INTEGRATING CARE - NEXT STEPS

17 May 2021

Purpose of report	The purpose of the report is to summarise the key proposals and legislative changes and next steps in response to NHS England and Improvement (NHSE/I) published *Integrating Care: Next steps to building strong and effective integrated care system across England.*
Recommendation	The paper is to Note only.
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1. Introduction

1.1 The Governments White Paper *'Integration and Innovation: working together to improve Health and Social Care for all'* published on 11 February 2021 setting out the proposed reforms which would see the formation of a statutory Integrated Care System (ICS) including:

- a statutory Health and Care Partnership that would bring together a wider group of partners to confirm their shared ambition for the health of their population and develop overarching plans across health, social care and public health
- a statutory ICS body to lead and oversee planning and delivery of NHS services across the whole system. The body will hold the NHS budget for the system and will maintain the appropriate governance and systems to ensure the proper management and accounting for public money.

1.3 The purpose of this paper is to:

- provide an overview of the ICS
- summarise the key proposals and legislative changes
- set out what does this mean for Dorset
- next steps.

2. Report

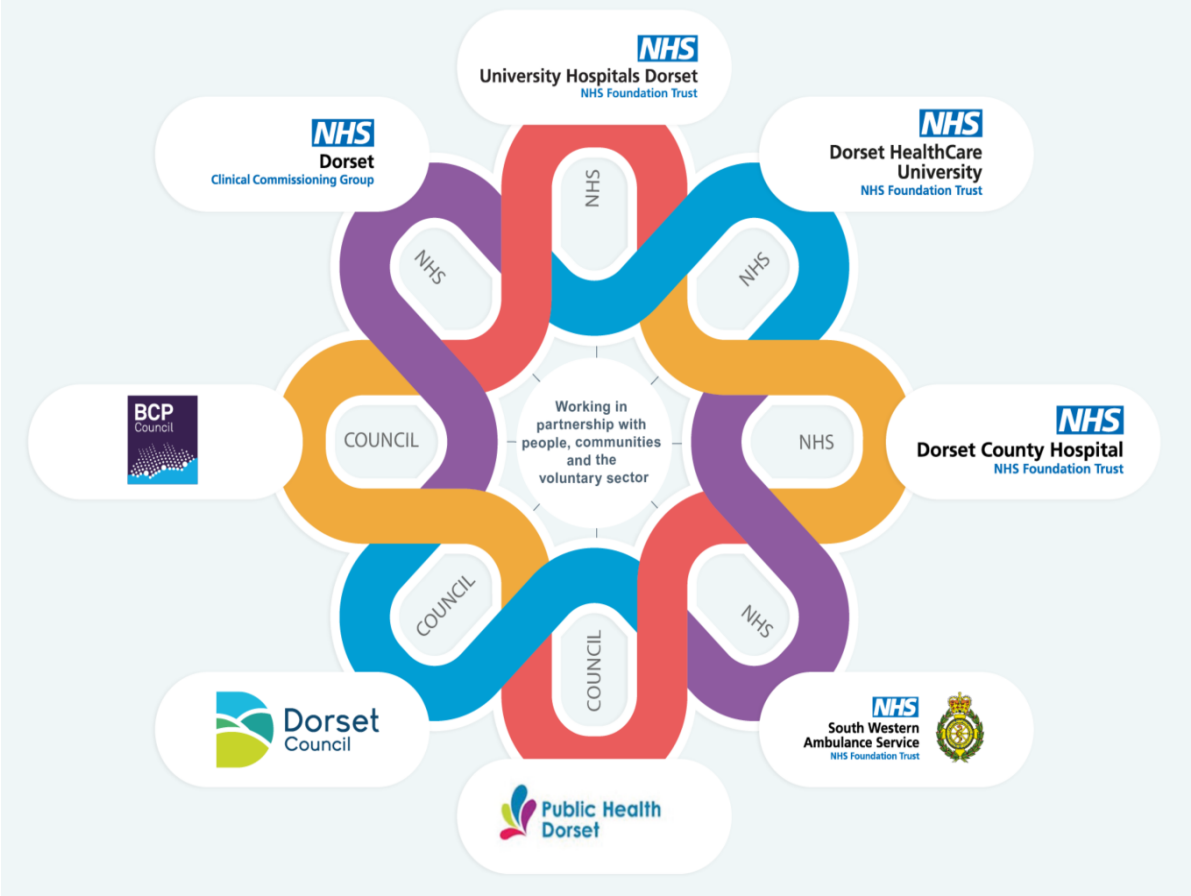
Integrated Care Systems (ICS) Overview

2.1 Integrated care systems are partnerships of providers and commissioners of NHS and social care services who work together across a geographical area to plan and integrate care to:

- improve outcomes
- tackle inequalities
- enhance productivity
- support broader social and economic development.

