An update on national progress towards integrated care

The NHS long term plan sets out the commitment that all areas will be covered by ICSs by April 2021, during this session we will discuss the progress made to date in reaching this target, the challenges systems have faced and the next steps for integrated care in the NHS.

March 2021 Prepared for HFMA Dr Karen Kirkham NHSE/I

Integrating care – building on progress

We embarked on this journey four years ago with the creation of Sustainability and Transformation Partnerships (STPs) in 2016 and Integrated Care Systems (ICSs) from 2018. There are now 29 ICSs serving 35 million people, more than 60% of the population, with 13 STPs working towards ICS designation.

Integrated care systems enable our health and care organisations to join forces and apply their collective strength to addressing the country's biggest health challenges, many exacerbated by COVID-19.

Learning from the pandemic has highlighted the importance of collaboration between health and care organisations and increased the appetite for statutory clarity.

We believe:

- decisions taken **closer to communities** give better outcomes, usually in established places rather than across whole systems;
- **collaboration at place** between NHS, local authorities and the voluntary sector is better than competition in creating effective and proactive care and support in communities;
- **collaboration between providers** on a bigger footprint is better than competition in driving joined-up, safe, high quality care across larger populations.

The ambitions for Integrated Care Systems

Extensive feedback on the next phase of ICS development shows we need to do more to remove barriers to collaboration. "**Integrating care – next steps to build strong and effective integrated care systems across England**" sets out proposals for how we take that forward.

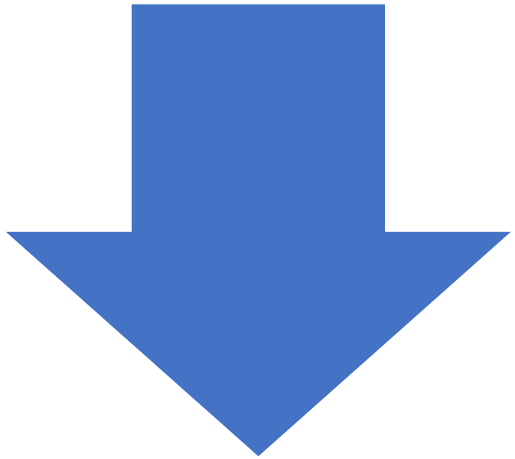
We heard about the importance of:

- Population health and addressing wider determinants of health
- Strong partnership working in recognised 'places'
- Cultural and behavioural factors including system leadership
- National direction on "the what" but local flexibility on "the how"
- Subsidiarity – decisions taken as close as possible to the people served

Fundamental ICS purposes in the document:

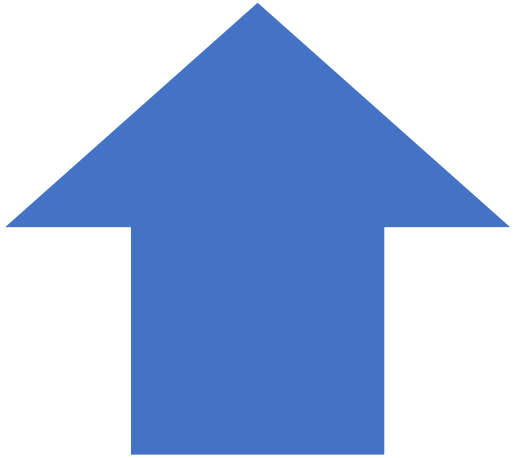
- Improving population health and healthcare
- Tackling unequal outcomes and access
- Enhancing productivity and value for money
- Helping the NHS to support broader social and economic development

