Designing integrated care systems (ICSs) in England

An overview on the arrangements needed to build strong health and care systems across the country

The NHS Long-Term Plan set the ambition that every part of the country should be an integrated care system by 2021.

It encourages all organisations in each health and care system to join forces, so they are better able to improve the health of their populations and offer well-coordinated efficient services to those who need them.

This overview is for all the health and care leaders working to make that ambition a reality, whether in NHS acute or primary care, physical or mental health, local government or the voluntary sector.

It sets out the different levels of management that make up an integrated care system, describing their core functions, the rationale behind them and how they will work together.

June 2019

Introduction

Since 2016, health and care organisations have been working together in every part of England in sustainability and transformation partnerships (STPs). These are a pragmatic way to join up planning and service delivery across historical divides: primary and specialist care, physical and mental health, health and social care. They are also helping to prioritise self-care and prevention so that people can live healthier and more independent daily lives.

The partnerships have begun to agree shared priorities and to make practical improvements. For example, ensuring that people can get a wider range of treatments closer to where they live or work, at a time convenient for them. Or that those who regularly use different services feel like they are dealing with just one team, who make time to understand their full health or care needs and goals.

Integrated care systems (ICSs) accelerate this work. The first 14 were confirmed in 2018, including two areas with health devolution agreements (Greater Manchester and Surrey). They cover a range of urban and rural geographies, with wide variation in population size and system complexity.

The NHS Long-Term Plan confirmed that all STPs are expected to mature so that every part of England is covered by an integrated care system by 2021. NHS England and NHS Improvement have worked with local teams to develop a consistent approach to how systems are designed, and the NHS Long-Term Plan set this out, highlighting three important levels at which decisions are made:

- **Neighbourhoods (populations circa 30,000 to 50,000 people)** - served by groups of GP practices working with NHS community services, social care and other providers to deliver more coordinated and proactive services, including through primary care networks.
- **Places (populations circa 250,000 to 500,000 people)** - served by a set of health and care providers in a town or district, connecting primary care networks to broader services including those provided by local councils, community hospitals or voluntary organisations.
- **Systems (populations circa 1 million to 3 million people)** - in which the whole area's health and care partners in different sectors come together to set strategic direction and to develop economies of scale.

Precise numbers will vary from area to area. In the earliest ICSs, they range from Gloucestershire, with a population of 528,000 and one recognised 'place', to the larger West Yorkshire & Harrogate with a population of 2.7 million and six recognised 'places'. The exact shape of each system will depend on local factors such as demography and need, and reflect where effective local collaboration is already established.

This work follows years of partnership between NHS and council teams at different levels. Many of the earliest ICSs, and other areas that are making great progress joining up services, build on a long history of planning and providing person-centred care for residents, and on councils' strategic plans to improve health and wellbeing.

They also incorporate learning from initiatives such as the 50 'vanguards' that tested and refined new care models. In the most successful of these vanguards, NHS providers and commissioners, councils, care homes and others developed more preventive approaches to care and saw significant reductions in emergency admissions.

Effective, collaborative leadership – with clear, common purpose, drawing support from all parts of the system including different professional teams – has consistently been shown to be essential to developing the partnership culture needed to create and sustain systemwide improvement.