2.2 Dorset has been an Integrated Care System in since 2018. Our eight partner organisations work together as anchor institutions to address our health, wellbeing, quality and financial challenges in line with the national vision.

Fig 1: Dorset ICS Partners



Summary of key proposals and legislative changes

2.1 The proposals set out the ambition for how all parts of the health and care system can work together as ICSs, involving

- stronger partnerships in local places between the NHS, local government and others with a more central role for primary care in providing joined-up care;
- provider organisations being asked to step forward in formal collaborative arrangements that allow them to operate at scale;
- developing strategic commissioning through systems with a focus on population health outcomes;
- using digital and data to drive system working, connect health and care providers, improve outcomes and putting the citizen at the heart of their one care

2.2 As described in paragraph 1.1, the legislative changes will see a statutory corporate NHS Body that brings the CCG statutory functions into the ICS, therefore:

- CCGs will be abolished and replaced with:
    - **ICS NHS Body** - Integrated Care Board (ICB), consist of representatives from NHS Providers, primary care and local government, alongside a Chair, a Chief Executive. The ICS will be able to appoint any other members as it deems appropriate.

      Responsible for developing a plan to meet population health needs; capital plan for NHS providers; and securing provision of health services. They have no power to direct NHS providers.
    - **ICS Health and Care Partnership Body** - Integrated Partnership Board, consist of representatives from the ICB, local government, Health and Wellbeing Boards, Public Health, voluntary, third and independent sectors.

      Responsible for developing a plan that addresses wider health, public health and social care needs of the system