Challenges

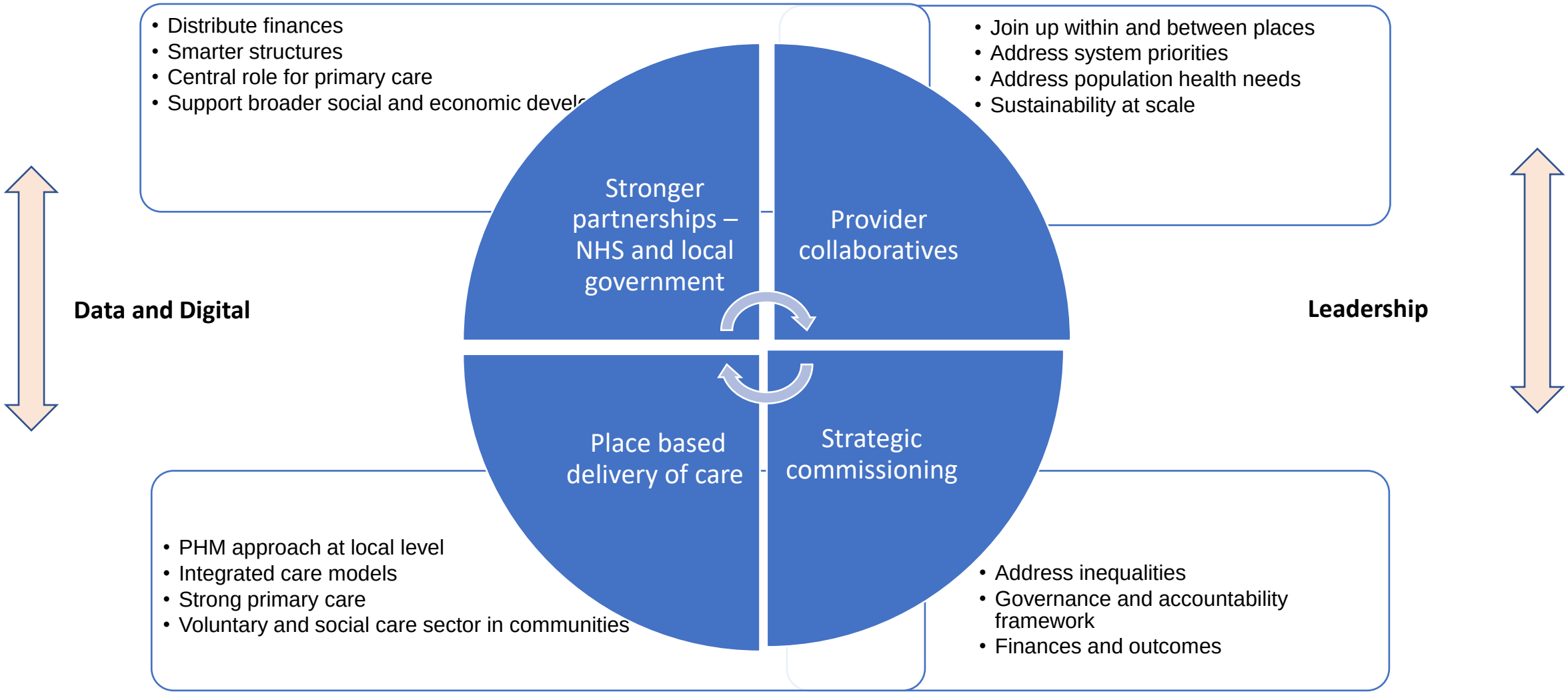


Independence

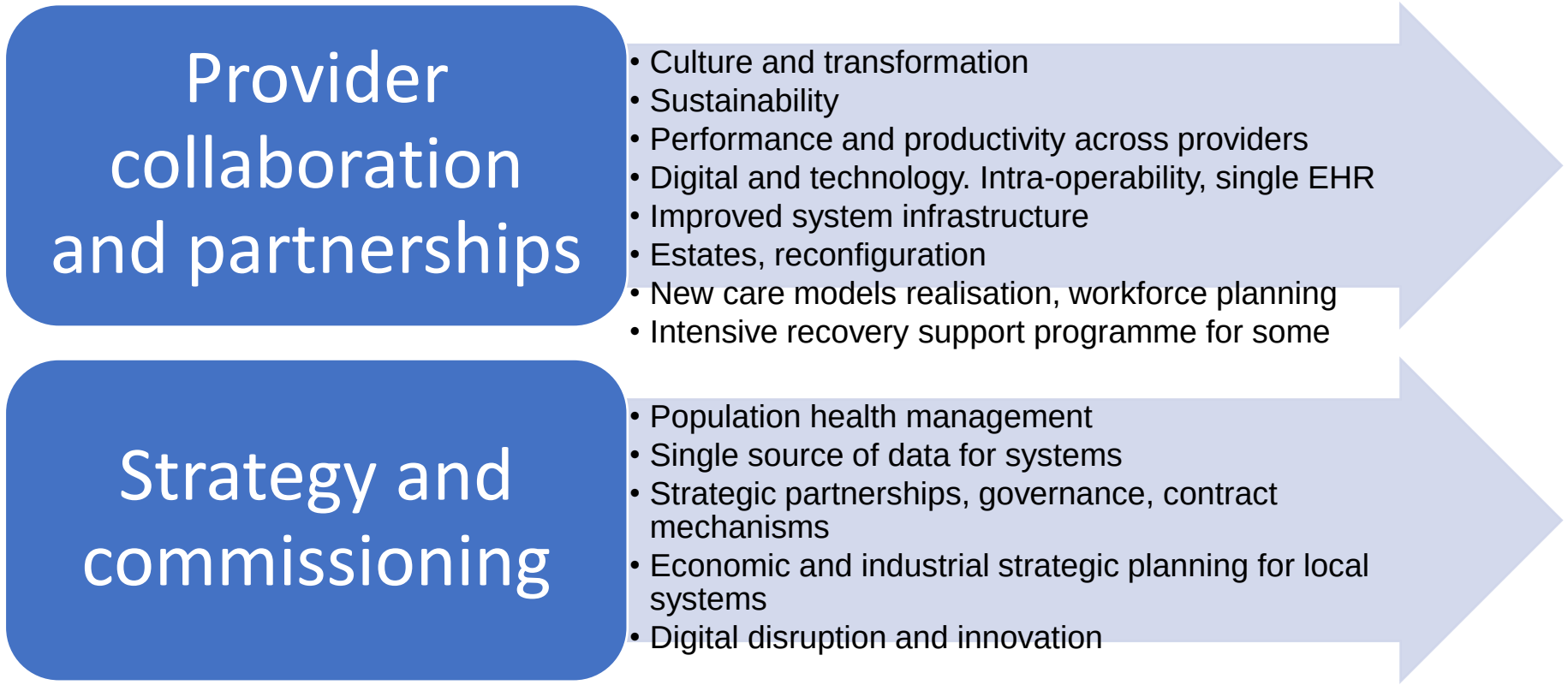
Integration



What's next for ICS



New ways of working



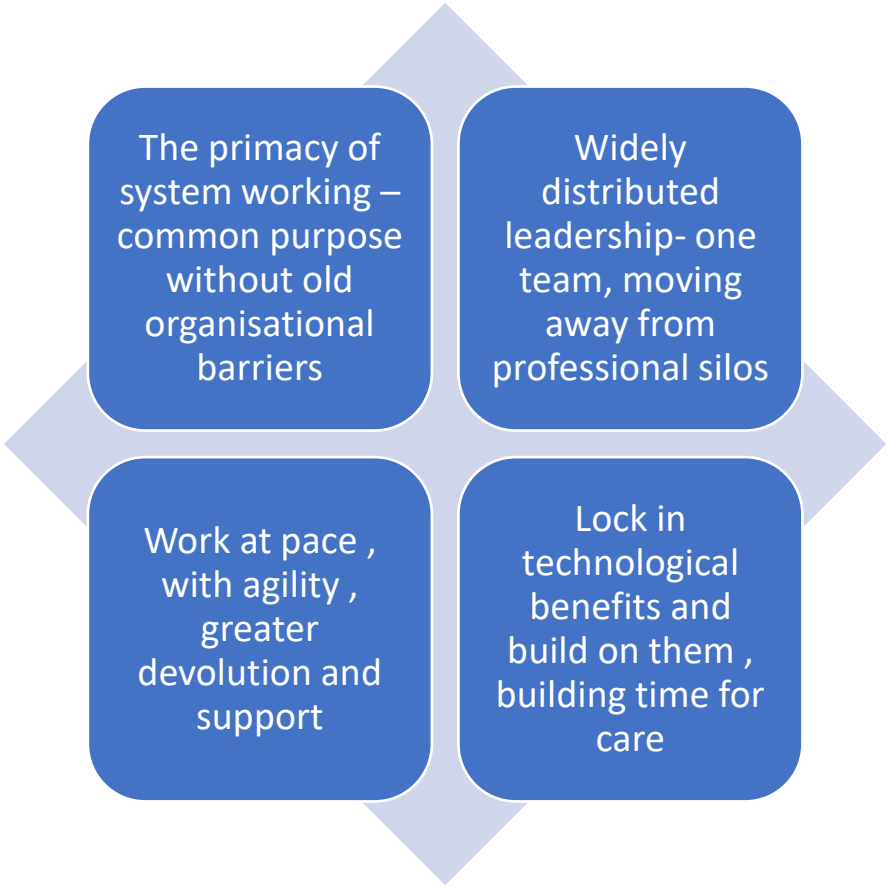
Practical changes to deliver the ambition

1. Provider collaboratives	Provider organisations will play an active and strong leadership role in systems. Through their mandated representation in ICS leadership and decision-making, they will help to set system priorities and allocate resources.
2. Place-based partnerships	Every area is different, but common characteristics of the most successful are the full involvement of all partners who contribute to the place's health and care with appropriate resourcing and agreed responsibility between partners
3. Clinical and professional leadership	ICSs should embed system-wide clinical and professional leadership through their partnership board and other governance arrangements, including primary care network representation
4. Governance and accountability	Systems have told us from recent experience that good partnership working must be underpinned by mutually-agreed governance arrangements, clear collective decision-making processes and transparent information-sharing
5. Financial framework	We will increasingly organise the finances of the NHS at ICS level and put allocative decisions in the hands of local leaders.
6. Data and digital	To fulfil the potential of digital and data to improve patient outcomes and drive collaborative working, systems will need to: (1) build smart digital and data foundations (2) connect health and care services (3) use digital and data to transform care (4) put the citizen at the centre of their care
7. Regulation and oversight	Focus on how effective local arrangements are at implementing better pathways, maximising use of collective capacity and resources, and acting in partnership to achieve joint financial and performance standards.
