NHS
Hampshire and Isle of Wight
Sustainability and Transformation Partnership

# Hampshire and Isle of Wight System reform proposal

## Statutory body pack

## August 2018

MOVING FORWARD TOGETHER

# Contents

# Introduction and context



## Purpose of this document

This document summarises the system reform proposal as developed to date through the work of the Hampshire and Isle of Wight Sustainability and Transformation Partnership's (STP) Executive Delivery Group (EDG) and informed by the broader health and care system leadership.

It forms the basis for NHS provider board, CCG governing body and local government cabinet consideration at their respective meetings in autumn 2018.

## Context

The health and care system across Hampshire and the Isle of Wight has been working together to develop a response to the national ambition to improve the integration of health and care for the benefit of local people.

**As the Care Quality Commission put it in its 2016/17 State of Care report:**

***"People should be able to expect good, safe care when they need it, regardless of how this care is delivered... It's clear that where care providers, professionals and local stakeholders have been able to do this – where they have stopped thinking in terms of 'health care' and 'social care' (or specialties within these) and instead focused their combined efforts around the needs of people – there is improvement in the quality of care that people receive. To deliver good, safe care that is sustainable into the future, providers will have to think beyond their traditional boundaries to reflect the experience of the people they support."***

## National context

The most recent mandate given by the Government to NHS England includes increasing integration with social care so that care is more joined up to meet physical health, mental health and social care needs. More recently, the House of Commons Health and Social Care Committee has expressed its support for improving integration of care, highlighting its potential to improve patient experience.

NHS England's policy goals in relation to this area have been clear for some time. NHS England's ambition to transform the delivery of care in this spirit was first described in 2014's Five Year Forward View (FYFV):

***"The traditional divide between primary care, community services, and hospitals – largely unaltered since the birth of the NHS – is increasingly a barrier to the personalised and coordinated health services patients need. And just as GPs and hospitals tend to be rigidly demarcated, so too are social care and mental health services even though people increasingly need all three"***

# Case for change

# What do our citizens and our staff tell us?



**Our citizens have been consistent in telling us that…**

- they want **better and more convenient access** to support to help them to live well for longer. We have diverse communities across Hampshire and the Isle of Wight and people want support better suited to their needs;
- **they value and have confidence in General Practice and the wider primary and community team,** but there is a bewildering array of teams who do not appear to communicate with each other. **People often have to repeat their story** multiple times, making accessing care a frustrating experience. So they want all of the clinicians and care workers involved in their care to know their care plan, to work together and to communicate with one another. Many people also want greater control of their care, from better access to their records through to personalised budgets;
- when they have an urgent care need, **rapid access to the right clinical advice and support** is the most important factor to them. They want the health and care system to make sure they know how to rapidly access a complicated and sometimes confusing system;
- when they are managing a long term physical and/or mental health condition they typically want continuity of relationship with a trusted clinician to support them; they want better support to understand and manage their condition; and they want to ensure that when they travel for specialist advice and support, then the journey is worthwhile. Currently **40% of people** whom have a long term condition tell us they **don't feel supported** to manage their condition.
- they are more **willing to travel a little further for specialist care** if the services they access will give them better outcomes. People also add however, that there is nowhere like home and that they would rather be there, than a hospital bed. Unfortunately a quarter of people in hospital still do not feel involved in decisions about getting them home.

**Our workforce are telling us that:**

- they are **under more pressure than ever** before. They often feel that there is not enough time in the day, with too many targets to reach and administrative tasks to perform, both of which take time away from patients;
- services are running on such **low staff numbers** that any unplanned sick leave or annual leave has a significant effect. Despite significant efforts of some providers, we continue to exceed our planned expenditure on agency and locum spend;
- care professionals want a means by which to **share information** with other professionals within the system. There is often a poor interface between primary, secondary and community care with time wasted trying to contact other care services;
- whilst it doesn't feel this way in general practice, and in the community and hospital services, our workforce has actually increased over the last few years. However so too has the number of people leaving within two years;
- many frontline staff have spent large parts of their professional careers **trying to integrate care for patients,** often working around policies that construct rather than remove barriers to integrated care at local level;
- they want **better career options** along with opportunities to improve their skills and expertise.

# What does the data tell us?



## We need to strengthen our approach to prevention, early intervention and supported self-management…

- We have a national reputation for developing innovative models of prevention, case finding and early intervention and supported self-management. However, we have not systematically implemented these innovative models. For example, within three years, 330 heart attacks and 490 strokes could be averted with improved detection and treatment of hypertension and atrial fibrillation. This represents a cost saving of up to £2.5m for heart attacks and £6.7m for strokes through optimal anti-hypertensive treatment of diagnosed hypertensives.
- For cancer services, for example, we have made real progress in improving the early diagnosis of cancers over the past 4 years, and are now are one of the best performing systems in the country. But we still only **diagnose just over half of cancers at stage 1 and 2**.
- The **life expectancy of people with serious mental illness is 15-20 years less** than the average life expectancy in Hampshire and the Isle of Wight, with two thirds of these deaths due to avoidable causes. And yet the number of health checks for people with severe mental illness in HIOW is below the national average.
- We are making improvements, but we are **not yet closing the inequalities gap -** the life expectancy gap (and disability-free years gap) across HIOW is not closing.

**The complexity and fragmentation of our current system (including siloed budgets and payment systems) is currently holding back a system focus on this agenda.**

## We have a significant opportunity to improve discharge and flow across Hampshire and the Isle of Wight…

- Our citizens continue to **stay in hospital for a long time** even though many are medically fit to leave. As we know the longer people stay in hospital, the more likely they are to develop complications and reduced independence; and it is also expensive to keep someone in hospital unnecessarily.
- Our flow and discharge is noted as being in the **lowest performance quartile in the country**
- We continue to be the **second poorest performing system in the country** with regards to **delayed transfers of care**.
- **We are the second poorest performer** nationally with regards to **CHC assessments in the community**.
- Recent data positions us as having one of the greatest opportunities nationally to reduce **excess bed days** and super-stranded patients.
- There has been a relentless focus on improving discharge and flow across all of our systems and yet despite this the number of delayed transfers of care per 100,000 population remains at the same rate it did two years ago*

**This data would indicate that continuing to operate as we have done in the past will not yield a different outcome. We need to reform the system in a way that best allows us to tackle the challenges we face.**

* with the exception of the Isle of Wight which now operates with three times fewer delays as other HIOW systems.

# What do we know about new models of care?



The past four years have seen significant progress in developing 'new care models' which are founded on integration between partners and a systematic focus on the whole population's needs. Nationally we have seen both Multispecialty Community Provider and the Integrated Primary and Acute Care Systems develop. More recently the Next Steps on the Five Year Forward View further articulated the ambition ***'to make the biggest national move to integrated care of any major western country'.***

Within our patch we are reporting very tangible benefits for our citizens as a result of health and care partners working together / integrating more effectively than we have seen before. In the most developed systems we are seeing:

- **1% reduced emergency admissions** compared to an average of 3.5% growth nationally;
- New models of care are successfully managing and treating people more effectively in the community **reducing potentially "avoidable" emergency admissions by 10%** on last year;
- **4% reduction in GP referrals** on last year;
- **Reduction in the number of people experiencing mental health crisis** / emergency admission to acute mental health beds as a result of enhanced support in the community
- **A&E attendances are holding at the same level** as last year compared to demographically similar systems which have increased activity on last year;
- Citizens engaging with integrated care teams are reporting **significant improvements in health status, personal wellbeing, experience and health confidence;**
- **Staff satisfaction rates significantly improving** where they are operating in integrated care teams.

These achievements are both important for citizens, staff and for the financial health of the system. We know that new models of care work, however, our integrated primary and community teams are at different stages of development and so too are their interfaces with local health and wellbeing footprints and the acute physical and mental health system.

# Finance and efficiency



## Increasing value for money

The current funding and budget systems make it hard to reallocate resources to where they are needed most. This can also be prohibitive to collaborative working between partner organisations. Frustratingly for all, the current payment systems can be unhelpful – rewarding activity rather than outcomes.

**Our financial position is unsustainable.** Hampshire and Isle of Wight NHS has forecast a 'do nothing' gap of £577million gap by 2020/21 (23% of our £2.5bn allocation) and in addition to this, the pressures in social care and local government more broadly are unprecedented. Whilst the required level of efficiency has been delivered to date we require a step change in productivity and cost reduction to ensure we meet our financial targets.

In many organisations too much resource and energy is focused on seeking to suppress expenditure in providers or generate additional income from commissioners, rather than work in partnership to focus on cost reduction, quality improvement and living within the system's finite resources. **We will require different approaches**, including **collaboration**, e.g. pathology, pharmacy distribution centres; scale, eg: collective procurement; **back-office optimisation**, eg: HR, finance; **greater partnerships**, eg: increasing retention of our workforce, reducing bank and agency costs; and **reduced unwarranted variation** in practice.

If we are to make the transformational changes required to improve outcomes, experience, satisfaction, quality, performance, financial sustainability and address our workforce challenges **we must radically enhance our functionality, removing obstacles to enable far greater collaboration and integration**. These radical changes will become a reality only if there is a collective commitment from all partners to transform and implement a new way of working.

## Reducing complexity

- We have **21 NHS and local authority statutory partners** as signatories to our transformation partnership **and three non-statutory partners** (with leadership responsibilities around workforce, innovation and research).
- We have **grown our workforce by 4.5%** over the past three years. Too much of this growth has, however, been in non-clinical roles. One of the key drivers for this is the continuing burden of reporting, assurance and inter-organisational contract management.
- **We are a complex system.** Whilst there has been collaboration between provider, commissioner and regulatory partners, our system reform work over the past six months has demonstrated significantly greater opportunity to reduce system complexity; reduce the burden of assurance and reporting and ensure all partners collaborate towards clearer strategic goals;
- NHS England and NHS Improvement are currently undergoing a national and regional integration programme. The expectation is that locally the Hampshire and Isle of Wight system will develop **simpler but more effective self-regulation and assurance models** that will allow NHSE/I to work more strategically with the system.

