NHS England
NHS Improvement

Meetings in Common of the Boards of NHS England and NHS Improvement

Meeting Date: **Thursday 27 September 2018**

Agenda item: Item 03

Report by:

Report on: **Integrated Care Systems Programme Update**

Overview

1. This paper updates the NHS England and NHS Improvement Boards on:
   - the progress made by the first wave integrated care systems (ICSs); and
   - the questions we are considering as part of the development of the forthcoming NHS long-term plan.

Background to the ICS programme

2. Health and social care services must change to meet the demands of an ageing population and a rising number of people living with multiple physical health, mental health and social care needs. 'Integrated care systems' are those areas of the country where commissioners and providers are addressing these challenges by:
   - Managing NHS resources more efficiently to improve the quality of care, health outcomes and access to care, as well as to reduce inequalities in quality, access and outcomes.
   - Designing and implementing integrated services aimed at preventing illness and/or unnecessary hospitalisation.
   - Building partnerships with community partners to help address the wider determinants of health and wellbeing, and promote better, more independent lives for people living with complex needs.
   - Creating the capacity to implement system-wide changes.

3. Integrated care systems build on the learning from the New Care Models programme, which supported 50 Vanguard sites to test 'whole population' approaches to delivering care. Early evidence on the evaluation of the vanguards demonstrates a meaningful reduction in the growth of emergency admissions and positive return on investment.[1] The most successful vanguards

[1] In its report 'Developing new care models through NHS Vanguards', the National Audit Office (NAO) reported early evidence that emergency admissions have grown significantly more slowly in areas that have implemented a MCP or PACS (population-based) care model. The vanguards have also forecast net annual savings of £324 million by 2020/21, with a return-on-investment in the five years from 2016/17 to 2020/21 that represents savings of more than £2 for each £1 invested.

demonstrated collaboration between commissioners, providers and local government as well as across professional boundaries. Sustainability and Transformation Partnerships (STPs) scale up this whole system approach. Integrated care systems are a term to recognise the most mature STPs.

4. NHS England and NHS Improvement established a joint development programme to support the first ten ICSs announced. In May we also announced that a further four systems would be joining the ICS development programme. Annex A sets out the current members of the programme.

Progress of Integrated Care Systems

Operational and financial performance

5. All but one of the ten first wave ICSs performed above the national average for cancer waiting times in 2017/18. Eight performed above the national average for referral-to-treatment (RTT) times, and seven performed at or above the national average for the A&E standard.

6. Six of the Wave 1 ICSs delivered a better financial position than they planned in 2017/18 (Berkshire West, Dorset, Frimley Health, Greater Manchester, South Yorkshire and Bassetlaw, and Surrey Heartlands). The remaining four Wave 1 ICSs performed worse than they planned in 2017/18. Overall, Wave 1 ICSs performed better against their financial plans in 2017/18 than non-ICSs and the country as a whole. This must be considered within the context of the Wave 1 ICSs being selected, in part, based on good financial control.

Early progress in care redesign

7. ICSs are building capability and improving services at three different levels:
    - Neighbourhoods, with networks of GP practices serving 30-50,000 patients that are responsible for strengthening primary care by developing enhanced services and increasing access. Primary care networks share primary care workforce, assets, back office functions and standardise IT systems. By collaborating and making more of non-medical staff, these networks alleviate working pressures and offer a more attractive career model. At their most mature, primary care networks proactively support people who are at risk of falling ill, drawing on NHS, local government and third sector services.
    - Places, which bring together GP, mental health, hospital, community and social care services serving 150-500,000 people. They will often be coterminous with boroughs or district councils. Places are the engine of integration, focused on specific groups of people for whom we could prevent illness or deterioration. They are not administrative bodies: they are alliances of providers (including GPs) that redesign and integrate services around people's needs.
    - Systems (the overall ICS), which typically serve populations of 1m+. They agree overall strategy and planning for that population, manage collective financial resources (through a system control total), develop and oversee strategies for workforce, estates and digital, and design the organisation of

more specialist services. They take increasing responsibility for performance across the system, operating through systems of mutual accountability.

8. All systems have made progress implementing primary care networks at the neighbourhood level. All report full or nearly fully coverage, although networks are naturally at different levels of maturity. By working as networks, ICSs have expanded access, found ways to alleviate day-to-day working pressures and begun to be more proactive in caring for patients at risk of falling acutely ill. For example, in Berkshire West GPs and Allied Health Professionals (AHPs) work together to free up more GP time for the sickest or most vulnerable patients. They have found that about two-thirds of patients can have their needs met by a health professional other than a doctor. In Frimley GP practices collaborate to provide same-day access to patients requiring urgent appointments, and community services have been aligned more closely with GP practices and adult social care. This has reduced hospital referrals by 7%. Integrated neighbourhood teams in Lancashire and South Cumbria are using telehealth to conduct remote triage for patients in very rural areas to reduce travel times and extend access.

