Healthier Together Sponsoring Board

21ˢᵗ March 2019

Item number & title	2b. Integrated Care System – Progress and next steps			
Scope: System-wide or Programme?	Whole system	x	Programme area (Please specify)	
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Sponsor / Director	Robert Woolley – STP Lead and Chief Executive, UH Bristol Julia Ross – STP Lead and Chief Executive, BNSSG CCG			
Presenter				
Action required:	Discussion			
Discussion/ decisions at previous committees	*Executive Group – 25ᵗʰ February*: The groups signed off Aspirant Programme roadmap and agreed to progress towards a becoming an ICS by April 2020			

Purpose:
To provide: • An update on progress since the Aspirant ICS Programme   • An outline of priorities for 2019   • A more detailed overview on the plans for developing governance arrangements over the course of 2019
Summary of relevant background:
In January 2019 the NHS Long Term Plan was published which confirms that all STPs across the country are expected to become ICS's by 2021.   The Healthier Together Office developed a "roadmap" as a result of the Aspirant ICS programme which sets out specific plans developed between August and December 2018 that enabled us to accelerate our progress towards becoming an ICS by April 2020.   Through this programme we have made some significant progress and anticipate there are some core requirements which we will need to develop upon in 2019 to strengthen system working and enable us to evidence that we are a sustainable ICS.

This paper outlines some of the additional activities which may be necessary over 2019 to progress towards an ICS.

Discussion / decisions required and recommendations:

Sponsoring Board is asked the note the contents of this report and to comment upon the development of the governance arrangements going forward.

Integrated Care System – Progress and Next Steps

Progress to date

Work is continuing to support progress towards the BNSSG Sustainability & Transformation Partnership (STP) becoming an Integrated Care System. In January 2019, the NHS Long Term Plan was published which confirms that all STPs across the country are expected to become ICS's by 2021.

The Healthier Together Office developed a "roadmap" as a result of the Aspirant ICS programme which sets out specific plans developed between August and December 2018 that enabled us to accelerate our progress towards becoming an ICS by April 2020. This can be found in Appendix One.

At the start of this programme, local system leaders undertook a readiness self-assessment against nationally determined criteria. This identified some areas of good progress to date, such as the development of primary care localities, effective leadership relationships and system-wide management of urgent care demand. However, feedback also highlighted a desire to use the Aspirant programme to accelerate maturity in some key areas:

  i. System-wide decision-making
  ii. Building a narrative that can be used to support wider communication of the system vision
  iii. Redesign of urgent care services
  iv. Embedding population health management

Over the course of the 11 weeks of the Aspirant ICS Programme we focused upon the following areas:

  i. Clarify our ambitions around Population Health Management and accelerate progress
  ii. Address our Urgent Care challenges directly whilst using it as an opportunity to consider our governance, performance management and financial model
  iii. Access expertise and space to consider our narrative and purpose

The Terms of Reference (ToR) for the programme, outlined that the majority of activity would be focused on our Urgent and Emergency care system with a goal to make

significant progress over 2019/20 and the ambition to have implemented tangible changes in advance of Winter 2019/20.

UEC workstreams are continuing to define specific and tangible impacts that will enable us to:

- Implement digital first access to urgent care
- Standardise some routing of access to urgent care
- Increase capacity in the community for urgent/on the day access
- Reduce demand on A&E and 999
- Target interventions for people more likely to require/use urgent care services

In addition to this work stream, our roadmap encompassed two further work streams; Population Health Management and System Culture.

For Population Health Management – we aspire by the end of 2019/20 for three goals in this area:

- All localities will have access to data to inform their proactive care models
- This information will have informed our five year plan
- We use this data to evidence impact of any changes

Over 2019/20 we aspire to make significant progress in developing the culture of our system and enabling this to pervade into individual partner organisations. This will achieved through:

- A robust communications strategy
- Leadership development across organisations

To support these plans our system has secured £572,000 of central NHSE funding to continue our progress in these key areas. The funding will be used to support, for example:

- A follow up event to consolidate our implementation plans from the urgent & emergency care workshop held in December
- Setting up some of the infrastructure and accelerate progress with population health management
- The next phase of our system leadership development programme for executive directors
- Developing a system performance management framework
- Establishing a wider network of non-executive directors

Self-assessment of progress to date

System leaders are currently undertaking a second version of the self-assessment against the national ICS criteria. The output from this will identify how much progress we have made since October 2018, and highlight remaining gaps in our development still to be addressed.