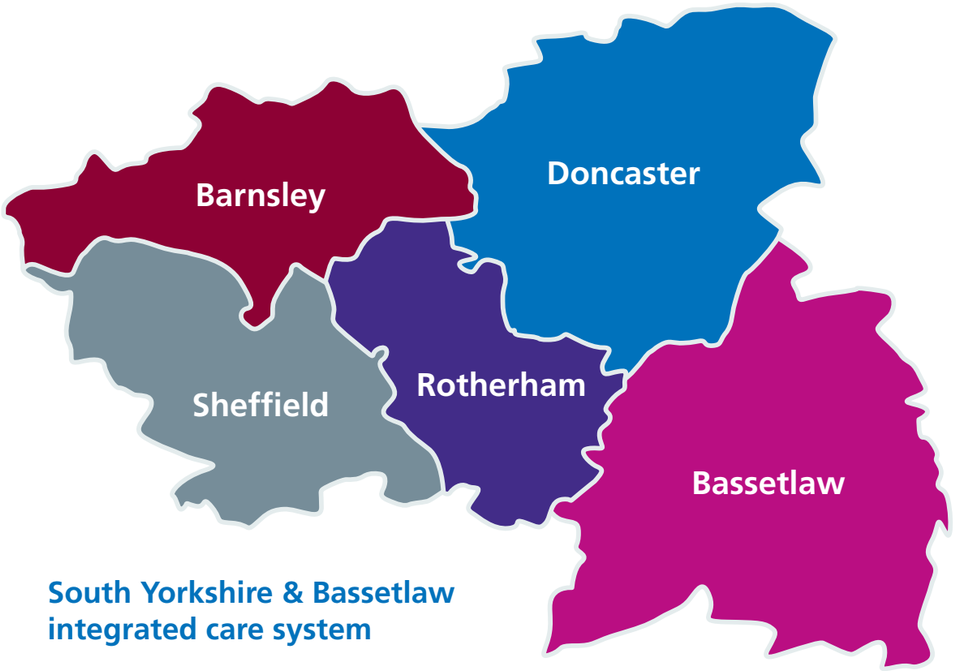
Each area is at a different stage in its journey, with even the earliest integrated care systems refining their approach as relationships and infrastructure mature. While some features are common to the most mature systems (such as behaviour that promotes collaboration at every level), priorities and solution will rightly vary between areas in reflection of different local geographies and histories of collaboration.

Systems work most effectively where functions at different levels are designed to support and complement each other – a truly interconnected approach. This overview is to help local leaders think through where functions should sit in their system; maximising resources, galvanising collective effort and systematically improving care for residents.

Overview of integrated care system and their priorities from the NHS Long-Term Plan

Level	Functions	Priorities from the NHS Long-Term Plan
Neighbourhood (c.30,000 to 50,000 people)	• Integrated multi-disciplinary teams • Strengthened primary care through primary care networks – working across practices and health and social care • Proactive role in population heath and prevention • Services (e.g. social prescribing) drawing on resource across community, voluntary and independent sector, as well as other public services (e.g. housing teams).	• Integrate primary and community services • Implement integrated care models • Embed and use population health management approaches • Roll out primary care networks with expanded neighbourhood teams • Embed primary care network contract and shared savings scheme • Appoint named accountable clinical director of each network
Place (c.250,000 to 500,000 people)	• Typically council/borough level • Integration of hospital, council and primary care teams / services • Develop new provider models for 'anticipatory' care • Models for out-of-hospital care around specialties and for hospital discharge and admission avoidance	• Closer working with local government and voluntary sector partners on prevention and health inequalities • Primary care network leadership to form part of provider alliances or other collaborative arrangements • Implement integrated care models • Embed population health management approaches • Deliver Long-Term Plan commitments on care delivery and redesign • Implement Enhanced Health in Care Homes (EHCH) model
System (c.1 million to 3 million people	• System strategy and planning • Develop governance and accountability arrangements across system • Implement strategic change • Manage performance and collective financial resources • Identify and share best practice across the system, to reduce unwarranted variation in care and outcomes	• Streamline commissioning arrangements, with CCGs to become leaner, more strategic organisations (typically one CCG for each system) • Collaboration between acute providers and the development of group models • Appoint partnership board and independent chair • Develop sufficient clinical and managerial capacity
NHS England and NHS Improvement (regional)	• Agree system objectives • Hold systems to account • Support system development • Improvement and, where required, intervention	• Increased autonomy to systems • Revised oversight and assurance model • Regional directors to agree system-wide objectives with systems • Bespoke development plan for each STP to support achievement of ICS status
NHS England and NHS Improvement (national)	• Continue to provide policy position and national strategy • Develop and deliver practical support to systems, through regional teams • Continue to drive national programmes e.g. Getting It Right First Time (GIRFT) • Provide support to regions as they develop system transformation teams	

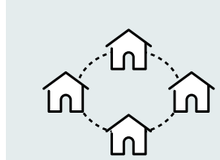
What do these look like in a local system?



