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# Barnet Integrated Care Partnership (ICP)

## The journey so far

January 2020



# Objectives

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The objectives for the session are to understand:

1. Different types of integrated care;
2. The NHS Long Term Plan ambitions;
3. NCL approach;
4. Progress of the Barnet Integrated Care Partnership

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## 1. Different types of integrated care

# Integrated Care

- There is **no single agreed definition**, but a variety of perspectives, concepts and models.
- At its core, integrated care is: joined up care, prevention and self-care.
- Integrated care may be judged successful if it contributes to better care experiences; improved care outcomes; delivered more cost effectively.

**Reference:** World Health Organisation: Integrated Care Models: An Overview, 2016

# Perspectives of Integrated Care

## Provider

Coordinate services, tasks and patient care across professional, organizational and system boundaries

## Care professional

Advocate for service users; provide and coordinate health and social care

## Manager

Build and sustain shared culture and values; maintain oversight of pooled resources and funding streams; coordinate joint targets; supervise diverse staff; manage complex organizational structures and relationships

## Policy-maker

Design integration-friendly policies, regulation and financing arrangements; develop appropriate care systems, processes and quality standards; support holistic evaluation of integrated systems and programmes

## Service user/carer

Experience improved access and navigation across elements of care, including information-sharing

## Regulator

Register integrated providers; assess care provision; monitor joined-up care; eliminate poor quality and safety

## Integrated care

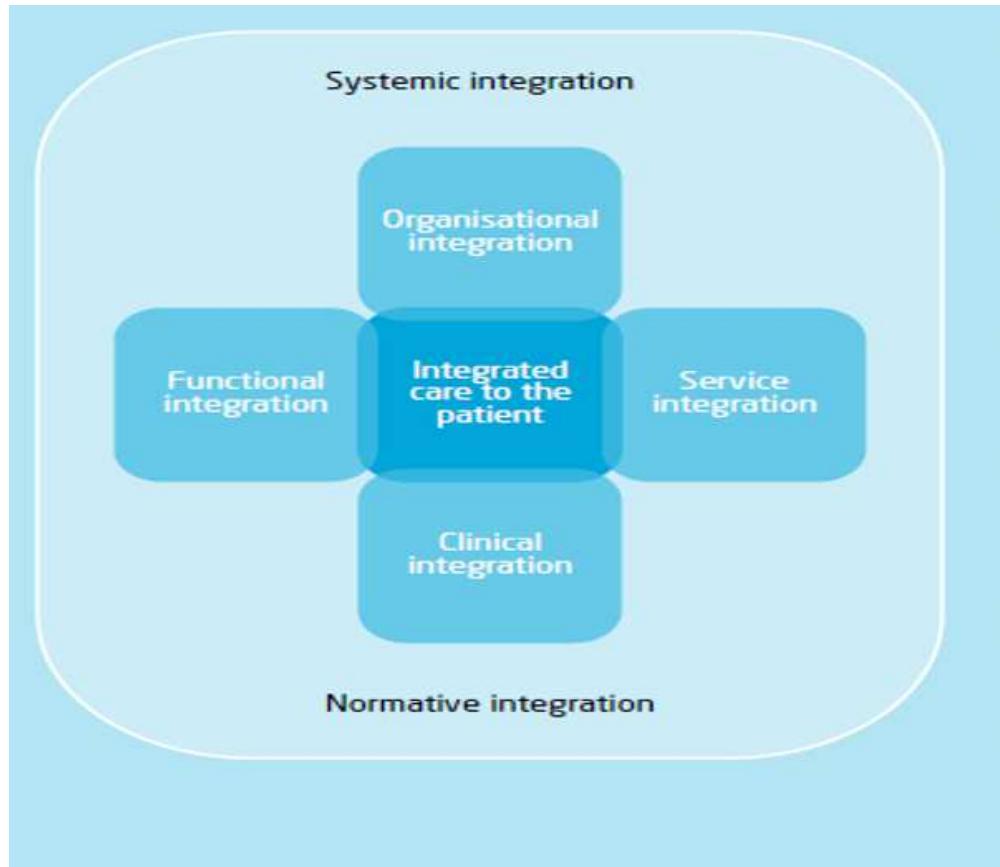
## Evaluator

Measure integration against national and local measures; contribute to evidence-informed integration

## Community

Help to shape local services

# Types of integrated care



The WHO distinguish four types of integration:

- **Organisational:** organisations are brought together formally by mergers or through 'collectives' and/or virtually through coordinated provider networks or via contracts between separate organisations brokered by commissioner
- **Functional:** Integration of non-clinical support and back-office functions, such as electronic patient records
- **Service:** Integration of different clinical services at an organisational level, such as through teams of multidisciplinary professionals
- **Clinical:** Integration of care delivered by professional and providers to patients into a single or coherent process within and/or across professions, such as through use of shared guidelines and protocols

