Healthy London Partnership

Title:	Health and Care Integration: Next steps
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London Health and Care Strategic Partnership Board

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1. Action required by Board members

1.1. The Board is asked to:

1.1.1. **Feedback** on areas/ issues for progression; and

1.1.2. **Agree** the approach for next steps.

2. Introduction

2.1. At the last meeting, it was agreed that there was a strong appetite to make the best collective use of the opportunities provided by the London health and care devolution Memorandum of Understanding (MoU) to progress diverse integration ambitions in London. Board members also asserted the importance of working together to enable delivery of integrated health and care across the city and benefit from collective problem solving, sharing of lessons learnt and spreading what works to add pace to local ambitions.

2.2. Recognising the importance of local leadership and the established principle of subsidiarity, Board members agreed the importance of local systems leading and influencing delivery. It was agreed that STP and borough leaders would be invited to come forward to express interests in their areas of choice.

2.3. This paper prompts members to consider issues that would benefit from collective consideration and problem-solving and refine areas of focus. Following this meeting, local areas are invited to come forward to formally express an interest in work themes of their choosing.

3. Integration enablers and possible focus

3.1. In the context of health and care integration, 'enablers' are changes which reinforce and sustain integrated delivery models. Some could impact on one delivery area and some could realise change across multiple delivery areas. The MoU commitments focus on enablers to integrated working (e.g. regulation; workforce), which were identified by the devolution programme and pilots. Additional enablers have surfaced through ongoing local or London work (e.g. digital).

3.2. At this point, partners collectively recognise the high-level challenges behind enablers[1]. The next step is to explore these in detail and work through the specificity of any required changes. Focus on particular delivery areas would allow partners to explore these enablers in greater detail. For example:

Enabler	Illustration of delivery area
Regulation Regulation has been a focus of both the London devolution work and national work (for example, the Integrated Care System programme). Partners recognise that there is fragmentation in the regulatory system and that focus on the performance of individual organisations (rather than the pathway) can discourage an integrated approach to care. London partners held a workshop with regulators in January 2018, during which it emerged that different organisations recognised different challenges with current arrangements.	Effective elderly care pathways are likely to require collaboration between secondary care providers regulated by both NHS Improvement and the CQC; primary care providers regulated by the CQC; social care providers regulated by the CQC; and a range of voluntary sector organisations subject to independent regulatory arrangements. This has the potential to create misaligned incentives between different organisations that are collaborating to deliver a common outcome, and means that often issues involving multiple organisations are not collectively targeted. Whilst much of the regulatory work nationally is focussed on advanced models of integration, changes to availability and visibility of data, reporting patterns and timing may better support integrated pathways for elderly people.
Payment models/contracting arrangements By placing a greater emphasis on population health outcomes rather than units of activity or individual components of a pathway, payment models can incentivise a more preventative approach.	Many CAMHS services commissioned locally are subject to block payment arrangements. Under such arrangements, providers are not incentivised to reduce activity through early intervention. Conversely, providers of nationally-commissioned specialised CAMHS services are reimbursed on the basis of activity and prevention and demand reduction are not directly reflected by payment approaches. Payment models that incentivise a population health approach are better able to manage the changes in activity that may occur. A risk/gain share arrangement could support all partners to manage the financial impact of the change in activity levels and ensure care is provided in the most appropriate place.
Workforce Implementing models of integrated care requires a real focus on the workforce. New models of care may require the development of new roles such as a 'Care Navigator' to support individuals	Many complex elderly care pathways entail multi-disciplinary team working where multiple staff employed by multiple organisations from the health and care, and voluntary sectors, collaborate to manage the complex needs of local

[1] Those highlighted below are regulation, payment models, workforce and digital/analytics; partners have also highlighted additional enablers including governance and organisational development.

Enabler	Illustration of delivery area
to access services provided by different partners. Some models are likely to require the development of a more flexible workforce, with roles that are more generic and enable cross-organisational working.	people. Roles may cross organisational boundaries to enable continuity of care in the home and could be supported by access to common care plans and more integrated teams.
Digital/analytics Digital infrastructure and analytical capability provide opportunities to develop a better understanding of the current and future needs of a population and support the provision of better coordinated and personalised health and care.	Delivery models designed to supported integrated elderly care use population health management tools to 'segment' patients, and enable focussed intervention(s) for the most at-risk individuals. Immunisations are provided by multiple partners, requiring strong data sharing arrangements to track coverage and identify problem areas.

3.3. Local systems may prefer to focus on one enabler and articulate the challenge by way of reference to a particular services area (e.g. the CQC place-based reports[2] examine regulation in the context of elderly care). An alternative approach could be to look at multiple enablers through the lens of a single delivery area. Input and direction will be required from the London Workforce Board, London Estates Board and London Digital & Informatics Boards for the corresponding workstreams.