**The system reform programme is a means by which we can reduce this complexity and develop strong self-regulation and assurance models.**

# The proposed system

# Our vision



“Our vision is to support citizens to lead healthier lives, by promoting wellbeing in addition to treating illness, and supporting people to take responsibility for their own health and care. We will ensure that our citizens have access to high quality consistent care 24/7, as close to home as possible.

# Our vision – tomorrow's system




## We are taking action to prevent ill-health and promote self care...

- Empowering citizens, patients, service users and communities
- Harnessing technology more effectively to support wellbeing

## We are strengthening local primary and community care...

- Developing integrated health and social care teams designed to support the needs of the local communities they serve
- Ensuring a strong and appropriately resourced primary care workforce
- Providing care in the right place at the right time by reducing over-reliance on hospitals and care homes
- Using technology to revolutionise people's experiences and outcomes;

## We are improving services for people who need specialist care...

- Identifying, understanding and reducing unwarranted variation in outcomes, clinical quality, efficiency;
- Through consolidating more specialised care on fewer sites;

**We will make intelligent use of data and information to empower citizens, patients, service users and support our workforce to be more efficient and effective in delivering high-quality care**

# Integrated care systems



**The HIOW Executive Delivery Group (EDG) – representing the HIOW health and care system – recommend that to deliver our vision for health and care, we need to reform our system to ensure 'form follows function', signalling a shift from the separation of provision and commissioning to integrated planning and delivery. Nationally there is a similar realisation, which has led to the national guidance on Integrated Care Systems.**

### What is an integrated care system (ICS)?

NHS England defines ICS as those systems in which:

"Commissioners and NHS providers, working closely with GP networks, local authorities and other partners, agree to take shared responsibility (in ways that are consistent with their individual legal obligations) for how they operate their collective resources for the benefit of local populations".

### What will an integrated care system do?

National guidance sets a number of expectations for ICS:

- ICS are expected to produce together a credible plan that delivers a single system control total, resolving any disputes themselves.
- ICS will assure and track progress against organisation-level plans within their system, ensuring that they underpin delivery of agreed system objectives.
- [ICS] will be given the flexibility, on a net neutral basis, and in agreement with NHS regulators, to vary individual control totals during the planning process and agree in-year offsets in one organisation against financial under-performance in another.
- NHS England (NHSE) and NHS Improvement (NHSI) will focus on the assurance of system plans for ICS rather than organisation-level plans.

There is an expectation that, over time, ICSs will replace STPs.

### Benefits of ICS – the national view

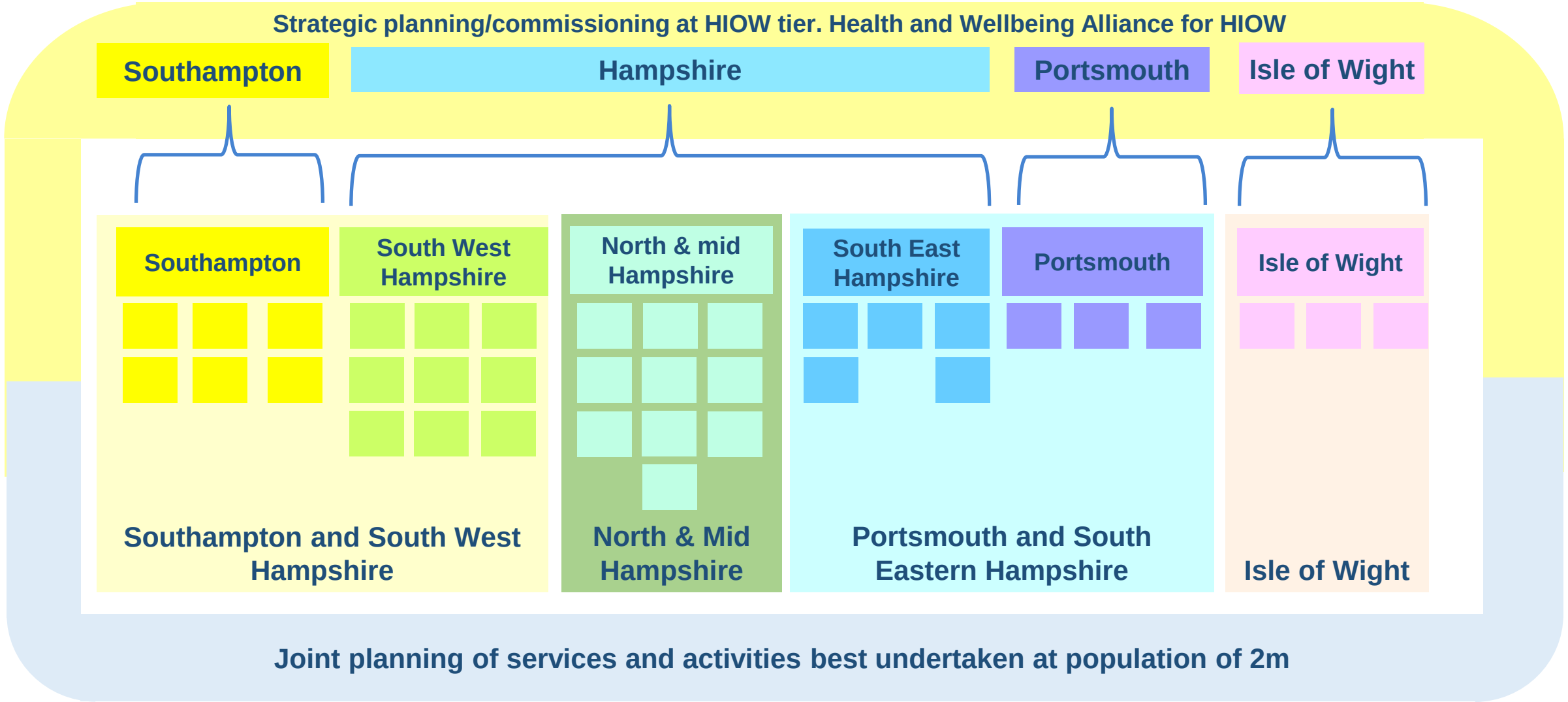
- Creating more robust cross-organisational arrangements to tackle the systemic challenges facing the health and care;
- Supporting population health management approaches that facilitate the integration of services focused on populations that are at risk of developing acute illness and hospitalisation;
- Delivering more care through re-designed community-based and home-based services, including in partnership with social care, the voluntary and community sector; and
- Allowing systems to take collective responsibility for financial and operational performance and health outcomes.

### Local alignment

The EDG tasked a sub-set of its members, supported by others, to form a series of task and finish groups to develop the key elements of a proposal for moving the HIOW system towards ICS ("the system reform programme").

# How could HIOW look in the future?

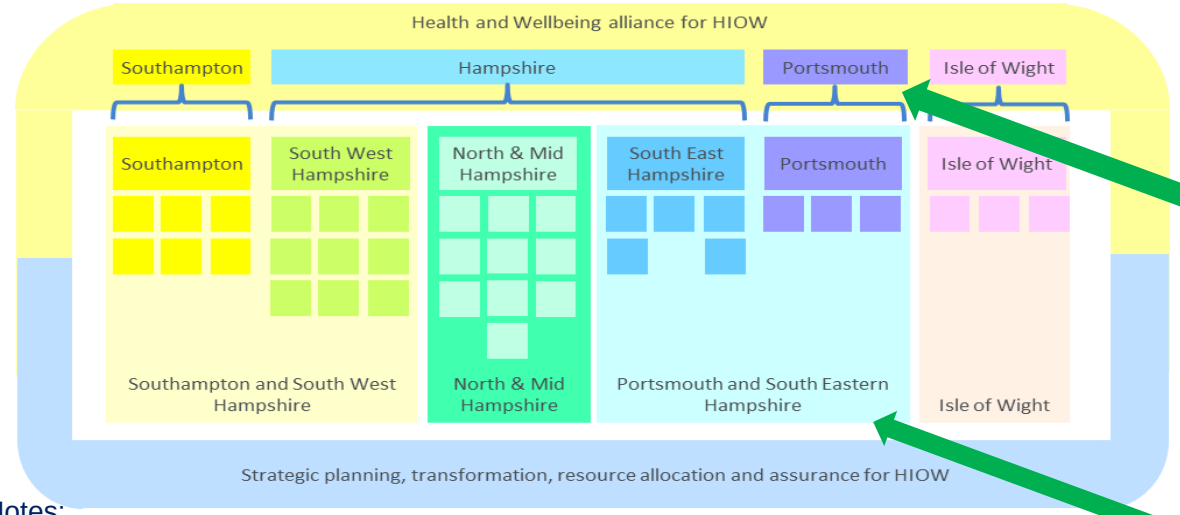




# The proposed HIOW integrated care system:
## A whole system planning, delivering and transforming in collaboration



The proposed reformed system envisages providers, commissioners and local authorities working in ever closer collaboration with each other and with citizens and voluntary sector organisations to address the case for change, empowering and supporting citizens to best manage their own health and wellbeing and frontline teams to provide and sustain the best possible services and care.




| Component | Purpose and description |
|---|---|
| **Accelerated implementation of 36 clusters**<br>Natural communities of 20-100,000 people | • The foundations of the reformed system<br>• Strengthening primary care<br>• Delivering integrated mental and physical health, care and wider services to cluster population<br>• 36 clusters, aligned to 'natural communities'.<br>• Proactively managing the population health needs |
| **Ongoing development of place based planning**<br>Existing Health & Wellbeing Board footprints | • Integrated local authority & NHS planning<br>• Aligned to HWB (local authority) footprints<br>• Health & LA aligned commissioning resource & agreed leadership/management models<br>• Basis of the JSNA, means through which HWB exert tangible influence on the direction of health and care services for the population through health and care commissioning and wider determinants of health |
| **Simplified structure of 4 integrated care partnerships**<br>populations of c600k served by acute partners | • Support the vertical alignment of care enabling the optimisation of acute physical & mental health services<br>• Design and implement optimal care pathways<br>• Support improved operational, quality and financial delivery |
| **HIOW integrated care system**<br>Drawing together the above component parts, delivering some functions at a scale of 2 million population | • System strategy and planning<br>• Implementing strategic change across multiple integrated care partnership footprints/places<br>• Alignment of strategic health and LA commissioning<br>• Provider alliances (acute physical & mental health)<br>• Oversight of performance and single system interface with regulators |

Notes:

1. The term 'cluster' is used for consistency to describe the foundation of the system where general practices with statutory and voluntary community health and care services work together in 20-100k populations to meet the needs of local residents. A variety of terms are currently used to describe this including localities, extended primary care teams, natural communities of care, neighbourhood teams.
2. Where HWB and integrated care partnerships are coterminous, activities are undertaken together. In areas where integrated care partnerships span more than one HWB footprint, the partners will work together to determine the most appropriate allocation of responsibilities between HWB area and the integrated care partnership to achieve the shared objectives.
3. The Hampshire HWB area also includes North East Hampshire, which is also part of the Frimley Integrated Care System and therefore omitted from the figure above

# Conditions for integration



The development of an ICS for Hampshire and Isle of Wight has been based upon a variety of national guidance and evidence from around the country about best practice approaches. We have studied the work ongoing in Surrey Heartlands Dorset, Manchester and South Yorkshire and Bassetlaw and learnt from their experiences.

