Levelling Up or Levelling Down:

The Impact of Integrated Care Systems on the Delivery of Care

Ration Watch

The Medical Technology Group
Improving patient access to medical technology

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Chair's Introduction

The Medical Technology Group's (MTG) purpose is to ensure patient access to medical technology across the country, regardless of where they receive their care. The group advocates to ensure that the patient is at the heart of all the NHS does, and that their voices are heard within the NHS.

The Group has delivered a range of impactful reports in recent years, including on ensuring meaningful patient involvement, supporting the adoption of medical technologies across the country, and precursors to this Ration Watch report.

As a constructively critical friend to the NHS and the Department of Health and Social Care, the MTG will continue to shine a light on Government policies which lead to inequitable access to care across the country.

In 2022, the MTG launched its Ration Watch report, *'Tackling Regional Variation in Healthcare: Inequalities, Innovation and Integration'*. The report focused on the performance and regional variation in the number of patient procedures performed per Clinical Commissioning Group. By comparing data on four key clinical areas across each NHS region, the report looked for consistency of service across a Clinical Commissioning Group's (CCGs) therapeutic delivery.

This report measures the impact of integration on the constituent parts of ICSs, and highlighting areas of good and bad practice over the past 24 months. It also highlights the increasingly siloed working of the NHS, and the failure of the system as a whole to learn from other areas and improve standards.

One suprising statistic is that the top performing former-CCG is seeing 160 more patients per month than its bottom performing counterpart. This disparity over time means there is a true postcode lottery for care for thousands of patients every single year.

While commonly understood to be a single organisation, the NHS in England actually operates as 42 ICBs, 154 Foundation Trusts, 124 Acute Trusts, 220 General Acute Hospitals and 6,925 GP practices[1].

Good practice is abundant across the NHS in England, whether nationally-led or driven within local NHS organisations. However, it is clear that it is often isolated and although sometimes shared within ICS structure, is not regularly shared with other ICSs. In the 2022 Ration Watch report, the MTG learned that best practice was shared only via informal networks, and not via any formal channels.

By sharing best practice, learning from others and adopting improved clinical pathways that utilise the most innovative medical technologies, the NHS has the ability to reduce the elective backlog of care.

The lack of communication within the NHS and between NHS bodies means that these problems will continue to exist. By doing what we have always done, we will continue to get the same results. Patients will receive different levels of care depending on where they live, and inequalities will become further entrenched.

Our recommendations in this report set out a roadmap for the NHS to deliver improvements by replicating, adapting and adopting best practice; providing the support to ensure medical technologies are available for patients regardless of where they live; and improving standards of care across the NHS.

Barbara Harpham,

Chair, Medical Technology Group

1. https://www.england.nhs.uk/nhsbirthday/about-the-nhs-birthday/nhs-in-numbers-today/

Introduction

The Covid-19 pandemic has had a seismic impact on the delivery of health and care services across the NHS, seen most evidently across the waiting lists within the NHS and its Integrated Care Systems (ICBs). In October 2023, the total number of incomplete pathways across the NHS sat at a staggering 7,705,539.

While the system has attempted to combat waiting lists, with total figures reducing in February 2024 to 7.6 million from 7.7 million in October 2023[2], there is still a long way to go before the system returns to normality, with the impacts including poorer outcomes for patients, challenges for staff and clinicians, and added financial pressures to the system as a whole, and for individual NHS organisations across the country.

There is also considerable variation in the geographical performance of NHS England's ICBs, and the resulting reality of where you live being a significant factor in the quality and speed of your care.

Launched in the months following the statutory introduction of ICBs, the 2022 Ration Watch report called for NHS England to ensure that ICBs levelled their care up to the best performing Sub-ICB Location (SICBLs, formerly CCGs) within their system. Within the conclusion of the report, the MTG recommended that NHS England improve the sharing, promotion and adoption of best practice across Integrated Care Boards (ICBs) and providers, and better utilise medical technologies to support the efforts to raise standards and promote better outcomes for patients.

This report examines the complexities of health inequalities and variations in patient access to treatment and access to medical technology within ICBs and highlights the opportunities to share best practice across the country. With so many areas tackling waiting lists in a meaningful way, there should be a greater focus on supporting NHS bodies to learn from others and improve outcomes for patients.

In this report, the MTG has examined NHS England's Referral to Treatment (RTT) data, alongside Freedom of Information (FOI) requests to every ICB, and assesses the impact of integration on the performance of ICBs and their constituent Sub-ICBs, demonstrating variation within ICBs, and the inequalities in access to healthcare that persist.

Although ICBs have carried out significant work in the past 24 months, there are entrenched challenges for ICBs and their constituent parts, leading to poorer outcomes for patients. Without direct intervention from the centre, and clear access to medical technologies and best practice, poor performance will continue within parts of the NHS.

This report underscores the importance of understanding the complete picture of SICBL performance to assess effectively the success of integration in raising overall standards and identifies areas where challenges persist.

Moreover, insights derived from Freedom of Information (FOI) data reveal limited sharing of best practices within and between ICBs. Although pockets of collaboration exist, the lack of cross-ICB sharing of best-practice limits ICBs' ability to learn from other areas on how to manage and tackle waiting lists.

The key findings and recommendations from this study emphasise the existence of deeply-embedded challenges in ICBs, leading to persistent poor outcomes for patients. Despite significant efforts by ICBs over the past 24 months, direct intervention from national bodies such as NHS England and the Department of Health and Social Care is essential to address persistent issues.