South Yorkshire & Bassetlaw integrated care system

	**36 neighbourhoods** with population of **30 - 50k**. At this level, primary care will be strengthened by working together in network.
	**Five places** with populations between **250 - 500k**. At this town / city / council level, health and care will work together more closely.
	**One system** with a population of **1.5m**. At this level, strategic planning and improvements can take place for the benefit of all as well as having an overview of system finance and performance.

We will now consider the three levels – neighbourhood, place and system – in more detail.



Neighbourhoods
(populations circa 30,000 to 50,000 people)

'Neighbourhoods' are the cornerstone of integrated care. Based on natural geographies, population distribution and need, and previous work across different professional teams, these networks draw on a wide range of professional skills including: GPs, care homes and home care, pharmacists, community and mental health teams, and the voluntary sector.

They will give community-based care through urgent community response and recovery support, by helping residents to age well and by guaranteeing NHS support to those living in care homes. By putting in place seamless care for both physical and mental health, they will allow the NHS and its partners to give care (including secondary care) as close to people's homes as possible.

Primary care networks, enabled by the new GP contract, are central to this. They will build on the experience of local partnerships already in place, and initiatives such as 'Primary Care Home', which have built locality-wide teams across organisational boundaries, often expanding what is offered in GP practices and other community settings.

As a minimum, primary care networks will consolidate this work to ensure extended hours access to GPs and to reduce day-to-day pressures by allowing NHS and local government services to share functions or staff. More mature networks will use increasingly sophisticated data to identify and give more proactive care to those at risk of unnecessary hospital admission and will use new technology and tools such as social prescribing to help people to care for themselves where appropriate.

Joining up services from a range of professionals

An integrated care 'hub' in Weymouth brings together a GP, community geriatrician, therapists, community nurses, social workers and mental health professionals to proactively support those at risk of hospitalisation. Early evaluation suggests a 10 per cent reduction in acute bed days for those treated, and improved staff experience. The ICS has supported the model to spread, with ten integrated care hubs now covering the whole county.

Improving care quality and experience with home visits

In West Berkshire, integrated paramedic home visiting gives residents rapid, one-stop care that takes account of their whole needs. Thanks to closer collaboration between primary care, social care and voluntary services, more are now treated at home. This has improved care quality, use of resources and staff experience, reduced deterioration and length of stay, and allowed the system to manage demand more evenly throughout the day. In the first seven months, 96 attendances were avoided, and 75 sessions of GP time saved.

Population health in Lancashire

Lancashire neighbourhoods including Chorley and Skelmersdale are developing 'population health management' approaches, to improve local people's health results, reduce inequalities and address the broad range of individual, social and environmental factors that affect these. To do this, GPs, councils, community organisations and others are building shared information and understanding about how different groups of residents live their lives. For example, bringing different data sources together to identify how those with two or more long-term conditions can best be supported to prevent complications and live independently.

Places
(populations circa 250,000 to 500,000 people)

This level may match local council boundaries or the natural geographies at which services are delivered. It will include clusters of primary care networks, linking these to care providers such as one or more acute hospital, care homes, mental health and community providers, local government and voluntary or community organisations.

Together, these will make a shared assessment of local need, plan how to use collective resources and to join up what they offer – including beyond traditional health and care services – to make best use of overall public and community resources.

Two crucial pieces of work are driven at 'place' level, both relying on collaboration and joint decision-making. These are clinical care redesign (simplifying and standardising care pathways across a whole area) and population health management (making better use of data to improve how health and care services address wider health determinants such as housing, environmental quality and access to good employment and training).

They may also be the level at which some local services are integrated and managed such as rapid response teams to support people with learning disabilities.

In the absence of a legal basis for statutory (NHS and local council) commissioners to form decision-making committees with statutory providers, the 'board' at place level will normally operate according to an NHS alliance agreement or initially with a lighter touch memorandum of understanding. ICSs will also be expected to work closely with health and wellbeing boards, the established statutory forum that brings together local leaders from different parts of the system, which will often coincide with place level.