The work of the Kings Fund on integration is also helpful in setting out conditions which support greater integration. Their assessment is that current and future ICS must address the following development needs if they are to succeed in transforming health and care, building on new care models and related initiatives:

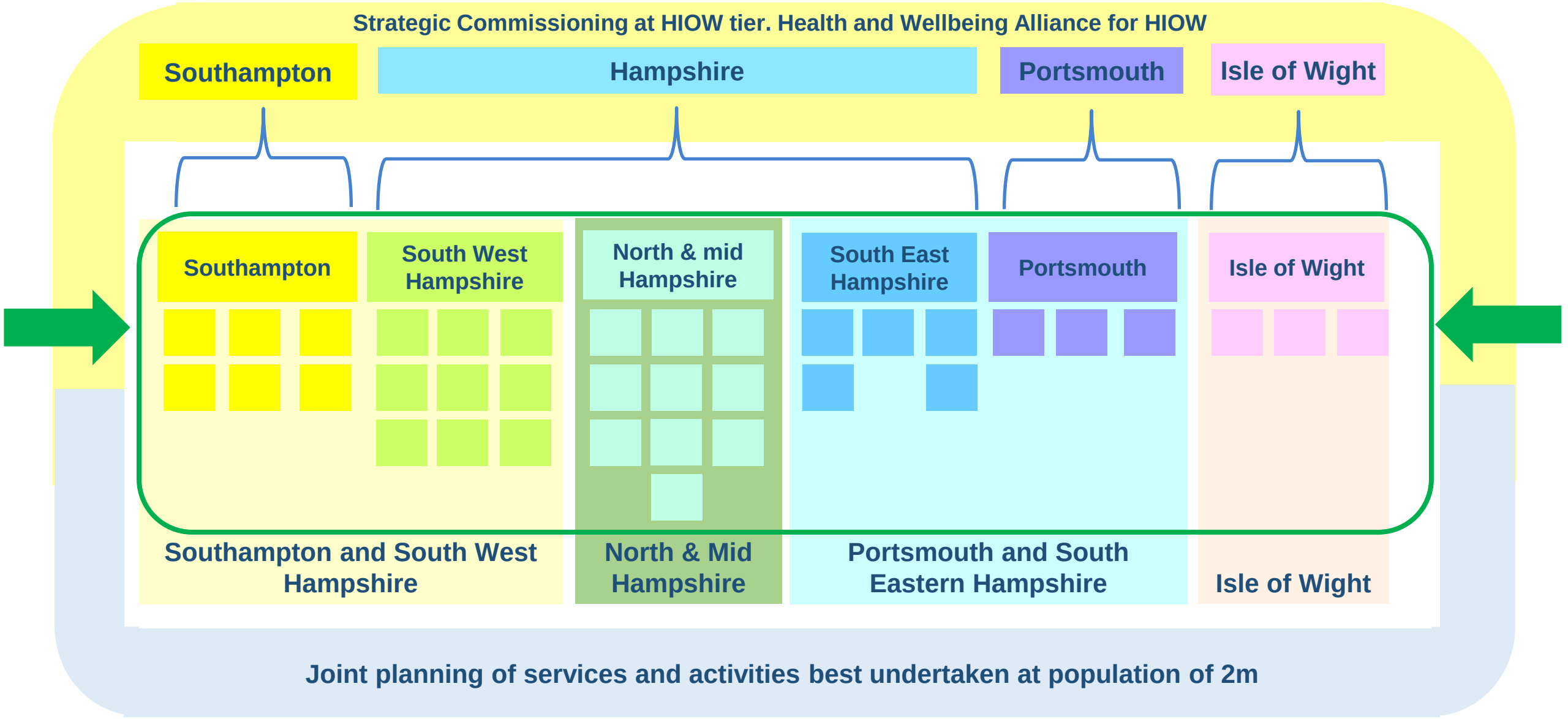
- Developing trust and relationships among and between leadership teams
- Establishing governance arrangement to support system working
- Committing to a shared vision and plans for implementing the vision
- Identifying people with the right skills and experience to do the work
- Communicating and engaging with partner organisations, staff and the public
- Aligning commissioning behind the plans of the system
- Working towards single regulatory oversight
- Planning for a system control total and financial risk sharing.

The work involved in addressing these needs is time consuming and cannot be rushed: ‘progress occurs at the speed of trust’, **collaborative rather than heroic leadership holds the key to progress.**

# Components of the system

# Clusters - integrated primary and community care teams





# Clusters - integrated primary and community care teams



**Clusters will be the bedrock of the reformed delivery system. The key purpose of our wider system reform arrangements is to support empowered clusters.**

**Role and benefits of clusters:**

- Clusters will see health and care professionals, GPs, the voluntary sector and the community working as one team to support the health and care needs of their local community. They will focus on helping people to manage long term conditions and improve access to information about healthier lifestyles and improving/maintaining wellbeing.

- Evidence shows that the most successful work of this type will reduce the overall number of people who need to be cared for in hospital and improve the health and wellbeing of communities. Clusters will shift the pattern of care and services to be more preventative, proactive and local for people of all ages

### Impact of clusters for people

- ✓ People are supported to stay well and take greater responsibility for their own health and wellbeing
- ✓ People can easily access support and advice that is timely, delivered close to home and with the right professional to meet their needs
- ✓ People with chronic or complex illness receive care that is consistent, joined up and centred around their needs and wishes, with fewer hand-offs and reduced duplication
- ✓ People are only in hospital for the acute phase of their illness and injury and are supported to regain/retain independence in their usual place of residence
- ✓ People have greater choice and control over decisions that affect their own health and wellbeing

### Impact of clusters for HIOW system

- ✓ Increased capacity in primary and community care to manage local health and care needs
- ✓ Reduction in rate of acute mental and physical acute non-elective activity growth and demand for urgent care services
- ✓ Optimised resource utilisation as a result of better managed chronic conditions and reduction in preventable conditions
- ✓ Reduction in variation in access and outcomes
- ✓ Fewer permanent admissions to residential and nursing care
- ✓ Primary care is sustainable and supported leading to improving GP recruitment and retention rates
- ✓ Attract and retain right workforce in all sectors with particular emphasis on those sectors in greater need such as mental health
- ✓ More efficient bed use and fewer delayed transfers of care

