Shropshire, Telford & Wrekin
Sustainability and Transformation Partnership

Towards Integrated Care Provider arrangements?

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Background

- CCG draft commissioning strategy presented to ICS Shadow Board on 19 May 2020 included an expectation that we are moving within STW to establish an Integrated Care Provider (ICP) model

- Discussions had already started on this locally:
  - PWC facilitated workshop in November 2019
  - Provider only session in December 2020
  - Agreement to establish an MSK alliance between SaTH, RJAH and Shropcom in February 2020

- However further progress has been delayed as a result of the COVID-19 response

- This paper summarises current thinking of leaders across the system and is based on individual interviews held by David Stout in June 2020 with Neil Carr & Cathy Riley, Andy Begley, Ros Preen, Jane Povey, Stacey Keegan, Louise Barnett, and Jonathan Rowe

- The paper sets out the key themes from these discussions and areas for further discussion to help us to agree next steps

CCG commissioning strategy – ICP expectations

Development of Integrated Care Provider (ICP) for tactical commissioning

- ICP arrangements to drive integration and co-ordinated delivery of care for our population.
- The priority will be improving long term health and care outcomes for the population.

Taking a more strategic approach

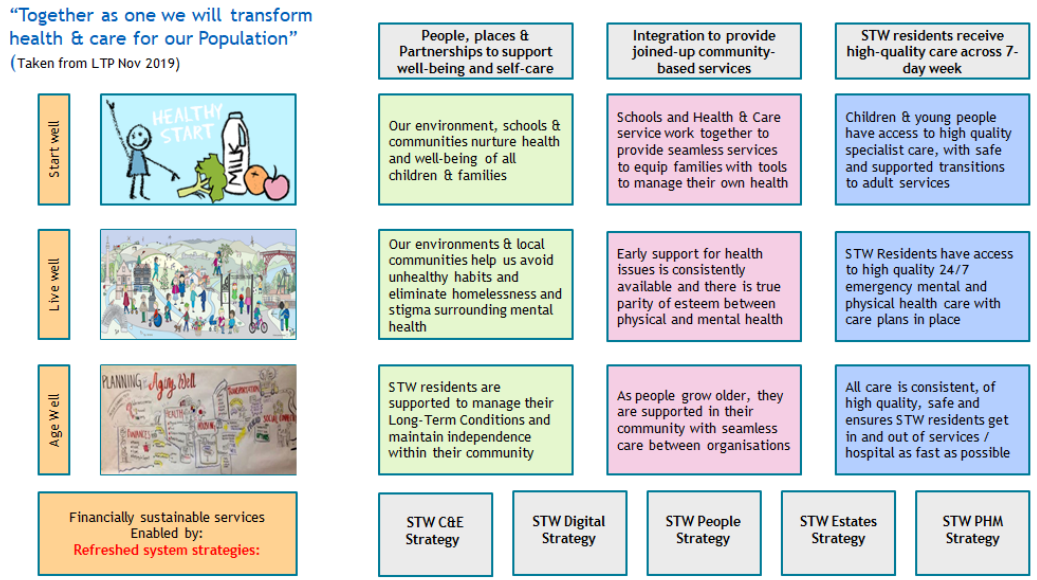
- Handing over responsibility for more commissioning to an ICP
- Set the outcomes and let the providers delivery them creating more integration of services
- Use a population health approach to define what really matters for each part of the population, and then set outcomes and allocate budgets accordingly
- Population health is based on use of data and intelligence from all parts of the system, and best practice
- Robust approach to prioritising key interventions and stopping doing other things

Purpose of ICPs

Primary purpose

- to put in place a means of delivering the ambitions set out in our STW Long Term Plan

- to deliver better coordinated care for local people leading to:
  - better outcomes
  - more efficient use of resources



Secondary purpose?