There are pockets of excellence within the NHS, with local bodies driving change through the use of innovative ideas, technologies, and effective leadership. These instances of best practice must be shared widely within the NHS, and used to shape services in poorer performing areas.

Patients across the country continue to face a postcode lottery for care, both in terms of accessing timely care, and accessing the most appropriate technologies to support their treatment, care and recovery. Without further consideration from national bodies, and seizing the opportunity to share best practice across ICSs, this postcode lottery will persist, and the NHS and patients will continue to face these challenges.

2. https://www.england.nhs.uk/2024/02/nhs-waiting-list-falls-for-third-month-in-a-row-thanks-to-efforts-of-staff/

Recommendations

The MTG recommends that:

NHS England

1. **Analyse the ICB areas where there are persistent challenges and variation, and provide support for them to raise their standards to meet the needs of patients.**
2. **Identify areas and examples of best practice within the ICS system that can be shared and adopted in areas with persistent challenges.**
3. **Develop forums for ICBs to discuss common challenges and solutions, and share best practice to help deliver better outcomes for patients.**
4. **Work with the Department of Health and Social Care and other national bodies (including NICE) to standardise the pathway for medical technologies and innovations to access the NHS.**

ICBs

1. **Analyse pockets of poor performance within their own Systems, and set up interventions, resources and support to raise standards across their ICB footprint. ICBs should strive to raise the standards of their poorest performing SICBLs, and improve patients access good care.**
2. **Ensure that patients have access to the most appropriate medical technologies, regardless of where they receive care within an ICB.**
3. **Seek support from national bodies and other ICBs where best practice is being carried out, to change practice, help improve standards and deliver best outcomes for patients.**

Best Performing Sub-ICB Locations

This section of the report looks at Sub ICB Locations (formerly CCGs) and ranks them based on their performance, measured by their completed patient pathway numbers using NHS England's Referral to Treatment Time (RTT) data.

Despite variation across the country, more patients are being seen within health and care settings. There were 6,156,844 patient pathways completed from December 2021 to November 2023 – a 46.82% improvement in the patient pathway completion.

For the most part, the best performing SICBLs remained consistent across all 24-months, in Wakefield, Dorset, and Noth East Lincolnshire. All three were mainstays in the top-10 for most of the December 2021 to December 2023 period.

The success measured in places like these is extremely positive. Despite ongoing pressures on service, all have maintained a consistently high level of output, improving, on average, month on month.

However, while the success in these pockets within the NHS in England are commendable, the variation in performance between neighbouring SICBLs and ICBs is of concern. For example, Wakefield is the best performing SICBL, whereas neighbouring SICBL, Leeds, ranks 73rd. In Humber and North Yorkshire ICB, the 3rd best SICBL (North East Lincolnshire) sits alongside the 98th (Vale of York).

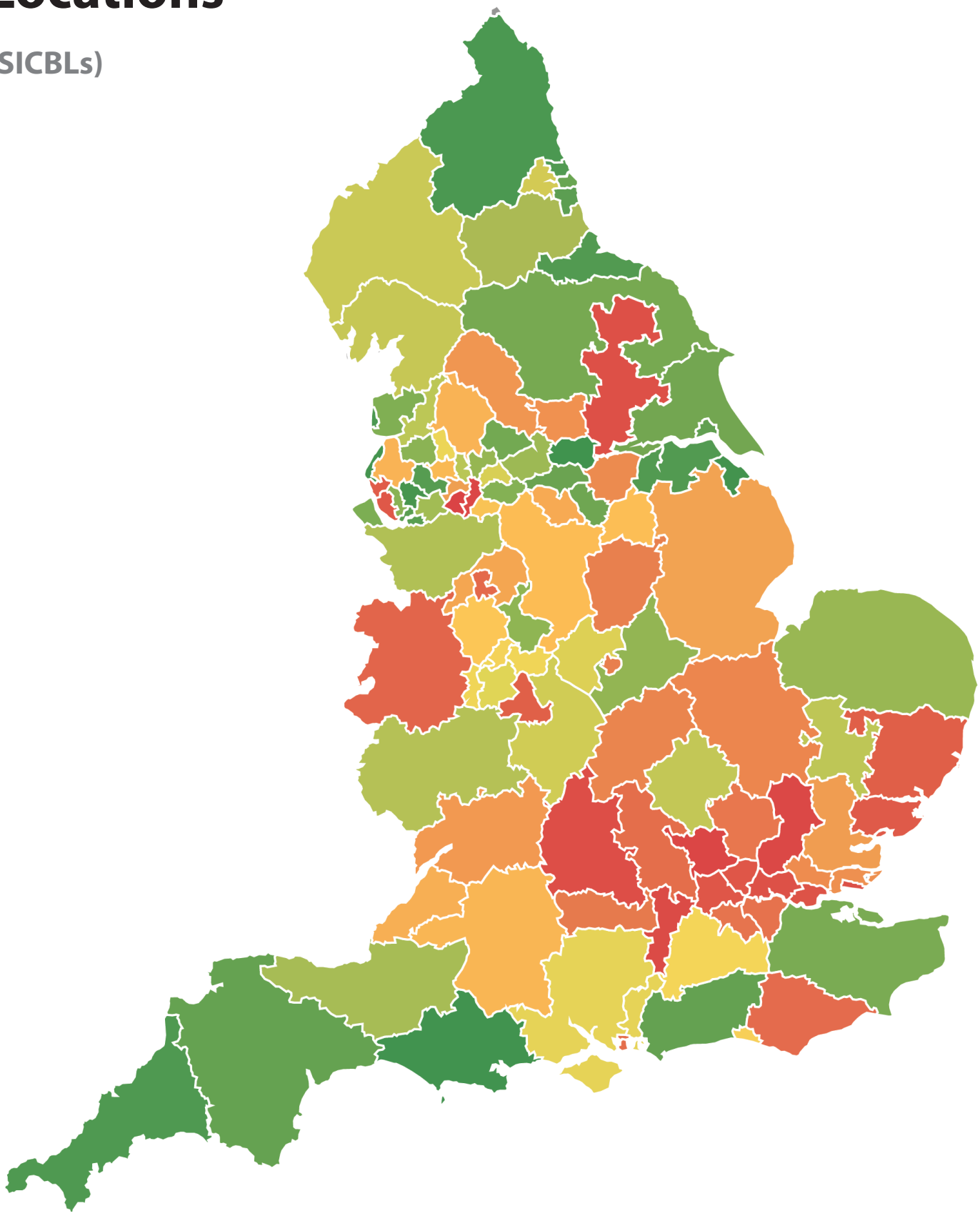
Tackling this variation must be a core focus for NHS England and ICBs, looking to take the learnings and best practice from the best performing NHS bodies to level up the worst performing SICBLs to the level of the best, reducing local variation.

