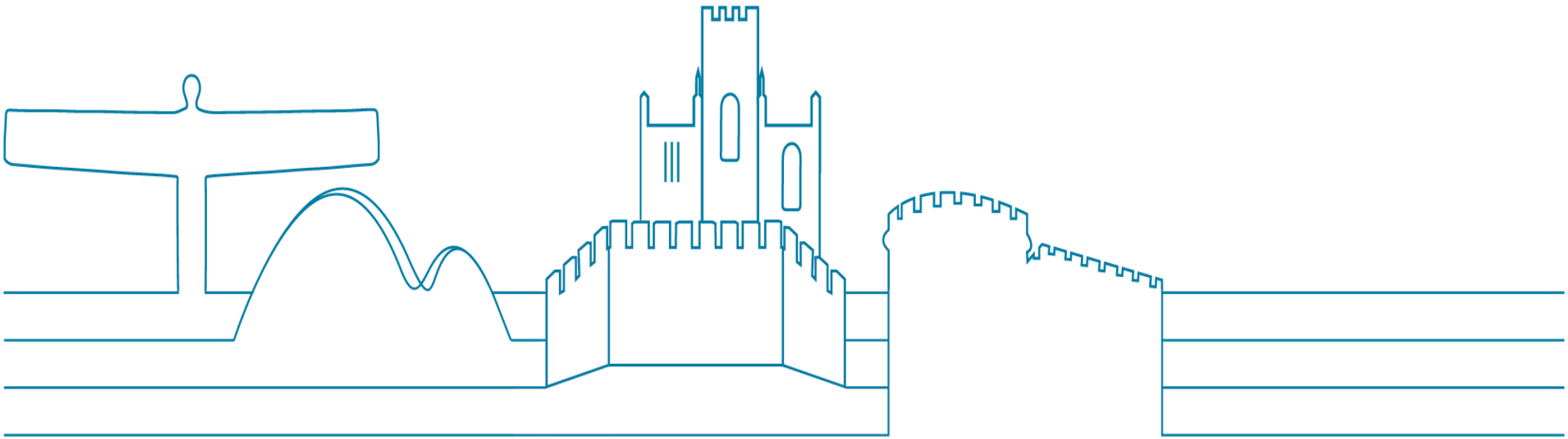
Integrated Care Systems

Update to Health and Well-being Boards

Siobhan Brown and Claire Riley

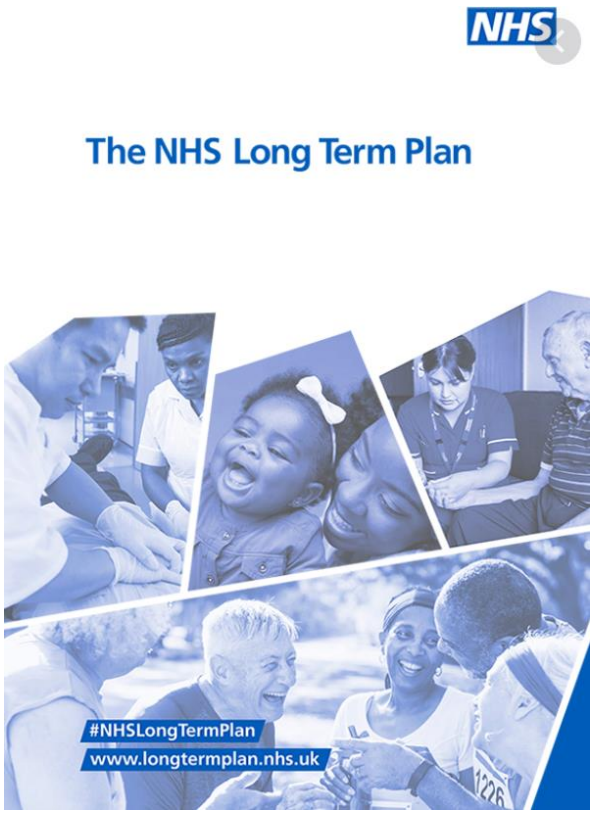


Summary

- Reminder of Integrated Care System and how it works in the region
  - Development of a regional Partnership Board
  - Collaboration
  - Coordination of Covid:19
- Update on national positioning and discussions
- What is happening locally
- Focus for local activity at a place level