- to allow commissioners to step back from 'micro-commissioning' to allow providers to drive clinically led service design closer to the front-line with commissioners taking on a more outcome focused strategic commissioning approach

- To move away from an operating model based on competition and procurement to a more collaborative clinically driven approach

Key components of ICPs (taken from PWC slides)

1 *Defining the Care Models and Pathways that refocus service delivery*

The care model:

- Sets out the **outcomes and benefits** you want your system to deliver
- Articulates what you want your system to do **(levers and principles)** to deliver these outcomes (e.g. focus more on prevention and wellbeing, proactively target highest risk group)
- Can be broken down into care and clinical pathways (e.g. frail and elderly) which are aligned to benefits
- Frames the requirements for the type of **interventions and services** required across the system to meet the needs of the population
- Cannot be delivered without an understanding of the **functions, capabilities and enablers** that need to be in place

2 *Designing the System Operating Model that enables you to focus your limited resources and manage flow of people through the system*

The System Operating Model:

- Sets out all the **functions and capabilities** that will enable delivery of the care model outcomes
- Enables a better understanding of the **interrelationships** of the delivery components across the system
- Supports systems to make **decisions and local choices** on how they want to deliver these functions, who will deliver the functions, and where it should be delivered
- Sets out all the **requirements** that need to be in place so that functions can be delivered in the right way - Technology, Process, Workforce, Estates, Data etc.
- It enables informed decisions about where you **need to invest resources**

3 *Realigning the incentives in the system to enable the new model*

Realigned incentives:

- Built around **keeping people out of hospital** and into the least care intensive and cost effective settings
- **Changing the flow of money** across the system, using risk and gain incentives to achieve system balance
- **Contracts, payment schemes and models** aligned with incentives that support and enable behavior change of partners and transformation into the new model.
- Need to be underpinned by a **clear framework for measuring outcome based performance**, whilst encouraging innovation and improvement by partners across the system

ICP - Form

- Integrated Care Partnership or Integrated Care Provider? Spectrum of options:

- STW Provider Leader's views:
  - There is no appetite at this time from provider leaders for organisational structural change e.g. formal merger of organisations
  - General view that we should start informally and flexibly to build trust and confidence in ability to work together, reinforced by the positive experience of working across organisational boundaries during the covid-19 pandemic . More formality would follow on naturally where necessary
  - Need to be confident that accountability and decision-making is clear
  - We do have some examples we can build from e.g.
    - Telford & Wrekin Integrated Place Partnership (TWIPP) – formal board but no delegated authority from partners
    - MSK Alliance - formal board looking to agree financial risk share, but service model not yet implemented

ICP - Geography

- Integration could take place at at least four levels in our system:

  - **Neighbourhood** level e.g. PCN or other locality)
  - **Place** level i.e. Shropshire or Telford & Wrekin
  - **System** level i.e. the STP footprint
  - **Supra system level** e.g. cancer network

- STW Provider Leader's views:
  - The general view was that we will need to integrate our services at all four levels
  - The form of integration may need to be different at the different levels – possibly with more degree of formality in terms of governance at the higher levels?
  - The development of PCNs is uncertain. They currently have relatively limited responsibilities but these may evolve

ICP - Scope

- There is a wide range of services which could be included in the scope of an ICP:

  - Specialist services
  - General acute services
  - Community health services
  - Mental health services
  - General practice
  - Wider primary care services
  - Social care services
  - Wider preventative services
  - Voluntary sector servics

- STW Provider Leader's views:
  - The general view was that the scope of integrated care should be broad
  - The initial focus is likely to be around delivery of community based health and care services (both physical and mental health and acute outreach) and preventative services to support our 'left shift' aspirations

Issues for discussion

- This summary sets out initial views on the potential approach to ICPs in STW on:
  - purpose
  - Function
  - form,
  - geography
  - scope

- Questions
  - Is this a fair reflection of current views?

  - Will the broad approach of evolution of provider partnerships have sufficient impact to deliver the scale of change we will need? If not, what else is needed?

  - Will the progress we have made in partnership working the first crisis phase of the coronavirus pandemic be sustainable once we move out of crisis mode and financial constraints are reintroduced? What will we need to do to make sure that it is sustainable?

Proposed priorities /next steps

- Following discussion at the STP Chief Executives Group we propose the next steps should be to focus on a small number of priorities to accelerate our development of ICP working:
  - Re-ignite MSK Alliance – implement new model as part of the covid-19 restore & recovery programme
  - Re-establish our care closer to home programme taking account of progress made during covid-19 on care home support, shielded patients support, advanced care planning
  - New Ways of Working: Identify a disease specific pathway for improvement (e.g. Diabetes, Respiratory) to include prevention
  - Back Office: BI/Analytics “one version of the truth”, open book, shared view