Healthy London Partnership

Supporting health and care system integration in London

DRAFT FOR DISCUSSION

24th May 2017

Public Health England

NHS

LONDON COUNCILS

SUPPORTED BY MAYOR OF LONDON

London's NHS organisations include all of London's CCGs, NHS England and Health Education England

Context

- While ‘integration’ means different things to different individuals, there is a widely acknowledged need for health and care to focus on the need for more joined-up, personalised care which puts the citizen, rather than the service, at the centre of the system.

- To achieve this aim, health and care partners need to move away from organisational silos and towards more systems-based thinking. The Five Year Forward View Delivery Plan references the need for the ‘triple integration’ of:

  1) Primary and acute care,
  2) Physical and mental care, and
  3) Health and social care.

  In addition, the move towards integration of services has required commissioners and providers to work more closely together (for example, through the STP framework).

- In London, much of this work has been developed organically at borough or multi-borough levels. The national emphasis on systems thinking and the devolution agenda provide opportunities for existing efforts to progress at greater pace and scale.

- This paper describes the efforts underway within London and nationally to adopt a more ‘systems-based’ approach and looks at how local areas can be supported to achieve this goal, to enable better integrated care for their populations.

01

Efforts are underway to improve health and care outcomes through greater integration

The need to ensure better integration of service delivery across health and care has been recognised nationally and within London

National

Integrated care pioneers (2013) – local areas developing joined up approaches to health and care

BCF (2013) – required all HWBBs to have a pooled budget and joint working between health and local government

When explaining what the future would look like, a key tenet of the **Five Year Forward View (FYFV)** (October 2014) was that *"increasingly we need to manage systems – networks of care – not just organisations…services need to be integrated around the patient."*

In 2015 50 vanguards were established to test and develop the **New Care Models** set out in the FYFV.

Sustainability and transformation plans (STPs) were announced in NHS planning guidance published in December 2015. STPs require CCGs, local authorities and providers to jointly create a plan for their local health economy.

London

In March 2015, the London partners signed **Better Health for London: Next Steps**, which set out a series of shared aspirations and actions to deliver them.

In December 2015, the London Partners signed the **London Health and Care Collaboration Agreement**. Central government and national bodies backed this vision through the **London Health Devolution Agreement**, which referenced the London integration ambition:

"the city…will lead the way to become one of England's first large urban areas to deliver integration of services and transformation at scale and pace."

Within the devolution pilot areas, local partners (including local authorities, CCGs, and providers of health and care services) have engaged in joined up working to accelerate the progress of transformation within existing powers.

All London **draft STP plans** (October 2016) acknowledged the need for further integration of services and a focus on person-centred care.

Health and care providers and commissioners are now working more closely together at all spatial levels

Localities

Many local, multi-borough and sub-regional plans are built on 'localities'. The 'locality' may simply describe a population defined by geography. In some cases, local areas prefer this population to be supported by a tailored delivery system.

For example, BHR describes populations of 50,000-70,000 with a capitated budget within each borough.

Boroughs

Local authorities, CCGs, and providers of health and care services have increasingly engaged in joined up working to accelerate integration within existing powers. Some areas, such as Hackney, Lewisham, Croydon and Kingston are developing joint governance arrangements or pooled budgets.

Multi-borough

Some areas are developing models of care delivery that respond to local needs, under the umbrella of consistent standards, and an 'accountable system' managing system-wide risk. This can be seen in BHR, where care models would be reinforced by a strong digital platform, responsive system-wide intelligence and innovation units, shared corporate functions and co-located estates.

STP

All London draft STP plans acknowledged the need for further integration of services and a focus on person-centred care.

Some STP areas, e.g. North West London, describe care pathways that are tailored to groups of citizens with similar needs e.g. mostly healthy adults; older people; those at the end of life.

Regional

In London the Health and care Integration Collaborative was conceived to share and spread learning. This will now be taken forward by the Strategic Partnership Board.

Integration has been an explicit area of focus for devolution, with commitments expected to support governance, commissioning, funding flows, regulation and workforce.