Reference: World Health Organisation: Integrated Care Models: An Overview, 2016

# Commonly known models of integrated care

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**1. Individual models of integrated care** – focus on high-risk individuals and/or multiple conditions, such as:

- Case Management
- Individual Care Plans
- Personal Health Budgets

**2. Group and disease specific models** – focus on specific groups and/or specific conditions in populations, such as:

- Chronic Care Model
- Integrated Care Models for elderly and frail

**3. Population based models** - based on stratification of populations, supply different services based on need, such as:

- Kaiser Permanente

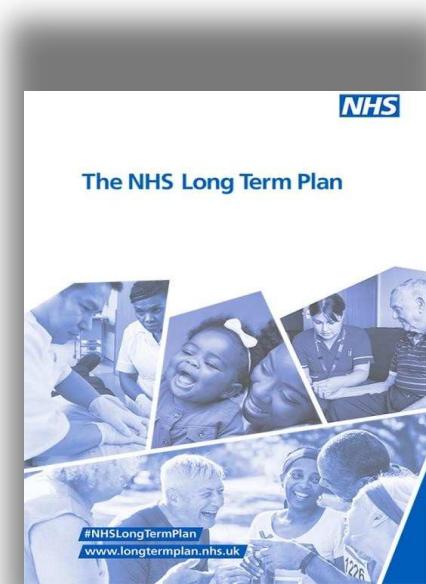
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## 2. NHS Long Term Plan ambitions

# NHS Long Term Plan

The NHS Long Term Plan was published in January 2019, and sets out requirements for the NHS to be:

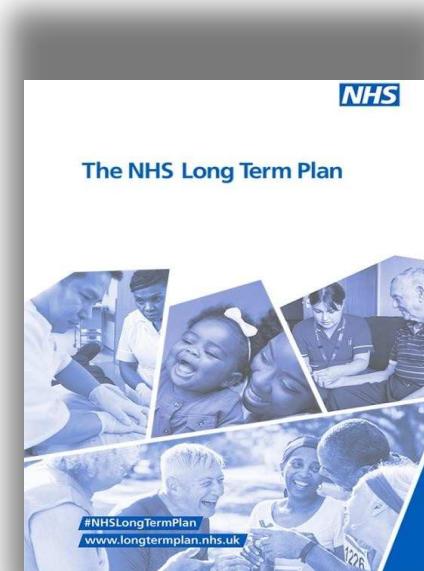
- more joined-up and coordinated in its care;
- more proactive in the services it provides;
- more differentiated in its support offer to individuals.



# NHS Long Term Plan

It details five major changes to the NHS service model:

1. Boosting ‘out-of-hospital’ care and reducing the primary and community health services divide
2. Redesigning and reducing pressure on emergency hospital services
3. Individuals having more control over their own health
4. Digitally-enabled primary and outpatient care will go mainstream across the NHS
5. Local NHS organisations focusing on population health and local partnerships with local authority-funded services, through new Integrated Care Systems (ICSs).



# NHS Long Term Plan

- The NHS Long Term Plan outlined the ambition that every part of the country should be a mature Integrated Care System (ICS) by **April 2021**.
- ICSs have evolved from Sustainability and Transformation Partnerships (STPs), and take the lead in planning and commissioning across a whole population.
- Every ICS will need **streamlined commissioning arrangements** to enable a single set of commissioning decisions at system level. This will typically involve a single CCG for each ICS area.
- The local Integrated Care System will cover North Central London (NCL).