Top 10 Performing Sub-Integrated Care Board Locations:

Rank	SICBL	Region	Population	Pathways Completed	Pathway Rate	24-mth Pathway Rank	Average of all 24-mth Ranks (Rank)
1	WAKEFIELD	NORTH EAST	348,312	69,853	200.55	1	**1.08 (1)**
2	DORSET	SOUTH WEST	773,839	132,879	171.71	2	**3.17 (2)**
3	NORTH EAST LINCOLNSHIRE	NORTH EAST	159,563	26,453	165.78	3	**4.88 (3)**
4	SOUTHPORT AND FORMBY	NORTH WEST	116,184	18,763	161.49	4	**10.83 (6)**
5	ST HELENS	NORTH WEST	180,585	27,938	154.71	5	**11.21 (7)**
6	NORTHUMBERLAND	NORTH EAST	322,434	49,695	154.12	6	**8.88 (4)**
7	BLACKPOOL	NORTH WEST	139,446	21,299	152.74	7	**10.13 (5)**
8	KERNOW	SOUTH WEST	571,802	87,274	152.63	8	**11.29 (8)**
9	NORTH TYNESIDE	NORTH EAST	207,913	31,606	152.02	9	**11.63 (10)**
10	NORTH LINCOLNSHIRE	NORTH EAST	172,292	26,130	151.66	10	**11.38 (9)**
11	TEES VALLEY	NORTH EAST	675,944	100,803	149.13	11	**13.67 (11)**
12	WIGAN BOROUGH	NORTH WEST	328,662	47,145	143.45	12	**21.13 (20)**
13	HALTON	NORTH WEST	129,410	18,538	143.25	13	**17.83 (13)**
14	SUNDERLAND	NORTH EAST	277,705	39,764	143.19	14	**16.63 (12)**
15	HULL	NORTH EAST	259,778	36,703	141.29	15	**19.21 (15)**

Sub-ICB Locations

(SICBLs)



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Worst Performing Sub-ICB Locations

Although the bottom ranked SICBLs improved their performance overall (with a greater percentage increase in seeing patients (47%) compared to the percentage increase in the top SICBLs (45%)) persistent challenges remain for these areas, particularly in major cities such as London and Manchester.

North Central London SICBL has been consistently the worst performing SICBL across all 24-months measured, placing 106th (last) in 14 months, and placing in the bottom five SICBLs in every month recorded. North East London SICBL, the neighbouring SICBL to North Central London, was also in the bottom ten-performing SICBLs over 24-months, ranking 97th. Both of these SICBLs were the worst performing London SICBLs in every month recorded, and are symptomatic of London's regional performance.

Similar to the situation of Greater London is that of Greater Manchester. NHS Manchester, the 103rd ranking SICBL, has the lowest percentage increase of all SICBLs, at just 7.3%, and ranking a couple of places lower than Manchester SICBL is Trafford SICBL, which ranked 105th.

This relationship is significant as these SICBLs not only share a geographical boarder, such as those in London, but also an ICS, the Greater Manchester Health and Care Partnership. Sitting in stark contrast is Wigan SICBL, also a member of the Greater Manchester Health and Care Partnership, which placed 12th over the 24-months, ranking as high as 5th in May 2023.

With such variation, the opportunities for best practice sharing within Greater Manchester should therefore be better-delivered, particularly given the ICS's 2023-2028 Strategy which notes that they strive to "adapt and implement best practice locally, in organisations and across systems".

Comparing the best and worst SICBLs nationally (Wakefield and North Central London), there is a difference of over 160 patients treated per calendar month. But what is more concerning is not necessarily the gap in patients treated, but the time over which this variation has persisted.

One trend which has been consistent is that the performance and ranking of an SICBL at the start of period examined determines its current position. It seems that those SICBLs who have performed poorly, will continue to perform poorly, with the same true for those who perform at the top of the rankings. This shows an embedding of either good or bad performance, which has been a challenge for SICBLs to tackle.

