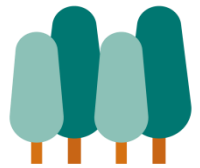
Northamptonshire
Health and Care Partnership

Northamptonshire Integrated Care System & ICAN

Overview and Scrutiny Paper – 20th July 2021



Northamptonshire
Health and Care Partnership

Presentation Overview

Integrated Care Systems (ICS')

- National context
- Local context
- Proposed statutory & governance changes
- Future operating model
- Suggested Key scrutiny questions

ICAN Programme

- Context
- The case for change
- The opportunity
- What does Good look like?
- ICAN vision and objectives
- ICAN Plan
- Suggested Key scrutiny questions

National Context: Integrating care systems everywhere

NHS began 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 England's population, with the remaining 13 STPs now designated as ICSs from April 2021.

Integrated care systems have enabled 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 and highlighted three things:

- 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.

Legal changes – Integrated Care Systems (ICS')

- In November 2020 NHS England and NHS Improvement published *Integrating care: Next steps to building strong and effective integrated care systems across England*. It described the core purpose of an ICS being to:
  - **improve outcomes** in population health and healthcare
  - **tackle inequalities** in outcomes, experience and access
  - **enhance productivity** and value for money
  - help the NHS support broader **social and economic development**
- National guidance published 16th June
- ICS development should be rooted in underlying principles of subsidiarity and collaboration.
- described common features that every system is expected to have and develop, as the foundations for integrating care, with local flexibility in how best to design these to achieve consistent national standards and reduce inequalities, as:
  - decisions taken closer to, and in consultation with, the communities they affect are likely to lead to better outcomes
  - collaboration between partners, both within a place and at scale, is essential to address health inequalities, sustain joined-up, efficient and effective services and enhance productivity
  - local flexibility, enabled by common digital capabilities and coordinated flows of data, will allow systems to identify the best way to improve the health and wellbeing of their populations.

Legislation to be passed

Statutory ICS arrangements will comprise:

- an ICS Partnership, the broad alliance of organisations and representatives concerned with improving the care, health and wellbeing of the population, jointly convened by local authorities and the NHS
- an ICS NHS body, bringing the NHS together locally to improve population health and care.
- Health and Care Bill newbook.book (parliament.uk)

Proposed arrangements - governance and oversight of ICS services from April 2022

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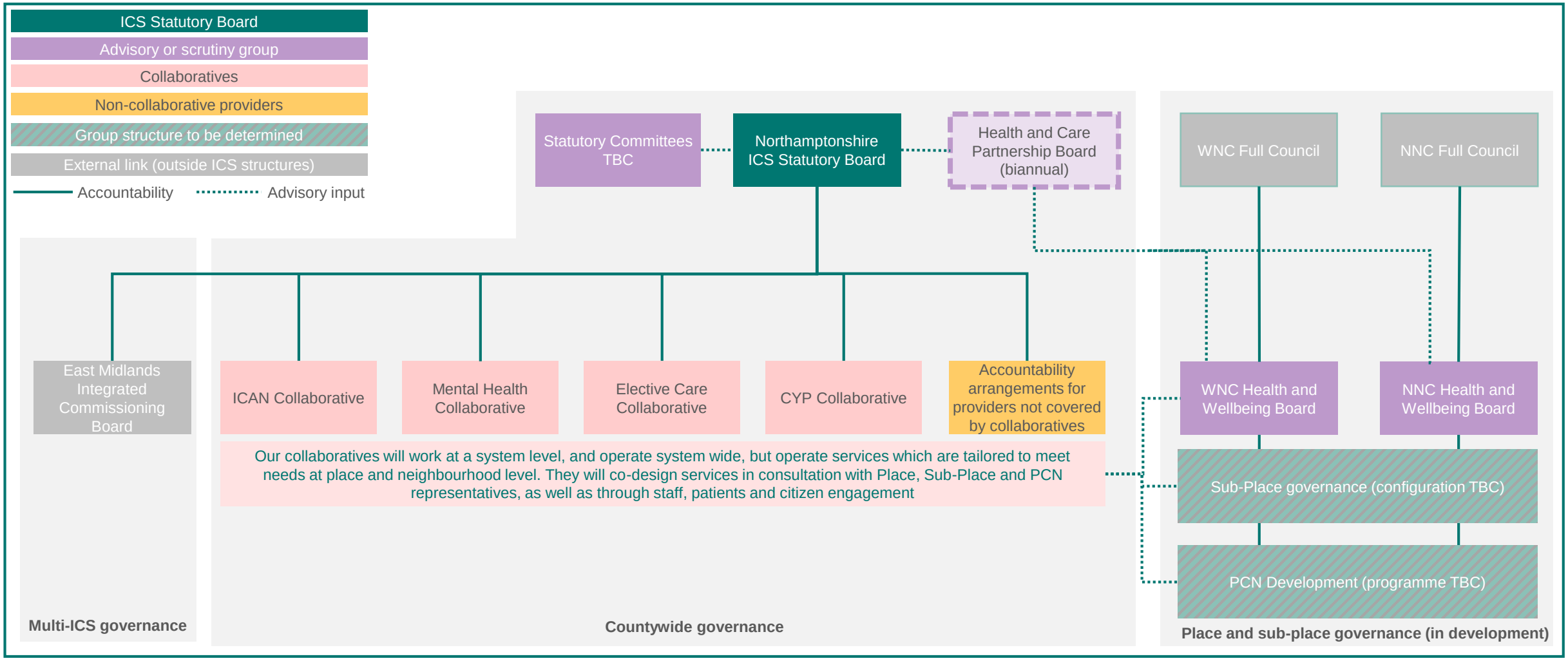
The diagram below sets out an initial proposition for ICS governance from April 2022 (when ICS statutory bodies will be formed). It aims to simplify and clarify accountability for delivering improved outcomes, as the Statutory ICS Board will directly oversee our four Collaboratives, each one of which will include both provider and commissioner representatives, working to improve outcomes for a defined population group. It also includes provision for services not covered by Collaboratives. **The key elements of the ICS design – including not only governance relationships but how each element will work, are explained in the following pages.**



