



Institute of  
Health &  
Social Care  
Management

**SPECIAL INSIGHT REPORT**

IN ASSOCIATION WITH



**INTEGRATED CARE SYSTEMS (ICS)**  
**AND DIGITAL TECHNOLOGY**

## INTRODUCTION AND ACKNOWLEDGEMENTS

The health and social care sector is actively preparing itself for a new age as integrated care systems (ICSs) begin to take over the old order of operational management. From Clinical Commissioning Groups to Vanguard projects, and from a fragmented and misunderstood system of social care provision to a mental health system faced with capacity issues, change is much needed.

The key word is **integrated** – a commitment to properly and effectively plan and execute the activity of health and social care in such a way as to remove the fault lines between service provision for the recipients of that care.

One of the key integration activities will be around digital strategies that effectively bring together and unite service providers so that care receiver data is uniformly accessed, and systems can be routinely rolled out and used.

The truth is that such digital integration is, for many of the fledgling ICSs, a huge challenge to achieve. There are issues with hardware – never mind software – availability and access, as well as user skills, training, interoperability between systems and leadership of regional plans.

This Special Insight Report is written by the Institute of Health & Social Care Management through liaison with members from the Digital Technology Special Interest Group. It also draws extensively on input from Cerner associates, who are long-standing partners of the IHSCM.

The aim of the report is to find and highlight best practice already being demonstrated across ICS organisations in England with respect to digital technology, so that others might quickly and easily adopt and benefit. Additionally, it makes recommendations for developing the ICS models of leadership and care.

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## KEY RECOMMENDATIONS

- ICSs should explore means by which similar approaches in other countries are being deployed and how successes are being achieved. There are numerous examples across the U.S., Canada and Scandinavia worthy of note, with the King's Fund having researched several including [Montefiore in South Bronx, New York](#).
- ICSs conduct an audit of hardware and software systems to determine their suitability and capability for supporting innovative technologies. Additionally, the audit should include an assessment of workforce skills and development thereof to use any new digital technologies effectively and confidently.
- NHS Shared Business Services (SBS) should extend their procurement framework negotiations and offers to all active participants in an ICS structure. This would include, for example, all social care service providers.
- NHSX should urgently provide clear and practical guidance for ICSs based on how to procure an 'oven ready' digital technology solution for, in particular, electronic patient record (EPR) systems across an ICS geography.
- Putting data accessibility and security as a priority, ICSs should create system specifications that properly and fully recognise the latest technologies for data sharing without the need for complicated system matching. Ask NHSX to explain what is available and signpost to organisations within the NHS / social care where the systems are already working well, then copy them.
- Support Devon ICS to roll out their single-source EPR and then use that as the template for every other ICS in the country.
- NHSXD to create a clear, unequivocal guide to demonstrate how money for ICS digital systems can be accessed and used from a central fund.
- Suppliers of digital technology ensure that their specified systems are delivered with appropriate training provision as a key element of the total procured package for all users.
- ICS EPR must support ICS staff seamlessly across organisations and care settings, have the same look and feel for all ICS staff, provide uniform and equitable levels of functionality across organisations and settings, and support differences in working for the three levels of ICS organisation (neighbourhood, place and system).
- Every ICS should publish a dashboard of key care performance measures to include metrics such as patient / service receiver experience, accessibility to services (time and scope), patient outcomes, costs v efficiencies and more. Into this mix should be added carbon reduction, staff wellbeing and health equality.
- Senior managers should create virtual or in-person 'town hall' meetings for citizens to ask questions and comment on care provision.
- Every ICS should provide a website dashboard where key metrics are displayed in live data so that citizens can see progress or otherwise being made and interact accordingly.
- A model, such as that presented by the Welsh NHS for citizens to see current wait times at A&E across the country, provides a basis for the approach - [My A&E Live - NHS Wales Accident and Emergency Departments](#).

# THE ROLE AND SCOPE OF INTEGRATED CARE SYSTEMS

Integrated care systems (ICS) are the new entities by which coordinated delivery of health and social care will be delivered across 44 English regions from April 2022.

The key word is coordination – how the experience of receiving health and social care for a citizen is joined up and seamless; each component part of service delivery aware and understanding of other service delivery partners.

In practice this means that, for example, the details and data of a person receiving domiciliary care who has been to their local GP owing to some dizziness, but who subsequently has a fall and has to be taken to hospital, would have their records and outcomes available to all clinical stakeholders.