8. How commissioning will change	A clearer focus on population-level health outcomes and a marked reduction in transactional and contractual exchanges within a system.

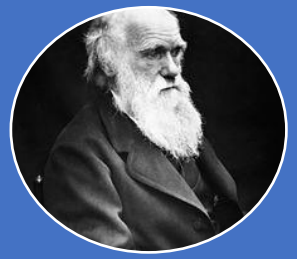
Collaboration as a driver for change

Stronger partnerships in local places between NHS, local councils and others	Formal collaborative arrangements for provider organisations that allow them to operate at scale	System-wide strategic commissioning with a focus on population health
Clear advice for local people; simple joined up care; digital services that put the citizen at the heart of their own care; proactive support for the vulnerable or high risk. A fuller role for the NHS in social/economic development and environmental sustainability. Delivery through NHS providers, local government, primary care and the voluntary sector working together in each place, built around primary care networks in neighbourhoods. Delegated place budgets: primary care, community health, mental health, social care and support, community diagnostics and urgent and emergency care.	Enable access to high-quality and fair access to acute hospital, mental health and ambulance services. Use provider collaboration for wider footprints – across an ICS or more extensively as required – to support: • higher quality and more sustainable services; • reduction of unwarranted variation in outcomes; • reduction of health inequalities with fair, equal access; • better workforce planning; • more effective use of resources, clinical support and corporate services.	**Strategic commissioning:** • a single system-wide approach, assessing need and how to deliver this; • reduction in transactional and contractual exchanges; • agreement by systems about where functions best sit - system or place; • evolution of organisational form coterminous with ICS boundaries. **ICSs agreement on:** • distribution of financial resources; • improvement and transformation resource; • operational delivery; • workforce planning; • emergency planning and response; • digital and data.