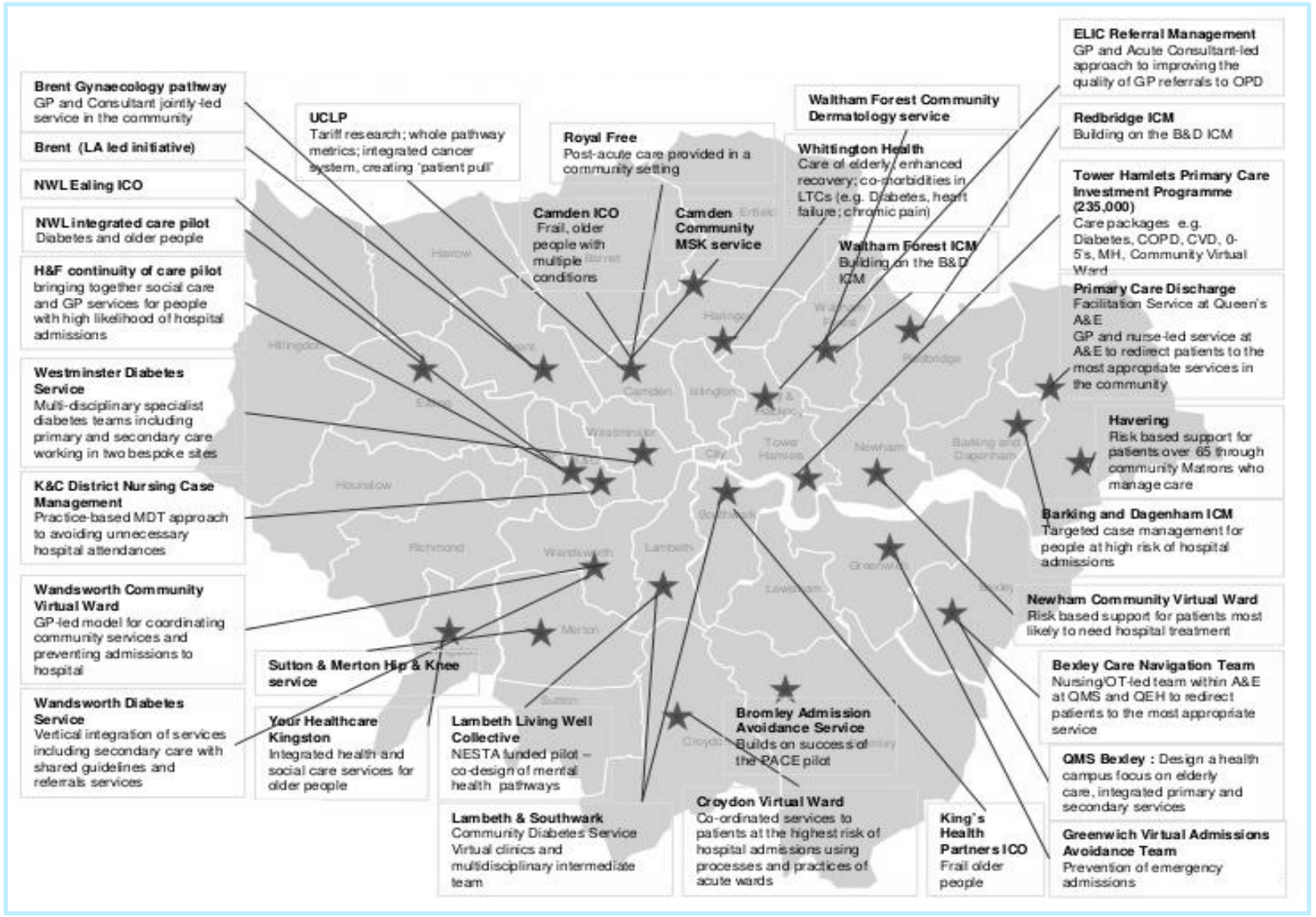
National

National policy decisions aim to reinforce integration. These include:

- Integration pioneers
- the Vanguards, announced in 2014
- Sub-regional planning through the STPs
- The recent emphasis on Accountable Care Systems

More integrated and person-centred models of care are being developed across London

The integration collaborative previously mapped some of these models. The landscape is likely to be even more diverse now:



The 5YFV delivery plan has just re-emphasised the importance of integrating care locally

The delivery plan expresses an aim to "***make the biggest national move to integrated care of any major western country***". The plan highlighted the following structures and processes as being integral to achieving this aim.

Local health and care system

STPs

The delivery plan describes a **shift from 'plans' to 'partnerships'**; recognition that organisational forms will differ across the country; strengthening the governance and implementation 'support chassis' with an STP board, an appointed STP leader (part funded by NHS England to ensure 'headroom') and programme management support.

The 5YFV delivery plan and preceding policy documents describe various care, commissioning and governance models designed to support integration.

1 New Care Models

The delivery plan describes the early findings of the 50 'vanguards' across the country, including Multispecialty Community Providers (MCPs) and Primary and Acute Care Systems (PACS).

These new care models are now to be 'mainstreamed', with capacity moving from NHS England's national team to a regional or STP model from Q4 2017/18.

2 Accountable Care Systems (ACS)

An ACS is described as being an '**evolved' version of an STP** or smaller multi-borough arrangement, where NHS commissioners and providers in partnership with local authorities take collective responsibility for resources and population health.

Development of an ACS is to be incentivised by enabling local areas to gain more control and freedom over the local operation of the health system.

Community participation and involvement

The plan emphasises **a renewed focus on involvement and consultation with local people** as plans are formalised and implemented.

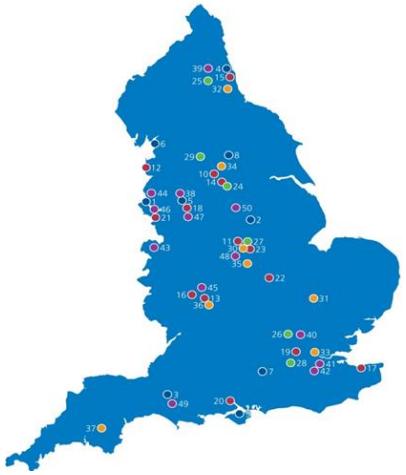
NHS England has also introduced a 'fifth test' for reconfigurations that result in significant bed closures - building on the four key tests of service change within the Government Mandate.

1

The New Care Models 'vanguard' programme was launched in the Five Year Forward View

All models require an increased level of integration between organisations within the health and care economy and look to put the patient at the centre of the care system.

Vanguards are developing the following new care models which are intended to act as blueprints for the NHS moving forward:



9	Integrated primary and acute care systems	1a
14	Multispecialty community providers	1b
6	Enhanced health in care homes	1c
8	Urgent and emergency care	1d
13	Acute care collaboration	1e

Vanguards are working along varying timelines, however the following **stages of development** are considered key requirements for a successful model:

Building a collaborative **system leadership** and relationships around a **shared vision** for the population.

Develop a **system-wide governance** and programme structure to drive the change.

Undertake the detailed work to design the **care model, the financial model and the business model**. This includes clinical and business processes and protocols, team design and job roles.

Develop and implement the care model in a way that **allows it to adapt and scale.**

Implement the appropriate **commissioning and contracting changes** that will support the delivery of the new care model.

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Multispecialty community providers (MCPs)

An MCP model combines the delivery of primary care and community-based health and care services in a 'place-based' model of care.

The range of services could include:

- GPs,
- Some services currently based in hospitals (e.g. outpatient clinics for the elderly and walk in centres),
- Community pharmacies,
- Mental as well as physical health services,
- Social care provision.

Redesigning primary and community care around the health of the population will require partners to work through a number of commissioning and governance considerations.

- The model requires a **new type of integrated provider, who will become the focal point for a wide range of care required by their registered patients**. The NHS England framework explains that *"in all cases, **an MCP will need to be a formal legal entity, or group of entities acting together** to form the MCP, that is capable of bearing financial risk, and which has clear governance and accountability arrangements in place for both clinical quality and finance".* Options include a limited company or limited liability partnership (potentially a GP federation) or an NHS trust or foundation trust, building on its existing assets and workforce.

