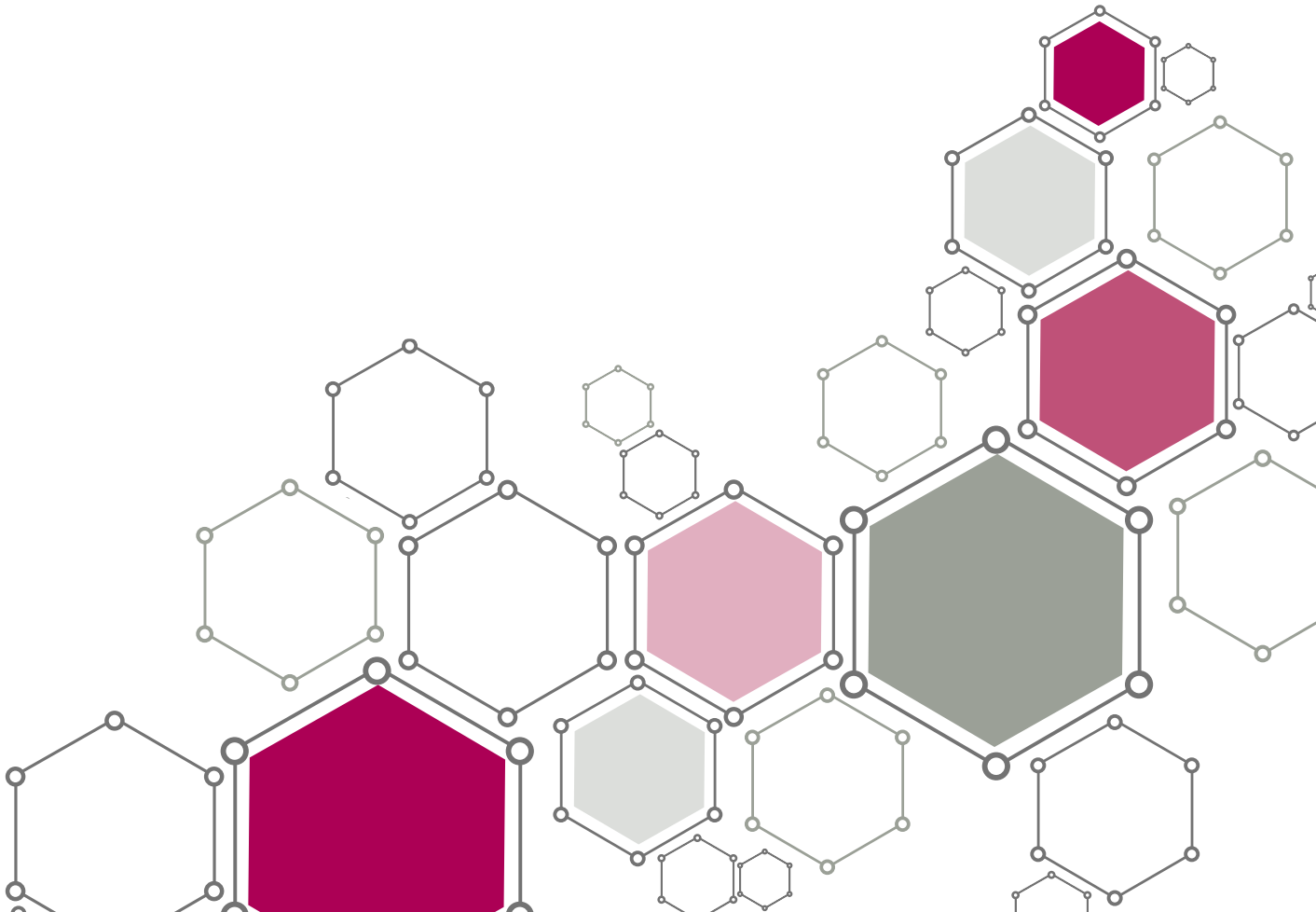
CAPITA

HEALTH AND CARE
TRANSFORMATION

Successful outcomes,
delivery innovation

A practical guide to establishing an integrated care system (ICS)

Part One



PART ONE
FOUR FOUNDATIONS OF A GOOD ICS

Establishing an Integrated Care System (ICS) is significantly more than just redesigning the organisations within the system. An effective ICS is a well-led system that scales the interventions that work and uses commercial incentives and digital innovation to improve outcomes. Our discussions with system leaders in the NHS, and our experience of working with some of the more integrated systems within Scotland and Wales, point to four overarching principles that underpin a good ICS:

1 Securing effective collaboration

Integration requires effective collaboration between the different provider and commissioner organisations in an area. The ultimate goal is collective management, with clear individual and shared responsibility for the health of the system's population. All organisations (primary care, acute and community providers, voluntary sector, private sector, patients and public) should have clearly defined roles in relation to integration. Collaboration has to extend beyond health, and we see a far greater role for Local Authorities and Health & Wellbeing Boards in tackling the wider determinants of health. For example, Salford Together is a partnership between Salford City Council, NHS Salford CCG, Salford Royal NHS Foundation Trust, Salford Primary Care Together and Greater Manchester Mental Health NHS Foundation Trust, all working towards a shared vision of population health improvement.

