SOUTHEND INTEGRATION.

REPORT ON AMBITION, PRESENT STATE AND OPTIONS FOR MOVING FORWARD.

PREPARED BY JOHN BEWICK OBE

MAY 2017

OUTLINE DRAFT for consideration V1.0 22/5/17 JB.

Content

1. Introduction
2. Context.
3. Ambition
4. Present state
5. Options for moving forward
6. Appendices
   1. Interviewees
   2. Canterbury New Zealand integrated care model diagram
   3. Southend existing integrated care model

1. INTRODUCTION

Purpose of report

This report brings together a reflection of local views on integration in Southend-on-sea along with an external independent perspective. Its purpose is to inform local leaders in reaching a shared agreement on the best way forward for delivering the benefits of service integration in Southend-on-Sea.

Subsequent work will then be needed to set out a practical programme which would deliver against that shared agreement.

Scope

Southend-on-sea Council, Southend Clinical Commissioning Group and partners are keen to explore options for moving further and faster in achieving improved outcomes for people in Southend through more integrated care delivery systems. In April 2017 the Southend-on-Sea Health and Wellbeing Board asked that a report be prepared to inform options for the way forward.

Through the Better Care Fund, in May 2017, 5 days of independent advice was secured to help build on the present BCF programme, setting out further shared local ambition, the present state of integration, and consider practical options for delivery.

It was agreed as a working assumption that successfully taking integration forward in any local area depends significantly on understanding the particular needs of the population and recognising the particular strengths and energies of local organisations to meet those needs. This work therefore strives to inform finding the right way forward for Southend in its particular circumstance.

Method

Interviews were carried out with a range of people who have key roles in integration including senior leaders and those leading implementation of agreed plans. In addition, existing BCF and integration documents were reviewed. Where appropriate, reflection against other local health and care systems was offered. (Interviewees are noted in appendix 1)

2. CONTEXT

With a unitary authority coterminous with one CCG, Southend has at its core a comparatively simple commissioner organisation structure.

In 2014, Southend Clinical Commissioning Group (CCG) and Southend Council signed a memorandum of understanding that agreed a set of principles and approaches for an integrated commissioning function spanning the council and the CCG with a focus including mental health, frail elderly and children's commissioning. Existing teams were brought together, a Director of integrated commissioning appointed (a role jointly funded) and a work plan agreed.

From past performance the Southend BCF system is assessed by regional bodies to be capable of delivering against the core expectations 2017/19 BCF. It is assumed Southend is intending to take service integration beyond this core level.

In broad terms, Southend service provision comprises Primary Care, (assessed as being amongst the weakest overall in the country), Essex Partnership University NHS Foundation Trust providing Community and Mental health services in the community, social care from the Unitary Authority and Southend University Hospital NHS Foundation Trust having a predominantly acute focus.

There is a relatively strong sense of place. Localities within Southend as a basis for delivering integrated services have been comparatively easy to agree. While there are now 5 CCGs and three councils within the Sustainability and Transformation Plan (STP) footprint, the sense of needing to retain a local Southend sensitivity to deliver integrated networks of care locally is strong.

There is a general view locally that Southend's proximity to London for commuting along with its geographical position bounded by estuary and sea may contribute to Southend being a little isolated, finding recruitment and retention sometimes a little challenging and at the same time promoting a can do culture of just getting on with things together locally.

In summary there is a view that while much has been achieved and relationships are relatively strong in Southend, there is an ambition to move further faster that sets the context for this report. Do nothing is not an option.

3. AMBITION

There is a clear and consistent expression of ambition across senior leaders and those leading implementation of service integration.

This can be summarised to include:

Ensuring the local population keeps as well and as independent as possible, enjoying the best mental and physical health outcomes possible within the overall allocation of resources available to Southend.

Pursuing a wide scope for the local care delivery model for integration to ultimately include all local services and resources in Southend which if integrated would better avoid illness, crisis and becoming dependent. Go well beyond the core health and care integration in BCF. Combining an assets/ strengths based approach to community development which avoids unnecessary illness

and care needs with excellent provision of traditional illness and care services when people do have a need.

To achieve the ambition above, strengthen ways off working together including:

1. Having a comprehensive analysis of the comparative position of Southend and its localities, both in terms of social and health outcomes and the cost of services to know the greatest opportunities for improvement through integrated services.

2. Having a clear integrated care delivery model for implementation over a set time scale agreed across stakeholders.

3. Always putting the needs of local people before the needs of organisations, considering organisational form changes against the test of whether they would better enable the integrated care delivery model to function.

4. Having clear processes to positively manage the risks of moving from effective pilots to systematic implementation at pace and scale.

5. Having an integration forum with appropriate time allocated where the collective strategic will of the local system can be set out and agreed and where mutual accountability for delivery can be exercised.

In summary, Southend has a clear and consistent ambition both for what more integration can achieve for local people and for addressing the necessary system, process and organisational issues to get there.