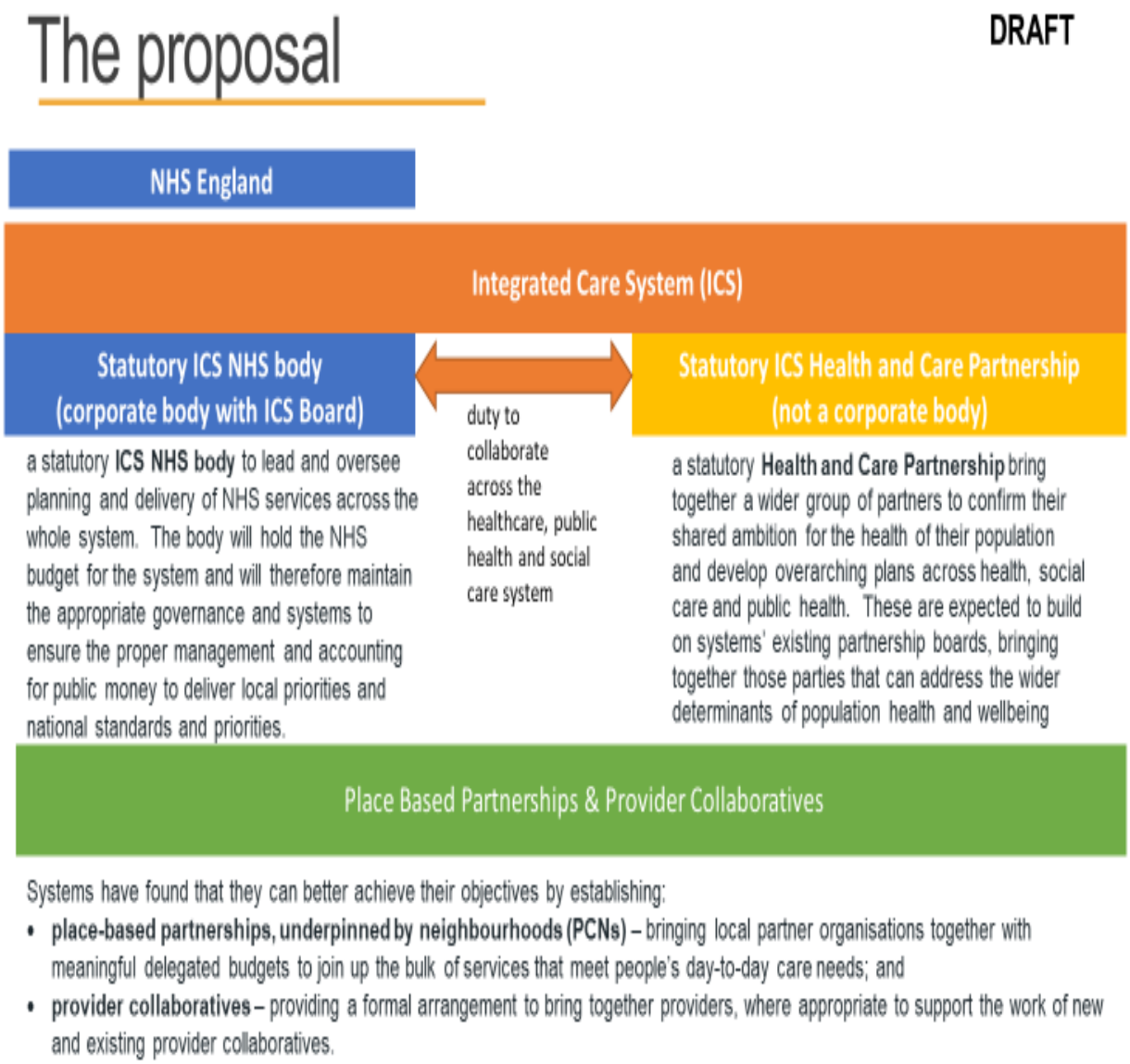
To support systems to better achieved their objectives, they should establish:

- Place Based Partnerships who will be responsible for services to meet the day to day care needs of their population for example:
  - Staying well and preventative services
  - Integrated care and treatment
  - Digital services (non-digital alternative)
  - Proactive support to keep people as well as possible where they are vulnerable or at high risk
- Provider Collaboratives- providing a formal arrangement to bring together providers to maximise the delivery of services at scale, where appropriate

2.3 There will be a number of new duties and powers aimed to remove barriers to integration across health organisations and with social care and foster collaboration as follows:

- **Duty to collaborate**- promote collaboration across healthcare, public health and social care system
- **Triple Aim** - shared duty that requires NHS organisations that plan services across a system and nationally, as well as NHS Trusts and FTs, to have regard to the 'Triple Aim' of better health and wellbeing for everyone, better quality of health services for all individuals, and sustainable use of NHS resources
- **Power over Foundation Trusts Capital Spend Limits** – NHS England reserve power to set a capital spending limit on Foundation Trusts, moving away from each organisation making decisions in its own interests, supporting the collaborative approach
- **Data Sharing**- health and adult social care organisations to share anonymised information that they hold where such sharing would benefit the health and social care system.
- **Patient Choice**- repeal s.75 HSCA and introduce a new NHS Provider Selection Regime for clinical services. Enable patients to choose provider from a list for specific clinical services