- Three broad commissioning options are emerging. The first is the 'virtual' MCP, under which individual providers and commissioning contracts are bound together by an 'alliance' agreement. The second is the 'partially integrated' MCP contract, the scope of which excludes primary medical services, supported by contractual arrangements between the MCP and the GPs to achieve operational integration. The third is the 'fully integrated' MCP contract model with a single whole-population budget across all primary medical and community based services.

Data suggests indicates that both PACS and MCPs are having a measurable impact on acute admissions

National data on growth of emergency admissions	Non-vanguard	PACS	MCPs
2016 calendar year (baseline year 2014-15)	3.3%	1.7%	2.7%
2016 calendar year (baseline year 12 months to Sept 2015)	3.2%	1.1%	1.9%

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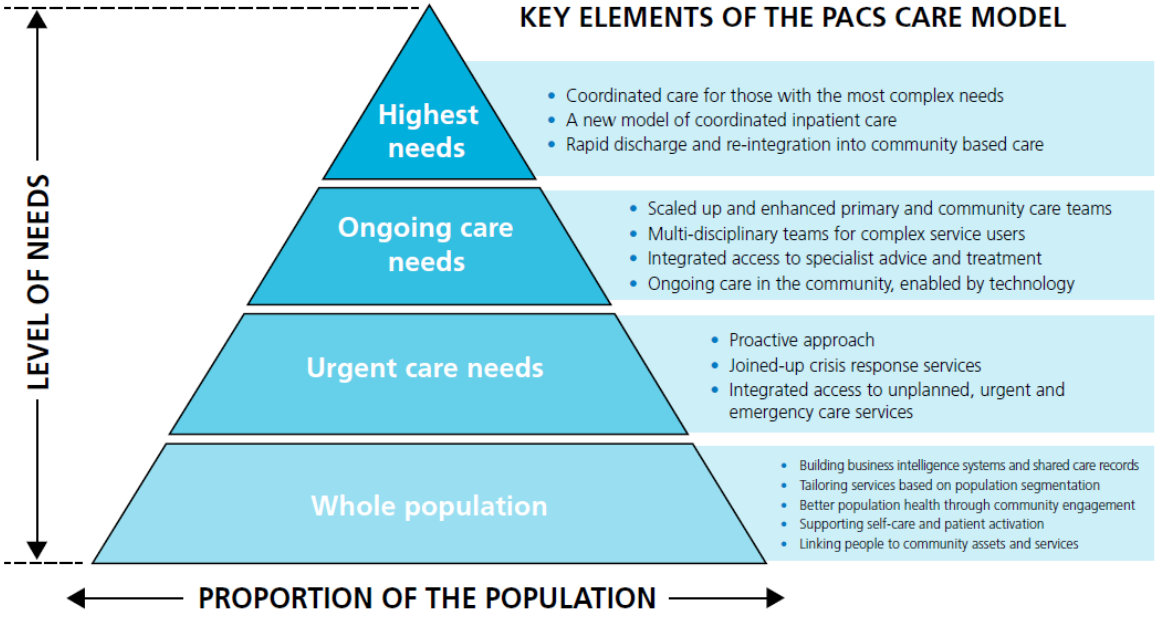
Integrated primary and acute care systems (PACS)

A PACS is a whole population health and care system.

The NHS England PACS framework explains that:
"At its most developed it will include primary, community, mental health, social care and most acute services for the population it serves. In terms of acute services, a PACS will include all secondary care and some tertiary care services. Some specialised services commissioned by NHS England could be in scope for a PACS."



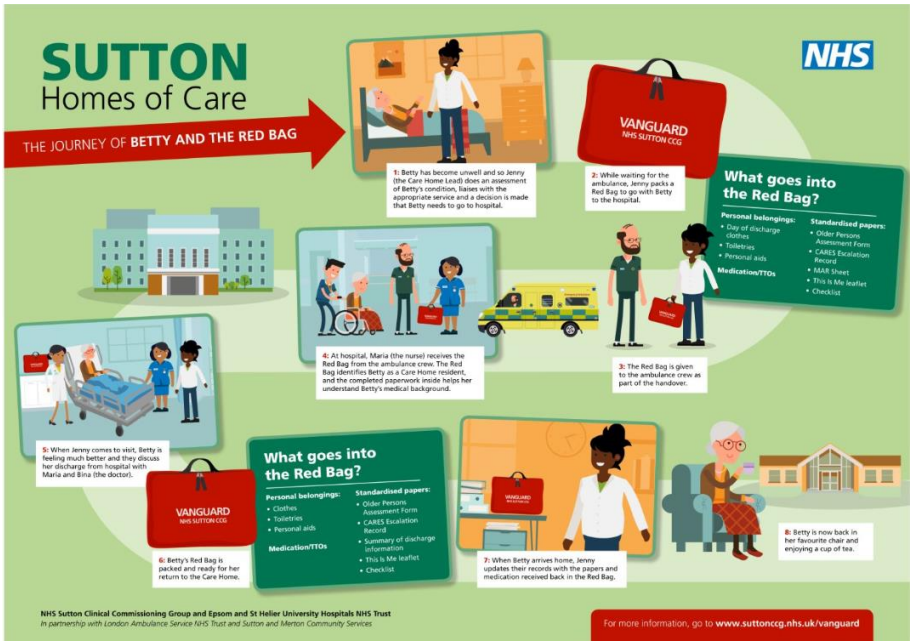
As with a MCP model, a PACS also redefines the roles of commissioner and provider.

- NHS England expect PACS to explore expanded collaborative commissioning models that bring together funding for NHS and social care services that have historically been funded separately.
- Commissioners will retain a strategic role, which would likely include setting contract outcomes, managing the procurement process, overseeing the PACS delivery against the contract, and ensuring service user voice and choice are maintained.
- The PACS provider, meanwhile, would have the freedom to define the detailed service model, determining how providers (including sub-contractors) would work together to deliver this and defining the operating and governance model across the PACS.