The MTG sees the sharing of best practice as a key tool in reducing this variation. For SICBLs like Wakefield or North East Lincolnshire to be performing so consistently highly, there must be programmes, leaders, technologies or systems allowing them to do so. The fact these are not being shared within communities or across borders is a factor in compounding the variation.

From the evidence recorded by the MTG, it is clear that ICBs, whilst in operation for over 18 months, are yet to fully transition in practice from the structures of the CCG system, to one built to serve the area's population as a whole.

NHS England must examine how to best-support those ICBs and SICBLs that have a status-quo of poor performance, and particularly utilise best practice and the more effective use of medical technologies to help reverse this trend.

Good practice exists across the NHS in England, however, it is only once the constituent parts of the system, whether ICBs, SICBLs, Trusts or Primary Care networks, are able to learn from this and ensure it is replicated elsewhere, that variation in output will persist.

Bottom 10 Performing Sub Integrated Care Board Locations

Rank	SICBL	Region	Population	Pathways Completed	Pathway Rate	24-mth Pathway Rank	Average of all 24-mth Ranks (Rank)
92	SOUTH SEFTON	NORTH WEST	160,226	14,533	90.70	92	**87.33 (92)**
93	NORTH EAST ESSEX	EAST	341,267	30,639	89.78	93	**88.17 (93)**
94	LIVERPOOL	NORTH WEST	498,042	44,643	89.64	94	**89.75 (96)**
95	NORTH WEST LONDON	LONDON	2,103,719	187,485	89.12	95	**88.63 (95)**
96	THURROCK	EAST	174,341	15,407	88.37	96	**92.00 (97)**
97	NORTH EAST LONDON	LONDON	2,023,383	175,405	86.69	97	**94.67 (99)**
98	VALE OF YORK	NORTH EAST	366,072	31,479	85.99	98	**94.25 (98)**
99	SOUTHEND	EAST	183,125	15,207	83.04	99	**95.42 (100)**
100	OXFORDSHIRE	SOUTH EAST	676,171	54,031	79.91	100	**98.83 (102)**
101	FRIMLEY	SOUTH EAST	744,974	58,922	79.09	101	**88.17 (93)**
102	WEST ESSEX	EAST	310,040	23,694	76.42	102	**101.08 (104)**
103	MANCHESTER	NORTH WEST	552,858	38,011	68.75	103	**96.88 (101)**
104	HERTS VALLEYS	EAST	598,034	40,219	67.25	104	**103.71 (105)**
105	TRAFFORD	NORTH WEST	237,354	15,762	66.41	105	**100.29 (103)**
106	NORTH CENTRAL LONDON	LONDON	1,510,806	88,866	58.82	106	**105.29 (106)**

Table 1.

Average Pathway Completion rates of SICBLs

A Snapshot of Performance London & Greater Manchester

London

ICS Rank	SICBL	ICS	Population	Pathways Completed (24mths)	Pathway Rate (24mths)	National Rank
1	SOUTH WEST LONDON	South West London	1,504,810	145,297	96.56	**83**
2	SOUTH EAST LONDON	South East London	1,819,271	175,488	96.46	**84**
3	NORTH WEST LONDON	North West London	2,103,719	187,485	89.12	**95**
4	NORTH EAST LONDON	North East London	2,023,383	175,405	86.69	**97**
5	NORTH CENTRAL LONDON	North Central London	1,510,806	88,866	58.82	**106**

Greater Manchester

ICS Rank	SICBL	ICS	Population	Pathways Completed (24mths)	Pathway Rate (24mths)	National Rank
1	WIGAN BOROUGH	Greater Manchester	328,662	47,145	143.45	**12**
2	TAMESIDE AND GLOSSOP	Greater Manchester	260,063	35,263	135.59	**27**
3	HEYWOOD, MIDDLETON AND ROCHDALE	Greater Manchester	222,412	28,697	129.03	**32**
4	BURY	Greater Manchester	190,990	22,808	119.42	**40**
5	OLDHAM	Greater Manchester	237,110	26,690	112.56	**48**
6	STOCKPORT	Greater Manchester	293,423	31,610	107.73	**59**
7	BOLTON	Greater Manchester	287,550	30,523	106.15	**62**
8	SALFORD	Greater Manchester	258,834	26,464	102.24	**69**
9	MANCHESTER	Greater Manchester	552,858	38,011	68.75	**103**
10	TRAFFORD	Greater Manchester	237,354	15,762	66.41	**105**

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Integrated Care Systems

Integration to ICBs

In July 2022, Integrated Care Systems were created, merging SICBLs (formerly CCGs) into single organisations. In the previous Ration Watch report, the MTG noted that the impact of the introduction of ICBs on SICBL performance was yet to be determined. However, from early indications, the potential for raising standards across ICB areas has not been delivered.

From the performance data collected over the past 24 months, it is evident that – as with the SICBLs –those ICBs who were ranked lowest have remained there, while those who were ranked higher last year continue to lead on performance.

The MTG's findings last year were that those ICBs who have poorer performing SICBLs within their boundaries should work to bring their standards in line with the better performing SICBLs. It appears that this has not happened across the country, although ICBs are still only two years into their existence.

Best Performing ICBs

Dorset ICB was the highest performer overall (based on aggregate pathways completed proportionate to their population), and now is made up of the 2nd highest ranked SICBL, NHS Dorset.

