On the right track

In the next few months integrated care systems will become pivotal in the bid to transform care in England. A recent HFMA roundtable, supported by Grant Thornton, looked at the steps they are taking, and the tools they are adopting, to speed up improvements in the quality and efficiency of care. Seamus Ward reports

HFMA ROUND TABLE

The time for talking about what system working will look like is almost at an end, with Parliament poised to pass legislation that will make integrated care systems central organisations in a new, collaborative landscape.

ICSs will be expected to drive forward the transformation of NHS services, and, by bringing together health and care organisations across geographical boundaries, offer a chance to rethink how care is delivered.

The opportunities are great – but how will systems set about taking the practical steps needed to deliver this objective?

The question was discussed at a recent HFMA roundtable, supported by Grant Thornton, which asked the question: how can integrated care systems accelerate healthcare transformation?

Currently scheduled to begin work in July, three months into the new financial year, the new systems will not have an easy first year. The operational and planning guidance for 2022/23 asks a lot of them – continuing to deliver the response to Covid-19, tackling health inequalities and making significant in-roads into the lengthening waiting lists, while taking out cost and finding further efficiencies.

Malcolm Lowe-Lauri, head of health and life sciences consulting, public services advisory, at Grant Thornton, said ICSs had the potential to bring about transformation, but they had to think creatively. There was a tendency to solve problems by asking for more – more staff, more infrastructure – rather than trying imaginative, broad-based solutions.

In its work with health bodies across England and health boards in Wales, he said Grant Thornton had seen problems addressed creatively, particularly during the pandemic, and this spirit had to be retained.

The roundtable acknowledged a clear intersection between the planning guidance spotlight on waiting times and the need to tackle health inequalities.

Systems have focused quickly on population health, and particularly on inequalities, Mr Lowe-Lauri said.

'When we are talking to clinicians and executives about what their future clinical models and clinical strategies would be, it is very much targeted at vulnerable segments of their population and how to address longer term issues. This is more than a traditional acute service perspective.

'The point of the conversation is changing. And, as we get into planning for those groups, there is, to coin a phrase, a bit of levelling up there – how we might deal with more vulnerable populations for whom services are less accessible,' he added.

Hannah Witty, chief finance officer at

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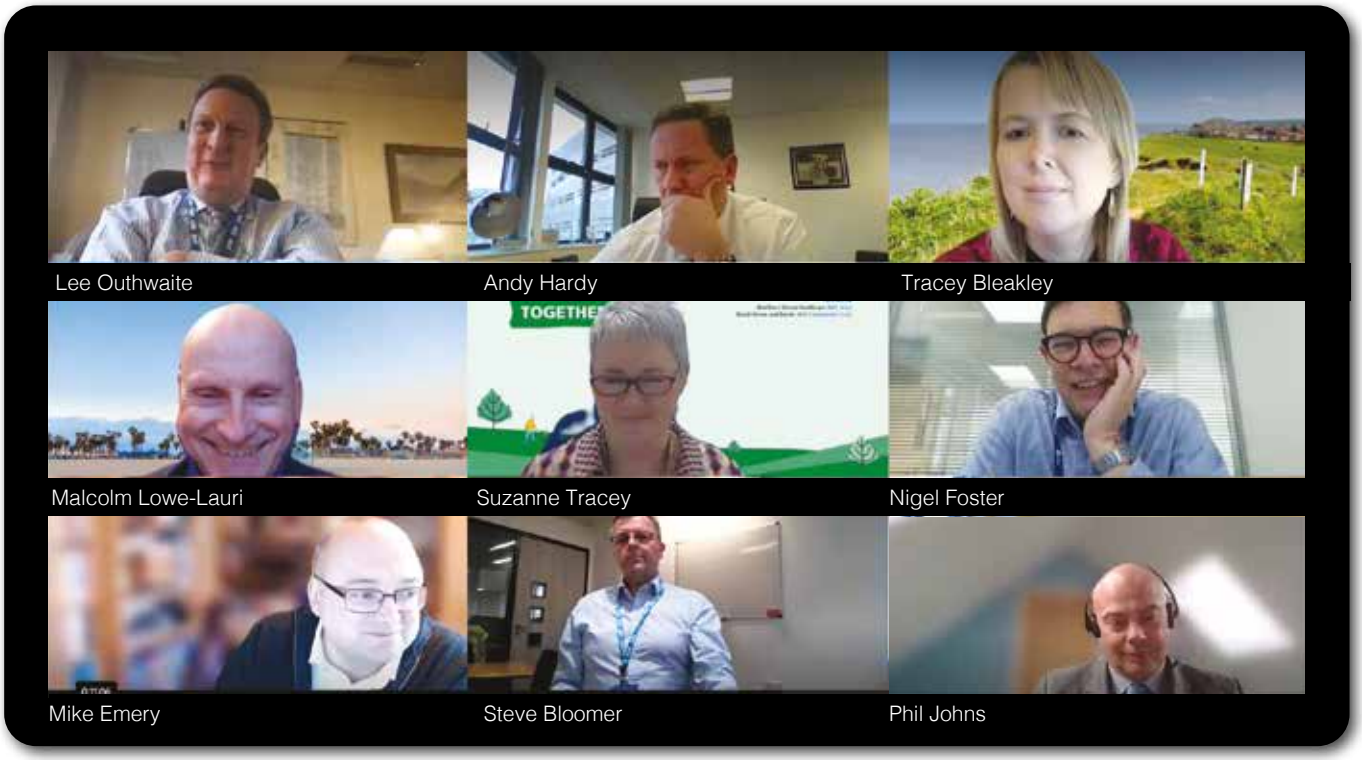