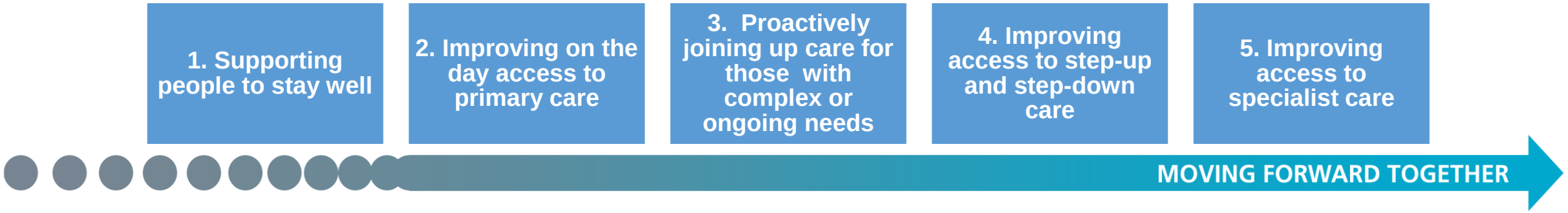
# Characteristics of clusters



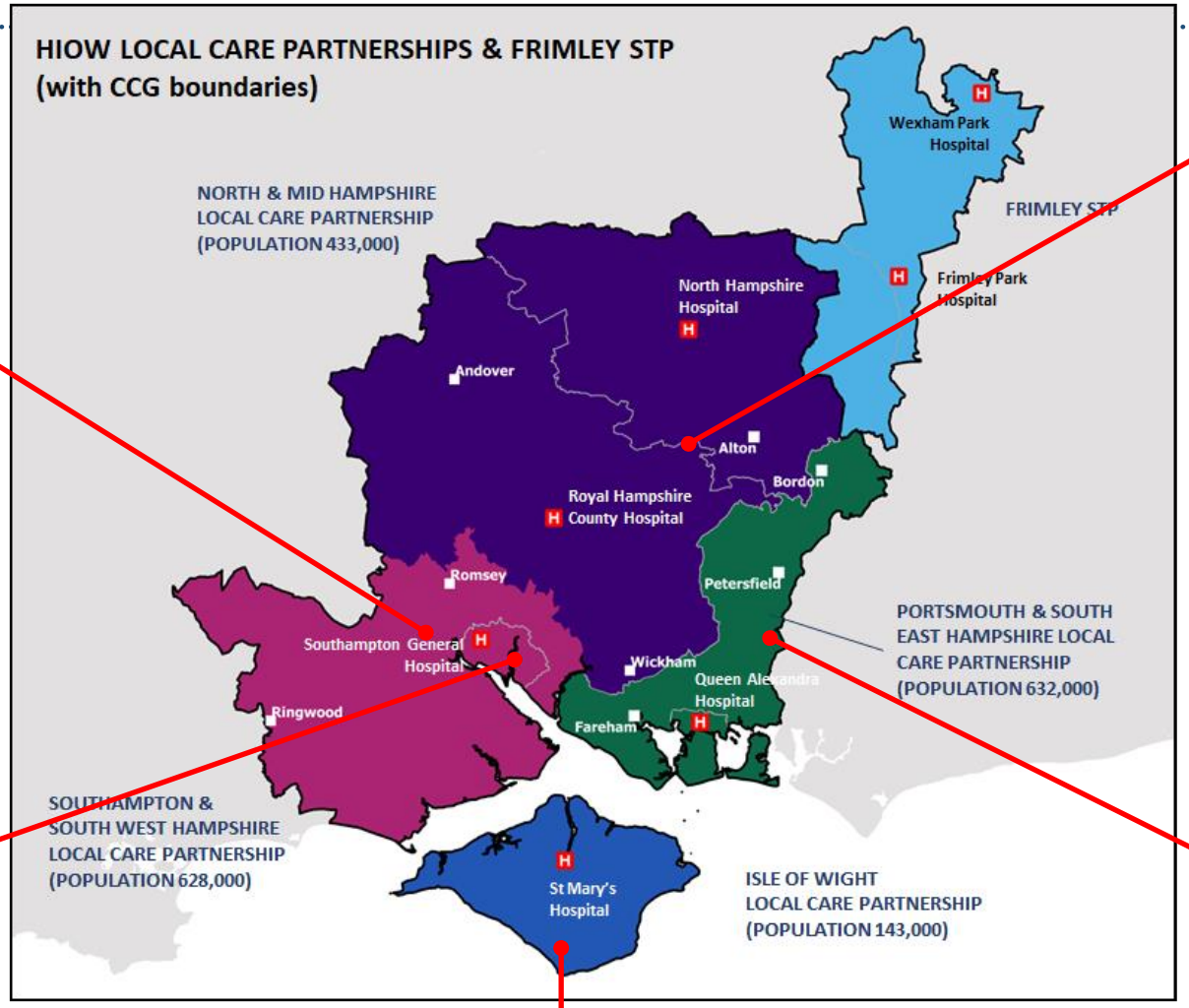
**Clusters will vary based on the needs of the communities they serve, but will be built on a common foundation and share common characteristics:**

- Clusters will be empowered to innovate in order to best serve their populations. In order to facilitate this, they will work to a specification which is outcome-based, but which is common across HIOW. Developing this specification will be an early priority.
- Cluster footprints align to 'natural communities of care.' Areas must be meaningful to those they serve, as they provide the basis for community-focussed services. Clusters' population range provides flexibility in cluster boundaries to ensure they align with both natural communities and GP registered lists.
- Clusters will include a range of mental and physical health, care and wider services in one place. Multi-professional working will be supported by multi-agency information sharing and, wherever possible, physical co-location.
- Co-ordinate services and teams from across organisations through alignment arrangements (MOU, alliance contract or joint venture) – allowing professionals to maintain their current employment status.
- Multi-professional (including clinical) leadership. Each cluster will have a named lead, and will be supported by a professional managerial team, who will be responsible and accountable for the performance of cluster services and the management of an indicative cluster budget. Clusters will manage their performance based on agreed datasets.
- GP federations will be vital in facilitating clinical leadership in clusters, as well as in leading the transformation of primary care, which will be vital to clusters' capability.
- Clusters will identify, understand and reduce unwarranted variation between their practices. Colleagues and systems across the footprint of HWB and integrated care partnerships will support clusters in this, as well as identifying unwarranted variation between clusters (see below).
- Clusters and acute physical and mental health providers will work together in integrated care partnerships, to ensure alignment of pathways and integrate services to optimise the health and care support they provide, responsive to the populations they serve.

## The 5 core functions of a cluster:



# 36 clusters across HIOW (as at August 2018)




**South West Hampshire**

1. Eastleigh
2. Eastleigh Southern Parishes
3. Chandler's Ford
4. North Baddesley
5. Avon Valley
6. New Milton
7. Lymington
8. Totton
9. Waterside

**Southampton**

1. Cluster 1
2. Cluster 2
3. Cluster 3
4. Cluster 4
5. Cluster 5
6. Cluster 6

**North and Mid Hampshire** 20

1. Mosaic
2. Whitewater Loddon
3. Acorn
4. A31
5. Rural West
6. Andover
7. Winchester City
8. Winchester Rural North
9. Winchester Rural East
10. Winchester Rural South

**Portsmouth and South East Hampshire**

1. East Hampshire
2. Waterlooville
3. Havant
4. Fareham
5. Gosport

1. Portsmouth North
2. Portsmouth Central
3. Portsmouth South

**Isle of Wight**

1. North and East
2. West and Central
3. South Wight

# Balancing autonomy and standardisation in clusters



**A key test of this proposal overall is that cluster governance must accelerate and facilitate, rather than impede, local change and improvement.** Therefore clusters will be encouraged to innovate and improve services for their citizens.

This innovation will be facilitated by both their contract /incentive structure and support from HWB and integrated care partnerships (see next slides).

HWB and partnerships will support clusters in identifying and reducing unwarranted variation, including striking the right balance between standardisation / consistency and local flexibility (ie. standardising only where this adds value).

Standardisation may apply across a HWB or partnership footprint, or more widely, as appropriate. We would expect some pathways, services, systems and processes to be standardised across HWB or partnership footprints, some to be standardised across the whole of HIOW. Elements not standardised will allow each cluster to take the approach which works best for them, but with encouragement and support to consider what other clusters are doing and the potential to spread best practice where it adds value (or reduces duplication of effort) to do so.

As part of this freedom to innovate, we recognise that clusters will continue to evolve. The current structure of clusters across HIOW (see next slide) may therefore change as clusters become established and take on an increasing role in service delivery.

**Operationalising clusters is a key priority. This will include developing an outcomes-based cluster specification and providing management and development resources to clusters from CCGs**

# Accelerating the implementation of clusters



Every part of the HIOW system has confirmed the development of integrated cluster teams as a key priority for 2018/19, and every area has a change programme in place to deliver this.

- The 36 cluster teams across HIOW are at variable stages of development and maturity.
- The most established teams, formed under Better Care and Vanguard programmes, offer a wealth of evidence and learning about what works; however we are yet to effectively capitalise on this across HIOW.
- There are currently different names for cluster teams in each care system, reflective of evolutionary local plans.
- However, there are high levels of congruence in the overall description of the function and form of these teams across the system.

Therefore, the ambition for cluster development for 2018/19 is to:

- Accelerate and embed the infrastructure for all 36 cluster teams by March 2019
- Evidence impact on patient outcomes, primary care capacity, hospital admissions and system flow

Current thinking about the development of the clusters by March 2019 and March 2020 is described on the following page.

# The developing role of clusters



| | October 2018 – March 2019 | By April 2020 |
|---|---|---|
| **Strategy and Planning** | • Cluster priorities identified and delivery plan in place<br>• Cluster level population data available and used to support priority setting and planning | • Longer-term cluster objectives being shaped, informed by data<br>• Mechanism in place for co-production of plans and services with local people |
| **Care Redesign** | • Practices working together to improve access and resilience<br>• Core cluster team membership defined<br>• Integrated primary and community care teams in place with joint assessment and planning processes<br>• Prototypes in place for highest risk groups<br>• Gap analysis undertaken, end state defined for key functions | • Components of delivery model in place for each of key functions (minimum 50% completion)<br>• Active signposting to community assets in place<br>• Shift of specialist resources into cluster teams<br>• Integrated teams fully functioning and include social care |
| **Workforce development** | • Cluster workforce plan defined with targeted action to support recruitment/retention of key roles<br>• Cluster level OD/team development plan in place | • Development of new/extended roles in cluster teams to meet local need<br>• Beginning to share workforce and skills within clusters |
| **Accountability & performance management** | • Information sharing agreements in place between all partners<br>• Plan for shared care record confirmed<br>• Cluster responsibilities documented via MOU/alliance agreement | • Data used to drive improvement and reduction in variation within and between clusters<br>• Shared care record (health) in place<br>• Cluster monitoring impact on key outcomes |
| **Managing collective resources** | • Cluster assets mapped to inform future planning (estate, back office, people, funding)<br>• Resources identified to enable/support cluster plan delivery (eg change management)<br>• Cluster level dashboard including outcomes in place | • Shift of specialist resources into cluster teams<br>• Clusters have sight of resource use and can pilot new incentive schemes<br>• Cluster level plan to optimise use of assets and early components in place |
| **Leadership & governance** | • Dedicated professional and operational leadership in place in each cluster<br>• Governance arrangements in place in each cluster, eg cluster board<br>• Cluster partners identified and engaged in the development and delivery of the cluster plan<br>• Cluster engaged in integrated care partnership decision making | • Cluster leadership embedded with defined responsibilities for co-ordination of cluster responsibilities<br>• Mechanism in place to share learning between clusters<br>• Practices have defined how they wish to work together going forward<br>• Cluster is full decision making member of integrated care partnership |

# Statutory bodies are asked to:

**Endorse:**

1. **The developing role of clusters as outlined on the previous slide**
2. **The recommendation that partners across HWB footprints and integrated care partnerships work together to define the resources required for cluster operation – a critical first step is establishing professional and operational leadership to drive cluster development**
3. **the proposed next steps for the cluster task and finish group which are summarised as follows:**

    a. Quantify the impact/expected outcomes of cluster teams (already in progress in most areas): defining outcome metrics for individual clusters and a small set of common metrics across whole HIOW

