ICS Development Update and Discussion

Humber Primary Care Collaborative (HPCC)

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ICS Development

Last meeting: Mike Farrar gave a sense of what Integrated Care Systems across England will look like

End May: Presentation pack circulated to show how it is shaping up locally

June-Jul:

- HCV will operate a 6/4/2/1 model (6 Places, 4 Provider Collabs, 2 Strategic Partnerships, 1 ICS)
- Strong focus on clinical leadership, population health and tackling inequalities throughout 6/4/2/1
- Humber is one of 2 Strategic Partnerships and will promote autonomy and authority to the Places.
- The ICS Primary Care Collaborative is one of 4 Provider Collabs and will draw from the 2 Strategic Partnership PCCs and advise the ICS on primary care strategy / at scale
- National ICS Design Framework published (slides 3-8 summarise this)
- Legislation published – confirms that primary care will nominate a member onto the ICS Board and that ICSs are in future expected to take on the majority of NHSE commissioning (dentistry, general practice etc.).
- Controversial clause re. general power to health secretary to direct NHS agencies over local service reconfigurations – no clarity on the conditions upon which it will be used.

Humber Engagement Pack shared with HPCC end of May in strongly in line with HCV and National Design Framework…

- Transitioning from what CCGs do into Place-based system leadership and integration – for Hull, East Riding, North Lincolnshire and North East Lincolnshire
- Working with defined population health budgets and outcomes
- Place-based (coterminous with Local Authorities) for Health, social care, primary-secondary care interface, Provider Collaboration/Planning.
- Neighbourhood-based (PCNs / LA localities): Primary Care enhanced services, Medicines Management, Social Prescribing, Wider Determinants. Primary Care Development.
- Major role for Primary Care – how does CCG (ICS) resource support?
  - What are the things that truly make a difference? Industrialise it.
  - What will you look back on and say we made a massive difference?
  - What is going to be strong? Where do you think there are gaps?

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Integrated Care Systems: design framework summary of v1 June 2021

This document does not cover the full breadth of ICS arrangements – only how the NHS will be approaching the proposed establishment of ICS NHS bodies

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The ICS Partnership and NHS Body

- The ICS Partnership: established by the NHS and local government as equal partners. The ICS Partnership will produce an **integrated care strategy** - Partnerships may use a range of sub-groups, networks and other methods to convene parties to agree and deliver the priorities. Chair could be the same as the ICS NHS Body but doesn't have to be. Consultation ahead of implementation on role, accountabilities of the Partnership and the Chair. Strong public health presence. Nurturing role in the culture and behaviours.
- The NHS Body will: develop a plan, allocate resources (striking the balance between local decision-making and scale across larger footprints for more specialist or acute services), establish joint arrangements including S75 of the 2006 Act (may happen at Place and will support the integrated care strategy), establish governance arrangements, arranging provision of services (contracts, transformation, CHC), people plan, digital plan, invest in local community organisations and infrastructure, EPRR, VFM, delegations from NHSE.
- The **NHS Body will have a unitary board** - responsible for ensuring the body plays its role in achieving the four purposes of the wider ICS. To include the following roles. A chair plus a minimum of two other independent non-executive directors; chief executive (who will be the accountable officer for the funding allocated to the ICS NHS body), director of finance, director of nursing and medical director; one member from NHS trusts and foundation trusts in the area, one member from general practice in the area, and one member from a local authority with statutory social care responsibility in the area. e expect all three partner members will be full members of the unitary board, bringing knowledge and a perspective from their sectors, but not acting as delegates of those sectors.
- The ICS NHS body will establish an audit and remuneration committee as a minimum. The board may establish other decision-making committees, in accordance with its scheme of delegation. The board should maintain a 'functions and decision map' showing its arrangements.

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Key Features

- **Place-based partnerships** will reflect meaningful communities and geographies that local people recognise and will build on arrangements such as Health and Wellbeing Boards. As a minimum, they should involve **primary care provider leadership**, local authorities, including directors of public health, providers of acute, community and mental health services and representatives of people who access care and support. The ICS NHS body will remain accountable for NHS resources deployed at place level.
- There are some functions where ICS NHS bodies will need to work together; for example, commissioning more specialised services, emergency ambulance services and other services where relatively small numbers of providers serve large populations
- **Provider collaboratives** are partnership arrangements involving two or more trusts (foundation trusts or NHS trusts) working across multiple places to realise the benefits of mutual aid and working at scale. Enabling specialty-level plans and decisions to be made and implemented. ICS can pay individual providers or a lead provider.
- We expect the contracts health service providers hold (NHS Standard and national primary care supplemented locally) to evolve to support longer term, **outcomes based agreements**, with less transactional monitoring and greater dialogue on how shared objectives are achieved.
- The **success of Trusts and FTs** will be judged against delivering their agreed contribution to system financial balance, improving quality and outcomes and reducing unwarranted variation and inequalities across the system as a whole, in the context of the new ‘triple aim’ duty to promote better health for everyone, better care for all and efficient use of NHS resources
- The **VCSE** should be involved in governance structures and system workforce, **population health management** and service redesign work, leadership and organisational development plans