3.4. However, it is recognised that different aspects of integration work will have variable importance to organisations across the London health and care system. The table below is offered by way of illustration of some areas where progressing integration through reform of enablers could enable partners to meet collective ambitions. Local systems may recognise these as core aspects of their own integration aspirations, or may have identified priorities not identified here. This illustrative list is not intended to be exclusive.

Delivery	Commissioning	Challenges	Potential benefits of solving challenges[3]
Mental Health Services			
Mental health services are provided by multiple delivery partners. In addition to NHS services (including acute and community), co-ordination with wider public services is crucial to deliver the best possible care centred around the holistic needs of the individual. For example, in the case of children, GPs, schools and social workers have	The commissioning landscape also involves a number of partners. For example, Children and Adolescent Mental Health Services (CAMHs) (tier 4) are specialist services and are currently commissioned nationally by NHS England. Other CAMHS services are commissioned by CCGs. Local government also commission a number of services	Services are accessible to the population in each borough and are supported by wider public services which are organised at borough level (e.g. education/social care) or smaller geographic levels (e.g. primary care). The central commissioning of some services (e.g. CAMHs) can mean it is challenging to ensure that pathways are co-ordinated at local level and responsive to local	• Holistic pathways and improved access to services. • Local solutions to access challenges, which can be co-developed with providers. • Ensuring that pathways are best responding to local needs is pertinent at a time of resource scarcity.

[2] http://www.cqc.org.uk/what-we-do/coordinated-care/quality-care-place
[3] Recognising that benefits will be dependent on the desired local approach

Delivery	Commissioning	Challenges	Potential benefits of solving challenges[3]
a key role in identifying and supporting children with mental health issues.	which support delivery of child mental health (e.g. social care and education).	needs.	
Avoidable hospital time for elderly patients			
Complex pathways and funding models, involving multiple sectors. Health services provided by NHS partners, including primary and acute care, and mental health. Local authorities commission social care. Elderly people are often also supported by the voluntary sector. Many care homes may also provide services which are privately funded.	NHS (CCG and NHSE for s.7A/specialised services) and local government.	Older, vulnerable people have high rates of admission to hospital care. In some cases this could be avoided by more proactive or flexible community based support to intervene earlier. Delayed discharges sometimes occur when a home environment cannot be made safe quickly or because new care arrangements cannot be put in place in a timely way. In some cases, this prompts transfer to residential care. Acute admissions from care homes are particularly high and evidence suggests that this could be reduced through focus on prevention and proactive care and community outreach. Access to NHS services for care home residents is variable, so homes sometimes default to urgent/ emergency care.	• Better outcomes for elderly patients. • Care home residents have equitable access to improved care that proactively manages their holistic needs. • Reducing avoidable activity for acute providers: Croydon has seen a reduction in non-elective admissions (-3%), non-elective bed days (-2%) and non-elective excess bed days (-25%). • Savings for health and care commissioners which can be re-invested into the system. • Through more proactive care and earlier intervention, a reduced pressure on social care.

3.5. Some issues impact multiple elements of integrated care. ***Boundary considerations*** have been raised as a challenge on multiple occasions in engagement with partners. For example:

3.5.1. Large London hospitals provide specialised care to patients from local areas and wider London boroughs. Some Trusts will also provide care to patients outside of London and some London citizens receive care outside of the city. Where local partnerships are looking to develop a more integrated

approach to health and care, the concern is that patients who reside outside the local system will be disadvantaged, with more siloed care.

3.5.2. Working across boundaries can also be problematic for providers and clinicians, who may face additional challenges in accessing patient records, accessing specialist expertise and ensuring timely discharges.

3.5.3. Boundary issues can also be problematic in systems proposing to develop new payment models, such as the integrated whole population budget or capitated payments. These new models largely replace existing block or activity-based models currently used to reimburse providers. In some of these new models, partners share the risk and benefits associated with the management of their combined population and commissioners pay, in part, on the basis of outcomes achieved for that population. Activity moving outside the partnership is likely to be subject to a different payment model, creating an additional administrative cost for the commissioner.

3.5.4. Many organisations are engaging in partnership working at multiple spatial levels. For example, SEL is designing a 'System of 'Systems' approach and partners in NEL are working on a multi-borough basis. Where organisations are working across multiple system boundaries, some common elements may be needed across the footprint for arrangements to be workable.

4. Approach for taking this work forward

4.1. **1 June 2018**: Areas are asked to indicate their interest in participating in particular work themes. In the first instance, we will be looking to understand:

4.1.1. ***The area of interest*:** Changes that the partnership are trying to realise, work underway or planned within the particular area, existing resources deployed to this area and perceived opportunities/benefits for the partnership in realising change.

4.1.2. ***The partnership approach*:** Confirmation of partner organisations and named leads. While one organisation may be leading the work, evidence of cross-partner development and delivery will be important.

4.2. Those who are interested are asked to approach [redacted]

4.3. **June 2018:** Workshops with interested areas will be hosted by HLP in June to co-develop the next steps.

4.4. **6 July 2018:** Feedback will be provided to the Board on 6 July.