An emerging new normal



Clinicians are critical to successful change

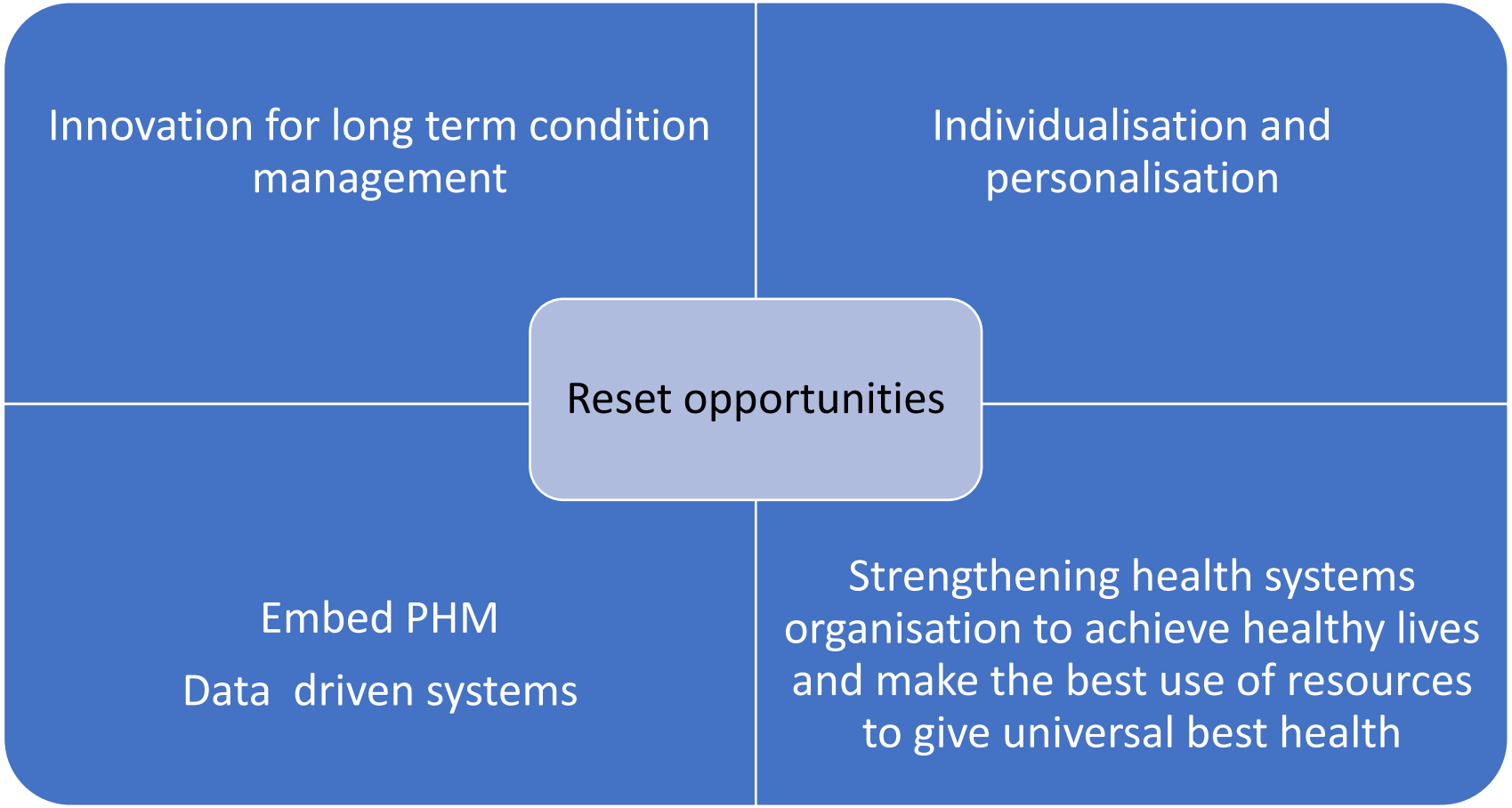


Adaptive leadership through change

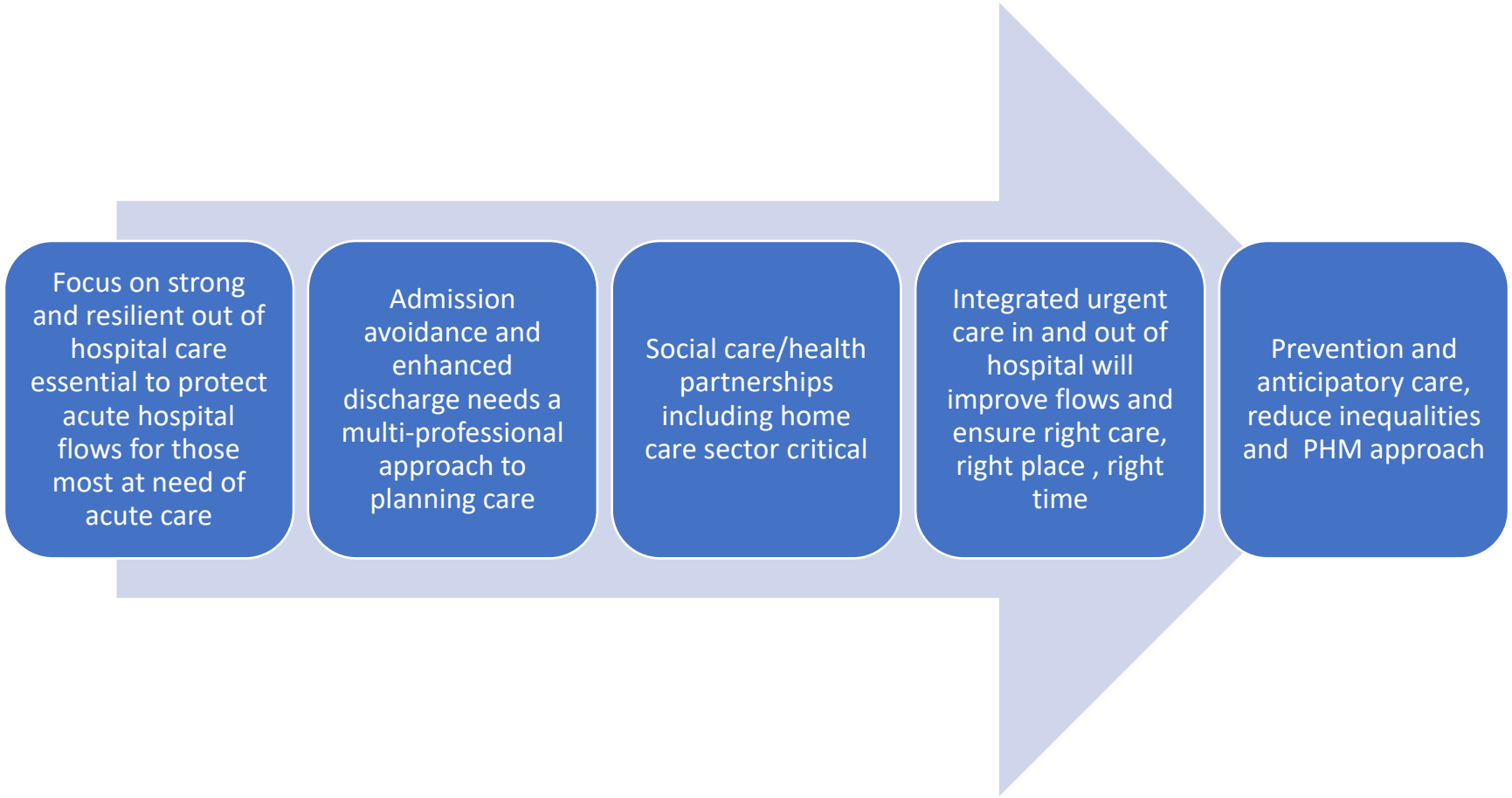
Many clinicians lead without formal authority and are close to the detail of what needs to change