Our ICS proposed operating model

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Regional/ Sub – Regional Partnerships

CCG/ Spec Com/ NHSEI Commissioning arrangements across whole pathways for regionally designed services

Outcomes framework and Population health management capability with aligned system financial framework

Whole System Working (County)

Overarching Strategic Plan, System Priorities and Financial Strategy

Consistent clinical standards, guidelines and thresholds

- System Outcomes Framework and Population health management
- Collaboratives
- Place ICPs

Strategic Commissioning function (CCG & Las) ensuring consistency of outcomes, care and standards across care pathways

ICP Place Working (West)

Partnership of health and care providers within collaboratives to influence priority areas and improve outcomes

Local delivery infrastructure to implement place transformation in line with place Health and Wellbeing Strategy

- Operational collaboration of all partners and with patients/ populations
- Aggregated integration wrapped round PCNs

PCN/ Neighbourhood working (sub-place)

- Integrated Care provision by local MDT teams
- Population based on GP lists
- Collaboration between local providers including VCSE and community groups/assets
- Robust use of PHM data
- Proactive case management, prevention and risk stratification
- Local implementation to meet specific population need

Our ICS Statutory Boards: combined leadership for health and care system

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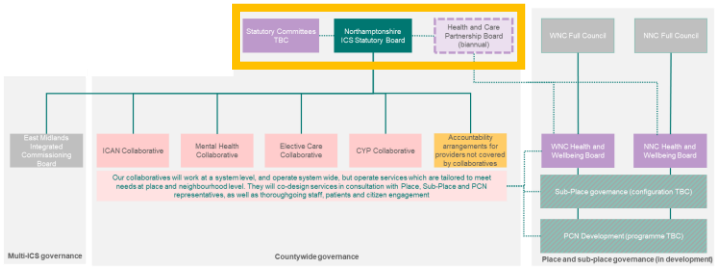
Governance relationship to other elements of the system:



Our ICS Statutory Board will fully integrate health and care organisations from the outset

- The Northamptonshire ICS Statutory Body will bring together leaders from across the system, and is accountable for overall performance and use of resources. The (small) size of our system means that we have an opportunity to build a Board which includes the **most comprehensive possible range of NHS and Local Authority partners working across the County.**
- The statutory body will include Local Authority Leaders and Chief Executives, as well as NHS leaders and non-executives (as will be required by legislation).
- The ICS Strategic Commissioner will provide a management function to support the ICS Statutory Board in strategic commissioning activities relating to countywide collaboratives, and to link to East Midlands specialist services planning.