4. PRESENT STATE

While comparatively good progress had been made on integrated commissioning arrangements and specific provision pilots and projects, views were expressed that the move to systematic implementation of integrated services could be moving further and faster. The main characteristics of the present state include:

1. Several views were expressed that Southend system does not presently have a clear, easily accessible analysis of the present comparative state of Southend in terms of population outcomes and potential opportunities to release resources across Southend for reinvestment. It was noted that some local areas nationally have or are commissioning such analysis as a basis system wide integration business cases.

   Progress is recognised on integrated commissioning and the resultant delivery of several innovative and successful integration pilots and schemes such as the harnessing of Complex Care Co-ordination service. The Better Care Fund, while expected to be agreed locally within national expectations, was seen as still comprising some previously existing, legacy schemes. It was felt there is the potential to now move beyond this, widening the scope of integration and deepening the commitment for, example as the pooling of significantly more resources if the business case and gains can be identified.

2. There is a sense that progress to achieving the full potential improvements in outcomes for local people and release resources trapped in avoidable more acute service episodes could be moving further and faster, pilots and projects could become systematic Southend wide programmes sooner. The challenge is seen as moving from incremental to step change progress.

3. Good demonstrable leadership of specific operational schemes was seen. However there are observations that a very senior leadership commitment to a specific care delivery model backed up by specific business cases, gain share arrangements and enabling

systems such as information technology and workforce development would be very helpful to move further faster.

4. There was a general leadership view that any organisational change should derive from its potential to better deliver the agreed care delivery model, and should not be an end in itself. In summary, form should follow function.

5. It was noted that developing the commitment of providers to work together systematically in an integrated model can be challenging with examples given of limited progress against ambition when providers or professionals within providers were not fully committed. It was noted that in terms of commitment to lead and coordinate complex integrated service delivery across the system, the presence of a lead provider or effective joint arrangements may not be as strong as is now needed.

6. It was clear that in common with many local systems across the country, changes in organisational leadership means that not everyone is aware of agreements and arrangements already in place and there is a constant need to refresh knowledge and commitment. It was noted that whilst there was a consistent commitment to locality based integration, both in the STP and from existing Southend based work, the specific scope and scale of the Southend Care delivery model was now varyingly understood.

7. It was noted that across the country, while there is clear statutory governance to take decisions within individual organisations, there are relatively weak comparable governance arrangements to take system wide decisions across organisations and to monitor progress on implementation. It is noted this is a common situation with varying arrangements being put in place to address this dependent on local circumstance. It was noted that in Southend, the existing arrangements of the HWB in terms of frequency of meetings, the balance of time in those meetings to develop a shared purpose and strategy across local organisations, and the system governance exercised through the HWB may not presently be sufficient to take an ambitious integration agenda forward.

5. OPTIONS FOR MOVING FORWARD

Derived from the gap between the ambition and present state above, it is proposed that there are four main areas leaders may wish to consider for agreement to move Southend forward. These are:

1. The specific benefits of integrated service delivery in Southend: outcomes, service, financial

2. The scope and scale of the care delivery model needed to deliver those benefits, over time.

3. The specific organisational arrangements to best deliver the care delivery model.

4. The local system wide arrangements for making binding decisions, allocating lead responsibilities and holding to account.

In each of the above, recommendations are set out to inform leaders' consideration and agreement. They are not exhaustive but attempt to focus on the critical issues, suggesting options where they exist.

The specific benefits of integrated service delivery in Southend: outcomes, service, financial

Moving beyond a general commitment to integrated working and the relatively limited core expectations of delivery in the existing BCF requires significant commitment from existing organisations and their leaders to change. Being clear about the benefits to local people in terms

of outcomes, improved services and resources released for reinvestment is a key factor in gaining that level of commitment, and is the basis for agreeing any gain share across organisations. Comparative analysis to other systems nationally and internationally is often a powerful contribution.

Recommendation: that stakeholders at the HWB request a comprehensive quantified analysis of the potential benefits of integration in Southend. This to be specified by the existing integrated commissioner team, in liaison with stakeholders.

Option: existing service, performance and finance teams across organisations deliver the specified analysis with an agreed coordinating lead

Option: engage an external expert resource to deliver the analysis engaging existing service, performance and finance teams as appropriate.

The scope and scale of the care delivery model needed to deliver those benefits, over time.

There is a wide range of ambition and interpretation of what an integrated care delivery model comprises across the country. As brief illustrations, in the BCF an early focus in some local systems was the bringing together of existing admission avoidance and discharge arrangements to positively affect the level of non-elective admissions to hospital. In some cases existing separate health and care services were badged within BCF programmes as making a contribution to that aim. It is sometimes the case that longer term preventative strategies have struggled to make their case in the one or two year planning frameworks.

Looking internationally, the Canterbury integrated system in New Zealand (appendix 2 diagram) is noted as being a good example of a much wider, holistic interpretation of integration reaching from self-care, healthy environments, community asset development, through housing, recreation and effective service signposting to appropriate, timely health and care services and access to excellent acute services when needed. The Alzira integrated healthcare model in Spain is an often quoted example of integration of predominantly healthcare services striving to reduce the amount of unnecessary use of acute services through effectiveness and efficiency.