This section of this paper will be tabled on the day.

Priorities for 2019

At the Executive Group meeting in February, leaders agreed to work towards becoming a fully-fledged Integrated Care System as part of the national wave 3 cohort of ICSs.

We anticipate there are some core requirements which we will need to make progress upon in 2019 which will both strengthen system working and enable us to evidence that we are a sustainable ICS:

1. Leadership and Capacity
    o Track record and history of journey
    o System approach, vision and single plan
    o Governance arrangements including executive and non-executive appointments, partnership board, delivery of programmes and assurance
2. Delivery
    o Performance
    o Finance
    o Care Redesign
3. Moving forward towards ICS
    o MOU
    o Accountability arrangements (including performance framework for owning and resolving system challenges)
    o System risk escalation and management approach

These areas are set out in more detail aligned to the ICS criteria below:

	Attributes of a developing ICS	Strengths	Opportunities to progress
System leadership, relationships and change capability	• Strong collaborative and inclusive system leadership and governance • Independent Chair in place • As a system, working to implement PCNs into the infrastructure of the ICSs, • Dedicated capacity and supporting infrastructure being developed e.g. ICS Partnership Board; System leadership networks/ forums including clinical leadership; and close-working with local government and H&W Boards • Clear shared vision, objectives and credible strategy with local stakeholders • Effective ways of involving clinicians and staff, service users/ public, and community partners in governance and service transformation • Focus on change management and quality improvement	• Increasing strength of system leadership – system plan testing and progressing this • Independent Chair • PCNs forming • System infrastructure in place • Vision clear and shared	• Increasing clarity of decision-making authority of system-groups • Formalised governance through MOU • Clarity over system, place, neighbourhood and individual level change initiatives and decision-making • Increase alignment of all change initiatives to system vision • Citizen and staff representation as standard at all Programme Boards • Alignment of change management and quality improvement tools across system

System architecture and strong financial management and planning	• Strong system financial management in place, with a collective commitment to system planning and shared financial risk management • Agreement to individual control totals or acceptable proposal for reapportioning system control total • Credible plans for meeting system control total and, where not already achieved, for moving towards system financial balance • System-level financial governance arrangements to enable shared decision-making e.g. on investment and efficiency opportunities • A single set of commissioning intentions	• Commitment to planning • Single set of commissioning intentions	• Within MOU, increase clarity around shared financial governance arrangements • Development of evidence-based five year plan that enables activity and financial impact to be monitored

Integrated care models	• Compelling plans to:
	
	   o Integrate primary care, mental health, social care and hospital services & collaborate between hospitals
	
	   o Effectively manage priorities outlined in the LTP e.g., DTOCs, CAS MDTs
	
	   o Redesign outpatient services using new technologies
	
	• Plans in place to tackle the prevention agenda and address health inequalities with system partners
	
	• Plans for implementing personalised care model across the system (tangible progress on implementing personal health budgets & patient activation measure)
		• Locality Plan
		
		• Acute Care Collaboration Strategy
		
		• Urgent Care Strategy
		
		• Mental Health Strategy
		
		• Outpatient Programme Board plan
		
		• Prevention plan
			• Integrated care strategy
			
			• Implementation of community mobilisation and social prescribing

Governance Developments

One of these key developments for 2019 will be to provide increasing detail and definition on the mechanisms for system-wide decision making.

A sub group of the chairs reference group is now starting work on how the Sponsoring Board can begin to evolve into a Partnership Board (as set out in the NHS Long Term Plan) to support how the system works differently as an ICS in future. The work will start with revised terms of reference, which are due to come to the Sponsoring Board in May.

In addition, we will begin work in April on development of a memorandum of understanding (MOU) that formalises new and future collaborative working arrangements and decision-making. This will need to be co-designed with all partners and approved by boards in due course. An indicative timeline and process to progress the development of an MOU is set out below:

Establish small task and finish group, executive lead and delivery resource	April 2019
Define framework for an MOU, based on an assessment of examples from elsewhere particularly identifying which terms need to be worked upon	May 2019
Work up detail and seek legal support to draft appropriately	June – Sept 2019
Final draft to be signed off by all partner organisation boards	Sept – Oct 2019
MOU published	Nov 2019

Sponsoring Board are asked to note the intent to develop a Partnership Board and Memorandum of Understanding.