Other New Care Models offer a more localised solution to address issues in specific parts of the health and care system

New Care Model	Overview and governance/commissioning considerations	Examples
Acute Care Collaboration (ACC) 1c	• The model involves local hospitals working together to enhance clinical and financial viability, aiming to reduce variation in care and efficiency. • This model may offer options for a viable future for smaller district general or community hospitals, and aims to integrate community and acute services. Initial steps often include sharing of guidance and back office and clinical support functions. • In terms of governance, ACCs could include buddying, partnerships and federations, or more formal moves such as mergers and acquisitions.	In mid-August 2016 the following four acute foundation trusts were accredited to lead groups of hospitals by NHS Improvement: • Guy's and St Thomas' FT; • Northumbria Healthcare FT; • Royal Free London FT; and • Salford Royal FT. **Guy's and St Thomas' NHS Foundation Trust** and Dartford and Gravesham NHS Trust are working together to explore how closer working between the organisations can improve care for patients in three pilot areas – cardiology, vascular and children's services. The model aims to allow the two trusts to collaborate and share information more effectively to improve patient experience and clinical outcomes, without the formal organisational change of a merger or acquisition. **Moorfields** have also created a "*networked satellite model of care*", out from its central London Eye Hospital with locations around the country. The vanguard aims to ensure a comprehensive range of eye care provision closer to patients' homes.
Urgent and Emergency Care 1d	• The model aims to develop new approaches to improve the coordination of services, thereby reducing the number of individuals inappropriately attending A&E. This reduces strain on the emergency services, costs incurred by unnecessary admissions and allows patients who truly require emergency care better access to necessary care and treatment. • This model is likely to require governance mechanisms which include providers of urgent and community/primary care services, commissioners and also voluntary sector partners.	The **West Yorkshire Urgent Emergency Care Network** vanguard is a partnership consisting of an FT, District Council and mental health charity. The partnership have recently opened the first of three mental health urgent crisis support units. Patients attending A&E with mental health problems can be redirected to the crisis unit to obtain more appropriate care and support. Patients can be signposted to the new unit through the region's telephone crisis line and by community mental health teams.

Other New Care Models offer a more localised solution to address issues in specific parts of the health and care system

New Care Model	Overview and governance/commissioning considerations	Examples
Enhanced Health in Care Homes (EHCH) 1e	The EHCH model has three principal aims: • To ensure the provision of high-quality care within care homes; • To ensure that, wherever possible, individuals who require support to live independently have access to the right care and the right health services in the place of their choosing; and • To reduce unnecessary conveyances to hospitals, hospital admissions, and bed days whilst ensuring the best care for residents. The model requires care homes to work closely with NHS providers (including community reablement/rehabilitation services and urgent care providers), local authorities, CCGs, the voluntary sector, carers and families.	The **Sutton Homes of Care** vanguard has designed the 'Red Bag' initiative, to help people living in Sutton care homes receive quick and effective treatment should they need to go into hospital in an emergency. The Red Bag keeps important information about a care home resident's health in one place, easily accessible to ambulance and hospital staff.  Early monitoring of progress shows that the average length of hospital stay for those with a bag is 8 days, compared to 12 days for those without a bag . It is anticipated that the following savings will be found: • £183,000 from reduced length of stay for care home residents in hospital through quicker and better assessment, treatment and discharge; and • £290,000 from reduced loss of resident's belongings such as, dentures, glasses and hearing aids.

Accountable Care Organisations

- The model of an **Accountable Care Organisation** (ACO) was first implemented in the US. The basic concept of an ACO is that a group of providers agrees to take responsibility for all care for a given population, for a defined period of time, under a contractual arrangement with a commissioner. To enable this arrangement, accountable providers come together in a formal organisational structure (for example, a physician hospital organisation or independent practice association). Part of the US eligibility criteria is that an ACO is required to "*develop a formal legal structure that allows the organisations to receive and distribute payments for shared savings*". It is through this structure that the ACO can build a leadership team and appropriate governance arrangements to manage risk across diverse providers, holding them to account for their part of the care pathway. If part of the organisation is not performing well, leaders have a range of structures and mechanisms at their disposal to incentivise improvement. In March 2014 the King's Fund reported that 57% of US ACOs had one contract only, with a single purchaser.

- The following features are common to most ACO models:

Provider(s) that take responsibility for the cost and quality of care for a **defined population**.	A **population-based or capitated budget.**	Focus on '**place-based working**', co-ordinating care and overcoming fragmented responsibility for the commissioning and provision of care.	A **preventative approach**, targeting patients at risk of avoidable hospital admission or A&E attendance.	Provider(s) held accountable for **achieving a set of pre-agreed specific health outcomes for their registered population.**	Provider(s) incentivised to **improve the quality of care and keep people well in less expensive non-hospital settings.**

- Early analysis has been mixed, but does identify positive outcomes. The Centers for Medicare and Medicaid Services (CMS) reported in 2014 that ACOs had improved overall mean quality scores in their first two years of operation. The Nuffield Trust reported in 2016 that 51.8% of ACOs in the US had achieved savings, when compared to their baselines. It was noted that those with higher initial baselines had, on average, achieved better savings. Total savings across all organisations surveyed (after discounting the losses) stood at £429,254, 696.

- The 5YFV Delivery Plan has differentiated between an **Accountable Care System** (ACS) and an ACO. Under the plan, an ACO is defined as being a model "*where the commissioners in that area have a contract with a single organisation for the great majority of health and care services and for population health in that areas*."

Sources:
Kings Fund: Accountable care organisations in the United States and England: Testing, evaluating and learning what works
Nuffield Trust: Accountable Care Organisations: The winners and losers

2

National and local organisations are increasingly taking a systems-based approach which draws on the ACO model

The **King's Fund** reported in August 2014 that:

*"The current mix and remit of providers and commissioners in the NHS does not singularly or collectively embody these [ACO] features…. **Very few acute hospitals or GP federations would feel comfortable sharing clinical and financial risk with other providers through a legal structure**.".*

The 5YFV Delivery Plan (March 2017) explains:

*"In time some ACSs may lead to the establishment of an accountable care organisation…A few areas (particularly some of the MCP and PACS vanguards) in England are on the road to establishing an ACO, but this takes several years. **The complexity of the procurement process needed, and the requirements for systematic evaluation and management of risk**, means they will not be the focus of activity in most areas over the next few years."*

*The **BHR business case*** explains the pilot's aim for a <u>phased move</u> to a more accountable model:

"In December 2015 BHR was selected as a devolution pilot to test the viability of an Accountable Care Organisation (ACO) for the BHR system…Over the past year, eight organisations…have worked together to develop a strategic outline case for an ACO…At this stage leaders have taken the view that form must follow function. The process of considering the ACO option has created a desire to further develop the system but in a phased and measured way. Going forward the programme is being framed in the <u>context of an accountable care system</u> rather than organisation…"

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Accountable Care Systems (ACS)

- These multi-borough arrangements were announced in the NHS Five Year Forward View Delivery Plan.
- NHS commissioners, providers and local authorities will take collective responsibility for resources and population health in 11 candidate areas (none in London). There is the opportunity to add to this list in Q1 2017/18.

