, and some will feel as though they have lost their identity, which will no longer be about power, but rather affiliation and achievement through others.

Finally, disputes will arise. This is where ICS governance needs to be stronger. STP arrangements are transitory and, while older leaders will recall the role of health authorities, it is inevitable that a more formal structure will be put in place at system level. However, instead of the previous command and control approach, what will be required for this new connected world will be leaders who are conductors of the ICS orchestra.

Conclusion

Three themes have shaped this article: the internal market has ended; a public policy epoch of civic good will leverage integrated working among partner organisations; and leaders must behave in a manner that works around legal frameworks. A number of conclusions therefore emerge from this article:

- An ICS, by definition, means that social care will become partners. This could prove tricky to implement in some areas, and will require focus on building relationships across the contrasting authorising environments
- Hospitals continue to represent the illness service, so should not lead the ICS. They will be willing partners, but the focus should be on horizontal care as the driver of change rather than vertical care
- All the money of partners in an ICS needs to be put on the table. Partners will need to reach collective agreement on the allocation of these resources for short- and long-term gain
- In the absence of formal ICS structures, there will still be a role for the CCG/s to hold the reins of resource allocation. It will not be their decision, but their influence, that holds sway
- ICS leaders will need to proactively engage citizens, communities and politicians who represent them. Clinical leaders should be in the forefront of this engagement, following a common narrative
- The ICS will be dynamic, responding to external factors so that it does not take on the form of a monopoly. Choice still has a role to play, so regulators will monitor performance against plan and intervene if necessary
- With the focus on the system in place of the organisation, leaders will need to align their staff to this new mindset. They will need to work on building trust for generative conversations to build the ICS 'team of teams'

KEY POINTS

- Though accountable care has been renamed integrated care, the principle of collective accountability among partners for effective allocation of the capitated budget remains
- Three themes underpin the implementation of an ICS: the end of the internal market; a new public policy epoch of civic good rather than competition; and the imperative of leaders to work around statutory frameworks to make the ICS successful
- Partner organisations in an ICS have motivations that may place them in conflict with other ICS partners, and it will be for leaders to build trust and have generative conversations to work through the numerous obstacles in their path
- Leadership of the future will be around building networks that foster mass collaboration across the ICS, with leaders becoming comfortable in ceding power to those who operate in the interests of the system and not the silo

- The emerging governance structure at ICS level will need to incorporate a role for non-executive directors. They will be as valuable, if not more so, in shaping the effectiveness of the ICS as they will be in the partner organisations that comprise the ICS.

Finally, having steered away from system design, let me finish on this area. The shift from organisations to systems as the modus operandi of healthcare provision means that organisation resilience will increase, not decrease. The hierarchal design of organisations makes them less adaptable to the fast changing environment in which health and care is provided. In contrast, the 'mass collaboration' (Collins, 2014) of an ICS opens up real prospects for adaptive approaches to the wicked issues that the partners in an ICS face. Integrated care organisations have a critical role to play in this new paradigm, and this will be the focus of the third article in this series. BJHCM

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