Our Health and Care Partnership Board will draw insights and expertise from our Health and Wellbeing Boards in order to exercise its statutory functions

- Our Health and Care Partnership Board will be made up from the membership of our two Health and Wellbeing Boards and our ICS statutory Board.
- The Board will meet twice per year, in order to (i) consider progress against our Outcomes Framework over the past year, and (ii) agree a systemwide health and care strategy (or an update to the existing strategy, as appropriate) to improve population outcomes. This then forms the key mandate for the ICS statutory board, our Places and our Collaboratives.
- This focussed role, membership and meeting arrangements will ensure that the Health and Care Partnership Board adds value over and above both the ICS Statutory Body and our Health and Wellbeing Boards, and also that it avoids involvement in operational business which duplicates other forums.
- The ICS Statutory Board Chair will also chair the Health and Care Partnership Board.

Health and Wellbeing Boards, Place and Sub-Place

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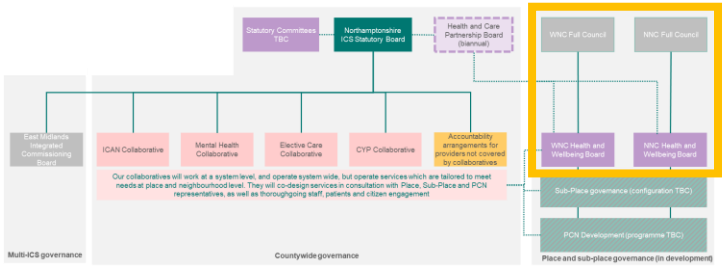
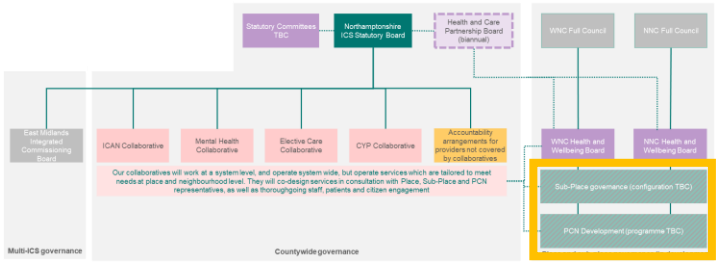
Governance relationship to other elements of the system:



Health and Wellbeing Boards will anchor ICS arrangements at place-level, continuing with their current functions as overseeing place-level commissioning

- Our ICS will have two places – aligning with the footprints for the new Unitary Authorities.
- Our two HWBs will maintain their current roles and responsibilities around needs analysis, strategic planning and scrutiny.
- ICS's will require an overall system strategy to be developed by the Health and Care Partnership Board. The recommendation is to merge this requirement with the current Joint Health and Wellbeing Strategies – producing a single, system-wide strategic plan for meeting health, care and wider wellbeing needs across the County.
- The Public Health team will work with the Health and Wellbeing Boards to create a Joint System Needs Analysis and System Strategy, ratified by the Partnership Board
- Joint commissioning will continue to take place at Place level (through Better Care Fund and current joint programmes). The ICS strategic commissioner and Local Authority commissioners will form virtual 'joint teams' for each Place, in order to undertake this activity.

Governance relationship to other elements of the system:



Neighbourhood (sub-place) arrangements will be crucial building blocks in the system, and will be where a good deal of integration is seen and felt. These arrangements require further development – built on local conversations in those areas

- 'Neighbourhood' arrangements will be needed, as a basis of effective integration and tailoring of services to local needs
- NHS guidance recommends neighbourhoods of between 30,000 – 50,000 people
- We have a range of organisations and providers operating at this level including PCNs and others
- Sub-place arrangements (potentially developed from the current locality boundaries, amended where needed) will help enable two way communication and coordinate strategy and programmes for neighbourhoods.
- We will support our two Places to develop the neighbourhood arrangements which best work for them (taking all services and populations into account). This will link to PCN development.

Suggested Key Scrutiny Questions

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- How are we ensuring that local, people communities, elected members and partners are engaged in the development of our Integrated Care System?
- How will the Health and Wellbeing Board ensure that health and social care services are making integration a practical reality?
- How are we defining place?