# Integrated Care Partnerships

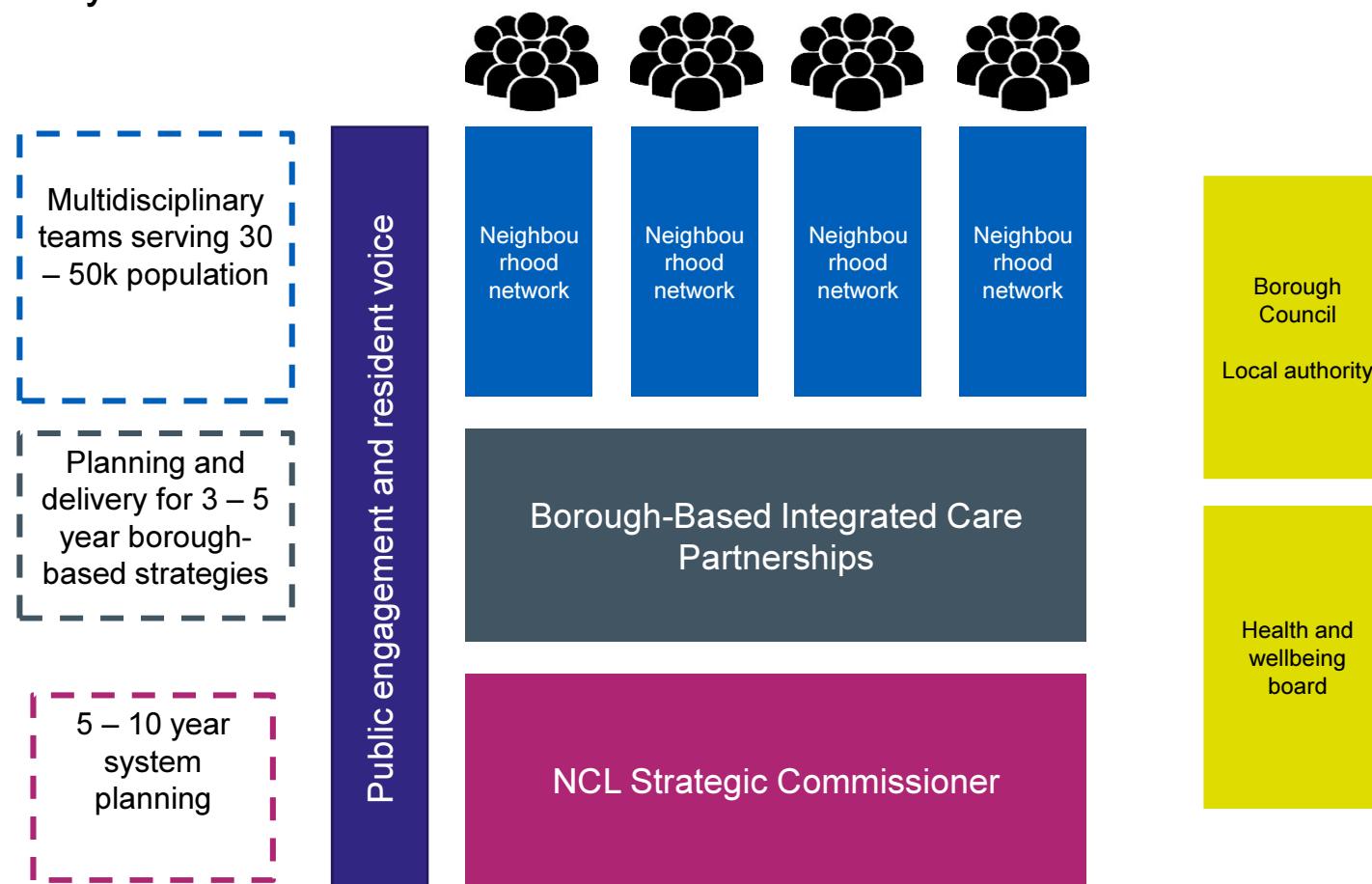
- An essential component of the ICS model is **borough based** commissioner and provider partnerships, known as Integrated Care Partnerships (ICPs).
- ICPs are alliances of NHS and Social Care commissioners and providers that work together to deliver care by agreeing to collaborate, rather than compete.
- Within NCL, ICPs are currently being developed in each of the boroughs.
- ICPs are developing their own priorities, reflecting the different needs of each local population.

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### 3. NCL approach

# Proposed NCL ICS

The NCL ICS would see a single NCL wide strategic commissioner working with borough based partnerships, supporting frontline integration of services at a community level.



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## 4. Progress of the Barnet Integrated Care Partnership

# The Barnet ICP

- The Barnet ICP brings together Barnet CCG; Barnet Council; Royal Free London NHS Foundation Trust; Central London Community Healthcare NHS Trust; Barnet, Enfield and Haringey Mental Health Trust and the Barnet GP Federation. With input from other key stakeholders from the voluntary sector.
- The ICP's vision is ***to maximise health and wellbeing for all people of Barnet by working together as an integrated care partnership.***
- The main aims of the ICP are to:
  - Keep people as independent as possible for as long as possible;
  - Support residents in self-care and prevention;
  - Reduce the number of avoidable unplanned hospital visits and admissions;
  - Address wider determinants of health such as employment, housing and education to improve outcomes; and
  - Make the workforce fit for the future through joint workforce strategies.