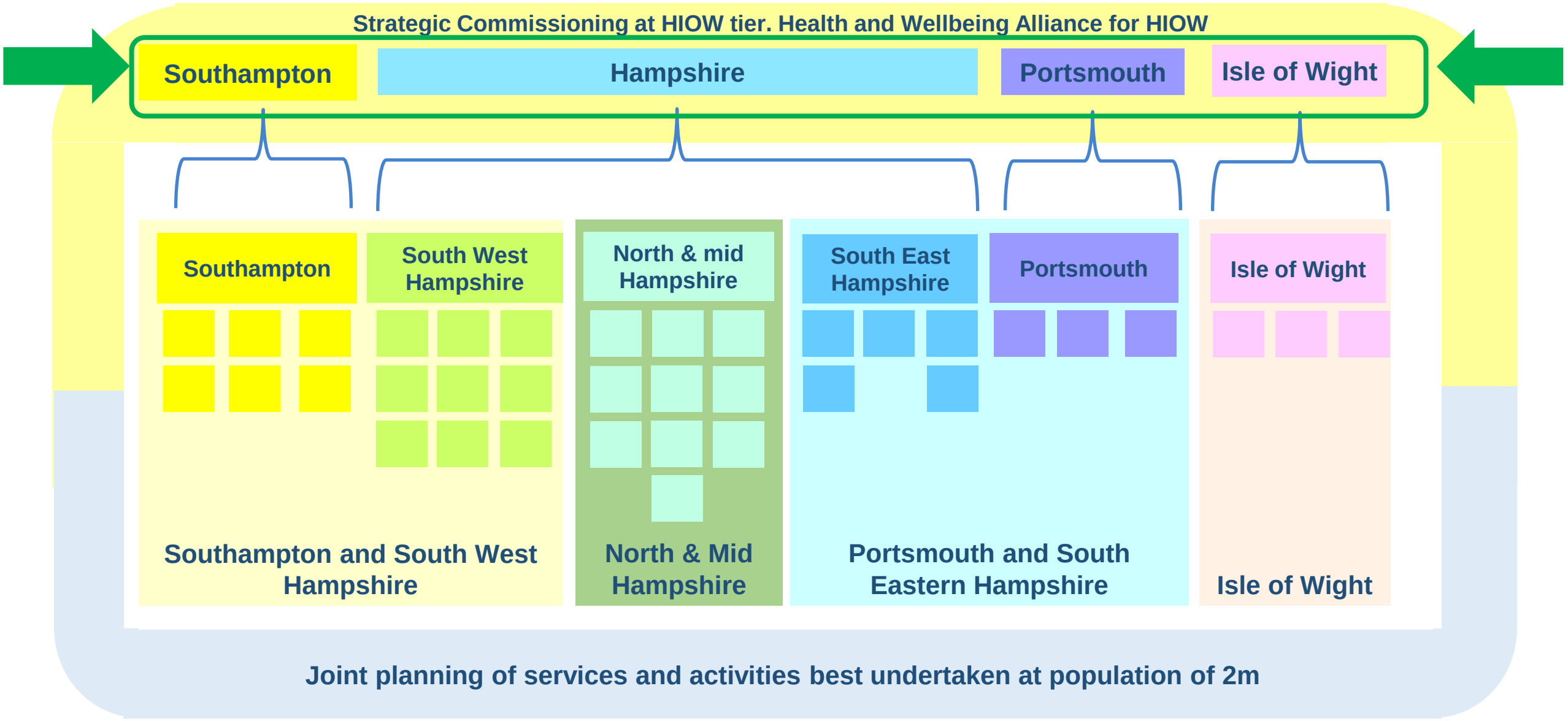
    b. Describe the support requirements and responsibilities to accelerate full cluster implementation

    c. Describe the proposed interplay between clusters and other components of the ICS, including governance and participation arrangements for clusters as part of HWB footprints and integrated care partnership structures

    d. Strengthen primary and social care involvement in this work at a Hampshire and Isle of Wight level (membership of the task and finish has already been extended to reflect this)

# Integrated planning for a place: Health and Wellbeing Board footprints





# Restating the function of Health and Wellbeing Board footprints within an integrated care system



**Local government partners have convened to start work on restating the critical function of integrated health and care planning and delivery on a Health & Wellbeing Board (HWB) footprint.**

**An early draft definition of the function is summarised below:**

HWB footprints will continue to be **the focus for place-based planning** (undertaking population needs assessment) and for aligning health, care and other sector resources to focus on delivering the improved outcomes for local people, building on the long-established integrated working arrangements, e.g. Better Care Fund, Section 75 arrangements, etc. Working in collaboration, partners will maximise the potential to further improve wellbeing, independence and social connectivity through the wider determinants of health including public health, housing, employment, leisure and environment.

The statutory role of the HWB with their political and clinical leadership, means that they should be central to the governance of health and care planning for a 'place'. The sustainability of the health and care system depends on public and political acceptability and support – as well as the right systems of design and delivery. So the active and effective democratic engagement at all levels (cluster through to whole HIOW) is vital. Strong and equitable relationships between NHS and local government will provide the necessary collective energy and focus required for system change. Furthermore, cross sectoral partnerships of public, private and voluntary and community organisations have important roles in all components of the system.

Much of our prevention and health improvement activities will continue to be designed and delivered in HWB footprints. We will use our ability to align / pool monies between NHS and local government partners to ensure that a clear focus for each HWB footprint is the resourcing of our 36 clusters (integrated primary and community care teams).

Our HWBs are based on local authority footprints. We will continue to integrate our CCG and LA teams focused on place-based health and care planning on these HWB footprints, reducing complexity and duplication. We will also be deploying some of our health (CCG) and care staff directly to support the operationalisation of our 36 clusters.

**All four LAs have committed to meet with health provider and commissioner colleagues during August/September as a task and finish group to further develop the above definition and proposed next steps (see more detailed recommendation on the next page).**

# Statutory bodies are asked to:



**Endorse the following recommendations from the EDG, informed by the task and finish group work to date:**

1. **The emerging ‘restatement’ of the function of partnership working on a HWB footprint as described on the previous slide**

2. **The proposed next steps for a task and finish group by the end of September, which are to:**

a. define the common functions of the role of HWB footprints in an integrated care system

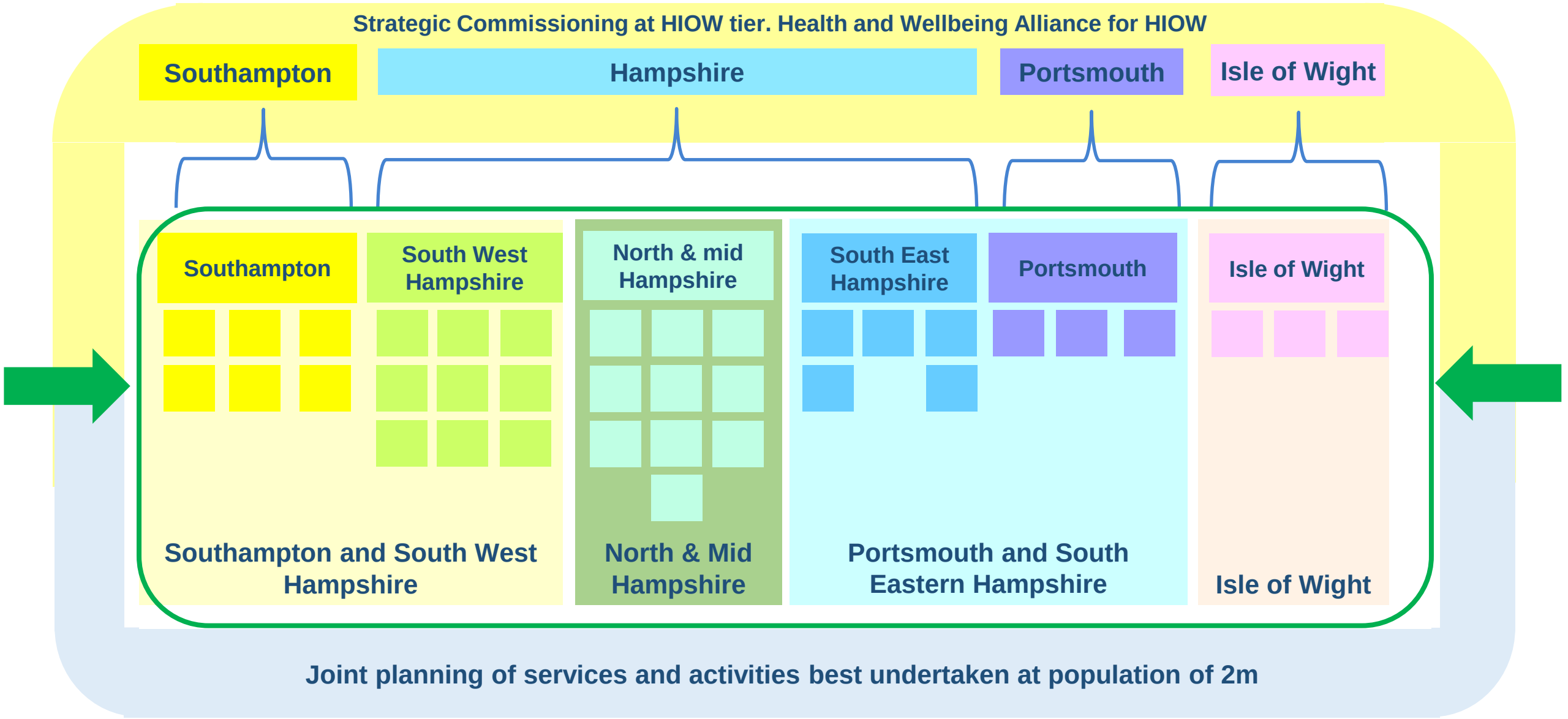
b. clarify the relationship between this and the other component parts of the proposed Hampshire and Isle of Wight Integrated care system

c. set out a mechanism for achieving ‘active and effective democratic engagement at all levels’ across the Hampshire and Isle of Wight integrated care system (including the role of HWB)

**Leads from the other Hampshire and Isle of Wight task and finish groups on integrated care partnerships, strategic commissioning and clusters will be involved in developing this thinking.**