Joining up health and care in line with local council areas

The six places in West Yorkshire & Harrogate (Bradford District and Craven, Calderdale, Harrogate, Kirklees, Leeds and Wakefield) are developing integrated care services, scaled up as appropriate for differing population needs. For instance, partners in Wakefield (including NHS organisations, the council, housing providers, fire service and voluntary and community sector) are working together to keep residents safe and well in their own homes via two 'connecting care' hubs.

Place-based commissioning in a combined authority

Ten areas in Greater Manchester are moving to place-based joint commissioning between local government and CCGs, in line with local council/ health and wellbeing board boundaries. Together, these will join up health and care services at scale, drawing on relationships with Greater Manchester's Mayor and Combined Authority, transport authority, police, fire service, housing providers and the voluntary sector.

Improving productivity by better reflecting patients' needs

The 'Better Together' alliance in Mid Nottinghamshire, which includes the county council alongside CCGs, NHS trusts and others, separates patients into different groups based on their risk levels. This has helped to improve care and timeliness for patients, avoiding unnecessary hospital admissions and bed days. Over time, it is expected to lead to all NHS providers in the area working through a single contract alliance.

Systems
(populations circa 1 million to 3 million)

The 'system' level provides strategic leadership across the whole population of the ICS. This will include overseeing a single plan covering both operational and long-term transformation priorities (building on, and aligning place-level plans), and managing financial performance against a system control total that encompasses CCGs and NHS providers.

It will take responsibility for delivering high quality services and access, reducing unwarranted clinical variation and addressing health inequalities. Other functions that will be undertaken at system-wide level include NHS workforce planning, agreeing how to make the best use of capital, estates and digital infrastructure, and spreading good practice that emerges at place level over a wider scale.

Clinical, managerial and support functions will be provided at system level when they can most efficiently and effectively be delivered once; for example, where analytical capacity or business intelligence capability is in short supply.

System leaders will take collective responsibility for financial and operational performance, typically through a systemwide board which includes all NHS partners. New governance arrangements will support this, enabling timely action on system-wide challenges.

Sharing information and freeing staff to work across a county

Dorset ICS developed the 'Dorset Care Record', a single, confidential system allowing health and care professionals across the whole county to see the same information about patients. Joining up information in this way means that people no longer need to repeat their story to different teams, and improves care by enabling a more comprehensive and up-to-date understanding of their whole needs.

The ICS has also introduced workforce 'passports' so staff can move freely between any organisation in the county. This allows people to develop different skills and perspectives and encourages them to stay in the system by providing a wider pool of career options.

Moving to a single accountable officer across commissioners

Five of the earliest ICSs (Dorset, Surrey Heartlands, North Cumbria, Gloucestershire and Bedfordshire, Luton and Milton Keynes) have appointed joint accountable officers across constituent CCGs. This has helped them to simplify commissioning arrangements, enabling a single set of system-wide decisions in line with agreed local needs and aspirations.

NHS England and NHS Improvement – national and regional support and oversight

NHS England and NHS Improvement's seven regional teams are responsible for holding systems to account, supporting their development and making interventions where necessary. ICSs will agree system-wide objectives with their regional director and be accountable for systemwide performance against these objectives.

National and regional teams will work together, steered by regional directors to encourage and support all systems to take on greater collaborative responsibility for improving quality of care, focusing on population health and improving their use of NHS resources.

Quality, safety and performance issues should be addressed as close to the system as possible.

The overall principles of this approach will be to:

- help to design the right support and intervention for local health systems, ensuring NHS England and NHS Improvement create maximum value and avoid unnecessary burden;
- decide when and how to intervene in systems, providers or CCGs in their region, or – where the seriousness of the intervention requires a national decision – make the relevant recommendations to the decision-making group;
- be responsible for managing all interventions with – or seeking information or assurances from – systems, providers or CCGs;
- treat performance management and improvement as a continuum, rather than in terms of fixed check points;
- help develop standardised national approaches to improvement and performance, but have discretion to allow systems, providers or CCGs to depart from standardised approaches where they are performing well.