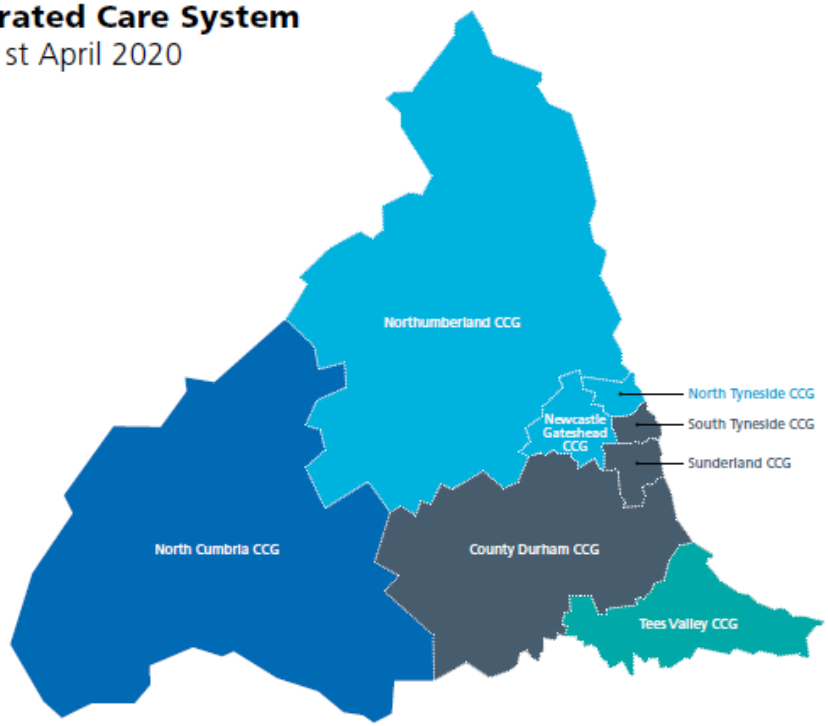
Integrated Care Systems

- Nationally created as part of the NHS Long Term Plan
- Ambition is….*for health and care joined up locally around people's needs. It signals a renewed ambition for how we can support greater collaboration between partners in health and care systems to help accelerate progress in meeting our most critical health and care challenges.*
- Updated position published in November 2021 – focus on recommended next steps including greater emphasis on;
  - improving population health and healthcare;
  - tackling unequal outcomes and access;
  - enhancing productivity and value for money;
  - helping the NHS to support broader social and economic development.



Reminder of our wide footprint

North East and North Cumbria Integrated Care System
From 1st April 2020



NENC ICS-wide

North East Ambulance Service FT covers: North of Tyne and Gateshead ICP; Durham, South Tyneside and Sunderland ICP; Tees Valley South ICP

CNTW Mental Health FT covers: North Cumbria ICP; North of Tyne and Gateshead ICP; plus part of South Tyneside and Sunderland ICP

TEWV Mental Health FT covers: Tees Valley ICP; plus part of South Tyneside and Sunderland ICP

Newcastle upon Tyne Hospital FT: provider of highly specialised and specialised national and regional services (including transplant, paediatric specialisms and major trauma)

North of Tyne and Gateshead ICP

Population: 1.079M
3 CCGs: Northumberland, North Tyneside, Newcastle Gateshead
Primary Care Networks: 22
3 FTs: Northumbria, Newcastle, Gateshead
4 Council Areas: Northumberland, North Tyneside, Newcastle, Gateshead

Durham, South Tyneside and Sunderland ICP

Population: 997,000
3 CCGs: South Tyneside, Sunderland, County Durham
Primary Care Networks: 22
2 FTs: South Tyneside & Sunderland, County Durham and Darlington
3 Council Areas: South Tyneside, Sunderland, County Durham