Considerable requirements are placed on ACSs:

1. Developing *collective governance and decision-making*
2. Agree an *accountable performance contract* with NHS England and NHS Improvement that will include delivering faster efficiency and service improvements than elsewhere in the country (priorities include cancer, primary care, mental health, urgent & emergency care)
3. Together manage funding for the ACS's defined population through a *system control total*
4. Demonstrate how providers will '*horizontally integrate*' whether virtually or through merger or joint management
5. Simultaneously '*vertical integrate*' with GP practice formed into locality-based networks or 'hubs' of 30-50,000 populations
6. Deploy rigorous and validated *population health management* capabilities
7. Establish mechanisms to ensure *patient choice*

In return, an ACS 'receives' benefits – many of these are part of the devolution MoU:

	ACS	London*
Delegated decision rights for commissioning of primary care and specialised services	✓	✓
Devolved transformation funding from 2018	✓	✓
Additional non-recurrent funding – £30m/year for 2 years for this cohort (transformation funding plus some extra)	✓	X
A single 'one stop shop' regulatory relationship with NHSE and NHSI	✓	✓
The ability to redeploy NHSE and NHSI staff and related resources to support the ACS	✓	✓ (underway)
A development programme for ACSs focused on solving common problems and generating learning for 'fast followers'	✓	X

* Powers granted to London, for local 'draw down', subject to robust business cases

The candidate systems will follow a roadmap to potentially become accredited ACSs within 12 months:

Finalise list of ACSs	Agree performance contract/MoUs, including funding and control totals	Development and support programme	Stop/Go decision based on progress and results in 17/18	'Go live' April 2018

Devolution aims to accelerate the delivery of ambitious health and care integration

- Within the London Health Devolution Agreement and London Health and Care Collaboration Agreement, a number of themes emerged as **enablers to support health and care integration**. The devolution pilots explored the barriers to achieving local and sub-regional ambitions as part of their early analysis, and the integration section of the London MoU was co-developed through an iterative process between pilots, London and national partners.
- This work identified the **four themes below as key devolution opportunities to support commissioners and providers to move at pace to design and implement new models of care and to enable local health and care integration**.
- Many of the devolution ambitions around integration are aligned with the work of the New Care Models Programme and pilots have benefited from key learning from the vanguards. Pilot work on integration has surfaced similar challenges to these experienced by CCGs working across borough boundaries or as health and care systems come together in Vanguards and STPs. **Devolution work therefore inscribes itself in the overall direction of travel to support health and care integration.**

Regulation	Commissioning Levers and Financial Flows	Workforce	Governance
Regulation is one of the key ways in which the quality and safety of the services being provided can be assured. However, the current system is based on each provider of health services being regulated (and each commissioner being 'assured') on an individual basis, against national standards. This traditional model of provider-based regulation does not directly support the more advanced integration models being developed.	The current structure of commissioning and the associated financial flows do not incentivise or enable more ambitious integration of health and social care. Funding flows are largely determined on an individual service basis, meaning that it is difficult to shift funding between services to address specific local needs or to prioritise prevention initiatives, rather than acute service provision. London partners see opportunities to commission services with a whole system outlook, with the overall aim of improving outcomes. Although there is much that can be done to develop integrated systems by flexing the current system, faster and more ambitious transformation would be enabled by the devolution of key funding streams and changes to the commissioning and financial frameworks.	In order to enable London's integration aims to move forward, the shape and skills of the workforce needs to evolve to support a more person-centred model. This will involve solving the current challenges pertaining to staff retention and turnover. Devolution gives the opportunity for action to be taken at London and local level to facilitate health and care workforce collaboration and integration and secure much needed talent to deliver health and care services to Londoners.	A more integrated system will require governance mechanisms to enable collaborative working and joined-up decision-making at every spatial level.

The London Health and Care Devolution MoU includes commitments to enable further integration through these themes

Regulation	Commissioning Levers and Financial Flows	Workforce	Governance

• Aligned regulatory approach through:
  • **Joined up processes for NHSE and NHSI** at regional level, including joint appointments for some key roles;
  • **Closer working between NHSE,NHSI and CQC at London level**, including alignment of regulatory actions and timelines where possible.
• Co-development of **a regulation and oversight model that meets the needs of the London system**, including the ability for an integrated delivery system to be regulated as a whole, and an approach that **enables freedoms and flexibilities** in the initial implementation stages.
	• **Devolution or delegation of NHS England functions** to within the London system, including primary care commissioning and London's fair share of transformation funding.
	• **Supporting personalised, joined up care at all spatial levels.** This involves developing a shared understanding of any current barriers to joint or lead commissioning arrangements.
	• Support to co-develop and adopt **innovative payment models** at pace and scale.
		• A **London Workforce Board**, bringing together health and care partners and ensuring a collaborative strategic approach to London-wide issues (such as maximisation of the opportunities offered by the apprenticeship levy).
		• Exploration of a **single employer framework**, to re-distribute and better target the existing pay envelope.
		• **Exploration of London weighting** in the context of the current challenges in staff retention and turnover.
			Governance arrangements will reflect the importance and complementarity of local, sub-regional, and London-level working, with decisions taken at the most local level so far as is possible within the legislative framework, consistent with the principles underpinning devolution. At London level:
			• A re-cast **London Health Board** will enable political accountability of health and care in London, and provide political oversight of wider London transformation efforts.
			• A **London Health and Care Strategic Partnership Board** will provide strategic and operational leadership and oversight for London-level activities, building on national direction (such as the Five Year Forward View) and London plans (including Better Health for London), but crucially emphasising the partnership approach and an agreed strategy for sustainability and transformation built up from local and sub-regional plans.
			• London-wide health and care operational functions will be administered in shadow form through a **London level Partnership Commissioning Board**.
			• A **London strategic delivery group** will support delivery, system transformation, and collaborative working at all spatial levels, and will build on the Healthy London Partnership.