The regions continue to have a role in managing system development and performance; with this responsibility shifting to the system as it matures. Therefore, regional teams will need to adopt different approaches to regulating systems based on their maturity.

Some functions, such as ambulance services, specialised commissioning or emergency preparedness may be best arranged in line with scale of delivery or prevalence of need. This may sometimes be at a geography that is sub-regional but wider than system-wide.

In more mature systems, the regional role increasingly becomes that of a critical friend, providing the system with further autonomy regarding regulation, avoiding engaging with individual organisations without the knowledge of the system and reducing the number of formal meetings.

Over time, we envisage that NHS regional teams and overall operation will become leaner and more strategic, as systems take on more self-development and self-assurance as they progress to becoming thriving ICSs.

NHS England and NHS Improvement's national team will remain the overall centre for policy and strategy development including overall health system strategy, the NHS provider landscape and heath commissioning strategy.

Maturity matrix for integrated care systems (ICSs)

The integrated care system maturity matrix has been developed to outline the core characteristics of systems as they develop. These were developed from observing and talking to the earliest ICSs, and from the objectives set out in the NHS Long-Term Plan.

It is based on similar tools used by the Local Government Association and others, who have experience in supporting system development and change. It provides a consistent framework for all regions and systems across the country.

The matrix outlines the core capabilities expected of emerging ICSs, developing ICSs, maturing ICSs and thriving ICSs. For a system to be formally named an ICS, they will need to meet the attributes of a maturing ICS.

It uses a progression model which shows a journey rather than a series of binary checklists, recognising that systems will not develop all domains at the same pace and will therefore have varying levels of maturity across each domain. By doing this, it seeks to support more nuanced and reflective discussions about system maturity.

System maturity matrix – five domains, four stages

System progression

	Emerging	Developing	Maturing ICS *System formally named an ICS and minimum level of maturity for all systems to reach by April 21*	Thriving ICS
System leadership, partnerships and change capability	• Leadership team that lacks authority with no collectively-owned local narrative or sense of purpose. • Lack of transparency in ways of working. • Little progress made to finalise system vision and objectives or embed these across the system and within individual organisations. • Minimal meaningful engagement with primary care, local government, voluntary and community partners, service users and the public.	• All system leaders signed up to working together with ability to carry out decisions that are made. • An early shared vision and objectives, starting to build common purpose and a collectively-owned narrative among the broader leadership community including primary care. • Plans to increase the involvement of local government, voluntary and community partners, service users and the public in decision-making at system, place and neighbourhood.	• Collaborative and inclusive multi-professional system leadership and governance; including local government and the voluntary sector. • Clear shared vision and objectives, with steady progress made visible to stakeholders and staff. • Dedicated capacity and supporting infrastructure being developed to help drive change at system, place and neighbourhood level (through PCNs). • Effective ongoing involvement of voluntary and community partners, service users and the public in decision-making at system, place and neighbourhood levels. • A culture of learning and sharing with system leaders solving problems together and drawing in the experiences of others.	• Strong collaborative and inclusive system leadership, including local government and the voluntary sector, with a track record of delivery. • Transparent and robust governance, with multi-professional leadership aligned around the system and system working closely with health and wellbeing boards. • A proactive approach to the identification and development of future system leaders at all levels. • Dedicated clinical and management capacity and infrastructure to execute system-wide plans. • A narrative that is well understood and strongly supported by the public and staff, outlining how integrated care is delivering on the ambitions of communities, with demonstrable impact on outcomes.
System architecture and strong financial management and planning	• Limited understanding of system architecture across the footprint and limited plans to organise delivery around neighbourhood, place and system. • Fragmented commissioning landscape with few agreed plans to streamline arrangements. • System not in financial balance and unable to collectively agree recovery trajectory. • Lack of system wide plans on workforce, estates and digital.	• Clear plans to organise delivery around neighbourhood, place and system. • Plans to streamline commissioning, typically with one CCG that is leaner and more strategic. • Good understanding of system financial drivers and efficiency opportunities, with a shared plan to address issues. • System wide plans being developed to address workforce, estates and digital infrastructure.	• System is working with regional teams to take on increased responsibility for oversight. • Plans to streamline commissioning are underway. • System has credible plans for meeting system control total and, where not already achieved, for moving towards system financial balance • System wide plans for workforce, estates and digital infrastructure being implemented. • System is managing resources collectively and signed up to the ICS financial framework.	• System has progressed to the most advanced stage of oversight progression – i.e. self-assurance, with clear communication and relationships with regional team. • Streamlined commissioning arrangements fully embedded across all partners. • System is in financial balance and is sharing financial risk using more sophisticated modelling of current and future population health and care needs. • Incentives and payment mechanisms support objectives and maximises impact for the local population. • Improvements in workforce, estates and digital infrastructure being seen across the system. • System is managing resources collectively and signed up to the ICS financial framework.

