South West London
Health & Care Partnership

ICS update - SWL CCG Governing Body

August 2021

Key elements of our ICS development programme

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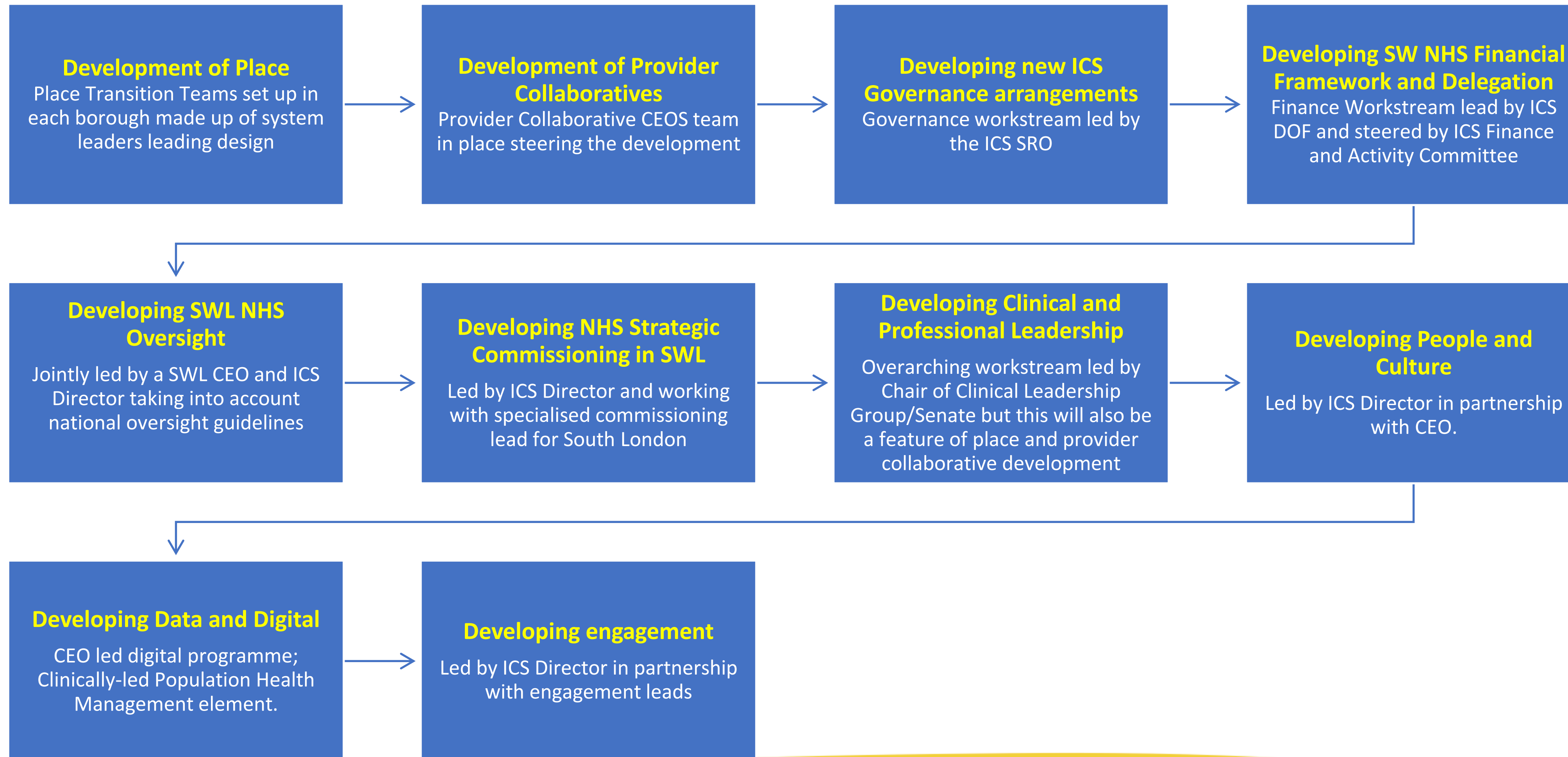