02

Local areas have identified priorities to support greater integration

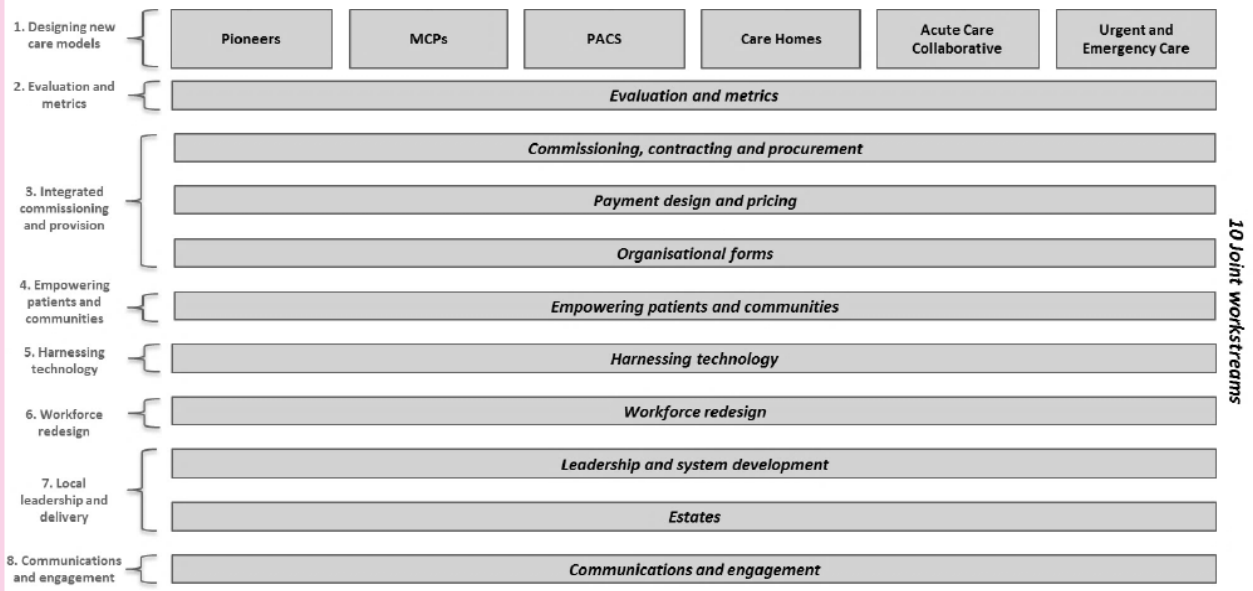
Given the increasing focus on health and care systems, a case is emerging for a London support offer

Any collaborative London partner programme would need to deliver on key aims:

- Ensure a **compelling case for change and narrative** that resonates with the public, health and care partners and politicians
- **Enable health and care systems to develop** at different levels across London, according to local appetite and priorities, where this will improve outcomes
- Provide additional **time-limited capacity and skills** where these are not available locally
- Enable **devolution commitments to be implemented** at pace and scale
- **Solving common problems** including through negotiation with national partners.
- **Advocate for share of national resources**.
- Generating, **spreading and sharing learning**

The STPs, devolution programme and new care models work have surfaced similar priorities to support system integration

The new care models support package aimed to respond to the needs of local systems through 10 joint workstreams



The relevant devolution commitments emerged from the work of the pilots

- Iteration between pilots, London and national partners identified key devolution opportunities under the theme of 'integration'.
- These aim to support commissioners and providers to move at pace to design and implement new models of care and to enable local health and care integration:

1. Commissioning & financial flows
2. Governance
3. Regulation
4. Workforce

London's STPs have surfaced many similar priority themes

The STP problem solving session in November provided an opportunity to discuss common challenges where collective action may be desirable:

- Having a clear, consistent vision and core narrative for London
- Incentivising the system: payment mechanisms
- Regulation
- Productivity improvements and stabilising the system
- Mobilising political support
- Workforce
- Digital and interoperability
- Estates
- Resources

- London's health and care partners have established the London Estates Delivery Unit to take forward work on estates.
- The Healthy London Partnership has an established Digital programme to support interoperability and technology considerations.
- These have therefore not been included in subsequent pages.

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From this, potential London priorities emerge that could inform a 'health and care systems integration' programme of work

1

Case for change and narrative

Pulling this learning together to ensure a compelling analytical base case and evidence to support the need for change; engage politicians, the public and key partners across the system

2

Options for integrated commissioning and delivery

Identifying benefits and challenges of the multitude of care, commissioning and governance models available to local areas.

3

The journey to greater integration

A 'toolkit' to help local areas navigate this, including leadership, organisational development, data and analytics.

4

An integrated approach to regulation

Working with NHSE, NHSI and CQC to develop and pilot an appropriate place-based framework for system regulation; ensuring regulators work better together.

5

A collaborative workforce

Developing and implementing preferred models of integrated working or single employer framework; exploring pay and co-location issues, with national bodies; unified job evaluation & performance management.

6

Supporting local approaches

Working with local areas to implement and scale up local integration and utilise devolution levers; disseminating learning across London.

Workstreams are focussed on providing a resource which all local and sub-regional areas will have the opportunity to draw on, subject to needs and appetite.