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iCAN Collaborative
Integrated Care Across Northamptonshire

Northamptonshire's health inequality, demographic challenges, and the future resource implications of the current model create a compelling case for change

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Public health indicators

Northamptonshire scores below the England average on a range of indicators including:

- Mother's smoking at birth (14%)
- Alcohol related hospital admissions (750/100k)
- Physical activity among adults (66%)
- Vaccination rates for MMR (88%)
- Hospitalisations for self harm (295)
- Deaths from pulmonary disease (59/100k)
- Hospital admissions due to falls (2604)
- Life expectancy for women

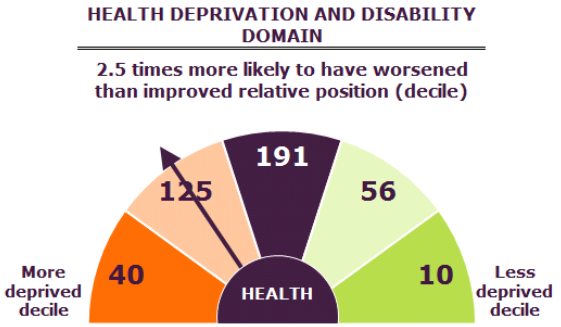
Demographics and inequality

There is a significant demographic challenge, with a projected 27% increase in over 65s by 2029, bringing greater demand.

There is also significant health inequality.

- More than 105,000 people live in 20% most deprived areas of the country
- On average, people living in the poorest parts will live 13 fewer years in good health than the richest with a 6.5 year gap in life expectancy

Health deprivation has got worse since 2015



Resource implications

NHCP's December 2020 commitment document notes the resource implications of the current model. By 2039, we will:

- Need 150 extra GPs
- See 10,000 more hospital admissions pa
- Spend £90 million more on older people needing unplanned hospital / recovery
- Need 516 additional acute beds for admissions of people aged over 65
- Deal with 2,500 more requests each year for social care support
- Have an annual health and social care shortfall of £148 million

If we do not make use of the opportunity we now have, to collectively come together as an ICS, change things locally by focusing on the wider determinants of health challenge and join up our services, we will soon no longer be able to maintain, let alone improve, the health of our population.

Local Context: In 2019, NHCP quantified some of the challenge it was facing

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£1 billion

Combined Health Spend across partners

£36m gap

Shortfall in funding 20-21 not closed until year 4 if we do nothing

Spend £68k per day

Supporting discharge and intermediate to support people at home

5% a year

Rise each year in demand for Accident and Emergency care and **rising**

90 Over 65s admitted daily

This is **8** more people each day than peers

900 stranded patients

We have **113** stranded patients on average more than our peers

15,000 more

Increase in 65s in population across the County **in three years**

GP Admissions

CQC review found we are **twice as likely** to admit from the community & **three times more** from care homes

55% of all demand came from hospitals last year, amounting to **4,000** new customers and additional costs of **£16m** in care

The way we care for a person determines their longer term outcomes

Once an elderly person has been in hospital for more than a week their likelihood of needing ongoing social care support increases by 200%...
after two weeks they are five times more likely to end up in a care home at an average cost of £29k per annum.

Study across 5 Health and Care Communities

Northamptonshire Health and Care Partnership

- Missed opportunities in community to avoid hospital admissions – e.g. falls prevention
- Missed opportunities for earlier discharge home
- Overstated needs for older people requiring discharge support – includes overuse of bedded solutions and care for those who could manage their own recovery
- Many professionals don't know what is available – often offer simplistic solutions including domiciliary care or residential care
- Those delivering front line care need a different skill mix to maximise efficiency and effectiveness

An average of 2.5% efficiency savings from getting this right

A review of the Northamptonshire System….

Northamptonshire Health and Care Partnership

We could listen more to people's choices
1 in 5 patients want a more independent outcome than the professionals involved in their care are aiming for.

We could do more to offer everyone the same choices
We see variation by where people live, what time they access our services, rather than just on the person's need

We could do more to tailor services for different needs
We see people who access our services more frequently, and yet we don't have an effective way of tailoring the way in which we interact

We could act sooner to avoid escalation
The CQC found that we were 4 times more likely to admit people to hospital in 2018 and today 90 over 65s are admitted to hospitals every day in our County. 35% of escalations that result in a visit to A&E could have been avoided in the 2 weeks before the escalation. The biggest opportunity is in accessing the right services to meet a changing need

We could be more aware of the services that exist
The knowledge of existing services varies, with both ambulance and front door teams unaware that urgent community services offering services like prescribing already exist

We could do more to always have the right services in place
For frail patients, the front door services differ across the county; we need to take the best practice and ensure a consistent offering to increase the 8% of admissions we facilitate

We could support patients in a better place for them
1 in 3 patients in our acute hospitals and 1 in 2 patients in our community hospitals are there despite that bed no longer being the best place for them to be.