Appendix One – Roadmap output from Aspirant ICS Programme

High Level Timeline - Urgent Care (1)

	Jan – Feb 19	Mar – May 19	Jun – Aug 19	Sept – Nov 19	Dec – Feb 20	Mar – May 20	Jun – Aug 20	Sept – Nov 20	Dec – Feb 2021
Clinical Model and Overarching Programme	Establish Programme Design Group; Establish Clinical Model working group; Articulate detail of clinical model	Follow Up event to bring all work together; Share and gain traction on vision across partner organisations		New Model to be implemented		Evaluation			
Finance	Establish finance / ops/ clinical working group; Define peer review approach; Agree baseline & terms of blended tariff	Implementation of blended tariff; Contract Signature	Monitoring of impact of contract; Agree investment criteria for any further UEC investments		Evaluation in advance of year 2				
Triage and Routing	Establish Implementation Group; Agree roll out of standardised triage & routing	Go-live of IUC/CAS service & NHS 111 online							
Governance, Risk & Operating Model	Establish Implementation Group; Development of system-wide MOU; Agree peer review performance framework; Performance Framework drafted and signed off by all partners	Establish process for monitoring risks of UEC changes for 2019; Sign Off System MOU; Commence reporting on to number of whole system & service specific metrics	Implement						

High Level Timeline - Urgent Care (2)

	Jan – Feb 19	Mar – May 19	Jun – Aug 19	Sept – Nov 19	Dec – Feb 20	Mar – May 20	Jun – Aug 20	Sept – Nov 20	Dec – Feb 2021

Locality Hubs

Implementation of Locality Hubs through community reprocurement

Data and Digital

Analysis of 1% who use UEC services

Increase use of Connecting Care (integrated care record) in Urgent Care settings

Establishment of PHM steering group

Single system performance reporting for UEC

EOL & Other Care Plans available to IUC / 111

Scoping of dynamic flow management tool

Implementation (as appropriate)

Digital & Data group in place

Development of Directory of Services

Workforce and Education

Explore communities of practice / self managing teams roll out methods

Build/buy resource

Implement

Design Group to identify opportunities for joint training across workstreams

Social Marketing & Communications

Establish subgroup

Work up specification

Commission supporting agency to develop campaign

Implementation in advance and through Winter 2019

Evaluation

Additional next steps may include: Baseline review of current activity, engage with existing public services/ voluntary sector in order to leverage other methods of accessing frail/vulnerable people

📍 Milestones

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High Level Timeline – Population Health Management

	Jan – Feb 19	Mar – May 19	Jun – Aug 19	Sept – Nov 19	Dec – Feb 20	Mar – May 20	Jun – Aug 20	Sept – Nov 20	Dec – Feb 2021

System wide PHM strategy

- Establish PHM steering group
- Engage leaders and wider stakeholders
- Feedback, finalise and sign off final plan
- Engage with support from NHSE & Others
- Agree overall system strategy
- Understand how strategy will translate to implementation – required changes for each organisation

Shared data (Infrastructure)

- Establish subgroup
- Scope Infrastructure needs
- Create agreement for data sharing
- Sign off DSA
- Engage IG specialist
- Build in primary care data
- Build/buy resource
- Implement
- Initial linked dataset hosted by CCG

PHM / Intelligence team

- Draft plan for creation of PHM/Int team
- Recruit and train clinical leads from partner organisations./localities
- Establish clinical/analyst PHM group
- Identify PHM opportunities and work into locality plans
- Review Impact

Interventions

- Data feed into localities
- Development of interventions at a locality level to implement PHM
- Use initial data outputs to inform local Long Term Plan response

📍 Milestones

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High Level Timeline – Developing a system culture - a compelling vision and narrative & leadership development

Jan – Feb 19	Mar – May 19	Jun – Aug 19	Sept – Nov 19	Dec – Feb 20	Mar – May 20

Creation & dissemination of narrative toolkit

- Review of outputs from workshop
- Creation of narrative key messages
- Development of collateral
- Updating branding to support toolkit development
- Dissemination through system comms group & CEOs
- Iterative review and development

Comms and Engagement Strategy

- Co-design of Comms Strategy
- Development of organisation & locality level activity plan
- Roll out of activity plan
- Review Impact
- Involving staff, public and stakeholder in developing BNSSG 5 year plan

Leadership Development

- Identification of leadership development partner
- Leadership development programme for SROs, SDOG and Clinical Cabinet
- Clinical Conference
- Second group through Value Programme

📍 Milestones

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