Central and North West London NHS Foundation Trust, asked where accountability for addressing health inequalities should sit across systems – which services should be offered at place level, for example?

Systems had a key role to play in the provision and analysis of data, including how inequalities are having an impact on the needs of people attending A&E, or whether they led to accessing care much later, adding unnecessary cost.

Systems must provide the right data to stimulate and inform conversations on place-based needs and subsequent pressure on acutes, Ms Witty said, adding that it was important these conversations included local authorities and the voluntary sector, as well as all NHS providers.

Community access

Community-based organisations, including faith leaders, had played a huge role in increasing vaccination rates, and similar help had to be enlisted to address inequalities.

'We need to make our services more available in a way that works for these communities to address current inequalities,' said Ms Witty.

'It's about how you give those local providers the platform to reach into the communities, to ensure that they are accessing services in a way that works for them, and ultimately treating them in our less expensive settings, in places that are closer to home, in places that work better for them.'

Lee Outhwaite, chief finance officer at Chesterfield Royal Hospital NHS Foundation Trust and Derbyshire Community Health Services NHS Foundation Trust, believed that in a post-commissioning NHS 'we won't have anyone to blame when the money runs out'.

'We need to do something different now, and we have got to think about practical alternatives about how we defragment care.'

A different community and third-sector response to chronic disease and frailty was needed, for example.

'If we were really to lean into what we are trying to do about different partnership working around chronic disease and frailty, a lot of the other priorities within that overall planning framework might sort themselves out,' said Mr Outhwaite.

An alternative service could mean, for instance, social prescribers in the local community trust, enabling referrals to Citizens Advice for help with benefits claims.

'This is about getting into the real causes of why people sometimes get into NHS services and get medicalised in a way that they don't need to,' continued Mr Outhwaite. 'It's

Participants

- Tracey Bleakley, Norfolk and Waveney CCG
- Stephen Bloomer, North West London CCGs and Integrated Care System
- Lee Bond, Hull University Teaching Hospitals NHS Trust and Northern Lincolnshire and Goole NHS Foundation Trust
- Mike Emery, Herefordshire and Worcestershire CCG
- Nigel Foster, Frimley Health NHS Foundation Trust
- Andy Hardy, University Hospitals Coventry and Warwickshire NHS Trust
- Phil Johns, Coventry and Warwickshire CCG and Coventry and Warwickshire ICS
- Malcolm Lowe-Lauri, Grant Thornton
- Lee Outhwaite, Chesterfield Royal Hospital NHS Foundation Trust and Derbyshire Community Health Services NHS Foundation Trust
- Peter Saunders, Grant Thornton
- Suzanne Tracey, Royal Devon and Exeter NHS Foundation Trust and North Devon NHS Trust
- Hannah Witty, Central and North West London NHS Foundation Trust

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about building and propagating that work. I think a lot of people are getting into that space, but it's different and it's novel, and it's contentious. And it isn't measured in finished consultant episodes.'