Fig 2: National ICS proposed structure

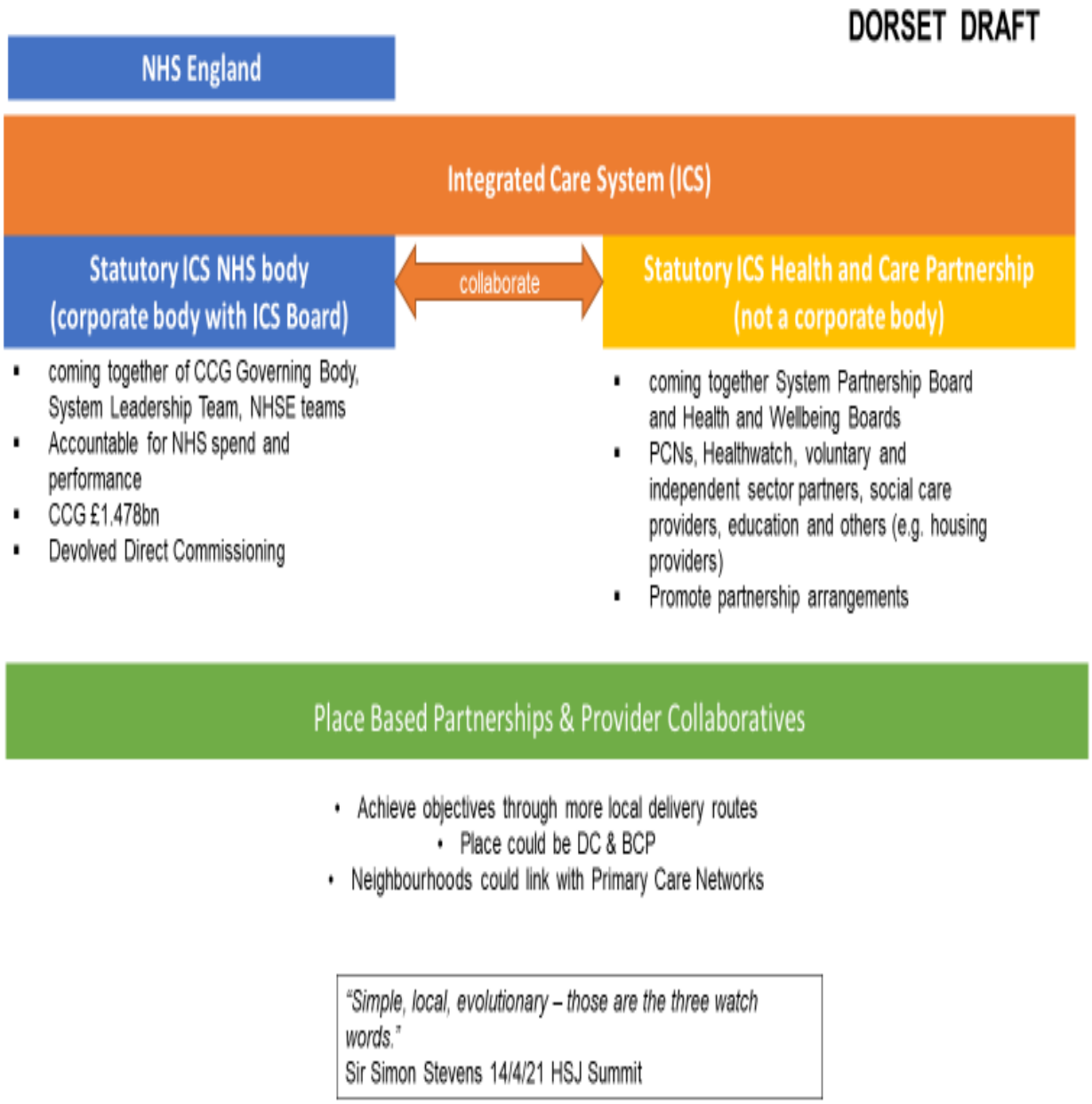


2.4 In Dorset we have we have many of the building blocks in place, the table in **Appendix 1** sets out eight main areas of change which will need to be in place by April 2022 and our current position in Dorset.

What does this mean for Dorset?

2.5 The proposal will see many changes as to how we work across the system, further integrating, collective responsibility for the health outcomes for the people of Dorset.