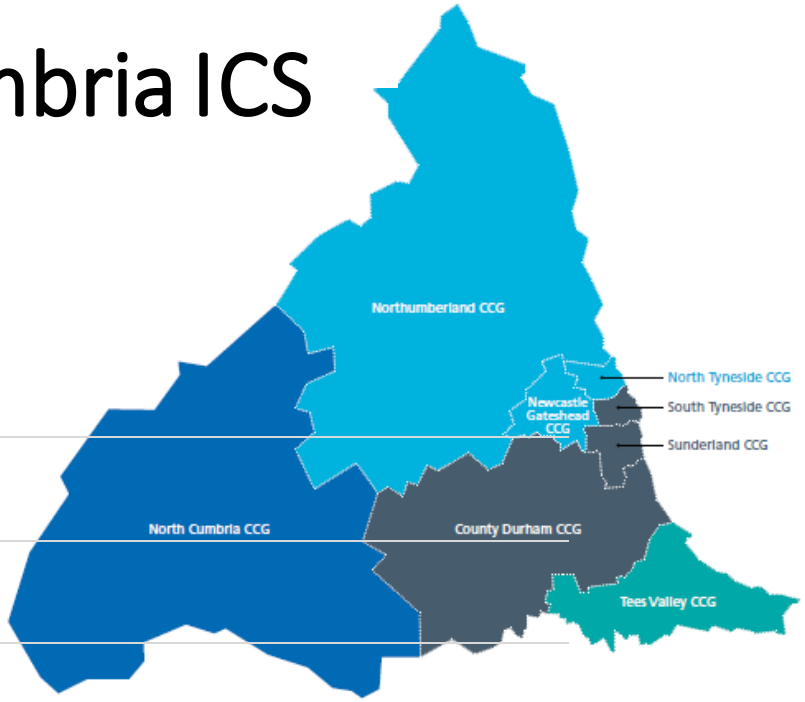
North Cumbria ICP

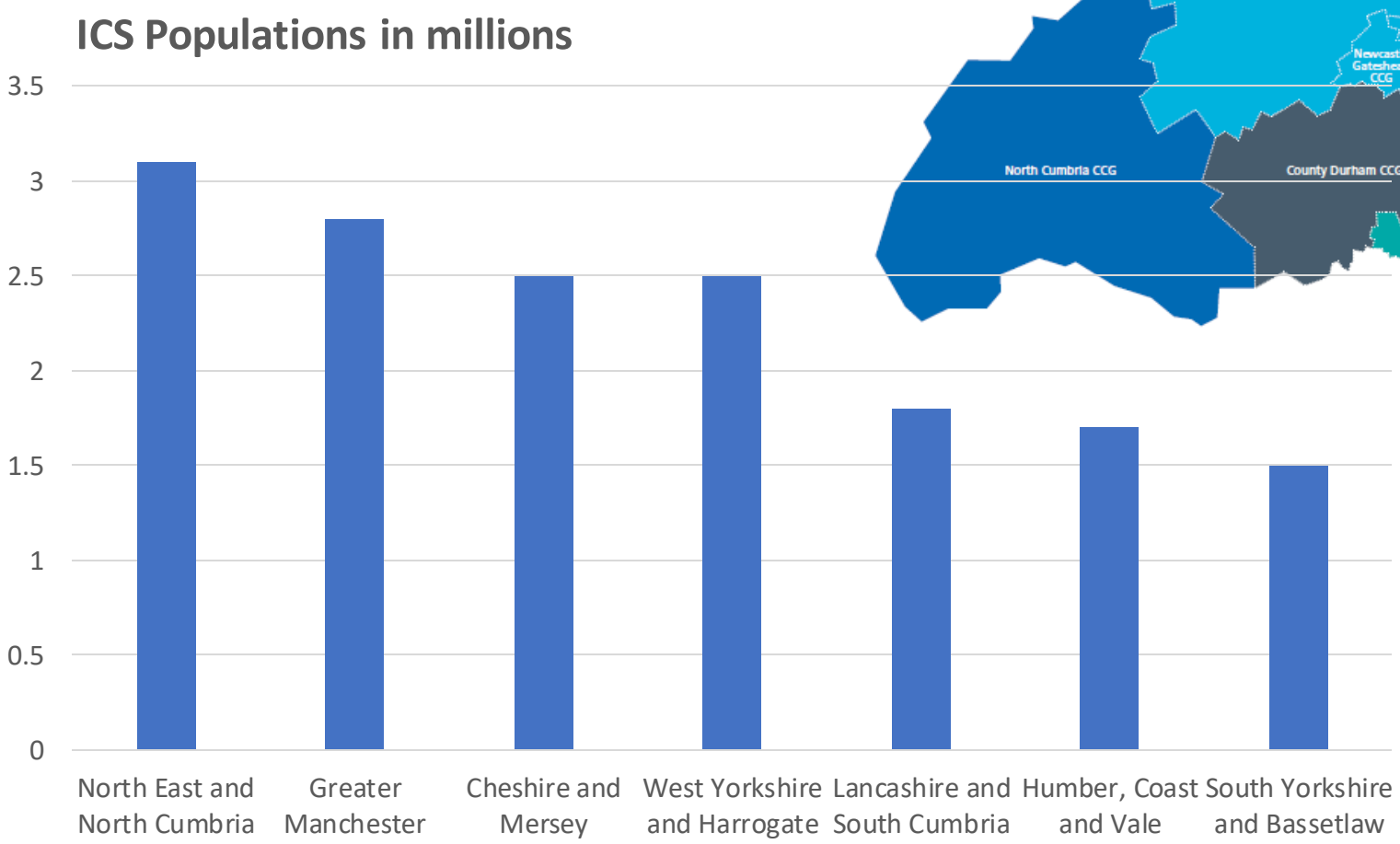
Population: 324,000
1 CCG: North Cumbria
Primary Care Networks: 8
1 FT: North Cumbria Integrated Care NHS Foundation Trust (NCIC)
1 Council Area: Cumbria County Council (with 4 District Councils)
North West Ambulance Service