# Integrated care partnerships





# Integrated care partnerships



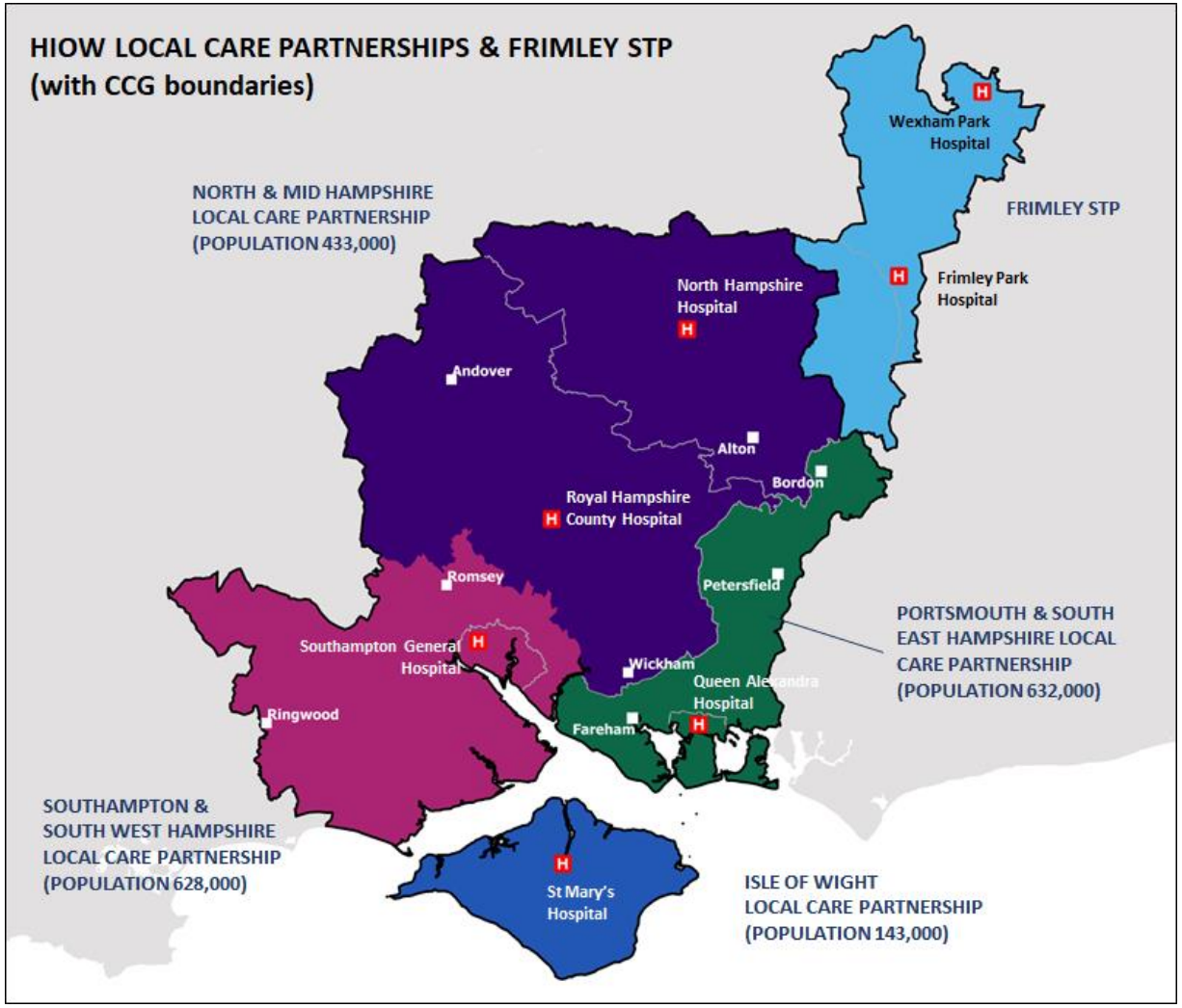
**Integrated care partnerships are where we align the work of the local clusters, community services, acute and specialised physical and mental health services, for the benefit of the local population.**

Providers of mental and physical health and care services including general practice, NHS commissioners, local authorities and voluntary sector organisations come together in geographies based on the local catchments of acute hospitals to benefit their local population.

The term ‘integrated care partnership’ [ICP] is being used to describe the collaboration of partners on these geographies.

The ICPs across HIOW will reflect local needs and will differ in the extent of their focus and work programme. For some, the focus may be predominately on improving operational ED performance. In others there is already an intent to work together on a more comprehensive basis with established governance structures to deliver agreed improvement programmes.

**The balance and focus of the planning and delivery that takes place in HWB footprints and integrated care partnerships will vary in each part of HIOW.**



# What could integrated care partnerships look like? 

The nature of Integrated Care Partnerships [ICPs] will vary according to local circumstances, challenges and opportunities. For some the arrangements will mirror current state. For others their development is such that by **April 2020, integrated care partnerships could be working together to:**

- implement a integrated care partnership delivery plan which sets out the collective priorities of the integrated care partnership, over the medium term (3-5 years) and in the short term (1-2 years) [noting that as previously alluded to, the balance and focus of planning and delivery that takes place in integrated care partnerships is likely to vary in each part of HIOW]
- design and implement optimal care pathways, and to identify, understand and reduce unwarranted clinical, operational and service variation
- make the best use of the collective resources of the integrated care partnership, including workforce, financial resources and estate, maximising system wide efficiencies and encouraging resources to flow to address the key risks facing the partnership
- support the ongoing development of the integrated care partnership:
    - progressively building the capabilities to manage the health of the population, to keep people well and to reduce avoidable demand
    - supporting the ongoing development of clusters, as the bedrock of the local health and care system
    - in some areas, potentially managing the transition to evolved organisational form arrangements that enable members of the integrated care partnership to sustainably meet the population needs

An integrated care partnership board could lead the partnership, providing strong system leadership, actively breaking down barriers that hinder progress in the delivery of integrated care, building trust and acting together to deliver improvements for citizens, for the system as a whole and through which partners hold each other to account for delivery of the shared priorities.

In integrated care partnerships, NHS providers including primary care, commissioners and local authorities work to overcome the barriers to collaboration associated with the separation of provision and commissioning. Whilst recognising the important individual statutory responsibilities of each partner, it is envisaged that:

- CCGs will deploy their people and resources to work collaboratively with other CCGs in the integrated care partnership, focussed on implementation of the integrated care partnership delivery plan – improving services, improving operational performance and delivering cost reduction.
- NHS providers will work together to make strategic and operational decisions that are in the best interest of the integrated care partnership.
- Where possible, in order to reduce duplication and bureaucracy, CCGs, NHS providers and if relevant local authorities, will seek opportunities to optimise corporate support services and infrastructure such as finance, quality, communications and governance teams.

**Current thinking about the development of integrated care partnerships by March 2019 and March 2020 is described on a subsequent slide.**

# ICPs: an example of a different approach



## We anticipate seeing:

- CCGs deploying their people and resources to work collaboratively with other CCGs in the local care system and with providers
- Providers making decisions and delivering care together – provider alliances
- CCGs, NHS providers and potentially local authorities sharing corporate support services and infrastructure?
- Over the next 18 months, working through together the impact on financial flows, contractual models and organisational forms (drawing national models such as the ICP contract consultation)

## Enabling us to have:

- Better grip on improving the money, performance and quality
- Integrated care partnerships supporting clusters to develop and thrive
- Whole system implementation of improved care pathways, and reduction in unwarranted clinical, operational and service variation
- Collective support for all services in the integrated care partnership to meet operational performance and quality standards
- Reduced transaction costs

**The ICP Task and Finish Group has been developing a vision of how the future <u>might</u> look. Each ICP will develop proposals that reflect their local context, challenges and opportunities**

# A potential timeline for the development of ICPs



| | October 2018 – March 2019 | By April 2020 |
|---|---|---|
| **Strategy and Planning** | • Develop and agree plan to make optimal use of acute and specialised physical and mental health services<br>• Aligning the work of clusters at HWB footprint with community and acute physical and mental health services | • Agreed single strategy and operational plan for the integrated care partnership describing collective priorities and how those priorities will be delivered<br>• Planning undertaken jointly by CCGs, providers and LAs |
| **Care Redesign** | • Implementing Urgent & Emergency Care priorities for the integrated care partnership<br>• Developing optimal care pathways across the integrated care partnership<br>• Agreed plan to support the development of clusters<br>• Engaging staff and local communities in redesign | • 100% of clusters thriving, with lower mental and physical acute care demand as integrated teams support people to stay well at home<br>• Managing a comprehensive programme of service improvement to address the integrated care partnership priorities<br>• Population groups with high service utilisation or unmet need identified and action agreed |
| **Workforce development** | • Understanding the workforce issues for the integrated care partnership | • Securing the right workforce, in the right place with the right skills in the integrated care partnership, and ensuring the wellbeing of staff |
| **Accountability & performance management** | • Working together to monitor and improve delivery of constitutional standards | • Instigating clinically led quality improvement<br>• Extensive use of data to drive improvement<br>• Oversight of delivery in clusters<br>• Leading recovery of standards without outside intervention |
| **Managing collective resources** | • Understand current resource use in the integrated care partnership<br>• Working together to make the best use of the collective resources (workforce, estate, financial) in the integrated care partnership<br>• Test new approaches to manage funding flows (e.g. DTOC)<br>• Maximising system wide efficiencies | • Managing the collective resources of the integrated care partnership<br>• Capable of taking on a delegated budget<br>• Directing resources to address the key integrated care partnership risks<br>• Shared corporate support services<br>• Shared medium term financial plan including efficiencies |
| **Leadership & governance** | • Understanding the context, ambitions and challenges of each member of the integrated care partnership, building trust, acting together<br>• Governance structure in place to enable collaboration<br>• Cluster leaders engaged in integrated care partnership planning and decision making<br>• Members of the integrated care partnership working together to agree any changes required to organisational structures | • Joint provider, CCG and LA leadership to enable planning and delivery in the integrated care partnership<br>• Care professionals leading service integration<br>• Governance mechanisms in place to enable decisions to be made in the best interests of the system and residents<br>• Implementing agreed changes to organisational structures to better enable delivery in the integrated care partnership |