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Key Features

- **Oversight:** May decide to take the role of provider collaboratives and place-based partnerships into account e.g. for support where poor performance is identified; or considering the effectiveness of collaborative working arrangements when considering whether systems/providers have an effective plan for improvement/recovery. Scrutiny provides a mechanism for local democratic accountability through local government elected members.
- The ICS will lead **System Quality Groups** (previously Quality Surveillance Groups) and have arrangements for ensuring the fundamental standards of quality are delivered including to manage quality and safety risks and to address inequalities and variation; and to promote continual improvement in the quality of services, in a way that makes a real difference to the people using them.
- **Funding:** will return to the model pre-Covid based on population need and will be informed by work ongoing led by ACRA. Existing allocations tools can be adapted to support ICS NHS bodies in making decisions about how to deploy resource to place. The ICS NHS board and chief executive (AO) will be ultimately responsible for services under delegation arrangements with place-based partnerships or through lead provider contracts. The ICS NHS body should engage local authority partners on the ICS NHS resources including variation from CCG budgets. Might include: primary care as delegated/transferred from NHSE, community services, community mental health including IAPT, community diagnostics, intermediate care, any S75 services, any acute or secondary care services agreed at place-level.
- **People** – one workforce plan – agree and deliver local strategic and operational people priorities. This will include ensuring there are clear lines of accountability up and across (e.g. HEE), leadership development, talent management and succession planning approaches
- **Digital and data** (NHS and coordinating with LA): Shared care record, co-ordinated offer of digital channels for citizens, cross-system intelligence function to support operational and strategic conversations, as well as building platforms to enable better clinical decisions. This will require ICSs to have linked data, accessible by a shared analytical resource that can work on cross system priorities, embedding population health management capabilities

Role of Clinical Leadership

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- effective structures and communication mechanisms to connect clinical and care professional leaders at each level of the system
- a culture which systematically embraces shared learning, supporting its clinical and care professional leaders to collaborate and innovate with a wide range of partners, including patients and local communities
- protected time, support and infrastructure for clinical and care professional leaders to carry out their system leadership roles
- clearly defined and visible support for clinical and care profession leaders, including support to develop the leadership skills required to work effectively across organisational and professional boundaries
- transparent approaches to identifying and recruiting leaders, which promote equity of opportunity and a professionally and demographically diverse talent pipeline which reflects that community it serves

What do you think?

Role of Primary Care

- Should be represented and involved in decision-making at all levels of the ICS, including strategic decision-making forums at place and system level.
- It should be recognised that there is no single voice for primary care in the health and care system, and so ICSs should explore different and flexible ways for seeking primary care professional involvement in decision-making.
- Enable plans to be built up from population needs at neighbourhood and place level, ensuring primary care professionals are involved throughout this process. *PCNs will develop integrated multidisciplinary teams that include staff from community services and other NHS providers, local authorities and the voluntary, community and social enterprise (VCSE) sector to support effective care delivery.* What do you think? Is this something you will do via relationships in Place? (use your existing meetings)
- Joint working between PCNs and secondary care will be crucial to ensure effective patient care in and out of hospital. PCNs in a place will want to consider how they could work together to drive improvement through peer support, lead on one another's behalf on place-based service transformation programmes and represent primary care in the place-based partnership. This work is in addition to their core function and will need to be resourced by the place-based partnership. How do CCGs support this in shadow operating? Senior management resources? Build up Primary-Sec care interface and transition to a PCN-Acute alliance?
- Consider the support PCN clinical directors, as well as the wider primary care profession, may need to develop primary care and play their role in transforming community-based services. Place based partnerships may also wish to consider how to leverage targeted operational support to their PCNs, for example with regard to data and analytics for population health management approaches, HR support or project management. Project management, population health managers, BI capacity pushed down to PCN level as we move to single version of truth for acute, mental health, community sectors?

Roles in relation to Integration / ICS

Role of PCC – Representation in ICS, decisions with one voice. Next 9 months (until March 2022), what next?

Role of PCN CDs – Operational roles about getting the PCN together… over time develop into the bigger picture, more strategic, more complex, or is this two roles – one network facing, one outward facing?

Role of (CCG) Clinical Leadership – Oversight, assurance, vision, facilitation, levelling up.

- Place MDs/Clinical Leads – a linking job and knowing the wider system.
- Portfolio Clinical Leads e.g. Children/families, people with LTCs, frailty and EOL, workforce, research, innovation

Can we (should we) seek to combine these roles [representation + operational + strategic] in some instances?

E.g. at present we can have the LMC, CCG and PCN in a room with secondary care for a meeting…each with different perspectives…should we aim to get to a point where these perspectives can be represented by one voice?

Role of (CCG) managers – resource wrapped around PCNs to deliver PHM in neighbourhoods

Integration (solutions about local models) – what works in x won't work in y

Example: HASR UEC Redesign – how should the Clinical Lead best engage with our 19 PCNs on the longer term changes?