2 Joining up pathways of care

Patients and service users cross several boundaries of care and have multiple inter and intra organisation handovers across a care pathway. In order to understand the impact of duplication, delays and inefficiencies within the system it is critical that the patient perspective on the local care pathways are captured and embedded in any redesign. A good ICS breaks down those barriers down by simplifying the discharge and referral processes between acute, community and social care to provide seamless care. Equally, an ICS will have to be realistic about the complementary community investment required to make this work, for example, through workforce change and the deployment of enabling digital technology.

We have already seen encouraging signs of this during our work with vanguards through a clear willingness by primary, community and social services to look after highly complex cases using an integrated approach, with patients and service users becoming the 'organising principle' for integrating care locally.

3 Developing a system of shared incentives

Payment mechanisms and incentives should be aligned to the integrated care pathways, and not to individual organisations and teams. As part of this the old adage that 'money follows the patient' should be repositioned to 'money follows the integrated pathway' ensuring that workforce and other resources are aligned to patient needs, rather than to organisational spending objectives.

Within the ICS, the system and its contributory organisations should be 'jointly and severally liable' for the system control total and financial sustainability, making them all accountable for their population health budget. This in effect requires a Shared System Outcomes Framework with the ability to track the right outcomes against system spend. An example of this can be seen at Royal Wolverhampton NHS Trust where their Vertical Integration initiative has seen GPs and practice staff directly employed by the Trust currently covering a population of 77,000, with clear accountability for their end to end health and care.

4 Developing the right metrics for success

Successful integration requires a new set of metrics and an outcomes framework which measures the effectiveness of integration. In addition to the day to day operational metrics and government targets, an ICS will need a structured approach to evaluating the impact of integrated care initiatives in a number of areas including patient outcomes, patient experience, care process improvement, and costs.

When designing integrated services system leaders will need to understand and assess the potential consequences of integration on other parts of the health and social care economy and how this should be routinely measured. Our research and modelling has shown that, as you make services more integrated and accessible, demand patterns will change and increase over time at a rate well above what would be expected through seasonal variation and population change.

PART TWO
THE SIX THEMES OF ICS DELIVERY SUCCESS

In its latest planning guidance, NHS England envisages that all sustainability and transformation plans (STPs) will transition to a model of integrated care over the next two years. We also cannot underestimate the scope of investment needed to support large scale change across multiple systems and organisations in a challenging financial environment. Capita has over a decade of experience in implementing international best practice in integrated care in the UK and understands the risks, pitfalls and challenges that it brings. We have developed an assisted transformation methodology – Definition, Transition and Optimisation (DTO) as a means to drive health and care transformation. This is underpinned by six key enabling themes to deliver a successful outcome.

1. Governance and system leadership	Enabling the right model for you by considering collective decision-making, legal and regulatory accountabilities, democratic stewardship, pooling resources and risk and models of arbitration.
2. Models of care and workforce	Designing and implementing innovative care and workforce models, for example delivering Primary Care and care-coordination at scale, sustainable recruitment models and integrated working through MDTs.
3. Commissioning and incentives	Defining the framework and incentives to manage system outcomes and a shared control total at both system and contributory organisation level.
4. Population health management	Targeting key patient cohorts, e.g. predictable risk / high benefit using actuarially based models to consider long term resident population trends.
5. Digital, infrastructure and estates	Leading edge digital support providing clinical decision support, demand management services, care quality assurance and accreditation. System-wide infrastructure strategy, planning and optimisation.
6. Agile transformation delivery	Extending the ambition of the traditional PMO. We embed the case for change and underlying business case and then support you to deliver transition through agile sprints. Focussing on the interventions that work.

PART TWO
THE SIX THEMES OF ICS DELIVERY SUCCESS

1. Governance and system leadership

The vanguards have been successful in establishing formal alliances and collaborations to manage health at a population level and drive forward change. However, the system is still maturing and organisational relationships are still forming. The key is in simplicity of governance structures and in inclusion of the relevant stakeholders.

The choice of local governance arrangements (e.g. formal commissioner and provider alliance, joint venture or committees in common supported by Memorandum of Understanding) should be based on analysing factors such as collective decision-making, legal and regulatory accountabilities, democratic stewardship, pooling resources and risk and models of arbitration. For example, The Greater Manchester Health and Social Care Partnership, which manages health and wellbeing for 2.8 million people, is made up of over 35 different NHS organisations and councils in the region and has established ten Local Care Organisations (LCOs) to transform and integrate health and social care services locally at the borough-level.

2. Model of care and workforce

Integrated models of care can be based on horizontal or vertical integration principles, or a hybrid model. The chosen model should be determined by the outcomes you want to influence and which part of the system is best placed to deliver those outcomes. What's important is that the system leaders should not be trying to achieve an integration 'silver bullet' in terms of which model of integration it deploys. Rather they should work out the interventions and incentives that are going to work in their system and very robustly implement them.