Alternatively, it might be a young person who is a mental health outpatient struggling with bipolar disorder, who has two long-term physiological conditions requiring regular attendance in primary care and who has an episode after a night out, resulting in A&E attendance.

Or a new single parent with a first child, battling post-natal depression exacerbated by debt and the threat of eviction, presenting at a local charity foodbank with her child clearly distressed.

All of the above examples require multi-disciplinary interaction and insight to help them back to full health and wellbeing. ICSs are expected to provide that infrastructure and strategy by which that recovery can be achieved.

This is a tough ask.

The daily testimony of people who receive such care demonstrate neither consistency nor seamlessness. The idea of a truly joined up experience is, for too many, something that is utopian and unrealistic.

For a turnaround to be made by April 2022 and thereafter, we suggest that three elements require attention, all of which will need strong digital support in order to deliver success:

1. **Data:** What data is available, what data is needed, how can it be shared securely and how do we plan to analyse, collate and present effectively?
2. **Money:** What money streams are available across the whole region for the delivery of health and care, how can this be monitored and how can it be accessed and shared in a coordinated manner?
3. **Workforce:** What roles need fulfilling, what staff are available, do they have the required skills and how do we train to fulfil if not? An initial review of these elements was conducted in 2019 and released by Health Education England as the [Topol Review: Preparing the healthcare workforce to deliver the digital future](#).

ICS organisations will have full responsibility for coordinating delivery of health and social care across a region, so will need representation and input from all of the following (this is not an exhaustive list!):

- Primary care
- Secondary care
- Mental health
- Community services
- Domiciliary care and nursing
- Residential care and nursing
- Charity sector
- Learning disability services
- Public health
- Tertiary care (dental, ophthalmic etc)

The extent to which the above categories of ICS participants are consulted with in designing new digital pathways and strategies will be indicative of the ultimate success of an individual ICS.

**RECOMMENDATION:**

**ICSs should explore means by which similar approaches in other countries are being deployed and how successes are being achieved. There are numerous examples across the U.S., Canada and Scandinavia worthy of note, with the King's Fund having researched several including [Montefiore in South Bronx, New York](#).**

# REVIEWING DIGITAL RESOURCES

It is all very well talking in macro terms about the strategies by which ICSs might advance their activities, but the reality of testimonies provided to the IHSCM by members in multiple different sectors is troubling. We therefore ask the simple question – what is the capability of the NHS and social care in respect of existing hardware and software systems?

The [‘Fit for 2020’ NHS digital capability review of 2017](#) was not positive in its headline findings, reporting that “the organisation relies on out-of-date technology, has skill shortages in multiple areas and its data services are operating below expectations.”

It is our view that these shortcomings remain and will be a significant obstacle to ICSs making the progress that they aspire.

**RECOMMENDATION: ICSs conduct an audit of hardware and software systems to determine their suitability and capability for supporting modern technologies. Additionally, the audit should include an assessment of workforce skills and development thereof to use any new digital technologies effectively and confidently.**

NHS Shared Business Services (SBS) has designed and negotiated a framework agreement for procurement of [digital workplace solutions](#), which began in August 2020 and runs to August 2022 with an option to extend to 2024. To complement this, NHS SBS has also worked to create a [‘Digital Workplace – Hardware’](#) offer for new hardware that runs from March 2021 until February 2023. This at least enables ICS organisations to procure pre-approved and priced PCs, laptops, mobile devices, VDUs, printers and scanners from a shortlist of suppliers, as follows:

### Digital Workplace: Hardware (Link 3)

Reference: SBS10044

## Potential saving opportunities 20-27%

<p><b>When does it start and finish?</b></p> <p>1st March 2021 and runs until 28th February 2023</p>	<p><b>What does it cover</b></p> <p>End User Client devices &amp; Accessories:</p> <ul style="list-style-type: none"><li>• Desktop PCs</li><li>• Laptops/Notebook devices</li><li>• Mobile Devices (Tablets, Mobile phones &amp; Wearables)</li><li>• Specialist Healthcare related IT Hardware<ul style="list-style-type: none"><li>- PC/Laptop Carts and Peripherals</li><li>- Clinical Displays and Peripherals</li></ul></li><li>• Printers/Scanners</li><li>• One-Stop Shop</li></ul> <p>Throughout the lots sustainable IT, deployment and support services are available</p>
<p><b>Who can take advantage?</b></p> <p>All public sector organisations across the UK, including the NHS, Local Authorities, the Education sector, Charities, Blue Light Organisations, Housing</p>	
<p><b>Why should I use it?</b></p> <ul style="list-style-type: none"><li>• <b>COMPETITIVE PRICING</b> Supplier range ensures Approved Organisations are supplied with IT solutions tailored to their needs, with innovative ‘Device as a Solution’ offerings, and ‘Core Basket’ item prices fixed for a minimum of 2 years.</li><li>• <b>UPGRADES</b> Upgrade of specifications over lifespan of agreement.</li><li>• <b>COST SAVINGS</b> By adopting a collaborative approach this enables lower pricing and cost-savings; by sharing the costs of programme management and procurement support.</li></ul>	<ul style="list-style-type: none"><li>• <b>MINI COMPETITION</b> Customers are available to conduct a direct call-off or undertake a mini-competition.</li><li>• <b>VARIED SUPPLY BASE</b> A total of 19 suppliers have been awarded to the framework which include manufacturers, resellers, and specialist medical IT providers.</li><li>• <b>QUALITY ASSURANCE</b> The framework provides assurance of supply for all IT hardware covered under the agreement and is fully PCR2015 compliant and was advertised in the OJEU.</li></ul>

## Digital Workplace: Hardware (Link 3)

Reference: SBS10044

Lots and Supplier Details		
Lot	Description	Suppliers
Lot 1	<b>Desktop PCs</b> <i>(small form factor units, all-in-one units and thin client devices)</i>	CDW, Computacenter, Dell, Getech, Insight Direct, Punch Technology, Softcat, SCC, Stone Technologies Ltd T/A Stone Group, XMA
Lot 2	<b>Laptop/Notebook Devices</b> <i>(notebook devices, ruggedized devices, two-in-one units)</i>	CDW, Dell, Getech, IDNS, Insight Direct, Ricoh, Softcat, SCC, Stone Technologies Ltd T/A Stone Group, XMA
Lot 3	<b>Mobile Devices (Tablets, Mobile Phones and Wearables)</b> <i>(Slate devices, Smartphones, Smart Watches)</i>	Academia, Bytes Software Services, CDW, Getech, IDNS, Insight Direct, Softcat, SCC, Stone Technologies Ltd T/A Stone Group, XMA
Lot 4	<b>Specialist Healthcare related IT Hardware</b> <i>(Mobile carts, Workstations, PACS monitors, Clinical displays)</i>	CDW, Dell, Insight Direct, Parity Computers, Softcat, SCC, Stone Technologies Ltd T/A Stone Group, XMA
Lot 5	<b>Printers/Scanners</b> <i>(3D printers, Asset/Barcode scanners, MFDs)</i>	Bytes Software Services, CCS Media, Desk Top Publishing Micro Systems, Insight Direct, Insight Systems, MTI Technology, Ricoh, Softcat, SCC, XMA
Lot 6	<b>One-Stop-Shop</b> <i>(a combination of products from all lots, or peripherals)</i>	Bytes Software Services, CDW, Dell, Getech, Insight Direct, Softcat, SCC, Stone Technologies Ltd T/A Stone Group, XMA

It is unclear whether non-NHS ICS participants (see list under Role and Scope of ICSs) will have access to these procurement frameworks, so:

**RECOMMENDATION: NHS SBS should extend their procurement framework negotiations and offers to all active participants in an ICS structure. This would include, for example, all social care service providers.**

We should also remember that in February 2016, the government announced a review of computer systems across the NHS, to be led by Bob Wachter, and which would report by June by that year. Its foremost objective was to: “look at ways to improve NHS IT, including electronic health records, to achieve a paper-free health and care system by 2020”.

With 10 recommendations the [Wachter Review](#) was published in September 2016 to an underwhelmed response. One of the key aims (that of digitising the NHS) was pushed back to 2023 and, reading it now in 2021, it is amazing how much of the emphasis was on the NHS rather than a joined-up review with social care.