Fig 3: A possible Dorset ICS structure based on the current national guidance



Key benefits could include:

Benefits for Communities	Benefits for the System
• Consistent advice and proactive support to help people stay well, particularly those who are at higher risk • Joined up care and treatment when needed • Digital services that put people at the heart of their own care • Support social and economic development through employment, training, procurement and volunteering activities	• Collective responsibility for managing resources, delivering care and improving the health of our population • More control over how local services are delivered • Freedom and flexibility to do things that benefit everyone in Dorset • Shared digital developments and data to drive better system working

The next steps for Dorset

2.6 Dorset ICS has well established ICS Engagement and Communications Leads networks – with representatives from across all partner organisations. As we move to the new ICS, our engagement and communications team will continue to work closely together, responding to opportunities in an agile way, working in line with Statutory Duties to Collaborate and Involve. The priority areas are as follows:

- Engagement and Communications to inform how the ICS will work in partnership with people and communities in the future.
- Engagement and Communications to support and inform the ICS development workstreams, reflecting what is nationally mandated and what is for local determination.
- Strengthening the existing "Dorset Story", setting out the Dorset ICS narrative and what we are collectively here to achieve and sign up to as a member of the 'system' (**see Appendix 2**).
- Dorset wide engagement and communications/overall ICS engagement and communications approach and mechanisms to support the above.

2.7 We have a number of key next steps and actions to take as follows:

By end Q1	• Update System Development Plans and confirm proposed boundaries, constituent partner organisations and place-based arrangements.
By end Q2	• Confirm designate appointments to ICS chair and chief executive positions (following the second reading of the Bill and in line with senior appointments guidance to be issued by NHSEI). Confirm proposed governance arrangements for health and care partnership and NHS ICS body.
By end Q3	• Confirm designate appointments to other ICS NHS body executive leadership roles, including place-level leaders, and non-executive roles.
By end Q4	• Confirm designate appointments to any remaining senior ICS roles. • Complete due diligence and preparations for staff and property (assets and liabilities) transfers from CCGs to new ICS bodies. • Submit ICS NHS body Constitution for approval and agree "MOU" with NHS England and NHS Improvement
1 April 2022	• Establish new ICS NHS body; with staff and property (assets and liabilities) transferred and boards in place.

3. Conclusion

3.1 Members are asked to note the report and next steps set out in paragraph 2.7.

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Date : **17 May 2021**

APPENDICES	
Appendix 1	**Eight Main areas of Change and Dorset Position**
Appendix 2	**Dorset ICS Narrative Presentation**

Appendix 1

Eight Main areas of Change and Dorset Position

Theme	Requirements	Current Position in Dorset
Provider Collaboratives	All NHS providers to be part of a provider collaborative either within or between places at ICS level – or pan-ICS level for providers working in smaller systems.	Two approaches to provider collaboratives: 1) NHS Led Provider Collaboratives e.g. Dorset HealthCare NHS Foundation Trust is working with strategic partners across the SW region and IOW to become lead provider an eating disorder provider collaboratives and Young Persons MH services in Dorset have become members of the CAMHS provider collaborative model. 2) Clinical Programmes – examples include programmes include Cancer Network, Renal Services, Urgent and Emergency Care Board, Elective Care Board, Maternity
Place-based partnerships	Place Based Model' focuses on improving the health and wellbeing through providing access to preventative services, advice on staying well, integrated care, self-care support. It focusses on supporting Primary Care Networks, other health, social care and the voluntary community service using a population health manage approach to improve the outcomes in health wellbeing and independence of local people	Our 'Place Based Partnership' model is based on the geographical boundaries of our two Local Authorities - Dorset Council and Bournemouth, Christchurch and Poole Council. We have in place: • 18 established Primary Care Networks, all of whom have Clinical Directors and appropriate leadership • Joint commissioning arrangement are in place with both local authorities as well as for placements such as home first.