Our principles for transition

- We start from the position that we have achieved a great deal in SWL so we will seek to preserve that which is good.
- We are clear that we want the new ICS to meet the needs of our citizens.
- Our overall objectives are:
    - Better health and well being for everyone
    - Better quality of health service for all individuals
    - Sustainable use of NHS resources
- We want to make sure that as we design the future ICS that it represents all views and needs - this is about doing things together
- We will respect and comply with statutory obligations
- We are clear that one of the Health and Care Partnership's strength has been the strong engagement we have had with our partners - we want to continue to develop the ICS in partnership
- Our objective is to evolve our partnerships and plan our transition supported by data, best practice, whilst being ambitious to get good to better now and in the future

September ICS update headlines …

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- **National Guidance**-The Health Care Bill has been published and is undergoing consideration in Parliament. Detailed ICS Design guidance has been published and has been reviewed locally to consider any new implications for us locally. Further guidance expected in July (see next slide) may be delayed until early August.
- **Future ICS Governance-**following local and London-wide discussions we are planning further detailed conversations on the future ICS governance design and transition during the summer to look at future arrangements and an ICS operating model. A number of listening exercises, led by Sarah Blow and Ian Thomas, will take place in September/October.
- **Place** – Local transition teams are progressing the refresh of local health and care plans and are identifying local development priorities and any organisational development support required.
- **Provider Collaboratives** – our acute and mental health collaboratives have pulled together their draft development plans. We will be meeting with each collaboratives to review and consider key development priorities and future areas of responsibility including leadership models, governance and organisational development plans.
- **Functional review** – We are completing the initial stages of the functions review to look at CCG and ICS Functions and how things might change in the future. The next phase will involve looking at the more detailed design of the future state for functions.
- **System Oversight arrangements-**we have developed a Memorandum of Understanding between ourselves and NHSE/I for how oversight and performance management arrangements will operate for the remainder of 21/22. CCG Governance will remain in place during this time and a plan for transition to the ICS will be agreed.
- **Exploring de minimis for ICS' in London -** There is significant pressure in the NHS currently – vaccination programme, covid-19 wave three, elective recovery, A&E pressure, ICS transition and more. It is therefore important to review the priorities for London to see how pressure in the system could be lifted. London conversations are therefore taking place on whether to set de minimis requirements for ICS' from 1 April 2022.

The roles of each part of our integrated care system

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Provider Collaboratives are partnership arrangements involving two or more trusts (foundation trusts or NHS trusts) working across multiple places to realise the benefits of mutual aid and working at scale.

The purpose of provider collaboratives is to better enable their members **to work together to continuously improve quality, efficiency and outcomes**, including proactively **addressing unwarranted variation and inequalities in access and experience** across different providers. They are expected to be important vehicles for trusts to collaboratively **lead the transformation of services and the recovery from the pandemic**, ensuring shared ownership of objectives and plans across all parties.

SWL ICS Places have four main roles:

- **To support and develop primary care networks** (PCNs) which join up primary and community services across local neighbourhoods.
- **To simplify, modernise and join up health and care** (including through technology and by joining up primary and secondary care where appropriate).
- **To understand and identify** – using population health management techniques and other intelligence – people and families at risk of being left behind and to organise proactive support for them; and
- **To coordinate the local contribution to health, social and economic development** to prevent future risks to ill-health within different population groups.

The role of SWL ICS is 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.

Within the ICS, the NHS Body will **lead integration within the NHS**, bringing together all those involved in planning and providing NHS services to take a **collaborative approach to agreeing and delivering ambitions** for the health of the population. It will ensure that **dynamic joint working arrangements**, as demonstrated through the response to COVID-19, become the norm. It will **establish shared strategic priorities within the NHS** and provide seamless connections to wider partnership arrangements at a system level **to tackle population health challenges and enhance services** at the interface of health and social care.