Neighbouring Cornwall and the Isles of Scilly ICB placed 2nd overall, being made up of the 8th ranked NHS Kernow SICBL.

Devon ICB was ranked third of the 42 ICBs, and was solely comprised of NHS Devon SICBL, which was the 18th ranked of the SICBL, demonstrating the positive impact of it's integration (albeit that the integration was one SICBL to one ICB).

NHS Kent and Medway ICB was placed 4th of all ICBs over that time, with North East and North Cumbria – which is made up of 8 individual SICBLs – ranked 5th.

Of the ICBs analysed above, NHS Dorset ICB, NHS Devon ICB and NHS Cornwall and Isles of Wight ICB are all made up of one SICBL.

NHS North East and North Cumbria ICB has one of the best performing SICBLs in the country (NHS Northumberland, 4th of 106) which improves the overall average ranking of the ICB, when compared to the other SICBLs, which range from 10th of 106 to 47th. In this instance, the positive pathway completion rate of one exceptional SICBL has improved the overall ranking of the ICB.

From the performance data collected over the past 24 months, it is evident that – as with the SICBLs –those ICBs who were ranked lowest have remained there, while those who were ranked higher last year continue to lead on performance.

Worst Performing ICBs

North Central London ICB was the worst performing ICB on average over the 24 month period, ranking above NHS North East London ICB (41st), NHS Hertfordshire and West Essex ICB (40th), NHS North London ICB (39th), NHS Frimley ICB (38th), and NHS Buckinghamshire, Oxfordshire and Berkshire West ICB (37th).

The two London ICBs and Frimley ICB are all made up of one SICBL, all of which have been consistently poor over the 24 month period.

In contrast, Hertfordshire and West Essex ICB contains three SICBLs - Herts Valley, East and North Hertfordshire and West Essex – all of whom rank in the bottom 25 performing SICBLs, experience little variation, but demonstrate widespread poor performance. This is also seen in Buckinghamshire, Oxfordshire and Berkshire West ICB, which is also a collective of poor performing SICBLS, with Oxfordshire (97th), Berkshire West (81st) and Buckinghamshire (86th) all also ranking in the bottom 25 SICBLs.

Whereas in ICSs like Greater Manchester, performance is reflective of the performance of some its parts, with the minority impacting the overall performance rankings of the majority.

The performance of Greater Manchester's SICBLs ranges from 12th (Wigan) to 103rd (Manchester). In theory, Manchester could take the learnings from Wigan to aid in the recovery of its performance, as ›learnings can be made locally, and change maintained internally. However in London, Oxford or Frimley, where poor perofmance is ICS-wide, the whole Integrated Care System must recover to improve efficiencies in service performance.

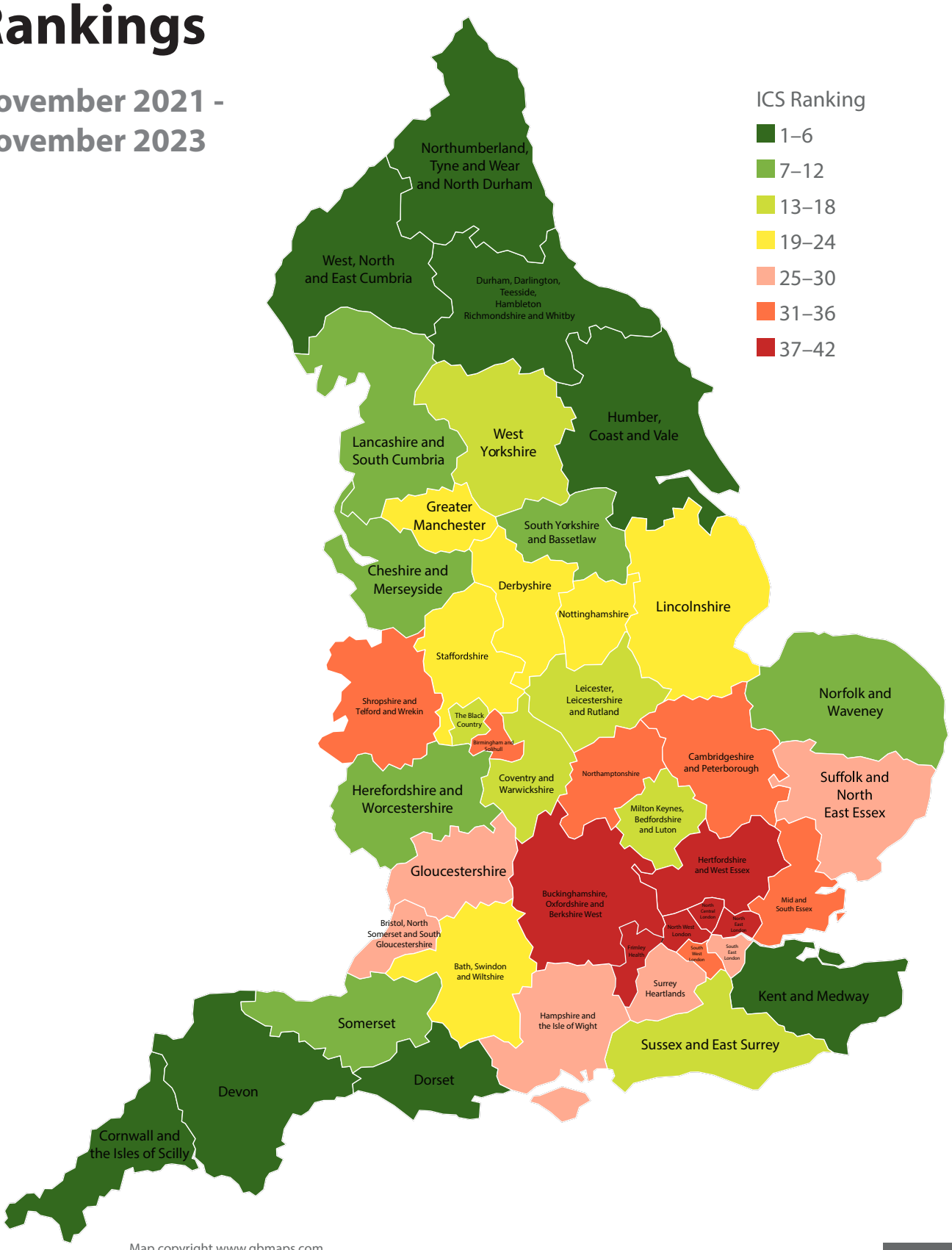
Best practice sharing is critical, however, it is implemented at present on different scales within the NHS. There are many areas which are implementing novel or innovative processes to deliver better outcomes for patients, and it is important that these are shared as widely as possible, so that NHS bodies can adapt them for their own areas and help to drive best practice.