We could make better use of our capacity
We have capacity of the wrong sort, and patients in beds who could have gone home whilst other patients for those beds, causing flow issues throughout the system

iCAN Opportunity Summary

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Home or Community

Are we preventing escalations from occurring in the community?

First Response

Are we ensuring people go to the right place upon escalation?

Front Door Services

Are we ensuring the right people are admitted?

In Hospital

Are people discharged as soon as possible?

Home or Community

Are people discharged to the optimum setting?

35% of escalations were non-ideal and may have been preventable

29% of escalations reviewed could have gone to a lower acuity setting

25% of admissions reviewed could have been avoided

37% of patients reviewed had no reason to reside

40% of patients could have received a more independent outcome

Annual recurrent benefits potential of £17m-£32m gross

Best Practice Objectives for integration?

- Reduce the numbers of delayed discharges
- Improve the patient experience in a more co-ordinated way
- Improve the outcomes for older people from the health and care system
- Make better use of the resources available (help deliver efficiencies)
    - More community interventions
    - Commissioning together – improved buying power and capacity where most needed
    - Less reliance on (expensive) bed solutions
    - Reduce transaction costs
    - Shift of budgets to communities and into prevention and intervention

What does good look like?

- Many older people will recover from a health problem (to varying degrees) but we need to design the system to help them achieve their goals
- We can reduce frailty in older people – if offering the right kind of help
- We can help people progress to levels of greater Independence if we offer the right interventions
- We can manage demand for discharges from hospital if we design an out-of-hospital care system that focusses on beds

- 90% of discharged people should be offered help which focusses on rehabilitation, recovery, recuperation and reablement
- Only 5% of people discharge from hospital should be sent from a hospital bed direct to a permanent residential/nursing care
- All care packages should be based on medium term goals that assist the person to move to a greater degree of independence

How will iCAN support the system vision and mission?

Northamptonshire Health and Care Partnership

The aims of the iCAN programme align with the NHCP mission for people to choose well, stay well and live well. We've looked at each of these elements in turn through our pillars; Primary & Community, Discharge and Frailty.

iCAN be sure that the right choices are available to me

iCAN be sure that the right services are there to help me look after my own health

iCAN be sure that the right services are there to detect, diagnose and treat my illness as early as possible

iCAN be sure that I get the right treatment

iCAN be sure that the right care and support exists to help me manage

iCAN be sure that the care and support is in the right place for me

iCAN STATEMENTS

I may in 2020

I may…

…not know how to access services

…get transferred or admitted to hospital when I don't need or want to be

…feel my choices aren't being heard

…not have access to what I need to be able to stay in my own home

…be discharged somewhere which isn't best to help me be independent

…have to repeat information about my needs to different professionals

iCAN in 2025

iCAN

... be sure that the right choices are available to me

… be sure that the right services are there to help me look after my own health

… be sure that the right services are there to detect, diagnose and treat my illness as early as possible

… be sure that I get the right treatment

… be sure that the right care and support exists to help me manage

… be sure that the care and support is in the right place for me

iCAN supports the wider ICS roadmap…

Northamptonshire Health and Care Partnership

Year 0

Outcomes include measuring DToC, super stranded, Pathways

Developing ICS

TOM: getting NASS house in order & laying the foundations for Unitaries

Year 1

Clinical leadership team established

New ways of working designed

Northamptonshire Care Record trial begins

Maturing ICS

iCAN begins

Commissioning and completing iCAN diagnostic

Clearing the decks for increased community capacity

Year 2

iCAN focus on

- Design
- Build
- Adopt

Thriving ICS

Build capacity for demand

e.g. Place based care, MDTs in each PCN, Frailty front door

Year 3

Community hubs & rapid response

iCAN focus on embedding new ways of working

Digital tools in place to support long term vision e.g. remote monitoring, NCR rollout

Year 4

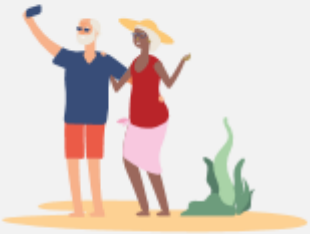
Full integrated pathway in place

iCAN focus on sustaining new ways of working

Focus shifted from hospital to community to enable appropriate use of acute capacity

Year 5

Outcomes focused on independence, community provision and engagement with patients, carers & staff



Sustained new ways of working

Next 5 year vision for Northamptonshire

2025 VISION!

Northamptonshire in 2025

2025

- Community hubs (referral point not hospital)
- Resource moving to community / primary care
- Community & primary focal point
- Removing organisational boundaries
- Community based teams (clinicians not hospital based)
- Smaller acute bed base
- Staff (voice, job satisfaction, care, quality)
- Remote monitoring systems and virtual working
- Patients (choice, voice, listened to)
- Digital solutions

What could be different for people in Northamptonshire?