One of the more interesting elements of the review was that concerning the self-reporting of digital maturity by NHS organisation respondents, with outcomes that were as follows:

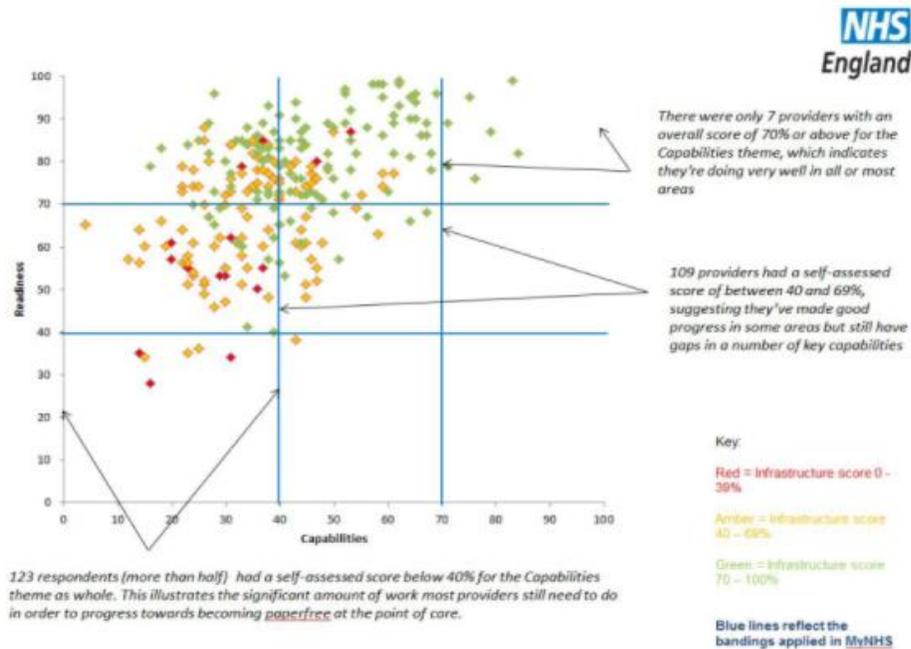


Figure 2: Key findings on the digital maturity self-assessment, based on the domains of capabilities, readiness and infrastructure

This reveals that, back in late 2016, nearly half of all NHS organisations felt that their digital capability was below 40%, whilst a third felt less than 70% ready.

Overall, our instinct based on testimony from numerous members across our various Special Interest Groups (SIGs), is that only slow progress has been made. There is a huge inconsistency across ICSs and across ICS regions, from absolutely up-to-date and enabled hardware and software systems, to hopelessly antiquated resources that have nowhere near adequate functionality.

How then, do ICSs rectify this and what does best practice look like?

# DESIGNING, REVIEWING AND PROCURING SYSTEMS

A significant problem in the process of designing, reviewing and procuring IT systems at the kind of scale required for ICS organisations is the history of difficulties associated with previous such projects. Few reading this report will have forgotten the [Lorenzo project](#).

Depressingly, it is the opinion of too many of our members that the reaction to the shortcomings of the Lorenzo project and others has been to make the process of specifying and procuring IT systems extraordinarily complex and difficult to follow.

As an example, we might point to a 2014 [General Practice IT Infrastructure Specification](#) document provided by NHS England with no less than 26 guidance points. Remember that this was intended for GP practice managers to implement.

Or how about the very recent NHSX [What good looks like](#) report for emerging ICSs containing seven success measures comprising 45 ‘your ICS should...’ recommendations.

To our mind, we need to get back to basics and provide ICSs with the essential guidance to get them working in a coordinated, collaborative and equal manner with all stakeholders able to access and share information quickly and easily.

What will that take?

**RECOMMENDATION: NHSX should urgently provide clear and practical guidance for ICSs based on how to procure an ‘oven ready’ digital technology solution for, in particular, electronic patient record (EPR) systems across an ICS geography. This needs to be a departure from the sorts of generalistic behavioural guidance provided in ‘what good looks like’ and much more around specific systems, costs, procurement pathways, timescales and funding. If this is not done, then the risk is that massive amounts of time are wasted in the individual ICSs as they all seek to invent their own wheels!**

Let’s go back to our original recipe:

- Data
- Money
- Workforce

## Data

Our members tell us that wide accessibility and security are the two key elements. Michael Morgan-Curran, a leading voice in our Digital Health SIG, puts it like this:

“As managers work to introduce new services and integrate delivery of care, Trusts need to develop the ability to receive data from external sources such as pharmacies, labs, telemedicine platforms, consumer health apps, social care providers and connected devices in patients’ homes.