Discussions bring the HASR and Out of Hospital programmes together

Working collaboratively as a system - workforce / digital / estates - to build community/primary care as part of long term proposals.

What is the best way to involve PCNs in the service design / art of the possible?

Via the PCC?

Via the Primary-Secondary Care Interface groups operating at sub system level?

Via PCN CDs individually?

Humber Population Health approach

Achieved through distributed System Leadership…

Operating from April as 15 organisations and 19 PCNs

ICS will establish a new function – will be operated by the Humber Strategic Partnership

We will coordinate via a small core team

We will increase our focus on ‘whole people’ and ‘end results’ in the midst of vertical and horizontal integration

We will expand PHM and population health capacity and capabilities across our organisations and PCNs

We will focus on population groups where capacity to benefit is greatest - to improve access to health services and outcomes, in order to reduce disease and service burden. Humber share of the total cost of health inequity in England (2011/12) av. £83m

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Why do we need it?

Humber is large enough to consolidate expertise and plan most services and close to communities to reflect local differences

We will need to be able to define, measure and monitor outcomes and resources.

Redress the balance after what was lost in the 2012 Act (new Act brings new duty for NHS to improve Population Health)

What will the core team do?

The core team in this function will support every level of the system to work with 'future state' Outcomes Based accountability frameworks and capitated budgets.

Develop and embed a network of intelligence drawn from PCNs, LAs, BI, PHE, health economics and bespoke insights

Develop and embed PHM and population health capabilities through vertical and horizontal partnerships.

Identify value opportunities across population cohorts (outcome chain diagnostics) to inform prioritisation and resource allocation decisions – which interventions impact positively on the end result, and which don't?

What are the core team roles?

Professional Lead

Triumvirate team:
Children & Families
Inclusion Groups
Frailty & End of Life

Population Health Information manager to create 'actionable intelligence'

PHN (Population Health Network) – Humber wide GP clinical leads and Local PH expertise

Not about design and delivery – that is led by Place / Provider Collabs

How will it work in practice?

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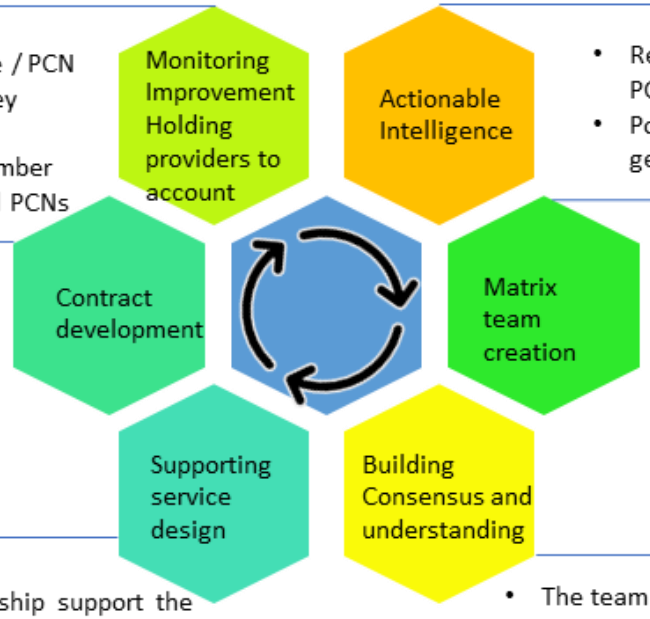
How do we operate a Population Health approach at Neighbourhood Level, to enable local teams to respond to populations of greatest need and at greatest risk of hospitalisation?

- Continuous risk stratification of patients enables the practice / PCN to monitor the impact on the population groups and how they move between segments
- The local data is aggregates and forms an integral part of Humber System Oversight and is used by all organisations, Places and PCNs

- Real time stratification of patients and supporting practice / PCN managers and clinicians
- Population Health managers work as part of the team in general practice to develop operational options



- Contracting specialists are deployed to understand which incentives will align organisations to resource the operational response
- Outcome chain diagnostics is built in so that provider attribution and causation for outcomes delivery can be monitored and resources redistributed to support any new 'micro interventions' requiring local community investment

- The team in general practice identify who they need to work with in order to develop the operational response
- Members of staff are supported through much more flexible lines of accountability to work in multiple teams on a daily basis
- A team is developed from the council ward area, a local communities group, the local dental, pharmacy, optometry, practices, community mental health and general practice

- The integrated delivery team in the Place Partnership support the neighbourhood team to get on with it and provide a voice via the Place Partnership joint committee and HWB
- The Humber Core Team provide support if it is requested, such as examples of innovation or impact modelling

- The team agree how members of health staff and council's communities staff might need to work differently, plus changes to local social prescribing and harnessing local community assets
- The integrated delivery team in the Place Partnership co-opts support in order to embed the new service delivery model and scale up if applicable
- Population outcomes are developed tailored to the LSOA level
- The team develops a logic model to describe the problem, the intervention, the impact

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Q&A