Any work at London level would need to support and complement local and sub-regional priorities

London

- Collating information on integration options
- Developing a toolkit to support local areas
- Working with regulators to ensure regulation and payment mechanisms support integrated systems
- Enable learning to be shared, spread and scaled
- Supporting engagement through materials for local tailoring

STP

- Identifying sub-regional priorities, building up from local plans
- Identifying baseline and intended outcomes
- Assessing interdependencies, opportunities and challenges across borough boundaries
- Supporting information sharing and evaluation
- Developing sub-regional partnerships
- Potential for ACS delivery at a sub-regional level (or multi-borough), if locally desired
- Particular focus on workforce, data, information sharing, estates and other enablers

Local

- Identifying local priorities based on local population needs and current services
- Identifying intended outcomes
- Developing local partnerships
- Decisions regarding whether to proceed with greater integration and which model(s), if any, are preferred
- Delivery of locally stated aims

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Case for change and narrative

Aim: Develop a compelling case for change and a narrative that resonates with the public, clinicians, health and care partners and politicians

Deliverables:

- A case for change supported by a strong analytics base [see next slides] grounded in the 'stories' of Londoners, that can be used to inform local decisions and debate on integration.
- A long term shared vision for health and care integration that sets out London's priorities for health and care over the next 20 years, building on *Better Health for London*.
- Core engagement and narrative materials for local adaptation: tailored to citizens, politicians, health and care workers, existing provider and commissioner organisations.

Process:

- Through engagement with key stakeholders, London Councils and devolution team - supported by all London health and care partner communications leads - to draft the emerging vision and narrative for health and care.
- Test the emerging narrative through senior leadership engagement across the sector. A series of workshops, targeted events and interviews will include political and officer groupings across both health and care.
- These events will also provide opportunities to identify existing integration efforts underway across London and to enable wider scale dissemination and engagement on health and care devolution and system transformation.

Timeline:

- Sub-regional workshops including both health and local government, to get more information on integration initiatives and inform the narrative – late June/July
- Series of key senior-level interviews - by end of July.
- Clinical workshop – including health and care front-line providers, involving the Clinical Senate – late June/July
- Publication of an integration narrative/vision document with evidence base - September.

Resources:

Undertaken internally by London partners

Key partners:

- London Councils, working with DASSs, Leaders, HWBB Chairs, CELC
- CCGs, NHS England, NHS Improvement, PHE
- Working with STP leads, all CCGs and provider groups

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Options for integrated commissioning and delivery

Aim: Enable local and multi-borough areas to understand the opportunities, challenges and implications of different options for integrated commissioning and delivery to make informed decisions about which, if any, option is appropriate.

Deliverables:

- Clear and accessible description of different health and care delivery and commissioning models, targeted to local and multi-borough areas.
- For each:
  - Benefits, including any data on health, service and financial outcomes
  - Challenges of implementation
  - Governance and accountability implications
  - High-level process for establishing the model
  - Illustrative case studies
- Development of a strong analytics base to inform local decisions

Timeline:

- Time-limited 'rapid review'
- 4 weeks, commencing June 2017.
- Completion of analytics base – July 2017.
- Aim for completion by end-July 2017, review at July London Health and Care Strategic Partnership Board, dissemination to local partners thereafter.

Resource implications:

- 3FTE (from existing resources) +/- external resources to support analytical base case

Process:

- 'Desk-based' research and phone interviews with think tanks, New Care Models and local and national systems with advanced implementation.
- Test emerging findings with local health and care partners to ensure relevant and applicable.

Key partners:

- London health and care partners – in particular, NHSE, NHSI, London Councils
- Working closely with the national vanguards, integration pioneers, and integrated systems across London.

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The journey to greater integration

Aim: Describe the steps that local areas may need to consider to move to a more integrated delivery or commissioning model. Specific support that is common across delivery models or can be procured at scale.

Deliverables:

- A clear description of the path to integration, starting from baseline requirements, identifying key priorities and testing the 'logic model' for action, moving to putting in place MoUs and moving towards implementation
- Leadership and organisational development: a support offer to enable system leadership across health and care, at local, multi-borough and STP levels.
- Governance and accountability:
    - Exploring how health and wellbeing boards can be meaningfully strengthened
    - A clear description of the path to new governance arrangements, including assurance requirements and phasing
- Analytics and data: clear understanding of baseline, relevant metrics and approaches to assess potential impact. Support with setting outcomes and evaluation mechanisms. In order to deliver greatest value for Londoners, it will be necessary to recognise both population health and financial outcomes.
- A shared approach to evaluation to allow spread/scaling

Process:

- Understand baseline support offers across the system
- Identify skills or expertise gaps
- Develop 'toolkit' for local areas focused on each 'theme' – early iteration with local areas, with full publication by end of 2017.

Timeline:

- Describing the path to integration – June/July
- Completion of baseline analytics document - July/August.
- Leadership and OD scoping – June; with support package in place by September.
- Descriptions of path to governance – July
- Discussions with new care models regarding analytics and data – June/July
- Discussions with potential partners regarding evaluation – June/July

Key partners:

- All London partners and STPs
- Think tanks, new care models, ACS support team
- Analytic partners (? Procure)
- AHSNs and academic partners

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An integrated approach to regulation

Aim: To ensure that national regulators support London's integrated health and care systems; to ensure that London's regulators are able to work as closely together as possible with an aligned regulatory approach.

Deliverables:

[It is recognised that there is a national move to place-based regulation and accountable care systems. A joint finance and delivery committee will be established nationally and a single operating model is under development between regional teams of NHS England and NHS Improvement].

- Developing joined up processes and some joint appointments between NHS England and NHS Improvement
- Developing and piloting a place-based framework for system regulation that involves CQC, NHS England and NHS Improvement

Process

- Developing a place-based framework for system regulation that involves CQC, NHS England and NHS Improvement
- Test the emerging framework with local areas to test implementation challenges in practice
- Iterate and publish a full regulatory framework

Timeline:

- [for discussion, contingent on wider national timelines]

Resourcing:

- [for discussion]

Key partners:

- Local systems – devolution pilots, vanguards, other local areas
- NHS England, NHS Improvement, CQC

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A collaborative workforce

Aim: To develop a workforce that is fit for purpose to support integrated health and care systems.

Deliverables:

- Clearly identify base case, stratified by STP (& multi-borough?) area.
- Analysis of different workforce requirements to support each delivery or commissioning model.
- Projections of changes needed in the workforce to ensure that it is fit for purpose to meet London's changing needs in 20 years – identifying possible gaps and needs.
- Describe options for an integrated workforce
- Propose a collaborative approach to workforce development
- Describing and proposing solutions to challenges facing health and care workforce integration such as: co-location, performance management, job evaluations, contractual issues, pay parity and career progression.
- Developing team-based care models, including a plan for up/side-skilling existing workforce.