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Introduction to the guidance

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- **Thriving Places** ***- Guidance on the development of place based partnerships as part of statutory integrated care systems*** published in September 2021 and co-produced by NHSE/I and the Local Government Association (LGA).
- Place-based partnerships will remain as the **foundations of integrated care systems** as they are put on a statutory footing (subject to legislation), building on existing local arrangements and relationships.
- It will be for system partners to determine the footprint for each place-based partnership, the leadership arrangements and what functions it will carry out.

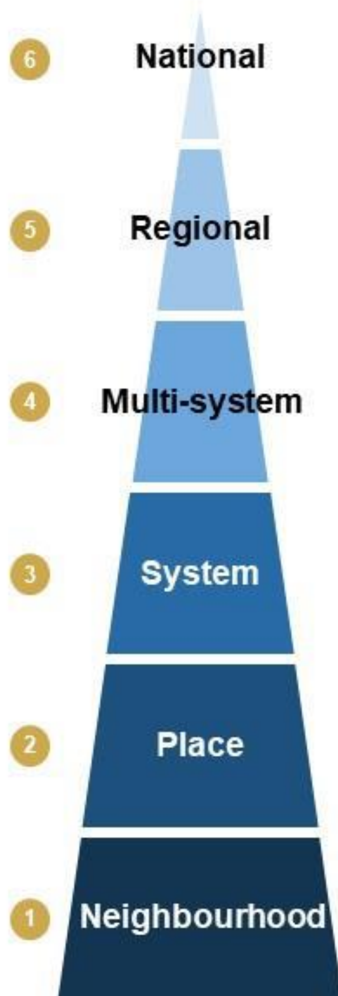
Guiding principles

- There is no single approach to defining how, and at what scale, partners should come together to work in an ICS. Place-based partnerships should start from understanding people and communities and **agreeing shared purpose before defining structures**
- Effective partnerships are often **built 'by doing'** – acting together and building collaborative arrangements to support this action as it evolves.
- Governance arrangements must **develop over time**, with the potential to develop into more formal arrangements as working relationships and trust increase
- Partnerships should be built on an ethos of **equal partnership** across sectors, organisations, professionals and communities
- Partners should consider how they develop the **culture and behaviours** that reflect their shared values and sustain open, respectful and trusting working relationships supported by clearly defined mechanisms to support public accountability and transparency

Action

As part of the establishment of new ICS arrangements from April 2021 ICS leaders should confirm their proposed place-based partnership arrangements for 2022/23, including their boundaries, leadership and membership.

The system



Services	Predominant collaboration partners	Collaboration arrangements	Activities
• Life sciences • Highly specialist services	• Specialist providers • Research universities • Industry	• AHSCs, AHSNs • Public-private partnerships	• Services need to be planned and coordinated on a broader footprint than a single ICS, working with neighbouring ICSs, other providers and national commissioners. • Provider collaboratives might span levels 4 and 5 but even when they are not, they must be sighted on decisions relating to the delivery of services at levels four to six in order to understand and calibrate the use of its collective resources for the delivery of all provider collaborative priorities. • Linked to commissioning of 999, 111 and IUC over multi-ICS as a Lead Provider model
• Highly specialist services • Specialised services	• Specialist NHS providers across a large geographic footprint	• Specialist clinical networks • Provider collaboratives	
• Specialist and specialised services • Community and mental health • Access to UEC	• Providers working over multiple ICSs	• Specialist clinical networks • Provider collaboratives	
• Elective and non-elective secondary care • Inpatient, crisis and specialist mental health, learning disability and autism • Community	• Providers working across an ICS • Providers with patient flow into an ICS	• Provider collaboratives	• Services in Level 3 are primarily delivered on an ICS footprint. • These services therefore particularly lend themselves to planning, coordination and delivery through a provider collaborative.
• Community health • Community mental health • 'Front door' acute • Social care	• Providers • GPs • LAs • Voluntary sector	• Place-based partnerships • ICP contracts	• Services in levels 1 and 2 are likely to be planned and coordinated at borough (place) level and delivered at neighbourhood or borough level, depending on the service in question. The primary "vehicles" for collaboration in these layers are place-based partnerships (of which the members of provider collaboratives are key partners). • Provider collaboratives play a role in areas where they can add value for at scale collaboration, across multiple places. but they should not duplicate work within each place.
• Primary care • Public health and wellbeing • Prevention • Community health • Social care	• Providers • GPs • LAs • Voluntary sector	• Primary Care Networks (PCNs) • Integrated multi-disciplinary teams	