Tees Valley ICP

Population: 701,000
1 CCG: Tees Valley
Primary Care Networks: 14
3 FTs: County Durham and Darlington, North Tees & Hartlepool, South Tees
5 Council Areas: Hartlepool, Stockton on Tees, Darlington, Middlesbrough, Redcar & Cleveland

North East and North Cumbria ICS





Key areas of focus

- Decisions taken closer to the communities they affect are likely to lead to better outcomes;
- Collaboration between partners in a place across health, care services, public health, and voluntary sector can overcome competing objectives and separate funding flows to help address health inequalities, improve outcomes, and deliver joined-up, efficient services for people; and
- Collaboration between providers (ambulance, hospital and mental health) across larger geographic footprints is likely to be more effective than competition in sustaining high quality care, tackling unequal access to services, and enhancing productivity.

Key areas for development

- ICSs also need to be able to ensure collectively that they are addressing the right priorities for their residents and using their collective resources wisely. They will need to work together across partners to determine:
  - distribution of financial resources to places and sectors that is targeted at areas of greatest need and tackling inequalities;
  - improvement and transformation resource that can be used flexibly to address system priorities;
  - operational delivery arrangements that are based on collective accountability between partners;
  - workforce planning, commissioning and development to ensure that our people and teams are supported and able to lead fulfilling and balanced lives;
  - emergency planning and response to join up action at times of greatest need; and
  - the use of digital and data to drive system working and improved outcomes.

Emerging functions

ICSs are likely to become statutory NHS bodies, taking over CCG commissioning functions, alongside strategic planning and oversight of quality, performance and finance.

Alongside this at Place Level we will see:

'a progressively deepening relationship between the NHS and LAs on health improvement and wellbeing.'

- Centrality of health and wellbeing boards, utilising JSNAs and public insight to inform decision-making
- A leading role for clinical primary care leaders through primary care networks, joining up services in neighbourhoods, linking to other public or voluntary services
- Greater use of population health management to target health and care services

Provider Collaboratives will operate at both place and system level

- **Vertical integration** within places (eg between primary, community, local acute, and social care, or within and between primary care networks) through place-based partnerships
- **Horizontal integration** between places at scale where similar types of provider organisation share common goals - such as reducing unwarranted variation, transforming services, or sharing staff and resources

Challenges

- Recognition that there are some challenges to delivering the objectives;
  - Covid
  - Questions posed recent engagement has seen thousands of entries to the national team that they are working through
  - Whilst this is still in development we recognise on the NHS side there are things we can work on
  - We also recognise that Covid has afforded us all to collaborate better than ever before across LA and NHS

Lots to be proud of..

- Provider collaboration - collective response to Covid:19 – supporting each other when we need it most especially across historical boundaries
- Vaccination programme – seeing more people the region vaccinated than any other area – massive efforts from primary and acute care
- Joint working with Public Health, Social Care and Local Authority colleagues to coordinate response and support those that need it most
- Population Health Management approach across the whole ICS

Important appointment of Chair

- Sir Liam Donaldson appointed as Chair – commencing 1st February
- Previous Chief Medical Officer for England
- Previous Chancellor of Newcastle University
- Advisor for World Health Organisation

What does this mean for Northumberland

- We have a Strategic Coordinating Group – involving partners across Local Authority, Social Care, Public Health, Clinical Commissioning Groups, Primary Care and Acute/Mental health providers.
- Ambition that focuses on ensuring we have the best possible health and well being offer for communities of Northumberland - including environment, transport
- Reminder that we have access to some of the best health and care services in England across Northumberland and therefore have much to be proud of locally
- Ambition that also recognises the importance of economic impact of services especially in light of COVID

MAXIMISING HEALTH AND WELLBEING ACROSS NORTHUMBERLAND

Northumberland joint health and wellbeing strategy – key programmes 2018 - 2028

OUR PLACE

A healthy life wherever you live

Drive health and other inequalities out of our system by working together to improve opportunities for healthy communities, employment, reducing poverty, flexible transport solutions, self-care, prevention and exploring IT and digital solutions wherever possible.

OUR CONNECTIVITY

Technology and digital solutions central to all we do

Northumberland now has one the best super-fast broadband coverage for a rural county across the UK. Not only does this bring our communities together and enable independent living and wellbeing, but it also supports the growth of our economy.