For London, Oxford and West Essex, the ICSs must look beyond borders, to neighbouring ICS and SICBLs to better understand what they can do better to improve access to care, this is the responsibility of both NHS England and the ICS themselves. For others, such as Greater Manchester, where best practice exists within, there must be improved policies and practice for learning and expiditing this within an ICS.

Best practice sharing is critical, however, it is implemented at present on different scales within the NHS. There are many areas which are implementing novel or innovative processes to deliver better outcomes for patients, and it is important that these are shared as widely as possible, so that NHS bodies can adapt them for their own areas and help to drive best practice.

Integrated Care System Rankings

November 2021 - November 2023



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Variation in performance

A range of ICBs have seen their constituent SICBLs vary significantly in performance, which impacts its overall ranking, therefore creating a false picture of ICB performance.

NHS Cheshire and Merseyside ICB

A range of ICBs have seen their constituent SICBLs vary significantly in performance, which impacts its overall ranking, therefore creating a false picture of ICB performance.

NHS Cheshire and Merseyside ICB (ranked 9th of 42 ICBs) is made up of 9 SICBLs. These range from 6th and 7th in the SICBL rankings (St Helens and Southport and Formby respectively), to 92nd and 96th (Liverpool and South Sefton). Although it is ranked 9th of the 42 ICBs, its component SICBLs vary so widely that this average ranking does not paint the full picture of performance in the area.

Greater Manchester ICB

Similarly, NHS Greater Manchester ICB (ranked 19th out of all ICBs) has two SICBLs in the top 25 (Wigan Borough, 12th; and Tameside and Glossop, 25th), but also contains two of the bottom 5 SICBLs (Trafford, 103rd; and Manchester, 101st). Again, this variation in performance is masked by the relatively high overall ranking, meaning that the challenges in areas of Greater Manchester may be missed when examining the ICB as a whole.

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NHS Humber and North Yorkshire ICB

NHS Humber and North Yorkshire (6th) has similar challenges in terms of range of performance. It is made up of 6 SICBLs, with the best performing North East Lincolnshire ranked 3rd of 106. However, its worst performing SICBL, Vale of York, is ranked 98th of 106.

NHS Lancashire and South Cumbria ICB

NHS Lancashire and South Cumbria ICB (11th) is made up of 8 SICBLs, ranging from 5th- 66th out of 106 – a wide range of performance, showing the variation within the ICB. Again, the overall ranking of the ICB hides the reality of variation within its constituent SICBLs.

Viewing the rankings of ICBs like Lancashre and South Cumbria, Humber and North Yorkshire, Greater Manchester and Cheshire and Mersyside in isolation only paints part of the picture. The scale of variation within each ICB speaks to the wide range of SICBLs which have been integrated into these ICBs, representing areas which have their own significant challenges that must be addressed.

Part of the challenge of integation is bringing increased resources; collective and centralised decision-making; and greater accountability to larger areas, in the hope of delivering better outcomes for patients. However, from the data shown in this report, inequalities and poor outcomes are embedded over time within each SICBL, and rarely improve to the level of other, better performing SICBLs in each ICB.

These SICBLs cannot be forgotten in the delivery of integration, and within the overall context of a more successful ICB. Although there are areas with clear challenges – including ICBs in London – there are pockets of poor performance across the country, often hidden within better performing ICBs, which must be addressed.

For integration and the implemention of ICBs to have been sucecssful, each ICB has to make concerted efforts to manage their systems at a macro level, but also concentrate on improving those SICBLs in each area to the level of their best performing SICBLs. To fail to do so will lead to postcode lotteries being in place within ICBs, not just between them.