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131,000 people over 65 live in Northamptonshire

Every day, 27 over-65s access urgent community intermediate care

Every day, 165* over-65s come to ED, 92* are admitted into hospital as an emergency admission, with 640 in a hospital bed at any time

Some people will still have a need that must be addressed, but we could support more people with a mix of urgent and routine **community based** services

By supporting people differently in our community, some of those people could remain healthy and well at home, their **needs not escalating**

By supporting people differently in our community, some of those people could remain healthy and well at home, their **needs not escalating**

75-79 people a day will still have a need that requires them to be admitted to hospital, but we could help them **return home quicker**

Some people will still have a need that must be addressed at the Emergency Department but we could help more of them, potentially with short term support, to **go home, rather than be admitted**

We could support more people who have had a need that must be addressed by admission to hospital to be **discharged home** on Pathways 0 or 1 rather than Pathways 2 or 3

By 2025

HOME

At any one time, **170 more people every day would be at home, not in hospital**

Key Dates

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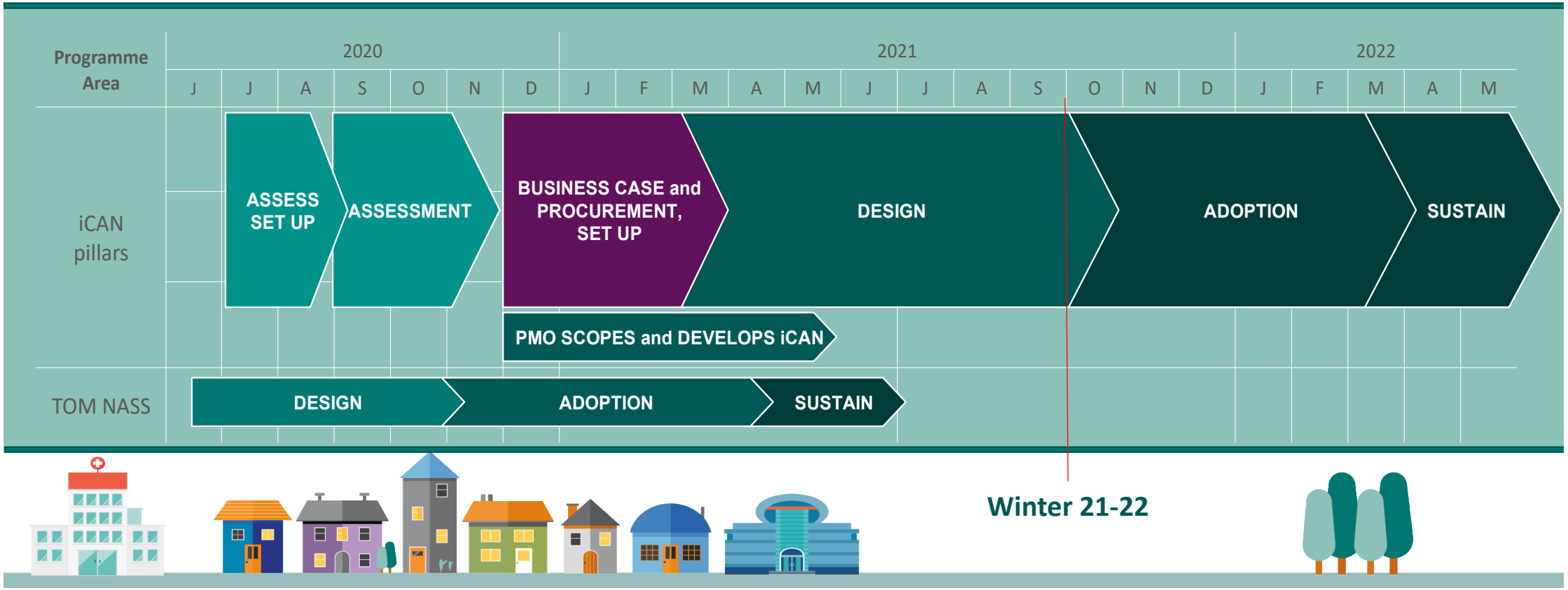
SCOPE & ENGAGE	ASSESS	DESIGN	ADOPT & SUSTAIN
Clarity of the problem we are trying to solve and the KPI we want to drive and sustain.	Data and evidence base for all pillars. Engagement of frontline teams. Creating insights that will drive action and improve care.	Design, with front line staff, the solution to the biggest problems. Measure the impact and iterate until it works. Focus on co-production with service users & patients.	Local teams adopt new ways of working and sustain the solution(s).