OUR CHILDREN

The best start in life

Helping children and young people to be happy, aspirational and socially mobile. Improving the early life experiences of children will, both directly and indirectly, result in improved health and wellbeing in later life.

OUR CLIMATE

A collective responsibility

All partners have a collective responsibility to act with a conscious and protect our environment.

OUR WORKFORCE

Local, flexible, sustainable

Partners working together, sharing recruitment and skills acquisition strategies to deliver Northumberland's employability and economic growth strategy.

OUR CARE

The highest quality care in the country

Maximise value from, and sustainability of, health and social care services to improve the health and reduce inequalities. People's health and wellbeing is improved through addressing wider determining factors of health that affect the whole community.

OUR COMMUNITIES

Thriving in our unique and diverse urban and rural settings

Empowering people: listening to, involving and supporting our communities and neighbourhoods to help them maximise their health and wellbeing.

OUR CULTURE

We're all on the same team

We have a unique county, amazing communities, strong foundations, the ambition and the people to deliver it. Our dream for Northumberland is that it becomes the healthiest, happiest and most vibrant county in the whole country with the highest quality services.

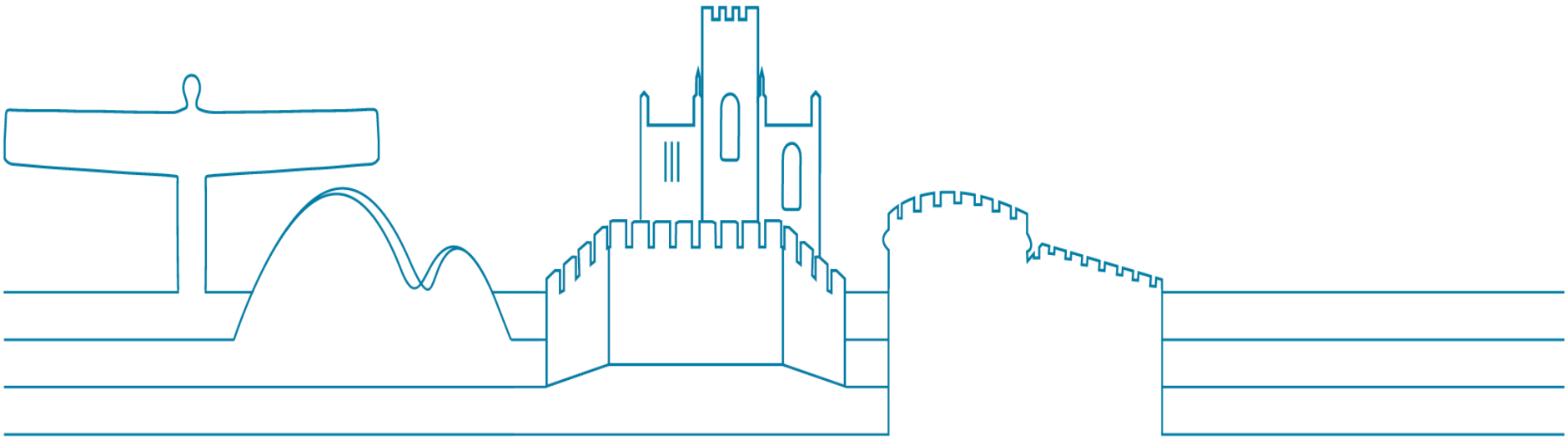
Working more effectively together as part of a whole system approach

Next steps and timeline

- Continued engagement with our partners at both place and system level
- Continue to use our influence as the largest ICS to shape the future direction of health and care policy
- ICSs need to develop a plan to meet ICS operating requirements by April 2021
- Creation of an ICS Partnership Board to be in place by April 2021 – and chaired by Prof Sir Liam Donaldson
- Awaiting further guidance following the engagement paper which was published in November