University Hospitals Coventry and Warwickshire NHS Trust chief executive Andy Hardy said the integration agenda had led system partners, including acute providers, to talk about and address health inequalities. Attendees agreed that data would play a central role in bringing forward such a system-wide response.

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'We've got so much data between us that previously we would have never shared or triangulated,' Mr Hardy said. 'It starts to give us a feel for what patients are actually getting access to or not getting access to.

'We've analysed the patients we've treated on an elective basis since the beginning of Covid, and I'm ashamed to say that, through no fault of our own, we identified that in all but one specialty, people in the most affluent postcodes we serve are the ones who have been treated the most. They are playing the system better. They've got personal agency.'

Tackling the backlog

How the NHS addresses the current estimate of six million people waiting for treatment in England could have a positive or negative impact on inequalities, he added.

The Coventry and Warwickshire trust has created a tool to see the individuals behind the numbers. Mr Hardy explains: 'We look at what difference we can make by treating person A quicker than treating person B. We can share that tool, which is quite enlightening.'

But going further could raise ethical questions – for example, if two people are waiting for a hip replacement and one is economically active and the other retired, should this be taken into account when prioritising their cases? 'Are we going to get into these conversations?' asked Mr Hardy. 'I think we need to.'

An analysis of waiting list data over the previous 30 months in Frimley Integrated Care System – which included shared data between health and local authority partners – did not find any significant variation in terms of ethnicity, deprivation or any other common indicators, once a patient had joined the waiting list.

However, for Nigel Foster, executive director of finance at Frimley Health NHS Foundation Trust, who also has responsibility for data and analytics and estates across the ICS, this raised questions. 'For me,' he said, 'it was about how to move the analysis back earlier – because it's not about who is on the waiting list, it's about those who are not on the list and perhaps should be.

'Also, given the size of the backlogs we all have, one of the key bits of work will be trying to maintain people's health while they're on the waiting list,' continued Mr Foster.

'That's a particular focus for us at the moment with our *Waiting well* campaign, which for the next two or three years is going to be pretty important for all of us.

Data opportunity

Using data to help make decisions about healthcare services, and how they can be improved, is not as simple as pressing a button. Roundtable participants heard that there were barriers to the use of digital information, including restrictions from regulators. But solutions may be available.

Provider collaboratives could have a role in analysing this data to augment care and defragment it, so that it is delivered by the most appropriate provider and in a more efficient way.

Mr Emery said there had been mature discussions on data sharing across his local system in Herefordshire and Worcestershire. He agreed that providers had to be at the heart of this activity.

But systems also had to have a 'grown up' conversation with the public about the uses of their data. In Wales, the NHS has made a data promise to the public, committing to use individuals' data to improve their health and make better healthcare decisions.

Hannah Witty said a study in North West London analysed mental health data, partly to inform spending decisions under the mental health investment standard, targeting it where it will benefit patients most.

Getting the green light from information governance colleagues felt like a long process, she said, though she fully appreciated they have an important job protecting patients' data.

But, having brought together multiple datasets across local authority areas, they are now able to begin identifying the hotspot areas where investment is needed. The work was commissioned by the mental health provider collaborative, but upcoming workshops will bring together a range of organisations, including local authorities, to agree practical steps from the issues raised in the analysis.

Three priority areas are emerging – as well as hotspot areas where there are mental health needs now, they are examining future demand, working on the hypothesis that further unmet need for physical and mental health services will be found. And, later in the planning cycle, there will be an opportunity to review and specify how services are delivered – the analysis has identified variation in service provision.

'It's about engagement with those communities, engagement with the voluntary sector in those places, with local authorities and with the communities themselves, where you can really start to transform the service offer to meet the needs of that community,' she added.

Mr Lowe-Lauri said some systems were at the early stages of using their data, discovering the information they hold, but there were wide variations in quality. 'There's something about data quality and getting that right. There's something about using the data you've got intelligently to attack specific disease areas, and there's something about just finding out where you're at to connect up the dots,' he said.