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Defining the purpose and role of the place partnership – Key Points

- Partners in place should ensure they have **shared objectives**, built on a **mutual understanding of the population and a shared vision for the place**. The vision for places should focus on improving the health and wellbeing outcomes for the population, preventing ill health and addressing health inequalities.
- The **shared objectives of partners at place should underpin the purpose and role of the partnership**. This will comprise the actions the partnership will undertake together, and the capabilities required to support this – which may include the statutory functions delivered by bodies in the partnership
- The programmes and activities that place-based partnerships may undertake together may be underpinned by shared functions or capabilities, such as people, digital and technology functions, business intelligence and analytics. They should always be supported by an **approach to working that embeds systematic involvement**
- The place-based partnership **may agree that these capabilities and activities should be led by individual organisations or resourced collaboratively** by programmes delivered across organisational boundaries avoiding duplication. They should work with other partners across the ICS to agree the activities and capabilities that may be most effectively delivered at scale across the system, or where a consistent approach across places is appropriate.
- Place-based partnerships will have a **role to agree the shared priorities of the wider system**, which will include working with at-scale provider collaboratives, where they have taken on responsibility for the delivery of certain services at-scale, to ensure this meets the needs of communities in their place and to avoid the duplication of activities
- Distinct from the role of the at-scale provider collaboratives **place-based partnerships may also consider different approaches to take locally to support providers of different types and from different sectors to work together** to co-ordinate care and integrate services in their locality.

Potential activities and approaches of place-based partnerships

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Health and care strategy and planning at place

Activity - The place-based partnership has a common understanding of its population, and has agreed a shared vision, including local priorities for the delivery of health, social care and public health services in the place.

Approach - The place-based partnership will have a role in informing and developing the integrated care strategy agreed by all partners in the ICP, which will also consider system-wide priorities, and inform the NHS plan developed by the ICB, which will also include national NHS transformation commitments

Service Planning

Activity - The place-based partnership continues to integrate and co-ordinate the delivery of health, social care and public health services around the needs of the population, and to empower people who use services

Approach – Across health and social care place-based partners should consider approaches to collaboratively monitor the delivery of services as part of the planning cycle, including quality monitoring, reviewing performance and outcomes

Service delivery and transformation

Activity - The place-based partnership continues to integrate and co-ordinate the delivery of health, social care and public health services around the needs of the population, and to empower people who use services

Approach - The place-based partnership continues to integrate and co-ordinate the delivery of health, social care and public health services around the needs of the population, and to empower people who use services

Potential activities and approaches of place-based partnerships

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Population Health Management	**Activity** - The place-based partnership has agreed with wider system partners plans to establish population health intelligence and analytical capabilities at-scale, as well as approaches to draw on this insight to support care redesign locally, building on existing expertise across the place and system **Approach** - This typically includes segmentation and modelling to understand future demand across different population groups and care settings, working with PCNs and other partners to understand their population's bio-psychosocial risk factors, and supporting the implementation of anticipatory care models.
Connect support in the community	**Activity** - The place-based partnership has agreed with wider system partners plans to establish population health intelligence and analytical capabilities at-scale, as well as approaches to draw on this insight to support care redesign locally, building on existing expertise across the place and system **Approach** - This typically includes segmentation and modelling to understand future demand across different population groups and care settings, working with PCNs and other partners to understand their population's bio-psychosocial risk factors, and supporting the implementation of anticipatory care models.
Promote health and wellbeing	**Activity** -The place-based partnership proactively works with local agencies and community partners to influence the wider determinants of health and wellbeing, and to support other local objectives such as economic development and environmental sustainability. **Approach** - Aligning plans with public health and other local government strategies and plans. The NHS and local government may consider opportunities to leverage their role as 'anchor institutions' to support economic opportunity and skills development in their communities, building on existing research.
Align management support	**Activity** – Place-based partners agree options to align and share resources **Approach** – Identify opportunities to align management support to operational and programme delivery e.g. PCN clinical directors should be supported to build their working relationships over time to be able to drive improvement through peer support, lead on service transformation programmes and represent primary care in the place-based partnership