Nationally, Torbey is striving to fully integrate community asset development, social services and healthcare services within one integrated care organisation, achieving some of the lowest delayed discharges in the country. Rotherham is striving to build wide based locality teams including health and care, community resources, housing and children's services, focused on meeting the particular needs of each locality with a more integrated targeted response.

The challenge for Southend at this stage in its journey, in common with many local areas striving to work together to better integrate services may be to agree more specifically what is in and out of its integrated care delivery model over an agreed timescale.
This would better enable firm commitment to delivery. Set against its ambition and the quantified potential benefits to local people, what are the activities that Southend is committed to integrate within localities (sometimes called horizontal integration), and along the pathway into and out of hospital (sometimes called vertical integration)?

Recommendation : That the leadership community confirm its shared strategic ambition for the further development of the integrated care delivery model in Southend comprising some or all of elements below:

developing the locality based, preventative and community asset development model harnessing the agreed local leadership of this agenda, also identified in the STP. Ensuring links to benefits of reduced acute episodes and resource release are identified.

developing the aspects of the integrated care model that use pathways into and out of existing shared acute facilities, working with neighbouring areas that have those same acute facilities in

common

developing the necessary infrastructure to support the care model.

Recommendation : that the HWB commission the integrated commissioning team to lead a review of the existing integrated care delivery model for Southend (appendix 3) against the agreed ambition, analysis of quantified potential, and know best practice nationally and internationally.

Recommendation: that a firm, costed business plan is agreed for staged implementation of the care delivery model over time.

The specific organisational arrangements to best deliver the care delivery model.

Across the country, various forms of new organisational working arrangements related to developing better integration of services are being considered, including better working between existing organisations, devolution, Accountable Care Systems and Accountable Care Organisations. More traditional rationalisation of services to achieve safer, higher quality of care and more efficient use of resources also continues as do mergers and acquisitions in the NHS.

The boundaries between commissioning and provision established in the early 1990's are being questioned in the search for more effective organisational arrangements. At the heart of some of these shifts is the idea that a capitated approach to funding services against agreed outcomes for a population in a place would remove some of the present mechanisms such as payment by results which at worst potential rewards activity which should be avoided, and cost shunting between separate health and social care organisations rather than overall resource release.

Given its ambition to deliver the benefits of integration for local people, Southend leaders will, at the appropriate stage need to consider what, if any, organisational integration best delivers that ambition.

This may be best considered in the light of the agreed care model and overcoming any barriers to delivering that model. It is noted that organisational change options are being developed within all STPs as part of delivering that agenda and the local integration agenda will need to recognise and work with those developments.

At this stage it may well be helpful to simply set out the range of organisational options and any proposed organisational developments deriving from the local STP process.

Recommendation: that the existing integrated commissioning function in Southend is reviewed in relation to:

the service scope of the commissioning function

the depth of integration in relation to pooling budgets and jointly commissioning the development of infrastructure.

the best balance between commissioning and provision moving forward, namely the balance between strategic commissioning that sets improvements in outcomes expected within allocations, and provision which is given the responsibility to propose effective provision arrangements and design services to deliver against that strategic commissioning intent.

the use of appropriate collaborative and procurement approaches to achieve the desired results.

Given the strong indication in the ambition locally that wider, deeper locality based integration of services is intended, a particular issue is the development of the provider market to have providers capable of delivering integrated service delivery models in localities.

Recommendation: that the issue of how best to coordinate provision of services within a locality is option appraised. Options include:

Option: commissioners coordinate service provision commissioned from each existing provider

Option: a lead provider is awarded an overall contract allocation with other providers working to the lead provider

Option: if none of the existing providers are considered in a place to fulfil the lead provider role, an independent, locality based provider coordination contact could be tendered.

Option: existing and new providers could work with partner providers to propose new forms of integrated provider organisation.

The above should be subject to an options appraisal, recognising the strengths and weaknesses of existing providers and potential new providers.

The local system wide arrangements for making binding decisions, allocating lead responsibilities and holding to account.

The considerations and decisions set out above are significant and will require a collective will across existing leaders of organisations to take it forward. It is recognised that existing ways of working may need to be strengthened to secure the commitment to a shared vision and implementation programme.

Recommendation: that consideration is given to the most suitable system wide arrangements to take Integration forward in Southend

HWB have limited statutory duties to

to assess the needs of their local population through a JSNA

to set out how these needs will be addressed through a joint health and wellbeing strategy.

to promote greater integration and partnership, including joint commissioning, integrated provision and pooled budgets.

Some HWBs across the country have taken on a bigger role moving towards acting by mutual agreement as a place based, one budget commissioner.

In other areas, HWB's have remained primarily active in the preventative public health arena and other place based forums have been created for the full agenda, or the STP is developing to take the place based lead.

Option: strengthen the existing place based role of the Southend HWB so that it can effectively enable local organisations to take forward the integration ambitions of Southend.

Option: create a separate, place based partnership forum with appropriate system governance to agree and take forward the integration ambitions of Southend.

Option: use the STP local health and wellbeing work stream as the partnership forum

6. **Appendices** to be added