The benefits for Councils

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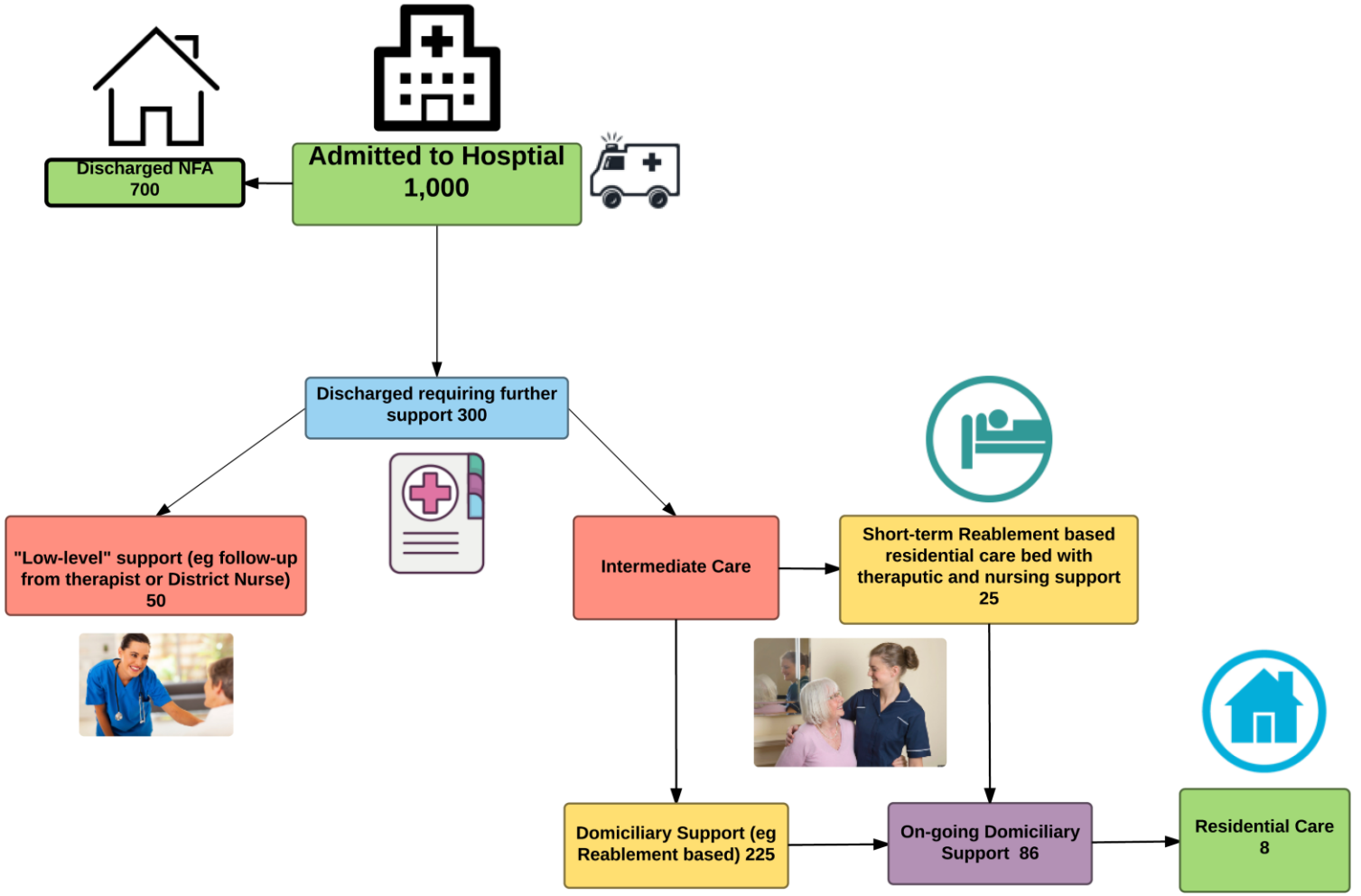

What happens if we do nothing?