System progression

	Emerging	Developing	Maturing ICS *System formally named an ICS and minimum level of maturity for all systems to reach by April 21*	Thriving ICS
Integrated care models	• Limited use of national and local data to understand population health and care needs. • Limited thinking about how to scale up primary care and how to integrate services at neighbourhood or place • Minimal collaboration or engagement across providers.	• Early development of the 5 service changes within the LTP, and care models aiming to: - address unwarranted clinical variation; - integrate services around the needs of the population in neighbourhoods; - integrate services vertically at place; - collaborate horizontally across providers at the system and/or place level. • PCNs developing clear vision for integrated care models and transforming population health. • Some understanding of current and future population health and care needs using local and national data. • Plans in place to support interoperable access to care records across health and social care providers.	• PCNs implementing new or redesigned care models with partners to meet population need – that is enabling integrated provision of health and care within neighbourhoods. • Integrated care teams operating at neighbourhood and place bringing together PCNs, mental health, social care and hospital services as per the triple integration set out in the LTP. • Starting to implement plans to: - address unwarranted clinical variation; - deliver the 5 service changes in the LTP; - tackle the prevention agenda and address health inequalities. • PHM capability being implemented including segmenting and stratifying population using local and national data to understand needs of key groups and resource use.	• Integrated teams demonstrating improvement in outcomes. • Fully mature PCNs across the system delivering care with partners that meets population needs. • Implementing priorities in prevention and reducing health inequalities as part of care model design and delivery. • Full population health management capability embedded at neighbourhood, place and system levels which supports the ongoing design and delivery of proactive care. • Implementation of the 5 service changes set out in the LTP demonstrating improvement in health outcomes.
Track record of delivery	• Slow progress towards delivering national priorities especially the 5 service changes set out in the LTP. • Lack of relative progress in delivering constitutional standards without system agreement to work together to support improvements. • Weak system operating plan developed and system unable to make collective decisions around system funding.	• Evidence of progress towards delivering national priorities especially the 5 service changes set out in the LTP. • Improved delivery of constitutional standards. • System operating plan in place that demonstrates a shared set of principles to start to manage finances collectively.	• Evidence of tangible progress towards delivering national priorities especially the 5 service changes set out in the LTP. • Consistently improving delivery of constitutional standards with credible system plans to address risks. • Robust system operating plan and system financial management in place, with a collective commitment to shared financial risk management. • Robust approach in place to support challenged organisations and address systemic issues.	• Evidence of delivering national priorities especially the 5 service changes set out in the LTP. • Delivery of constitutional standards including working as a system to mitigate risks. • Demonstrating early impact on improving population health outcomes. • Consistently delivering system control total with resources being moved to address priorities. • As issues emerge, leaders join forces to tackle them as a system including when under pressure.
Coherent and defined population	• A meaningful geographical footprint that respects patient flows • Where possible contiguous with local authority boundaries; where not practicable has clear arrangements for working across local authority boundaries • Covers an existing STP of sufficient scale (~1m pop or more)	• A meaningful geographical footprint that respects patient flows • Where possible contiguous with local authority boundaries; where not practicable has clear arrangements for working across local authority boundaries • Covers an existing STP of sufficient scale (~1m pop or more)	• A meaningful geographical footprint that respects patient flows • Where possible contiguous with local authority boundaries; where not practicable has clear arrangements for working across local authority boundaries • Covers an existing STP of sufficient scale (~1m pop or more)	• A meaningful geographic footprint that respects patient flows • Where possible contiguous with local authority boundaries; where not practicable has clear arrangements for working across local authority boundaries • Covers an existing STP of sufficient scale (~1m pop or more)