“Managers will need to ensure this flood of data from outside the organisation is authentic, uncompromised and transferred to patient records without error. They will also need to assure that other parts of the local care system can trust data shared with them.

“Integration with data providers is a big headache. Integration projects add cost and delay. Tight coupling with partners introduces complexity and brittleness as problems in one system touch everything else. The other option has been to manually transcribe data into medical records.

“There is another way...

- Decentralised technologies like blockchain mean parties no longer need a big integration project before cooperating.
- New identity and data model standards mean **data** can now be made interoperable without systems needing to speak to each other.
- This provides flexibility and resilience, and cuts vendor lock-in, as open standards bring interoperability.”

Michael’s observations are powerful and relevant. If data is going to be widely shared and securely accessed, then there needs to be a commitment to enable this in the specification and procurement process with a full view of the latest methodologies for enabling access.

#### **RECOMMENDATION:**

**Putting data accessibility and security as a priority, ICSs should create system specifications that properly and fully recognise the latest technologies for data sharing without the need for complicated system matching. Ask NHSX to explain what is available and signpost to organisations within the NHS / social care where the systems are already working well, then copy them.**

Even before this recommendation, however, perhaps the biggest missing piece is a unified and agreed vision and strategy for how data will be collected, analysed, collated, made accessible and used across any ICS geography.

As far as we can tell at present (November 2021), only one ICS (Devon) is actively proposing to commission a single EPR system to cover the entirety of acute, primary, community and social care.

By way of reference for geographies using a pan-region EPR across all care provision, there are existing best practice examples aplenty from the USA (South Bronx, New York; Providence Health, Washington), Canada (Alberta Health Services), Finland (Apotti Project) and Norway (Trondheim region).

#### **RECOMMENDATION:**

**Support Devon ICS to roll out their single-source EPR and then use that as the template for every other ICS in the country.**

### **Money**

If ICSs are trying to specify and procure digital systems for the benefit of all stakeholders, then logic tells us that there should be a budget pool from which such systems are funded.

Funding for digital systems can currently be secured from the [Unified Tech Fund](#), which will be available to ICSs as they become statutory bodies. Additionally, there are numerous other funding streams as well as, of course, local level IT budgets.

As for data, it is the absence of a unified and agreed vision and strategy for how the ICSs will specify, procure and pay for new digital systems which causes the most anxiety.

**RECOMMENDATION:**

**NHSXD to create a clear, unequivocal guide to demonstrate how money for ICS digital systems can be accessed and used from a central fund.**

**Workforce**

It is clear that there is massive inconsistency across health and social care provider organisations in respect of the skills, numbers and abilities of IM&T staff working within such organisations.

HEE's [Data Driven Healthcare in 2030: Transformation Requirements of the NHS Digital Technology and Health Informatics Workforce Interim Report](#) (March 2021) paints an awkward picture, identifying a huge required increase in skilled workforce across all manner of IT roles. Their figure says that a workforce expansion of 69% (an additional workforce of 32,000 on top of the existing 41,000) will be required by 2030.

Our opinion is that such a significant increase in highly skilled workforce is unrealistic to achieve. Therefore, a more practical solution is called for.

**RECOMMENDATION:**

**Suppliers of digital technology ensure that their specified systems are delivered with appropriate training provision as a key element of the total procured package for all users.**

## ACCESSING DATA

David Kwo from the IHSCM’s Digital Health Technology SIG has worked with colleagues to publish an important report – *Future EPRs for ICSs*. The full report is available by emailing [jwilks@ihm.org.uk](mailto:jwilks@ihm.org.uk).

At the foundation of David’s report is what he and colleagues refer to as ‘core ICS business needs’, which they outline as follows:

<b>System Level</b>	<b>Place Level</b>	<b>Neighbourhood Level</b>
<b>1 Patient Activation</b> – ability to empower patients in the decision making about their care and to provide them with a seamless experience of care and services at all contact points and levels		
<b>2 Service Delivery</b> – ability to deliver ICS provisioned services e.g. surgery hubs, shared pathology labs, cancer hubs, maternity networks, etc.	<b>2 Service Delivery</b> – ability to deliver seamless services through organisations in a place. E.g. virtual vascular hubs across 2 acutes in a locality and diagnostic hubs in a community.	<b>2 Service Delivery</b> – ability to deliver seamless services through organisations in a neighbourhood
<b>3 Population Health</b> – ability to manage the population at system level (using health and illness profiles, risk stratifications, forecasting of needs)	<b>3 Population Health</b> – ability to manage local place residents using case management and care planning processes	<b>3 Population Health</b> – ability to manage local neighbourhood residents using case management and care planning processes
<b>4 Innovations and Developments</b> – ability to develop new care models and services across the system	<b>4 Innovations and Developments</b> – ability to develop new care models and services across the place	<b>4 Innovations and Developments</b> – ability to develop new care models and services across the neighbourhood
<b>4 Data Management, Analytics and Reporting</b> – ability to manage and curate data, manage data quality, analyse big datasets for modelling and research, generate reports for operational, management, financial and statutory purposes		
<b>5 Management</b> – ability to manage corporate functions (e.g. performance, quality, workforce, finance, IM&T, estates, commissioning) at system level	<b>5 Management</b> – ability to manage relevant corporate functions (e.g. performance, quality, workforce, finance, IM&T, estates, commissioning) at place level	<b>5 Management</b> – ability to manage relevant corporate functions (e.g. performance, quality, workforce, finance, IM&T, estates, commissioning) for organisations within a neighbourhood

We welcome David’s observations, particularly the recognition of the three-layer approach – system, place and neighbourhood when specifying digital technology requirements.

Further into the report comes an important statement in regards the issue of data:

“We expect EPRs in the future to be working in different ways than they have in the past. For instance, we expect the future ICS EPR to support ICS staff seamlessly across organisations and care settings, have

the same look and feel for all ICS staff, provide uniform and equitable levels of functionality across organisations and settings, and support differences in working for the three levels of ICS organisation (neighbourhood, place and system).”

To our mind, this enshrines the key principles of data availability and access that we are happy to repeat it as a recommendation from this report.

**RECOMMENDATION:**

**ICS EPR must support ICS staff seamlessly across organisations and care settings, have the same look and feel for all ICS staff, provide uniform and equitable levels of functionality across organisations and settings, and support differences in working for the three levels of ICS organisation (neighbourhood, place and system).**

In practice, such an approach might translate as follows (with thanks to David Kwo and colleagues for reproduction permission):

Table 4 – Potential ICS EPR Functionality for Each Care Setting (UK)					
Functionality	Primary Care	Secondary Care	Community Care	Mental Health	Social Care
<p><b>1. Patient Activation</b>            Ability for patient/citizen to: view his/her medical record and medications, schedule appointments, request repeat prescriptions, attend virtual consultations, message clinical team for help, access education materials, answer questionnaires, use applications for wellness, chronic conditions, manage his/her personal health<sup>7</sup> record, use patient kiosk at facility, access medical record when on a ward.</p>	✓	✓	✓	✓	✓
<p><b>2. Service Delivery System</b>            Ability for health and care staff to: schedule appointments, track patient flows, support pharmacy operations, request diagnostic tests (path and rad), prescribe drugs, administer drugs, use decision support logic, document clinical findings, communicate with other clinicians, support social care, support ITU processes, review patient record and plot trends, integrate EPR with medical devices and pumps, support infection control needs, manage patient care plans and education, support clinical pathways across care settings, message colleagues securely, support voice recognition and natural language processing technology, support triage processes, provide support for specialties including: anaesthetics, theatres, ED, pathology, cancer, orthopaedics, cardiology, dermatology, ENT, fertility, genetics, genomics, ophthalmology, endoscopy, transplant, radiology, rheumatology, maternity, dentistry.</p>	✓	✓	✓	✓	✓
<p><b>3. Population Health Management</b>            Ability for ICS staff to: document and manage patient care plans; use case management tools to coordinate care teams across organisations and settings; manage a directory of ICS-wide services; manage costs and utilisation of services; provide a web portal for ICS staff; maintain a longitudinal plan of care for each patient; maintain clinical registries for cohorts of patients, manage risk stratification.            Ability to combine data from multiple sources from within and outside the health and care system to be able to accurately risk stratify populations based on the wide determinants of health and wellbeing to inform the allocation of finances, resources and interventions to reduce the demand in the system and enable better health and wellbeing outcomes overall. This requires combining data from health economists, research and</p>	✓	✓	✓	✓	✓