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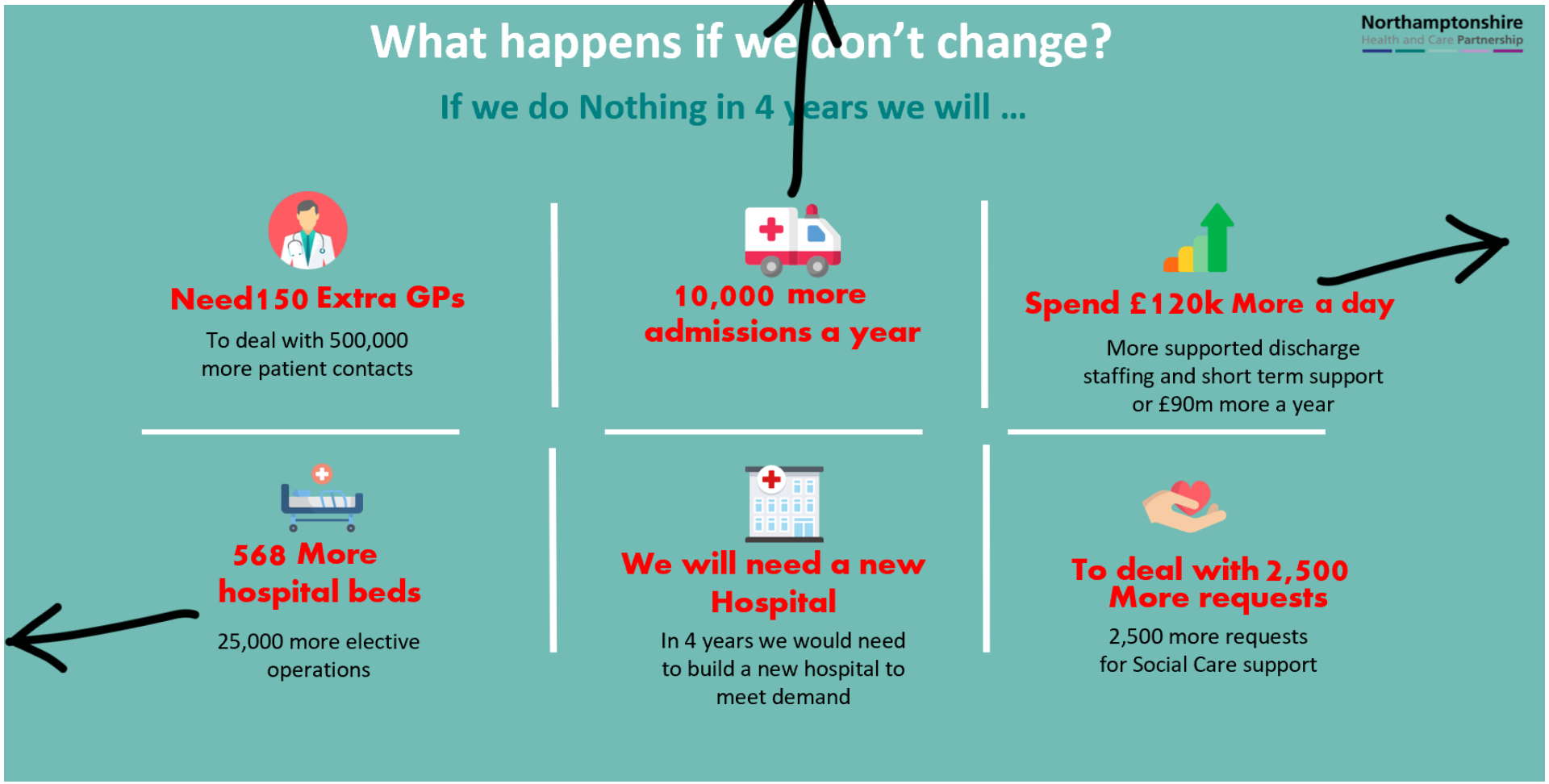
iCAN will help by driving 5,000 fewer admissions



iCAN will release up to £18m p.a. or more savings in future

iCAN will help by needing 180 fewer beds

Suggested Key Scrutiny Questions

Northamptonshire Health and Care Partnership

- How are we ensuring that iCAN is consistent with the way we work in Adult Social Care?
- How will risk around the programme be managed?
- How will iCAN support us to manage Winter pressures?
- What would be our rationale for investing in iCAN?