• The HFMA's *Integrated care system finance and governance guidance map* brings together key resources for ICSs – see hfma.to/mar221

"It's about how you give local providers the platform to reach into the communities"

Hannah Witty

'I think there will be different rates of deterioration of our patients while they're on that waiting list and that may well come back to differences in terms of inequalities.'

Longitudinal datasets allowed the NHS to look at the long-term impact of care on individual patients, added Mike Emery, director of digital strategy and infrastructure at Herefordshire and Worcestershire Clinical Commissioning Group.

'We have a huge opportunity to make better use of our data because we're beginning to see the tools that can mine it and use it, which is really exciting.

'It's all very well having the data – we need to understand whether some of those interventions are successful and measure those impacts.'

Systems must work with primary care networks (PCNs) to provide appropriate information and analysis to primary care networks, Mr Emery said.

'They've got a really important role to play. We are working with our primary care networks to see how data is best presented and facilitate the discussions about how they can identify where PCNs and partners can target their interventions.'

Analysis had to be relatively easy to understand. 'If I present them with a very complex data analysis, that's not going to work. It's got to be meaningful, and we've got to develop something jointly, we've got to understand how it's going to make a difference to their practice and their patients.'

Complexity issues

The complexities of systems will make it difficult to tackle health inequalities, the roundtable heard. Lee Bond, chief finance officer at Hull University Teaching Hospitals NHS Trust and Northern Lincolnshire and Goole NHS Foundation Trust, until recently led the finance function at Humber Coast and Vale Integrated Care System.

The demographics of the system – ageing and relatively affluent in Harrogate to the north of the patch, but with some of the most deprived wards in the country in Hull and Grimsby to the east – make it tricky to address inequalities across the whole patch in a way that everyone recognises and supports.

Mr Bond said: 'If I go to the north of my patch, and say: "We're going to level up over the next five years and focus on the most deprived areas at the expense of your populations", they may find it intellectually hard to resist, but quite clearly they would say: "Hold on a minute, our populations have needs as well".'

"This is about getting into the real causes of why people sometimes get into NHS services and get medicalised in a way that they don't need to"

Lee Outhwaite

Bridging that gap is a massive challenge facing ICSs. 'This will start to manifest itself when we understand the financial aspects of what we're being asked to do over the next one to three years,' said Mr Bond.

'That will put a fine point on it, and I think it will draw some people out in terms of whether or not they're just talking about integration and levelling up, or whether or not they actually mean it.'

Steve Bloomer, North West London (NWL) Integrated Care System chief finance officer, said proposals to move funding from one area to another can be challenging as moves between local authority boroughs can attract the attention of politicians.

'One of the more successful tactics in NWL has been to target our new money or investment funding into the areas of need based on our inequality data,' said Mr Bloomer.

'An example of this is to increase the investment in some out-of-hospital services to improve outcomes on diabetes in a particular borough. We are aiming to do the same in all areas of spend, including primary care, where we are trying to level up.'

Practical process changes can help too. The local acute provider collaborative has a shared waiting list, allowing patients to be moved to different providers as places become available.

This has made a difference, said Mr Bloomer. However, he acknowledged that this may not be useful in other parts of the country, where the distances between providers are greater.

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Philip Johns, acting designate chief executive for Coventry and Warwickshire ICS, who previously served as ICS finance lead for Birmingham and Solihull, said the system was trying to work at place level. This made shifting funding easier as it was moved within, rather than across, council boundaries. It was also relatively easy to target primary care funding on deprived areas.

He added: 'We know the answer to waiting lists isn't more acute care. We know we have to sort out waiting lists. But at what point are we going to shift resource – which we have talked about for many years – into community and voluntary settings? How do we deal with the consequences of that?

'I don't have the answer to the latter – how we deal with the huge amount of fixed cost we are then left with – but given the size of current waiting lists, we are probably three or four years away from that.'

Mr Foster echoed the roundtable's thoughts on the power of bringing together multiple datasets, but warned against getting bogged down in figures and trends.

'All of this analysis is a waste of time unless we actually use it and do something different,' he pointed out.