analytics communities and health and care system strategists and operational managers. Ability to make data available for research, new insight and innovation by the academic and research sector combining some of the major national initiatives e.g. geonomics.					
<b>4. <u>Innovation and Development Systems</u></b> Ability to: support development of apps using open standard APIs; allow secure access to staff outside of the ICS boundary to the patient record and request services; support telemedicine apps for: stroke, dermatology, mental health, ICU, remote home monitoring and links to patient sensors, specialty specific remote consultations. Enable the growth of a wide and diverse ecosystem of both digital and health and wellbeing providers to contribute to achieving personalised and individualised health and care for the different populations in the UK and beyond. This includes hundreds of thousands of third and independent sector health and wellbeing providers and contributors. It includes potentially making the UK the best country for health tech in line with the digital ambitions set out by government to deal with the significant challenges facing the health and care system the most obvious being the aging population .	✓	✓	✓	✓	✓
<b>5. <u>Data Management, Analytics and Reporting System(s)</u></b> Ability for ICS staff to: develop dashboards and reports, analytics, benchmarking with peers, on-demand end-user reporting, manage an enterprise-wide data warehouse, applications using machine learning tools, support research including trial recruitment and participant tracking, research billing, research requesting and documentation.	✓	✓	✓	✓	✓
<b>6. <u>Management Systems</u></b> Ability for ICS staff to use applications such as: finance systems, quality management systems, human resource systems, estates systems, performance management systems, etc. These are typically packages with some interfacing between them and use of extracts for reporting and analysis purposes. The EPR systems often provide data feeds for management systems.	✓	✓	✓	✓	✓

The point here is that EPR functionality that has historically been available for acute hospitals, for instance, should now be made available equally and seamlessly for all the care workers in the ICS, for the simple reason that all care workers are now being asked, rightly and at last, to collaborate and work as a single team because patients naturally move between them in course of their care journey. Our contention is that integrated workflows require integrated functionality.

A number of examples of best practice in how to begin this 'access to all' approach have been identified by various sources, including our partners in this report, Cerner. They are as follows:

**Shared care records:**

[Health & Social Care integration in West Suffolk \(blog & video\)](#)

[Health Information Exchange in East London](#)

[Health Information Exchange in Wirral](#)

**Population Health - UK**

[Medication reviews - Wirral](#)

[Learning disabilities - Wirral](#)

[Diabetes - Lewisham](#)

[Vulnerable people during the pandemic - Lewisham](#)

[Covid response - NCL](#)

Of course, data availability and access in itself is no good if ICSs' focus is not on the measurable effects of what their data driven care is creating for citizens. As such, this report has the following recommendation.

**RECOMMENDATION:**

**Every ICS should publish a dashboard of key care performance measures to include metrics such as patient / service receiver experience, accessibility to services (time and scope), patient outcomes, costs v efficiencies and more. Into this mix should be added carbon reduction, staff wellbeing and health equality.**

**Senior managers should create virtual or in-person 'town hall' meetings for citizens to ask questions and comment on care provision.**

# MEASURING EFFECT

If we return to the rationale for the establishment of ICS organisations, then the measurement criteria that should be applied become clear, all enabled by digital data technologies for collection, collation and analysis.

ICSs are designed to look holistically across provision of health and care in a geographic region and design strategies and plans to better integrate services to the benefit of citizens.

In this regard, we would suggest measurement headings as follows:

1. **Health outcomes:** Mortality by key disease, admission by key disease etc
2. **Access to health and care:** Waitlists by key category (acute, mental, primary, community, social etc) and numbers treated in each key category
3. **Health inequality:** Variations by region on key public health measures
4. **Workforce:** Numbers employed, training metrics, unfilled vacancies, median pay, wellbeing and morale – all by key employment category
5. **Finance:** Expenditure by major spend category v budget

## RECOMMENDATION:

Every ICS should provide a website dashboard where key metrics (as above) are displayed in live data so that citizens can see progress or otherwise being made and interact accordingly.

A model, such as that presented by the Welsh NHS for citizens to see current wait times at A&E across the country, provides a basis for the approach – [My A&E Live - NHS Wales Accident and Emergency Departments](#).

**Jon Wilks**

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## **ACKNOWLEDGEMENTS**

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Members of the IHSCM Digital Technology Special Interest Group

Michael Morgan-Curran

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David Kwo and colleagues

Cerner associates