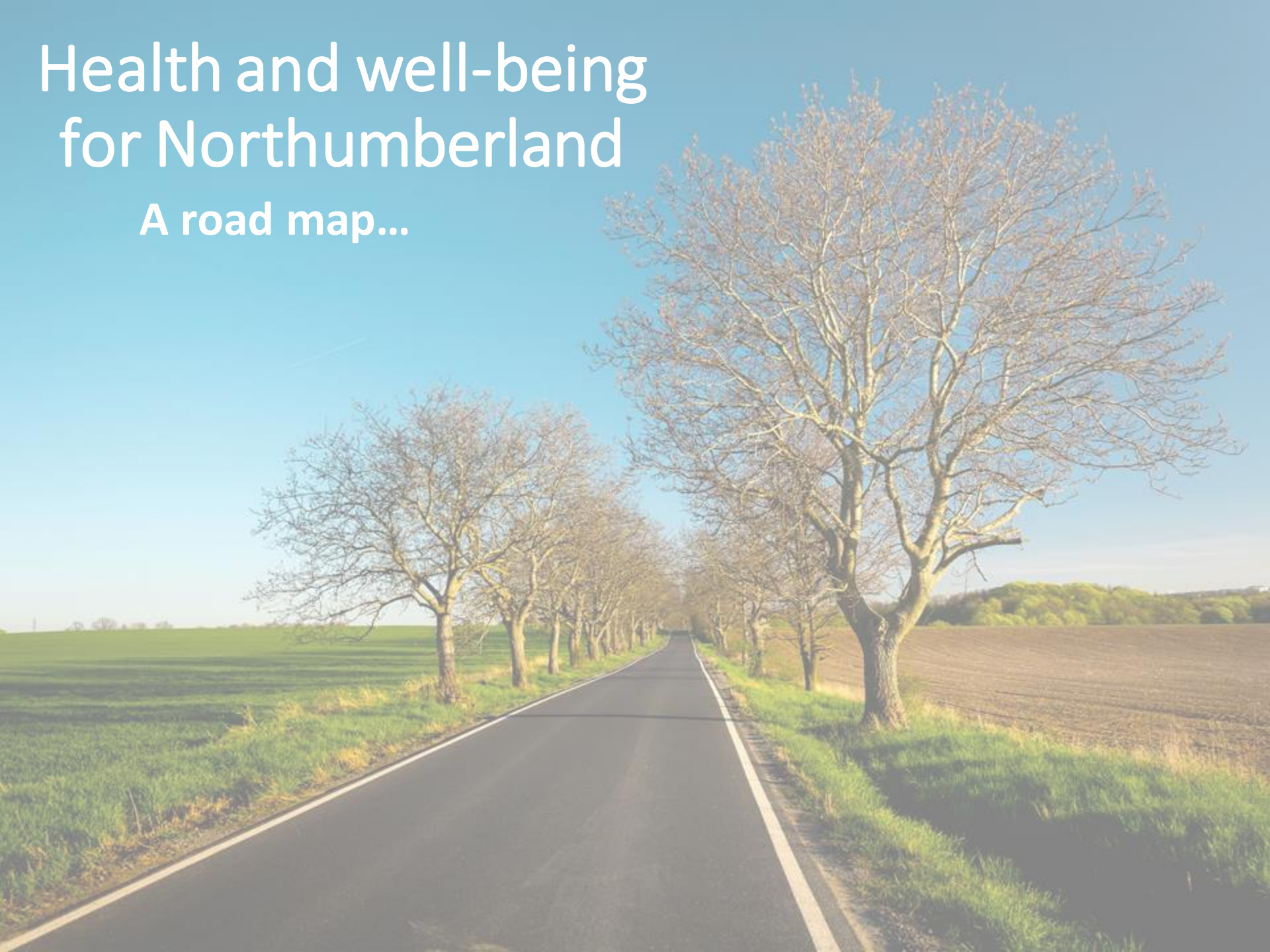
ICS
Integrated Care System
North East & North Cumbria

Questions?