Place Based Partnerships Options

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Option 1 Consultative Forum

- Would be a backwards step to existing place based arrangements
- Would not give the autonomy required at place

Option 2 – Individual Executives or staff

- Would be an option but may not give autonomy to place require
- Executive support would be needed regardless of delegation arrangements so executive support would need to be considered in the round

Option 3 – Committee of the ICB

- Would give local autonomy and delegation to agreed outcomes
- Would give local autonomy to decide on TOR and membership subject to agreement by ICB
- Provides a de-minimus smooth and safe transition for SWLondon whilst dealing with BAU

Option 4 – Joint Committee of partners

- Currently not preferred option as there is not yet agreement at local level of budgets and accountabilities of partners to be delegated and managed by a joint committee structure
- No agreed structure for managing clinical and financial risk agreed yet locally for joint budgets outside of BCF
- This could be an option for the future

Option 5 – Lead Provider

- Would need agreement across the system – including decision making and holding of budgets for different providers through a lead provider

Committee – known as Place Based Partnerships

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- TOR and reporting to be agreed with ICB for delegated budget
- Chair - could be decided between members, could be the lead executive or independent (to be locally proposed and agreed by the ICB)
- Executive lead will be through shared arrangements either across Boroughs or with ICS and provider/s and will have an accountability line to the ICS CEO or delegated arrangements
- Membership from guidance, locally determined and proposed to the ICB:

  - People who use care and support services, and their representatives including Healthwatch
  - Local authorities
  - Social care providers
  - The voluntary, community and social enterprise sector (VCSE)
  - The ICB
  - Primary care provider leadership, represented by PCN clinical directors or other relevant primary care leaders
  - Providers of acute, community and mental health services, including representatives of provider collaboratives where appropriate

Working with People and Communities

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The guidance highlights the relationship that place-based partnerships need to build with local communities and stakeholders as part of their decision-making process. This includes:

- Systematically involving professionals, people and communities in their programmes of work and decision-making processes building on existing approaches to engaging and co-producing with people and communities
- Arrangements for inclusion should be a source of genuine co-production and a key tool for supporting accountability and transparency of the system. They should establish a shared understanding of the community's needs, build relationships with all communities, including excluded groups and those affected by inequalities in access or outcomes, and use continued engagement to measure if partners are improving people's experiences of care and support
- Where decision-making affects communities, groups or specific services, these arrangements (including any formal consultation) should fully engage those affected, including populations, people who use services and carers across health and social care
- Partners should ensure they provide clear and accessible public information about the vision, plans and progress of the place-based partnership to build understanding and trust, and to start engagement early when developing place-based partnership plans and feed back to people and communities how their views have influenced activities and decisions.

ICS implantation guidance on working with people and communities has been published
Building strong integrated care systems everywhere: ICS implementation guidance on working with people and communities

Merton progress

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- Agreed the Committee of the ICB option as the aim for 1st April 2022. This will allow the smooth transition to a local place partnership
- Provisional membership of the Merton Committee agreed – to be ratified by participating organisations, members and ICS
- Health and Care Plan review well underway, engagement workshops held across August and September
- Health and Wellbeing Board and OSC presentations
- Expanded the transition team Merton Health and Care Together remains the partnership vehicle
- Organisational development plan for MHCT
- Programme Director recruitment, CCG and provider resource
- Stakeholder mapping, engagement and communication plan
- Primary care networks development sessions completed
- Co-production and joint design – build on the great platforms in place
- Process for Chair and Executive roles being developed