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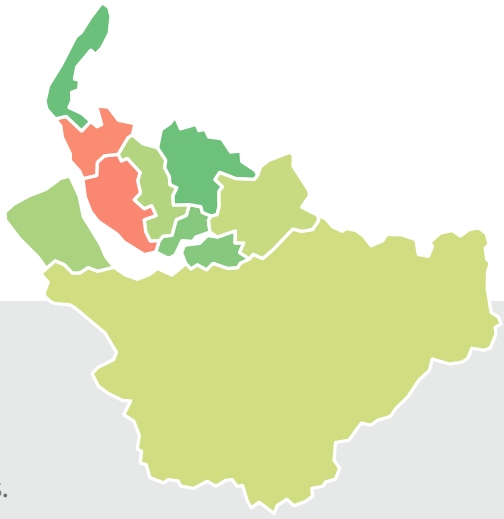
Cheshire and Merseyside ICB Case Study



Cheshire and Merseyside is the largest ICB in England. It has 9 places, made up of 22 Trusts, 250 GP practices and around 1,400 Care Homes.

Since inception, Cheshire and Merseyside ICB has been working to rationalise services to ensure equal access to treatments, regardless of where they live in the region.

Although there was some variation in how fast people were treated across the ICB, its individual Trusts provided mutual aid to tackle some of the elective backlog in a more joined-up and consistent way.

They have around 120 policies regarding treatments from across the new ICB organisations, which are being rationalised as ICB-wide policies. Given the scale of this work, it has taken some time to progress through them, but it is being led by the leadership team, and remains a focus for the ICB, particularly given its size and the potential impact on patients. In areas such as gynaecology, ophthalmology and "problem areas", there has been a focus on utilising resources, time and collaboration to help tackle patient waiting times. This helps to ensure patients are being seen faster; allows resource to be allocated for maximum impact; frees up capacity in other areas; and promotes areas as centres of excellence in driving patient outcomes.

Cheshire and Merseyside ICB is also examining its policies around digital, data and medical technologies to harmonise best-practice across the region. This rationalisation has been carried out with the best clinical evidence available, ensuring better patient outcomes, and focusing on effective medical technologies that can produce the best result.

The ICB leadership team is also taking on board the recommendations of the Hewitt Review, and are driving innovation where possible, including through the development of their own digital tools, such as the Merseyburns' App.

They have also run a unique project to drive early intervention for patients who require additional physiotherapy and dietary support, particularly those living with high risk of chest infection. They have utilised technology and data to find a cohort of patients for early intervention, and have reduced the rate of chest infection significantly. This has created a halo effect, reducing cardiac complications and reduced bed stay by 2 days and readmission reduction of £1,100 per patient.

As a large ICB, they are interested in comparisons with others, and replicating best practice where possible. They have stood up an Elective Recovery Board, and a Regional Recovery Board, with links to academic, clinical trials and other sectors who can support to reduce waiting lists for patients, and help to get new technologies into their hands quicker.

In a recent Board meeting, a draft ICB Digital and Data Strategy was presented, with the recommendation for the inclusion of the digital teams to sit within the Medical Directorate, to ensure intelligence on latest innovations is directly feeding though to the strategy and putting patients at the central of the decision-making process around all aspects of their care, including the digital aspects.

Cheshire and Merseyside ICB have also developed a digital exclusion heatmap. This helped the organisation to identify where people were most at risk at being left behind digitally. This data would be used to identify where resources such as kit and training, should be focused.

Best Practice

The role of sharing best practice and utilising medical technology to improve performance

In the MTG's previous Ration Watch Report, the recommendations included a call for NHS England to create platforms and forums for sharing best practice at a national level, as well as support ICBs to improve standards across all of their constituent parts. The MTG also called on the Government to develop strategies and support to raise the performance of poorer performing SICBLs within ICBs.

It is clear that these recommendations have not been delivered by either body, and the variation between and within ICBs remains persistent.

The MTG submitted FOI requests to each of the ICBs to determine where best practice is being shared, and where this may have had an impact on the performances of ICBs and their SICBLs.

North Central London ICB

North Central London, the worst performing ICB, does have formal structures for sharing best practice. When asked of the work the ICB has undertaken to ensure best practice is shared, it said:

Shared Learning and benchmarking comparisons between Boroughs, both best practice and areas of improvement are part of routine ICB business, the subject of routine discussions between Directors of Integration and the staff working on Borough and ICB footprints including through our Borough Partnerships, wider partners and the sub-groups. This includes ICB wide learning events.

Hertfordshire and West Essex ICB

The ICB leads a Design & Delivery group on behalf of the system, which meet 6 times a year and provides a forum to share good practice, update on progress of transformation schemes and test new ideas. This covers work undertaken at an ICB and Health Care Partnership (HCP) level.

South Yorkshire ICB

We constantly share best practice and learning across South Yorkshire, it is key to our delivery of the 4 aims for our ICB and enables us to deliver our core purpose to improve the health and wellbeing, the quality and experience of care, eliminate health inequalities and ensure the people of South Yorkshire have access to the services they need to live well throughout their lifetime.

Nottingham and Nottinghamshire

Sharing of best practice is undertaken in a variety of forms – both formal and informal and across clinical teams and networks.

Examples of this include, the Clinical & Care Professional Leaders Group (CCPL) workshops on COPD and Frailty. As an ICB, we review our care gaps and identify the most appropriate evidence based interventions for our populations.

At a Place level, similar examples would be projects currently being implemented by Mid Nottinghamshire Health Inequalities Oversight Group. Projects operate across the Mid Nottinghamshire Primary Care Networks (PCNs) and include Fuel Poverty Intervention Case Finding, Diabetes Low Calorie Diet Case Finding, Hypertension Case Finding, Case finding for Health Improvement and Financial Incentive for Tobacco Dependency in Maternity Services.