Key

LTP – Long Term Plan; PCNs – Primary Care Networks; UEC – Urgent and Emergency Care; PHM – Population Health Management

ICS will drive forward five major practical service changes set out in the LTP – These are: (1) boost out-of-hospital care, and finally dissolve the historic divide between primary and community services; (2) re-design and reduce pressure on emergency hospital services; (3) give people more control over their own health, and more personalised care when they need it; (4) implement digitally-enabled primary and outpatient care; and (5) increasingly focus on population health and local partnerships with local authority-funded services.

Freedoms and Flexibilities for 2019-20

System progression

	Emerging	Developing	Maturing ICS *System formally named an ICS and minimum level of maturity for all systems to reach by April 21*	Thriving ICS
Oversight	• Systems can provide advice and guidance on individual organisations within the system to support conversations • NHSEI will use a single performance, oversight and assessment framework	• Systems will develop and implement a plan to support ICS development, which will be reviewed and agreed with NHSEI • NHSEI will invite system leadership to attend and contribute to discussions relating to individual organisations within the system • NHSEI will consult the system position before any escalation action/ intervention is approved and enacted through a single identified lead • NHSEI will align roles within the regions to support systems	• ICSs will agree and implement system-wide objectives agreed with regional teams, covering care quality and health outcomes, reductions in inequalities, implementation of integrated care models and improvements in financial and operational performance • ICSs will conduct and contribute to the assurance and improvement of individual organisations performance • NHSEI will keep ad hoc data requests and routine reporting outside the performance framework and agreed ICS objectives to a minimum, and coordinate through an identified lead • NHSEI will not engage with individual Trusts or CCGs without the knowledge of the ICS • NHSEI will co-locate regional roles within the ICS to provide bespoke support requested by the ICS	• ICSs will lead the assurance of all individual organisations • ICSs will agree and coordinate any trust or CCG intervention carried out by NHSEI, other than in exceptional circumstances • ICSs will be able to lead and shape how gathering any data from individual organisations is managed where required • NHSEI will agree a minimum dataset with ICSs • NHSEI will embed regional resources within the ICS to operate under the direction of the ICS • NHSEI will undertake the least number of formal assurance meetings possible with individual organisations
Finance		• STPs will demonstrate strong financial leadership and governance for financial decision-making.	• ICSs will take up the 19/20 ICS financial framework • ICSs will commit to delivering the objectives of the relevant national programmes and report progress against this. Appropriate governance arrangements to account for use of funds will be in place before any funds are released • NHSEI will delegate authority for the direction of transformation funding from national programmes to the system, where possible	• ICSs will take up the 19/20 ICS financial framework
Planning	• Organisational financial recovery plans will be developed with the system leaders to ensure consistency with five year system-level strategic plans, with system efficiency plans overseen by a system efficiency board • NHSEI will lead review and assurance of organisational and system operating plans. • NHSEI will work with the system to develop and strengthen these plans	• NHSEI will work in partnership with system leaders to review organisational and system operating plans	• Organisations that are in financial surplus will play an active role in the development and delivery of financial recovery plans of organisations within their ICS • NHSEI will support system leaders to assure organisational plans, and will work in partnership with system leaders to ensure system operating plans are sufficiently robust.	• ICSs will lead assurance of organisational plans. • System operating plans will have a light touch review by the NHSEI
Support	• Intense support, regionally led and nationally coordinated	• Based on needs identified in development plan • ICS Accelerator Programme TBC • Access to regional and national subject-matter expertise where required	• ICS Development Programme	• ICS Development Programme • Expectation to work alongside regional and national teams to support less developed systems

Find out more

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