Importance of patient and families views

From person to system



Returning to a new normal post Covid



Moving to system decision making:

- Data driven insights
- Population data – integrated “single source of the truth”
- Health and care
- System investment needed in the infrastructure , business analysts and business intelligence tools
- Public health embedded in local teams owning the PHM agenda
- Population health management transformation of clinical services

What is Population Health Management?

Population Health…

… is an approach aimed at **improving the health of an entire population.**

It is about **improving the physical and mental health outcomes** and wellbeing of people, whilst **reducing health inequalities** within and across a defined population. It includes action to reduce the occurrence of ill-health, including **addressing wider determinants of health**, and requires working with communities and partner agencies.

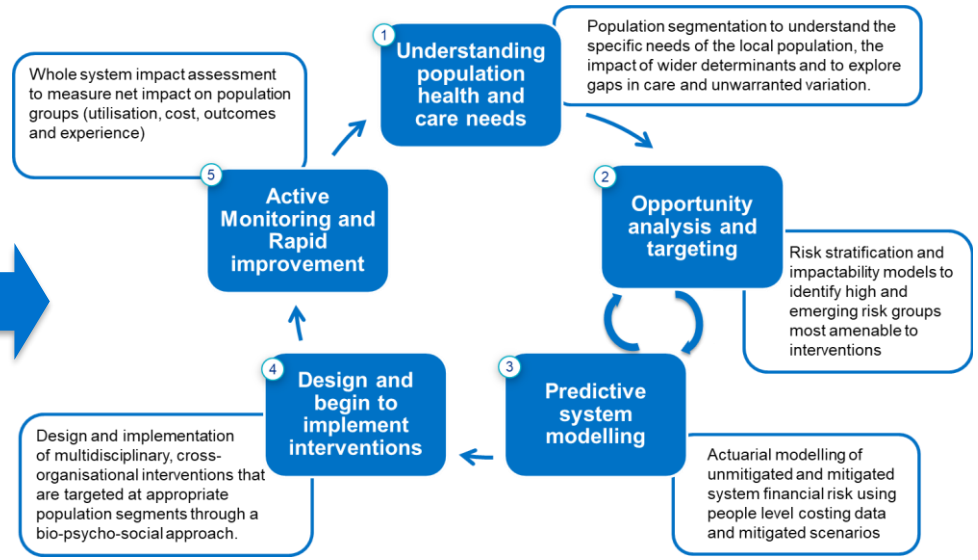
Population Health Management…

…improves population health by **data driven planning and delivery of proactive care to achieve maximum impact**.

It includes segmentation, stratification and impactability modelling to identify local 'at risk' cohorts - and, in turn, designing and targeting interventions to prevent ill-health and to improve care and support for people with ongoing health conditions and reducing unwarranted variations in outcomes.

Population Health Management is about:

- Using data-driven insights and evidence of best practice to inform **targeted interventions to improve the health & wellbeing of specific populations & cohorts**
- **The wider determinants of health,** not just health & care
- **Making informed judgements**, not just relying on the analytics
- **Prioritising the use of collective resources to have the best impact**
- **Acting together** – the NHS, local authorities, public services, the VCS, communities, activists & local people. **Creating partnerships of equals**
- **Achieving practical tangible improvements for people & communities**



Linked data can used to understand whole population need

Place-level intelligence

Segmentation identifies risk-based cohorts, unwarranted variation

Neighbourhood-level intelligence

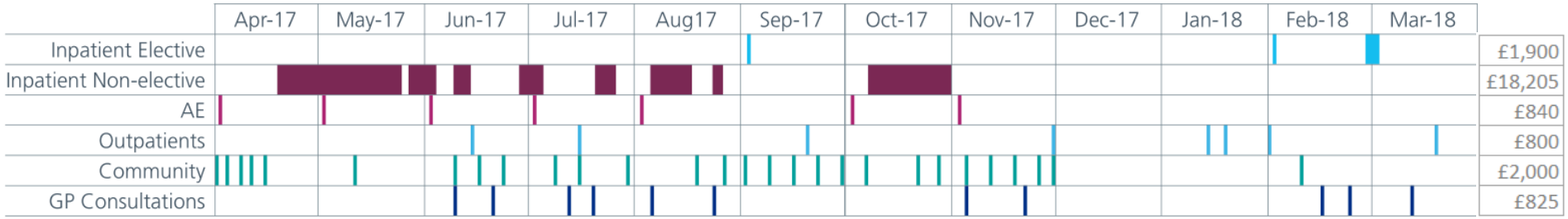
Person level data can analysed to identify the drivers of care utilisation so that proactive interventions can be put in place.