# Statutory bodies are asked to:

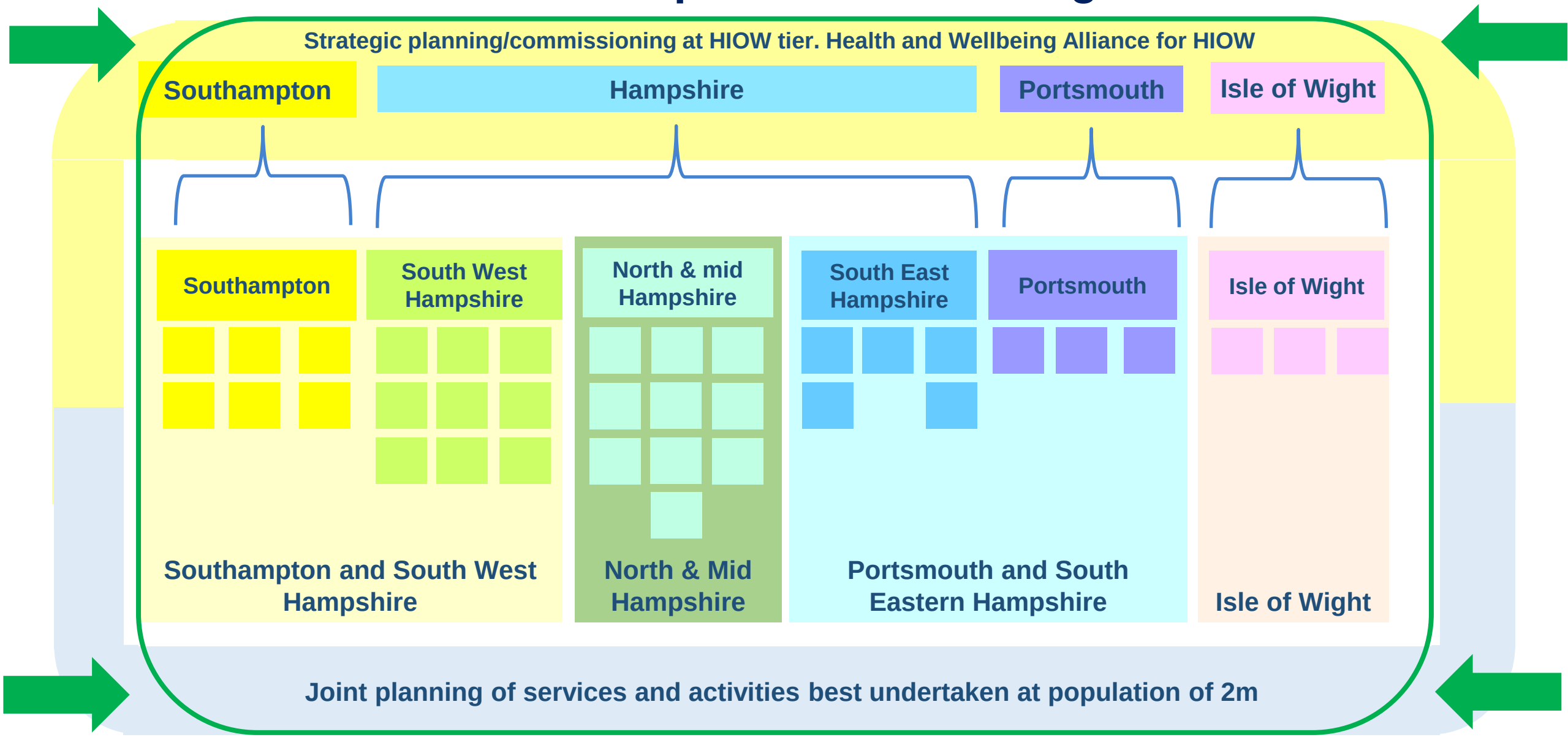


**Work with geographically aligned partners within the identified four ICP footprints to:**

1. Discuss and agree the remit and focus of the ICP;
2. By October 2018 prepare a Memorandum of Understanding [MoU] that sets out the remit, focus and the leadership / governance / decision making arrangements of the ICP and how the local Health and Wellbeing Boards (Care systems) and the ICP interface with one another - the balance and focus of each;
3. Set out the key milestones for the ICP for April 2019 and April 2020.

# Strategic planning, transformation, resource allocation and assurance at the scale of Hampshire & Isle of Wight





# Strategic planning, transformation, resource allocation and assurance at the scale of Hampshire & Isle of Wight



**In order to support and add value to the work of clusters, HWB footprints and integrated care partnerships, it is envisaged that providers, commissioners and local authorities will work together to undertake strategic planning, transformation, resource allocation and oversight activities at HIOW level.**

**This could be achieved, by April 2020, through a single entity for HIOW which, in its mature form, would develop strategy, set priorities and provide strategic leadership and direction to the HIOW integrated care system.**

The strategic planning and transformation function in the HIOW integrated care system would:

- include the input and expertise of providers, CCGs and local authorities
- programme manage the implementation of HIOW level transformational change (change that spans more than one integrated care partnership or which is most appropriately managed at HIOW system level)
- proactively support the development of integrated care partnerships
- manage the specialised commissioning budget for HIOW
- align the resources coming into HIOW from a wide variety of sources around the delivery of the agreed strategic priorities, in order to increase the impact for populations
- act as the assurance body for HIOW, providing oversight of operational, quality and financial performance, and enabling the HIOW integrated care system to take action to improve performance without the need for outside intervention.

Whilst recognising the important role of external regulation, it is anticipated that the integrated care system will increasingly develop the capacity and capability to role-model ‘self-regulation’ – where robust processes are in place to ensure that action is taken to identify issues and improve performance without the need for outside intervention.

Creating this strategic planning and transformation function for the HIOW, which involves providers, CCGs and local authorities, is an opportunity to bring together in one place a number of functions including: those CCG functions best undertaken at HIOW level, STP functions, functions currently undertaken by the Director of Commissioning Operations, NHS England/NHS Improvement regulatory functions, specialised services commissioning and potentially other NHS England direct commissioning activities; HIOW clinical networks.

**Current thinking about the transition towards this new way of working, by March 2019 and March 2020, is described on a subsequent page.**

# The characteristics of the HIOW integrated care system



**It is proposed that, based upon national ICS, national guidance and evidence of best practice, an entity operating at the scale of HIOW could display the following characteristics:**

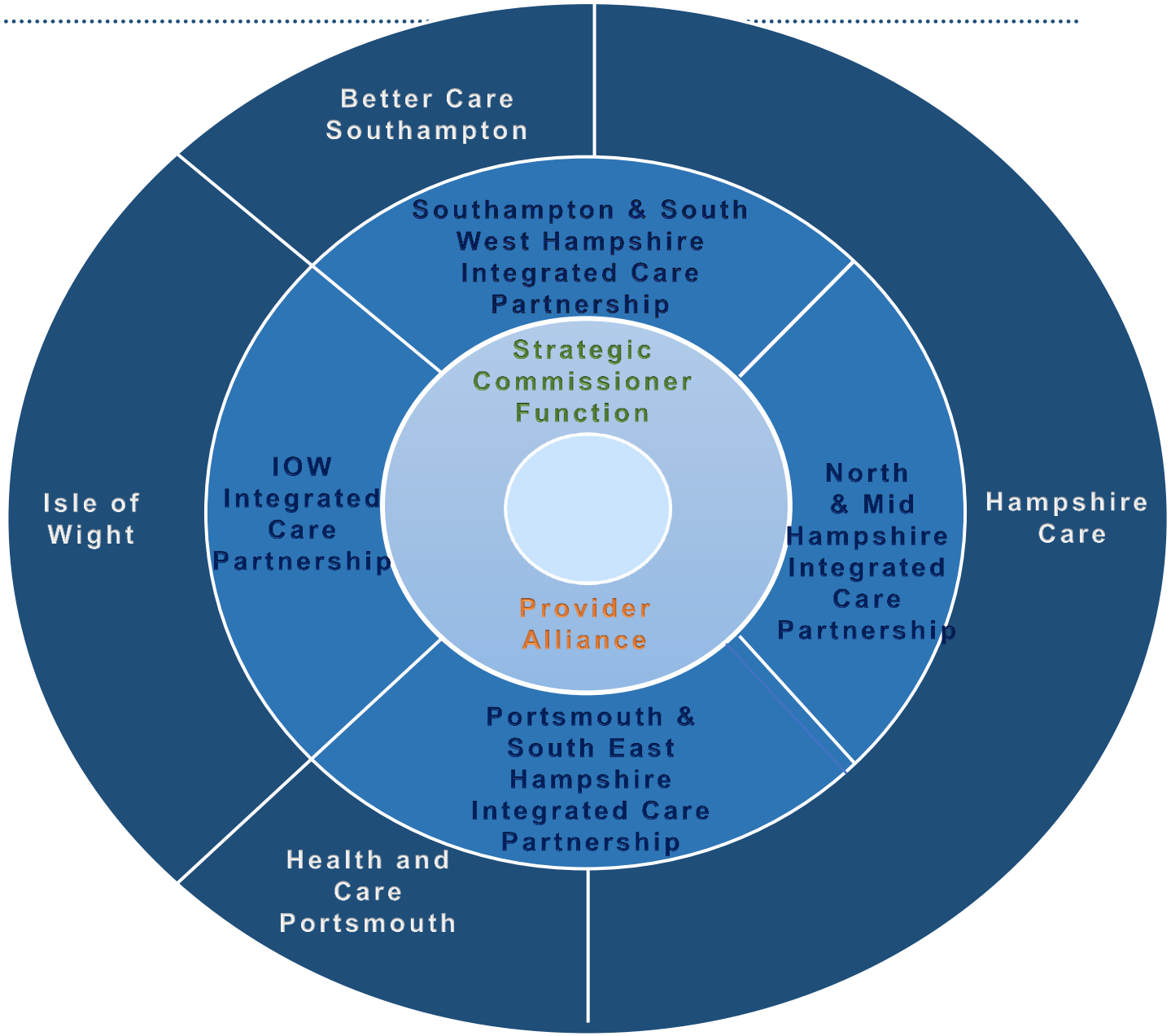
**Subsidiarity:** only undertaking functions that for reasons of cost or complexity need to be undertaken at the scale of 2m+ population. Unnecessary complexity and bureaucracy are stripped out with 80% of the transformation process led by local place-based teams;

**Inclusive:** national models / guidance show that prospective ICS are founded on partnership; for HIOW this would draw together:

- A newly established strategic commissioning function
- the four HWB footprints
- the four integrated care partnerships
- provider alliance

**Founded on self-regulation:** all components of reformed systems have effective self-regulation and enable a model of collective assurance at the scale of the ICS. This allows NHS England and NHS Improvement to deploy resource into the ICS and have a single touch point on delivery to the newly reformed regional and national infrastructure;

**Politically-led:** prospective ICS all demonstrate strong political leadership and close connection with Health and Wellbeing Strategies and Boards.