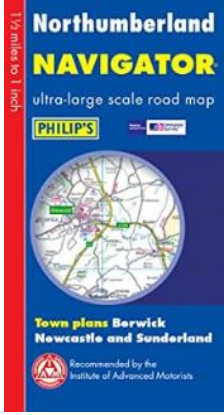


Health and well-being for Northumberland

A road map…



Population Health Management building blocks

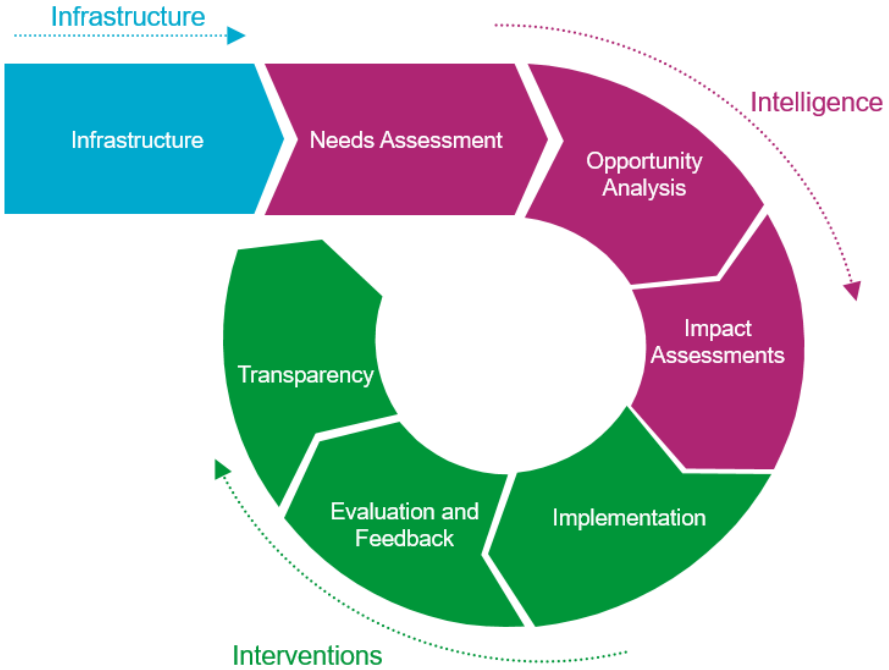


1) Infrastructure

Leadership across the system
Information Governance
Shared datasets
Common language
Defined population

2) Intelligence

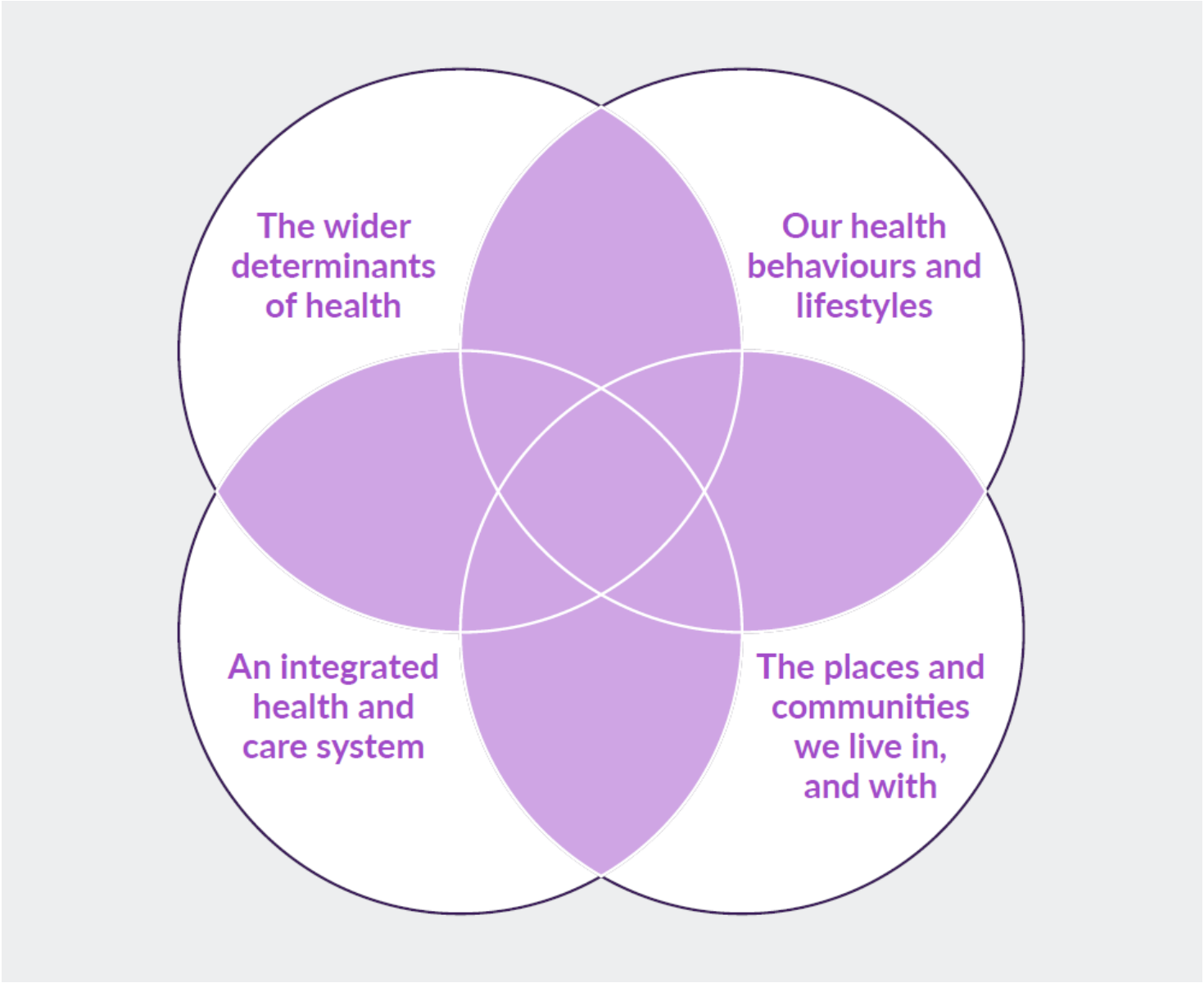
Identify inequalities & Vulnerability
Social and Clinical Evidence
Cohort Selection/Stratification
Prioritisation and Modelling
Community Engagement