Process:

- Through interviews with local systems and from New Care Models work, identify the key challenges facing workforce integration and the workforce requirements to support different delivery models.
- Test emerging findings with London and national partners, including HEE, Skills for Health, Skills for Care, DH (through London Workforce Board)

Timeline:

- Base case analysis – June 2017
- New Care Models and other interviews – June/July 2017
- Forward projections – September 2017
- Proposing and iterating solutions – September-December 2017

Resourcing:

- [for discussion]

Key partners:

- London Workforce Board partners (STPs, London and national partners)
- Working in partnership with wider providers including UKHCA

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Supporting local approaches

Aim: To support local areas to move towards full integration by 2020, with variations of approach according to local appetite and priorities.

Deliverables:

- A map of local integration initiatives, with key outcomes.
- A platform to share and spread learning to scale up local integration
- Focused support for local and STP areas to take on integrated arrangements
- Provision of time-limited skills and resources as required, including advice and support on procuring external support

Timeline:

- Map of initiatives – July 2017
- Platform in place to share and spread learning – September 2017
- Local and STP support - iterative

Process:

- Engage with local and STP areas to develop a picture of the developing London landscape , enabling more focussed and tailored support.
- Develop platform for sharing and spreading learning, building on the commonly used systems
- Workshops to disseminate learning from different local areas.
- Work with local and STP areas to identify appetite for London level support and local challenges requiring focused attention.

Key partners:

London local authorities, CCGs, providers (community, primary and secondary care)

Working closely with local areas through HWBs, DASSs etc.

London health and care partners

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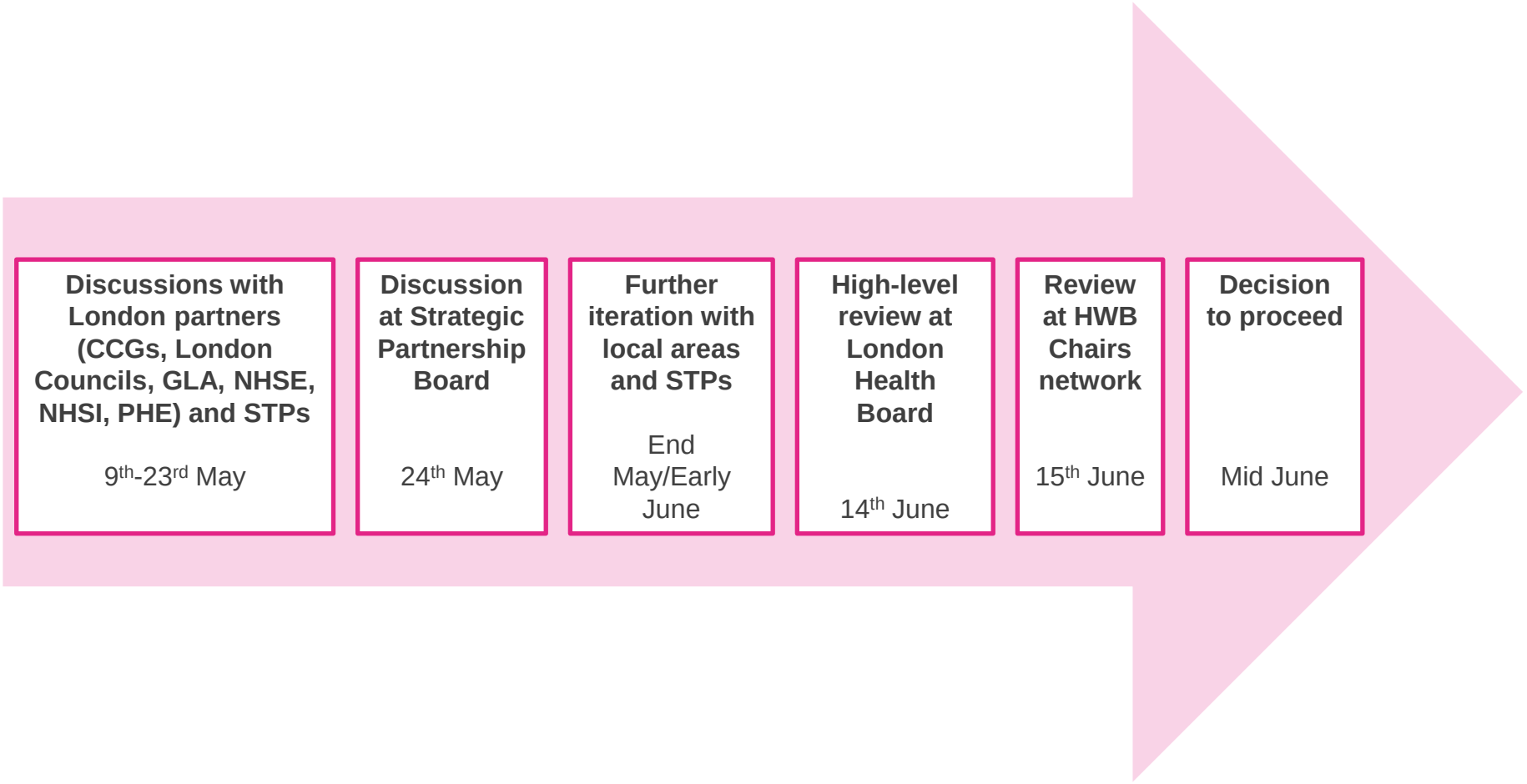
This ‘strawman’ will need to be iterated over the coming weeks



For discussion

- **Scope:**
  - Are these the most appropriate priorities and where we most need to concentrate support?
  - What type of support is likely to be needed by local areas?
  - Is this work best done at London or a different spatial level?

- **Engagement:**
  - How can we ensure primary and community services are meaningfully engaged and involved?

- **Resourcing:**
  - Where can we repurpose existing resources or capabilities?
  - Where do we need to bring in specialist capabilities to support local skills gaps?
  - How can we best leverage national support?