# Strategic planning/commissioning at the scale of HIOW



**As an immediate next step in the transition to this future system model, it is proposed that HIOW CCGs and local authorities establish a strategic planning/commissioning function during Q3 2018/19.**

**By working together at HIOW level, CCGs and local authorities expect to be able to reduce fragmentation and bring the following immediate benefits:**

- stronger alignment of health and local authority commissioning
- the development & agreement of consistent whole system strategic priorities for HIOW
- improved and simplified commissioning decision-making for HIOW wide issues.

The functions of the strategic planning/commissioning function in its initial form would include:

- Setting consistent commissioning strategy and strategic priorities for HIOW
- Managing whole system resilience at HIOW level
- Management and deployment of supra-allocation resources (including capital)
- Demand and capacity planning and commissioning decisions about the future configuration of acute physical and mental health services for the 2 million population of HIOW
- Oversight of NHS constitutional standards, financial performance and quality improvement – with work to be done to ensure this activity isn't duplicated elsewhere
- Work with specialised commissioners, understanding current activity flows and costs, inputting to and aligning decision making
- It is also proposed that the strategic planning/commissioning function incorporates the transformation programme function of the HIOW Sustainability and Transformation Partnership.

**Proposed governance:**

- Established through a joint committee, in the first instance, during Q3 2018/19
- Members include CCGs, NHS England (specialist commissioning and Regional Director of Commissioning) and local authorities
- Joint committee will have delegated authority to make binding decisions in relation to the in-scope functions and responsibilities
- Expect by April 2019 the governance and organisational arrangements evolve further

**The strategic planning/commissioning function is a mechanism through which commissioners can pool skills, expertise, resources and accountability to deliver transformation at HIOW level. There is a strong desire to create a new way of working, rather than add layers to existing ways of working.**

# The developing functions at a scale of HIOW



| | October 2018 – March 2019 | By April 2020 |
|---|---|---|
| **Strategy and Planning** | • Clear commissioning priorities agreed for HIOW<br>• HIOW system strategy and priorities being refreshed/updated<br>• Demand and capacity planning for HIOW acute services<br>• Agree aligned planning process for 2019/20-2020/21 | • CCGs, providers & LAs setting shared strategy & priorities for HIOW with aligned health & LA planning processes<br>• Fully own a single HIOW system operating plan that brings together plans of constituent parts of the system |
| **Care Redesign** | • Decisions being made about future configuration of acute physical health and mental health crisis and acute care<br>• Leadership of plans to improve urgent care for HIOW, including oversight of delivery of the Integrated Urgent Care Plan<br>• Decisions about community services provision for Hampshire | • Well developed plans being enacted to support the development of integrated care partnerships<br>• Programme managing the implementation of HIOW level strategic change programme<br>• Leading on implementation of acute service and estate reconfiguration |
| **Workforce development** | • Understanding the workforce issues for the system<br>• Influencing the addressing of key workforce issues | • Strategic workforce plan in place and being implemented<br>• Influencing future workforce supply and training requirements |
| **Accountability & performance management** | • Oversight of HIOW winter resilience and preparedness<br>• Oversight of delivery of integrated urgent care plan<br>• Acting as interface with assurance bodies for HIOW | • Collective oversight of quality, operational performance and money<br>• Acting as the assurance body for HIOW – supporting the system to take action to improve performance and address challenges without the ned for outside intervention |
| **Managing collective resources** | • Agree system wide capital and estate priorities and sign off wave 4 capital allocations<br>• Develop understanding of whole system financial plans and financial risks<br>• Plan for aligned management of specialised commissioning | • Take accountability for a HIOW system control total<br>• Managing collective finances & risk openly and as a system<br>• Aligning resources flowing into HIOW to achieve priorities<br>• Support integrated care partnerships to take delegated budget<br>• Managing the specialised commissioning budget |
| **Leadership & governance** | • CCGs operating with a single decision making committee for HIOW level commissioning business<br>• All STP partners involved in the design of the future HIOW level system strategic planning, implementation and assurance function<br>• STP partners providing leadership to strategic change programmes | • A single coherent entity in place that brings together HIOW level CCG functions, STP and NHSE/I functions<br>• Strategic alignment of providers, commissioners and local authorities around the system strategy and priorities<br>• Clear clinical leadership for the system and input from HWB footprints and integrated care partnerships in decision making |

# Statutory bodies are asked to:



**Endorse the recommendations of the EDG, informed by the work of the strategic commissioning task and finish group, that:**

1. The strategic commissioning task and finish group further develop the proposal with an aim to establish a strategic commissioning function by October 2018, initially through a joint committee which will have delegated authority to make binding decisions in relation to its in-scope functions and responsibilities.

2. That a new task and finish group is convened including providers, commissioners, local authorities, and NHS England and NHS Improvement, to work together and take responsibility for the development of the next phase of the work to build the strategic planning, transformation, resource allocation and assurance function for HIOW, constructing ICS governance that supports our approach.

# Summary of recommendations

**In summary, the governing bodies and boards of statutory organisations are asked to endorse the following recommendations from the EDG, informed by task and finish group work to date:**

## Clusters

1. **The developing role of clusters as outlined earlier**
2. **The recommendation that partners across HWB footprints and integrated care partnerships work together to define the resources required for cluster operation – a critical first step is establishing professional and operational leadership to drive cluster development**
3. **The proposed next steps for the cluster task and finish group which are summarised as follows:**
   a. Quantify the impact/expected outcomes of cluster teams (already in progress in most areas): defining outcome metrics for individual clusters and a small set of common metrics across whole HIOW
   b. Describe the support requirements and responsibilities to accelerate full cluster implementation
   c. Describe the proposed interplay between clusters and other components of the ICS, including governance and participation arrangements for clusters as part of HWB footprints and integrated care partnership structures
   d. Strengthen primary and social care involvement in this work at a Hampshire and Isle of Wight level (membership of the task and finish has already been extended to reflect this)

## Health and Wellbeing Board Footprints

1. **The emerging 'restatement' of the function of partnership working on a HWB footprint as described earlier in the document**
2. **The proposed next steps for the task and finish group by the end of September, which are to:**
   a. define the common functions of the role of HWB footprints in an integrated care system
   b. clarify the relationship between this and the other component parts of the proposed Hampshire and Isle of Wight Integrated care system
   c. set out a mechanism for achieving 'active and effective democratic engagement at all levels' across the Hampshire and Isle of Wight integrated care system (including the role of HWB)

## Integrated care partnerships

Work with geographically aligned partners within the identified four ICP footprints to:

1. Discuss and agree the remit and focus of the ICP;
2. By October 2018 prepare a Memorandum of Understanding [MoU] that sets out the remit, focus and the leadership / governance / decision making arrangements of the ICP and how the local Health and Wellbeing Boards (Care systems) and the ICP interface with one another - the balance and focus of each;
3. Set out the key milestones for the ICP for April 2019 and April 2020.

## Strategic commissioning

1. The strategic commissioning task and finish group further develop the proposal with an aim to establish a strategic commissioning function by October 2018, initially through a joint committee which will have delegated authority to make binding decisions in relation to its in-scope functions and responsibilities.
2. That a new task and finish group is convened including providers, commissioners, local authorities, and NHS England and NHS Improvement, to work together and take responsibility for the development of the next phase of the work to build the strategic planning, transformation, resource allocation and assurance function for HIOW, constructing ICS governance that supports our approach.

# Next steps

# System reform programme next steps



**A number of recommendations have been set out linked to each component of the proposed ICS. In addition to those associated with the specific components of the proposal, there are a number of overarching 'implementation programme deliverables', some of which will result as a coming together of the outputs from the various task and finish groups. These include:**

- System reform implementation programme plan
- Structure and leadership plan – transitionary and end state
- Development and implementation of a communications and engagement plan
- Request for support (endorsement , agreement in principle, technical and financial) from NHS England , NHS Improvement and other arms length bodies such as the Local Government Association, NHS Leadership Academy, Health Education England
- Proposals to replace STP infrastructure (inc. Chair & SRO) to align with future form
- Organisational change plan and talent management plan
- HIOW ICS Chair and relevant leadership appointments
- Indicative budgets and financial framework for all components of the ICS
- Three year financial plans

**It is recommended that a working group is formed, reporting to the EDG, to support the development of the above. Members of EDG are asked to nominate a representative to represent the interests of their part of the system.**

# Glossary

# Glossary of terms



**Clusters -** also referred to locally and nationally as neighbourhoods, localities, primary care networks. Multi-disciplinary teams delivering integrated health, care and wider services to cluster populations based on natural communities of 20-100,000 people.

**Health and Wellbeing Board (HWB) footprints –** also known as care systems and are based on local authority footprints. The basis of the joint strategic needs assessment (JSNA), means through which HWB exert tangible influence on the direction of health and care services for the population through health and care commissioning and wider determinants of health. Locally the HWB footprints come under the guise of Better Care Southampton, Health and Care Portsmouth, Hampshire Care and the Isle of Wight Care Board.

**Integrated care partnerships –** also know as local care partnerships and are based on acute (physical) hospital footprints. Integrating care delivered in clusters with broader community and acute physical and mental health services; optimising the utilisation of acute services; designing and implementing optimal care pathways.

**Integrated care system -** the Hampshire and Isle of Wight health and care system, serving a population of 2 million citizens.

NHS England defines ICS as those systems in which:

“Commissioners and NHS providers, working closely with GP networks, local authorities and other partners, agree to take shared responsibility (in ways that are consistent with their individual legal obligations) for how they operate their collective resources for the benefit of local populations”.