Age	Paeds (0-17)			Adults (18-74)			Elderly (75+)			
Complexity	Low	Middle	High	Low	Middle	High	Low	Middle	High	Whole Pop
Overall Population Measures										
Population	49,726	2,210	124	138,611	24,220	1,710	4,670	6,736	1,316	229,323
Average age	9	6	4	42	54	60	81	82	83	38
Average Deprivation Decile	6.0	5.8	5.5	6.1	6.0	5.3	6.6	6.4	6.1	6.1
Average Acute & Chronic Conditions	1.0	6.2	12.4	1.4	6.4	12.6	2.5	7.0	12.9	2.2
Symmetry Risk Score	0.2	1.3	3.7	0.6	2.8	7.5	2.0	4.4	8.8	1.0
LACE Index (0-4 Low; 5-9 Mod; 10+ high)	0.4	2.9	5.8	0.6	2.8	7.6	3.9	5.9	10.0	1.2
Activity & Economic Measures										
Spend - Total	£13.8m	£4.7m	£1.1m	£59.1m	£54.2m	£14.9m	£7.7m	£27.4m	£14.9m	£197.9m
Spend PPPY - Total	£278	£2,149	£8,534	£427	£2,238	£8,739	£1,652	£4,070	£11,326	£863
Acute Elective	£74	£592	£1,699	£130	£798	£2,255	£322	£827	£1,458	£242
Acute Non-Elective	£74	£894	£4,671	£106	£552	£3,636	£521	£1,371	£5,196	£257
MH & Community	£63	£425	£1,666	£40	£221	£1,181	£210	£632	£1,934	£109
Social Care	£0	£0	£0	£33	£253	£886	£355	£747	£1,993	£94
General Practice	£66	£238	£497	£117	£415	£782	£243	£494	£743	£161
Activity PPPY - Inpatients	0.1	0.9	3.4	0.1	0.7	2.3	0.3	0.9	2.2	0.2
Activity PPPY - A&E	0.2	0.8	1.6	0.1	0.5	1.7	0.2	0.5	1.6	0.2
Physical Health										
Asthma	12.5%	12.2%	10.5%	12.5%	12.5%	13.0%	12.3%	12.0%	12.0%	12.5%
Cancer	0.0%	1.0%	3.2%	1.6%	8.6%	15.7%	7.6%	17.6%	28.0%	2.8%
COPD	3.6%	3.3%	4.0%	3.6%	3.7%	3.4%	3.9%	3.4%	4.2%	3.6%
Chronic Renal Failure	0.0%	0.2%	0.0%	0.0%	0.8%	8.2%	0.6%	5.0%	20.1%	0.4%
Diabetes	0.2%	1.2%	4.8%	2.7%	18.1%	41.5%	8.8%	22.0%	35.6%	4.9%
Heart Failure	0.0%	0.5%	2.4%	0.8%	9.2%	32.6%	6.7%	25.4%	56.2%	2.9%
Hypertension	0.0%	0.6%	2.4%	6.6%	37.7%	66.7%	32.5%	67.5%	85.9%	11.6%
Infectious Disease	4.8%	41.5%	73.4%	1.1%	5.1%	17.9%	0.5%	4.2%	18.2%	3.0%
Mental Health										
Depression	0.2%	1.1%	2.4%	5.7%	22.4%	38.5%	2.0%	7.4%	21.0%	6.5%
Dementia	0.0%	0.0%	0.0%	0.0%	0.3%	1.9%	2.7%	6.2%	15.0%	0.4%
SMI	0.0%	0.3%	0.8%	0.5%	1.7%	4.0%	0.3%	0.7%	1.4%	0.5%
Other Characteristics										
Obesity	0.1%	0.6%	3.2%	1.2%	11.3%	31.5%	0.7%	4.3%	11.0%	2.4%
Smoking	0.2%	0.8%	0.8%	10.3%	18.1%	22.6%	5.4%	7.6%	8.3%	8.7%
Falls	2.3%	5.2%	4.8%	2.3%	8.9%	24.7%	8.6%	21.5%	46.2%	4.1%
Housebound	0.3%	0.5%	2.4%	0.7%	4.7%	17.8%	7.0%	18.6%	40.7%	2.1%
Social Vulnerability	0.2%	0.4%	0.8%	0.3%	1.8%	5.3%	5.8%	11.1%	16.8%	1.0%
Weight Loss & Anorexia	3.2%	8.2%	15.3%	1.8%	7.2%	17.3%	4.2%	9.5%	18.5%	3.2%

Theographs demonstrates cross-sector patient timelines and activity-based cost across the System

Sample Patient Detail

Age: 72 **Gender:** Female **Deprivation Decile:** 4 **ONS Socio-Economic Category:** Established Farming Communities	**LTCs**: 4 **Frailty:** Severe **Disease Casemix:** Chronic kidney disease, depression, diabetes, hypertension, polypharmacy, SMI **Approximate Costs:** 16/17 £18,100 | 17/18 £24,570