3) Interventions

Multi-agency response
Evidence based interventions
Address inequalities
Proactive care
Continuous Improvement

Population health areas



Source: Kings Fund, 2019

Direct impact of actions on health outcomes

Area	Scale of problem in relation to public health	Strength of evidence of actions	Impact on health	Speed of impact on health	Contribution to reducing inequalities
Best start in life	Highest	Highest	Highest	Longest	Highest
Healthy schools and pupils	Highest	Highest	Highest	Longer	Highest
Jobs and work	Highest	Highest	Highest	Quicker	Highest
Active and safe travel	High	High	High	Quicker	Lower
Warmer and safer homes	Highest	Highest	High	Longer	High
Access to green spaces and leisure services	High	Highest	High	Longer	Highest
Strong communities, wellbeing and resilience	Highest	High	Highest	Longer	High
Public protection	High	High	High	Quicker	High
Health and spatial planning	Highest	High	Highest	Longest	Highest

Source: Buck and Gregory (2013)

A case study in brief:

Blackpool: intervention with residents of multiple occupancy housing

PCN cohort identified through the analytics:

- Blackpool identified residents of houses of multiple occupancy, with depression and other health issues.

Locally-designed intervention:

- Holistic and proactive health assessments by health coaches in the PCN.
- Follow-up assessments of social situation by health and wellbeing workers in the council. This included assessment of particular risks to health.
- Signposting individuals to other psychosocial services – counselling, peer support and other social support.

Impact:

- Bringing together multiple stakeholders is important to make and sustain change. *"The programme brought together people who have the same purpose building a sense of camaraderie"* (GP).

Example: 'Barbara' from Blackpool

- The Blackpool team **linked up data on health and housing** to find Barbara.
- As well as suffering from depression, Barbara lived in **poor quality housing,** was **unemployed** and had recently experienced a **bereavement**. She was in rent arrears and using alcohol to help her cope.
- Barbara was assessed by a health coach in the PCN, who arranged for a **health and wellbeing worker** from the council to visit Barbara on regular basis.
- The worker identified severe **risks in the quality of Barbara's building,** and supported Barbara to call her letting agent and get housing support.
- Barbara was **referred to a local charity** to support her with her bereavement, linked up with **employment services** and **supported to build her skills and confidence**.
- **Barbara's patient activation rose from a level 2 to a level 4 during this time,** demonstrating how confidence in managing her health changed with this social support.

A case study in brief:

Pudsey, Leeds moderate frailty patient intervention

Cohort identified through the analytics:

- 80 people, aged 60-74 within moderate frailty segment, multiple Long Term Conditions (LTCs), balance and nutrition issues, not connected to the neighbourhood teams (health or social care)

Locally-designed intervention:

- Proactive outreach with telephone-based triage
- Assess areas of strength and struggle, including how they feel about ability to self manage
- Triage to one of three interventions based on level of self-care ability and need:
    1. Refer to group 'live well' consultation
    2. Individual medical consult in clinic
    3. Home visit led by an OT

Example: 'Paula' From Pudsey

'Paula' is a 63 year old woman with **moderate frailty**. She has multiple medical conditions as well as challenges associated with falls, memory and nutrition. She is not well connected into health and care. Looking at data, clinicians in the programme noticed that **nutrition data was a good predictor of risk**. This insight, together with analytics provided in the programme, identified Paula as potentially needing further attention. **Telephone triage confirmed** this and Paula was visited at home by an occupational therapist (OT). The at-home visit gave a holistic view of Paula's needs, with a focus on preventing falls, enabling better nutrition and improving Paula's ability to self-care. **Paula and the OT had a discussion about her needs and her own personal goals**. The OT identified specific opportunities to enable a healthier lifestyle for Paula at home – for example by enabling easier use of kitchen tools to help her prepare food.

Health Improvement Journey

Infrastructure
Leadership & System Team

Culture
Community Co-design

Resources
Project team "Social movement"

Intelligence
Datasets & Information governance

PHM academy
Senate & Learning arena

Intervention
Map all relevant work already underway to form coherent whole

Project work
(1) Best Start in Life
(2) Emerging Risk cohort (40-56)
(3) End of Life Case Studies

Project work
Finance & Contracting Programme Jan 2021

Ambition
scaling up

Evaluation
Learning system