With provider organisations under significant financial and demand pressures, much can still be achieved with horizontal integration between primary and community care, for example through co-locating multidisciplinary teams and taking a case management approach for patients in the community. Whatever the chosen model, the ICS will need to ensure that integration within one part of a health economy does not result in increased fragmentation elsewhere in the system, for example by causing staffing pressures or creating unmet demand. During our discussion with NHS system leaders, some concerns were expressed about the capacity needed to deliver services closer to home whilst addressing increasing acute activity and workforce pressures.

Workforce redesign has to support the chosen integration model and care pathways. The GP Forward View places strong emphasis on widening the clinical workforce with new roles for nurses, paramedics and pharmacists taking over workload from GPs, and to shift activities such as consultations, home visits and patient correspondence either to other staff in a practice or to patient self-management. In any workforce redesign, care should be given to the risks of deskilling some specialist staff and the time it requires to reskill the workforce.

3. Commissioning and commercial incentives

By designing tariffs that encourage delivery across the whole integrated care pathway commissioning arrangements should support and enhance integration rather than act as a disincentive. The issues of choice and competition will need to be considered and addressed as part of achieving the goals of integration. The ICS will need to have plans for developing formal and informal contractual or cooperative/network arrangements to support integration, for example partnering with local GP practices and federations as clinical delivery hubs.

Moreover, focus now has to shift to addressing how demand and delivery risks can be more effectively shared between commissioners and providers and between different commissioners. All players in the system have to be incentivised to deliver on the same outcomes framework, presumably requiring commissioners to let complementary contracts. Differentiation also needs to be made between strategic and tactical commissioning – i.e. things that will be commissioned strategically at an ICS level and those that are more tactical and commissioned locally.

4. Population health management

Population health management is a key principle of an integrated care system, with the focus being on managing healthcare for an entire population living in a geography. Our experience of working with vanguards suggests that the starting point should be to focus on specific patient cohorts, whether patients with long term conditions, or those with a more functional set of conditions e.g. frailty. The cohorts can be selected based on the outcomes you want to improve or the patients who would benefit the most from new care models. Success depends on achieving a balance between accurate prediction of need and capacity to improve a patient cohort's outcomes through targeted interventions. Rigorous economic modelling is required to understand the interventions that work and long term actuarial modelling to effectively identify patient cohorts. Our work with care systems on population health management suggests this ICS delivery theme is in its infancy. In reality, vanguards have experienced challenges around identifying target patient cohorts and aligning the new care models with cohorts, for example, some patients were found to be too unwell to take advantage of a proactive and self-care initiative with limited benefits realised from the scheme.

PART TWO
THE SIX THEMES OF ICS DELIVERY SUCCESS

5. Digital, infrastructure and estates

An ICS would need to develop a clear strategy for how digital, infrastructure and estates will support and enable the new models of care and integration outcomes. An effective approach begins with the design of the care service and considers the best technology and functional requirements that can support that.

Hwyell Dda University Health Board in Wales (HDUHB) has embarked on an ambitious transformation programme and aspires to be a population based health organisation delivering "Safe, Sustainable, Accessible and Kind services". Since June 2017, Capita has been working in partnership with Hywel Dda University Health Board (HDUHB), to help design and deliver their Transforming Clinical Services Programme. The Board is currently reviewing service configuration across its multiple sites and care settings to optimise the impact of any planned changes on patient flows and activity and developing supporting service and infrastructure scenarios to map out the benefits, efficiency opportunities and risks.

An ICS also needs interoperable IT systems that are configured for supporting clinical and operational decisions from a systems perspective, e.g. flagging up patients who are already receiving care packages when they attend the emergency department, and to provide shared visibility across health and social care records. Data sharing agreements will be required between different organisations to enable integration and monitoring.

6. Agile transformation delivery

Failure to embed robust programme delivery arrangements and invest in delivery are two of the single biggest causes of integration failure. STPs and now the emerging ICSs are building on their progress from the MCP and PACS pilots, and scaling up from that starting point using small incremental changes. Delivering the transition to operational ICSs will require an agile approach that allows lessons to be learnt quickly and change to be rolled-out at scale across the system. Agile delivery should not be confused with perennial pilots, since the aim is not to continually tinker, rather manage a portfolio of tightly scoped interventions that move the system closer to its desired objectives. This allows for rapid evaluation cycles which identify the effectiveness of an intervention whilst highlighting key enablers and barriers.

CONCLUSION

There is no one size fits all model for integrated care within the NHS and wider place it serves. Systems must work collaboratively to establish shared outcomes, and the interventions that are genuinely able to contribute to those outcomes. Once identified, those interventions should be rolled out at scale and pace across the ICS footprint.

For more information on Capita's Four Foundations of a Good ICS, the Six Themes of ICS Delivery Success or our ICS Healthcheck to evaluate your transformation, contact Capita's Health and Care Transformation Practice.

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