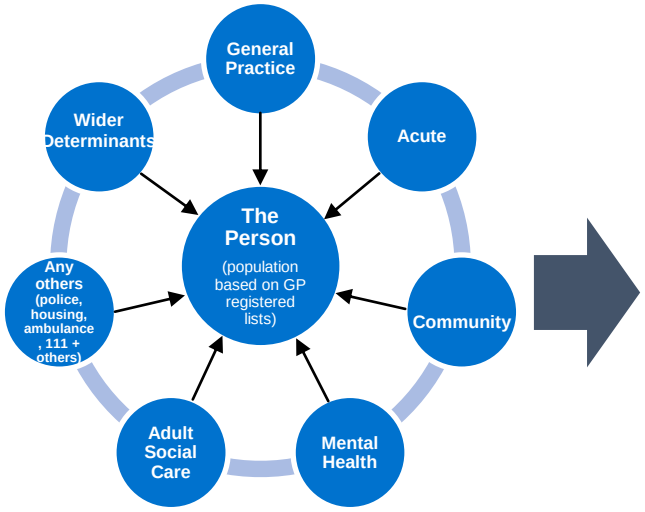
Theographs allow us to visualise the health journey of a single patient, across the entire continuum of health and care

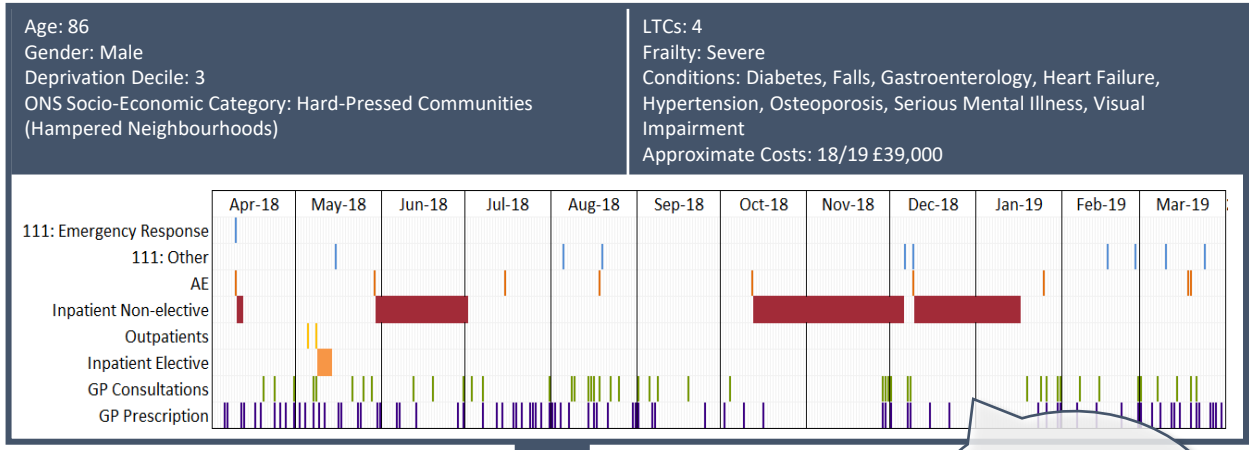
How could the the cost of this patient's care be better spent in a way that incentivises integrated and joined up care?

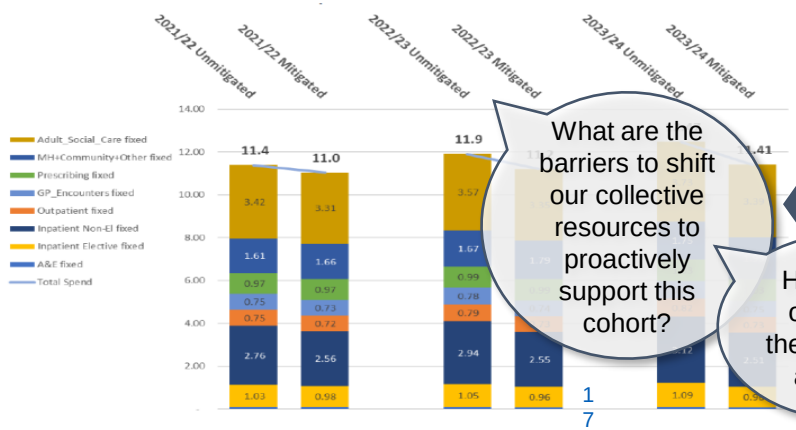
Linked data across Place unlocks new whole person models of care redesign and resource allocation

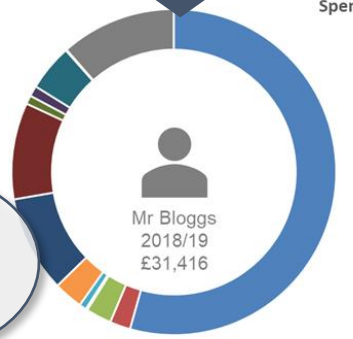
A single source of the truth enables system and clinical teams to build an understanding of need and priorities for their population **demonstrating current - and predicting future - cost per provider per person within a chosen cohort.** This linked data is essential to enabling:

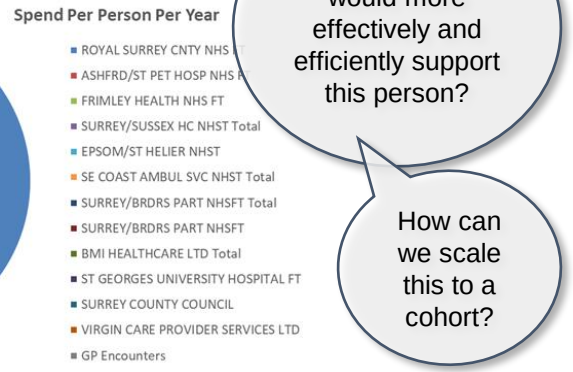
- Enabling integrated working by creating a shared source of truth that engages all partners equally and objectively represents their experience in managing a cohort's activity and cost
- Supporting the design and delivery of an outcomes-driven integrated care model that can proactively track impact on activity, resources, and costs through a population lens
- Allowing risk and incentives to be appropriately allocated based on population need/outcomes











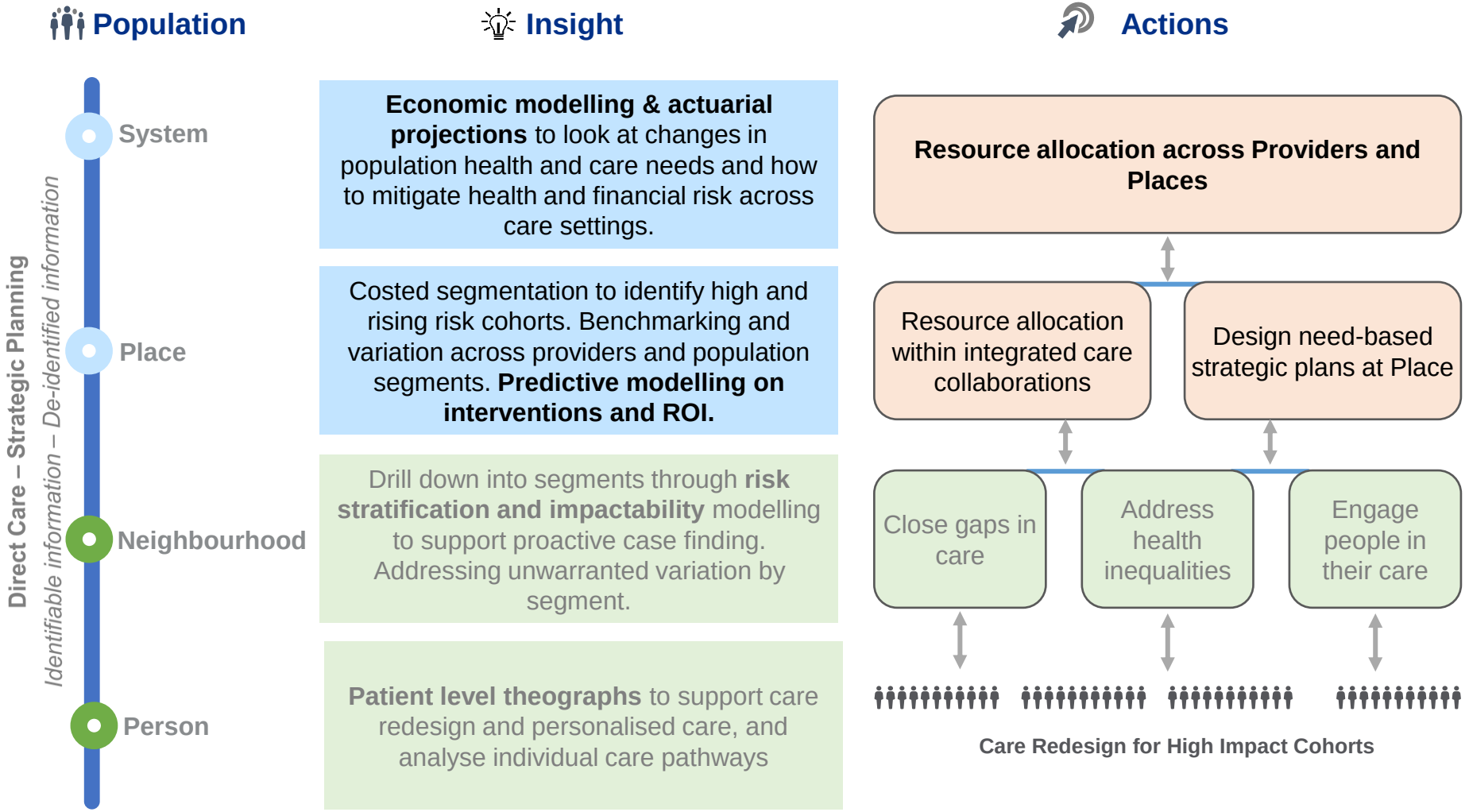
What are the barriers to shift our collective resources to proactively support this cohort?

How do we overcome these barriers at scale?

What care model would more effectively and efficiently support this person?

How can we scale this to a cohort?

Improving population health and supporting System recovery by enabling integrated teams at every level to make data-driven decisions



Objective: a population-based payment & contracting system

We need to ensure payment flows support the activities that create patient value….

- Currently payment flows are to a large extent dictated by historic/existing cost structures
- Payment is generally focused on inputs rather than outcomes
- To **support the LTP objectives** around sustainable and high quality care, payment needs to better align to the needs of patient populations
- We need to ensure that **differences between types of patients are reflected in the design of the payment & contracting system**, while avoiding excessive complexity
- A population-based approach is also well-aligned to a **'system first' approach**, aligned to the SCFMA
- That said, there will always be a place for some activity-based payments for some services (and will be required for out of area and independent sector)

Thank you for listening

- Dr Karen Kirkham
- Karen.kirkham@dorsetccg.nhs.uk
- @karen_kirkham2