However, from the data provided by ICBs, the sharing of best practice generally only takes place within the ICB, when it does occur. Some ICBs do not have formal structures at all for sharing of best practice.

Where there are structures for sharing best practice, they often do not include formal structures for sharing best practice between ICBs. If ICBs like North Central London are only sharing best practice within its own, poorly perfoming ICB, it is unlikely to consider the full range of options for delivering better outcomes for patients.

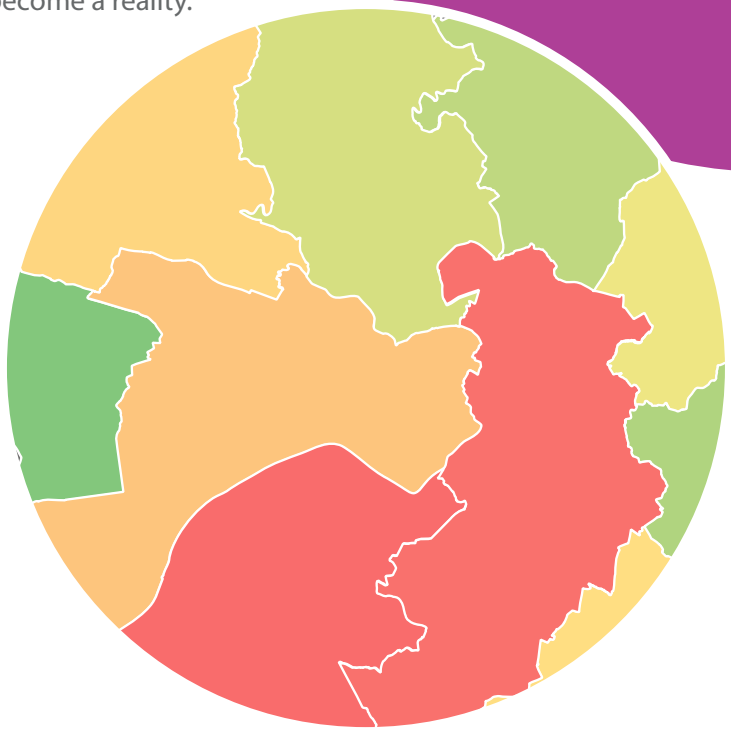
It is unlikely, given their focus on delivering for their own locations and managing the day-to-day challenges the NHS is facing, that ICBs will have the capacity to establish or manage formal knowledge exchange forums to share best practice in the integration of services, or within specific treatment pathways. Where these do take place currently, it is often informally or through personal or existing networks.

NHS England should take a lead role in setting up, delivering and monitoring forums to allow ICBs to learn from each other, and to raise standards across the whole country. To fail to do so will mean a further entrenchment of poorer performance in those areas which are currently struggling.

Cheshire and Merseyside provided an interesting case study into the rationalisation of policies to ensure the most effective technologies were in place across their ICB footprint. However, it was not possible to gague whether this policy of rationalisation has been fully realised, or to what extent it has taken place in ICBs across the country.

To deliver real change to patient outcomes, to support the health service to tackle its backlog, and create a sustainable NHS, medical technologies must become a core component of patients' care, where appropriate. Patients must be able to access the right care, at the right place and the right time, and without consistent commissioning of medical technologies through consistent adoption pathways, this will not become a reality.

Medical technologies play a key role in delivering efficiencies within health and care settings, provide options and improve outcomes for patients, and support NHS staff. However, it is clear that in many places in the country – due in part to challenges with adoption and spread of the most effective tchnologies – that patients are faced with a postcode lottery in accessing the most appropriate technologies in their treatment. The NHS must ensure the standardisation of choice and access of medical technologies for patients.



Key Findings and Recommendations

Although ICBs have carried out significant work in the past 24 months, there are entrenched challenges for ICBs and their constituent parts, leading to poorer outcomes for patients. Without direct intervention from the centre, and clear access to medical technologies and best practice, poor performance will continue within parts of the NHS.

There are pockets of excellence within the NHS, with local bodies driving change through the use of innovative ideas, technologies, and effective leadership. These instances of best practice must be shared widely within the NHS, and used to shape services in poorer performing areas.

Patients across the country continue to face a postcode lottery for care, both in terms of accessing timely care, and accessing the most appropriate technologies to support their treatment, care and recovery. Without further consideration from national bodies, this postcode lottery will persist, and the NHS and patients will continue to face these challenges.

The MTG recommends that:

NHS England

1. **Analyse the ICB areas where there are persistent challenges and variation, and provide support for them to raise their standards to meet the needs of patients.**
2. **Identify areas and examples of best practice within the ICS system that can be shared and adopted in areas with persistent challenges.**
3. **Develop forums for ICBs to discuss common challenges and solutions, and share best practice to help deliver better outcomes for patients.**
4. **Work with the Department of Health and Social Care and other national bodies (including NICE) to standardise the pathway for medical technologies and innovations to access the NHS.**

ICBs

1. **Analyse pockets of poor performance within their own Systems, and set up interventions, resources and support to raise standards across their ICB footprint. ICBs should strive to raise the standards of their poorest performing SICBLs, and improve patients access good care.**
2. **Ensure that patients have access to the most appropriate medical technologies, regardless of where they receive care within an ICB.**
3. **Seek support from national bodies and other ICBs where best practice is being carried out, to change practice, help improve standards and deliver best outcomes for patients.**

Ration Watch

The Medical Technology Group

Improving patient access to medical technology