He was starting to see some local practical examples based on shared data. For example, in one part of the Frimley system, GPs can see in real time if one of their patients presents at the hospital emergency department. One GP is using that information to call their patient to see if that is the best place for them – offering a GP consultation if appropriate.

He said the balance between what provider collaboratives should do and the role of ICBs is still up in the air.

'One view of the future might be a relatively small role for an ICB but a massive role through provider collaboratives,' said Mr Foster. 'The balance could be different in different parts of the country.'

There was a danger of all ICBs looking the same, he added. 'Local systems need to stand up for what they believe to be the right thing in their patches, and not just follow the national guidance on everything.'

Roundtable chair Suzanne Tracey asked what behavioural and cultural changes were needed to help ICBs drive transformation forward. Overall, attendees agreed systems had to adopt different ways of working, and rediscover the levels of co-operation that had happened during the early months of the Covid pandemic.

They also insisted that the NHS should not

"[The next few years] will draw people out in terms of whether or not they're just talking about integration and levelling up, or whether or not they actually mean it"
Lee Bond

get bogged down in discussions over individual organisations' responsibilities.

Mr Outhwaite said he thought the service needed to focus on optimising its use of beds. 'I don't think it's an enormous academic problem; it's a perfectly factual problem. We didn't manage to do some of that well with the commissioning-provider split because we had a way to conduct ourselves through silos that didn't help.'

For example, understanding which care homes needed more GP and community support could reduce hospital admissions of this group of patients, freeing up hospital staff to provide preventative care.

'There's no need to talk endlessly about the vehicle – what it looks like, what's the colour of the wing mirrors – as opposed to the destination and what we are trying to do differently,' he added.

GP questions

The GP contract can be a barrier to place-based working and engaging with family doctors, according to Mr Hardy.

'There are some fabulous GPs out there, but the current model for contracting with them makes some integration, some transformation really, really difficult.'

Mr Lowe-Lauri agreed with this to an extent, but he felt optimistic as frontline doctors were engaging with discussions on clinical strategy against the background of a new hospital build or implementation of a population health programme. He pointed to a determination not to revert to pre-pandemic ways.

'What I'm seeing is an opportunity to harness some momentum about redesign that is system-wide. It's not necessarily institutional, and there's an onus on us to exploit that.'

Better engagement and support for GPs and primary care networks is vital, said Mr Outhwaite. Clinicians had to be encouraged out of their silos, he added, giving the example of an acute frailty lead who did not know the local community frailty lead, and a GP who did not know the community trust frailty lead.

'It is unsurprising, if those three people have never spoken, that we deliver fragmented care,' he said.

'It's not big moon-and-the-stars stuff we're trying to correct; we're trying to link different clinicians in different care contexts together to have a conversation. Seemingly we've not done this terribly well. It's about micro conversations, a social movement for change, linking people to other people. Some of the new architecture will help, I hope.'

Mr Bond detected a change in the mindset of younger GPs, who are looking for a better work-life balance than their older colleagues. 'In conversations with GPs coming out of medical school,' he said, 'they said they would quite happily take flexible contracts with acute organisations where they can start to blur those boundaries between acute care and the work they might do in primary care.'

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Finance call

The need for finance teams to do things differently was raised by Nigel Foster.

'I'm hearing a lot of very traditional talk from people about not being able to live within the budget they have currently, and cost improvement schemes that are very traditional and not very transformational. As health systems, we have got to get the focus on doing some things differently over the next two or three years.'

North West London FT's Hannah Witty added that planning for the future should start 'from the ground up' in community and primary care, rather than just at acute trust level. While some acutes needed investment or rebuilding, systems should look at alternative ways of providing services.

She continued: 'You need to have a look at the estate that sits across local government, and the virtual opportunities too. Maybe some of that investment in acutes would have been better channelled into those upstream services to enable them to meet that demand at source?

'You could invest in something that's a more agile space to provide services that can be more responsive, as opposed to putting all the investment into something that's going to be standing for years and years that doesn't have that agility.'

ICSs have a huge agenda in front of them. They are looking at how they can harness the power of data analysis, tackle health inequalities and waiting lists in tandem, change cultures and make new connections as they seek to transform services, making them better for patients.

But it's clear that 'getting on with it' is at the forefront of their thinking.