9. ICSs are also developing partnerships between NHS organisations and local authorities at the 'place' or locality levels. For example, in Greater Manchester, ten 'Local Care Organisations' are building much closer links between NHS organisations and local authorities, giving greater emphasis to prevention and population health as well as the integration of health and social care. West Yorkshire and Harrogate has developed safer spaces for adults, children and young people in mental health crisis, which are providing a community alternative to admission to hospital and helping to minimise unnecessary attendance at A&E departments. Gloucestershire has worked with 63 local schools to encourage an extra 11,000 pupils to walk or jog a 'daily mile'.

10. At the system level, ICSs are exercising increasing leadership in how providers should work together within the available resources. Systems like South Yorkshire and Bassetlaw and Nottinghamshire are conducting service reviews with the aim of improving outcomes, reducing duplication and reinforcing fragile services. Each has produced a capital and estates strategy to underpin its overall clinical vision. Several systems are now shaping their own workforce plans and addressing workforce gaps. Gloucestershire, for example, has worked over the last three years to successfully reduce the number of GP practices carrying long-term vacancies from 31 practices to fewer than 10. The system has also added considerable additional workforce capacity beyond GPs and nurses to improve care, such as clinical pharmacists, physiotherapists, paramedics and community matrons, as well as four health inequalities GPs. All ICSs are developing the governance, capability and processes to manage their own performance and financial discipline at a system level.

Managing financial resources together

11. Eight of the ten Wave 1 ICSs (see Annex A) are now working under a new financial framework, which we have evolved with the systems, in which the

ICSs link some or all of their provider sustainability funding to the collective financial performance of the system. This reinforces the shared commitment of the providers and commissioners in these systems to work together to manage their collective resources as efficiently and effectively as possible in support of better quality of care and health outcomes.

Memoranda of Understanding for 2018/19

12. We have agreed Memoranda of Understanding for 2018/19 with each ICS, which include national expectations based on implementing priorities set out in *Next Steps on the Forward View*, as well as each system's local priorities for the coming year. These agreements have a focus on redesigning and integrating care across organisational and professional boundaries, applying validated population health management approaches.

NHS England & NHS Improvement regions

13. At the last Board meeting in common, we set out the steps we are taking to align the work of NHS England and NHS Improvement, including the creation of single integrated regional teams. A core responsibility of these regional teams will be to support all systems, however advanced, in developing their maturity. We are considering this as part of our ongoing work to design the new joint operating model.

Rolling out integrated care systems across the country

14. ICSs will be a foundational part of the future NHS system 'architecture'. In support of the forthcoming Long-Term Plan, we are considering how we can put ICSs on a firm consistent footing across England; how we clarify the essential functions of ICSs and their relationship with commissioners and providers; how we will work with local government; and what we will do to support the most challenged systems to accelerate their journey to becoming ICSs. This work is being overseen by a Working Group including a number of ICS leaders and informed by a programme of engagement with stakeholders across the health and care sector.

Recommendations

15. The Boards are invited to note the update on the development of ICSs.

Annex A: Integrated care systems

Wave 1 integrated care systems:

1. Bedfordshire, Luton and Milton Keynes
2. Berkshire West*
3. Blackpool & Fylde Coast**
4. Buckinghamshire*
5. Dorset
6. Frimley Health
7. Greater Nottingham***
8. Greater Manchester
9. South Yorkshire & Bassetlaw
10. Surrey Heartlands

Note that:

* Berkshire West and Buckinghamshire are developing options for an integrated care system on a larger population footprint
** Blackpool & Fylde Coast is coming together with the rest of the Lancashire & South Cumbria STP to develop a single integrated care system for Lancashire and South Cumbria
*** Greater Nottingham has now combined with the rest of the Nottinghamshire STP to create a single Nottinghamshire integrated care system

These Wave 1 ICSs, with the exception of Buckinghamshire and Blackpool & Fylde Coast (Lancashire & South Cumbria), are now working under the new financial framework described in paragraph 11 of this paper.

Wave 2 integrated care systems:

1. Gloucestershire
2. Suffolk and North East Essex
3. West, North and East Cumbria*
4. West Yorkshire and Harrogate

Note that:

* West, North and East Cumbria is working with the STPs for Northumberland, Tyne & Wear and Durham, Darlington, Teesside, Hambleton, Richmondshire & Whitby to develop a single integrated care system for Cumbria and the North East.