		• Our both Health and Wellbeing Boards have representation from across the system and focus on priorities within the geography •
Clinical and professional leadership	Embed system wide clinical and professional leadership through partnership board and other governance arrangements, including primary care network representation, specialist clinical leadership and wider professional such as nursing, social care	We have a strong history of system wide clinical involvement and collaboration and supporting ongoing leadership. We have in place: • Clinical voice within our governance from System Leadership Team to our oversight and assurance groups such as Clinical Reference Group, Quality Surveillance Group, People Board • Clinicians from across all sectors supporting our Dorset programmes • Primary Care represented within our System Leadership Team
Governance and accountability	• Place leadership arrangements, which includes joint decision-making with local government, with Director of Public Health, providers of community and mental health services, primary care leadership and HealthWatch representation on ICS Board • Provider collaborative leadership arrangements, including joint decision-making arrangements across providers and appropriate representation on ICS Boards	• Formally appointed ICS Independent Chair and Leader • System Partnership Board (Chairs and CE from across the system), with an Independent Chair • System Leadership Team- Executives across the system representing provider trusts, primary care, local authority • Assurance and oversight groups (OFRG, CRG, QSG, DWAB)- representation across they system

	• Individual organisational accountability for their current range of formal and statutory responsibilities and relationship between the organisation and system at place and provider collaborative	• System wide programmes such as Urgent and Emergency Care, Elective Care
Financial framework	• ICS to manage a 'Single Pot' bringing together the CCG commissioning, primary care budgets and majority of specialist commissioning spend and sustainability and transformation funding • ICS Leaders to have allocation decisions and duties - working with provider collaboratives to distribute in line with national rules for mental health/community and primary care, as well as local priorities • Blended payment model for secondary care services • Each ICSs to agree how financial risk will be managed across places and between provider collaboratives. • New powers will make it easier to form joint budgets with the local authority, including for public health functions.	• Financial strategy development underway, including the agreement of an ICS financial vision and risk appetite. • Whole system revenue prioritisation process (transparency of risk within the system) and learning taken from this. Ensures system agreement, alignment and overview of increases to cost base. • Supported strategic revenue investment decisions particularly linked to workforce pipeline for RNDA and digital over the medium term. • Collective understanding of the underlying financial position as we exit covid financial regime. • Compliant CDEL capital plan for 2021/22 and H1 2021/22 revenue plan
Data and digital	• Build smart digital and data foundations- including Board accountability and digital transformation plan, digital and data literacy and invest in infrastructure • Connect health and care services- shared care records, tools to allow collaborative working e.g. shared booking	• Board level leadership and accountability in place for digital and data • developed Dorset Intelligence & Insight Service (DiiS), range of dashboard and tools to support patient care and commissioning

	and referral management, follow nationally defined standards • Use digital and data to transform care- technology to drive pathways, cross system intelligence and analytical functions • Put citizen at centre of their care- citizen digital channels, remote monitoring.	• early implementer and received national recognition for our PHM approach • deployed the Our Digital Dorset App Library empowering self care • Dorset Care Record , Wessex Care Record (one of the first Local Health and Care Records (LHCR)) in place • Supported remote working through Covid through the deployment of laptops and Teams • Created robotic automation reporting for the testing and vaccination of our workforce and patients • Draft 'Our Digital Dorset Strategy' setting out our ambition and recommends several development priorities
Regulation and oversight	• ICSs greater role in regulation and oversight • System oversight framework (national) • Intensive Recovery Support Programme for those system facing greatest quality/ or financial challenges • 'Integration index' to support greater adoption of system and place level performance and outcomes measure to be develop by each ICS	• Programme boards • Oversight and assurance group e.g. operations and finance reference group • Executive oversight through System Leadership Team • Memorandum of Understanding with NHS England and Improvement • NHSEI are members of our SLT, Dorset programmes
How commissioning will change	• Strategic commissioning will take place at ICS level, including assessing population health needs and prioritising how to address them, modelling capacity and	• Population Health Management already rolling out across Dorset. • Joint Commissioning Board in place for some areas between CCG and LAs.

	demand, and tackling health inequalities • Other commissioning activities will move to provider organisations/collaboratives/place-based partnerships, including service transformation and pathway redesign • Greater focus on population health and outcomes in contracts and collective system ownership of financial envelope – shift from transactional contracting and managing performance	• Co-design and productions already in place in some areas.