# Barnet ICP Progress to date

## Developed strong collaborative system leadership

- Identified system leaders across multi-organisations in Barnet
- Held 'Integreat' workshops and informal meetings over the summer to build relationships
- Held detailed discussions about vision, outcomes, governance and financial management of the Barnet ICP to develop shared understanding

## Developed joint governance

- Developed interim governance arrangements
- Established the Barnet ICP Board and Barnet Integrated Care Delivery Board
- Agreed Terms of References and Memorandum of Understanding
- Established workstreams to progress ICP development

## Developed high level outcome domains

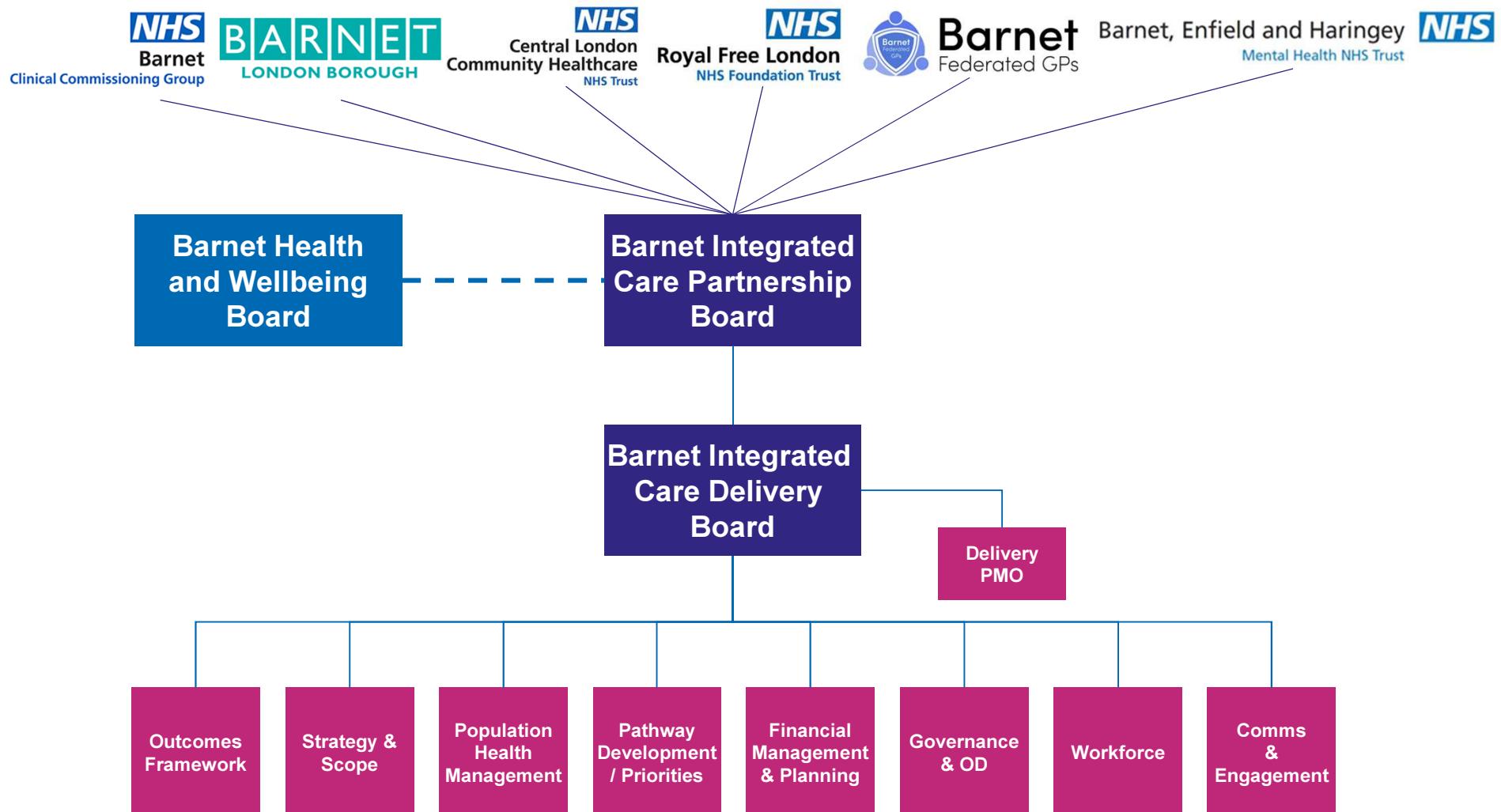
- Developed five high-level outcome domains around access, workforce, population health, wider determinants and community resilience
- Agreed an approach to develop detailed outcomes based on priority pathways

## Identified areas to progress local integration

- Identified areas to progress integration, informed by the emerging outcomes, existing schemes, and areas of existing priorities and pressures for the local health and social care economy
- The areas are Dementia and Urgent and Emergency Care pathways, under the framework of an 'Ageing Well' model.

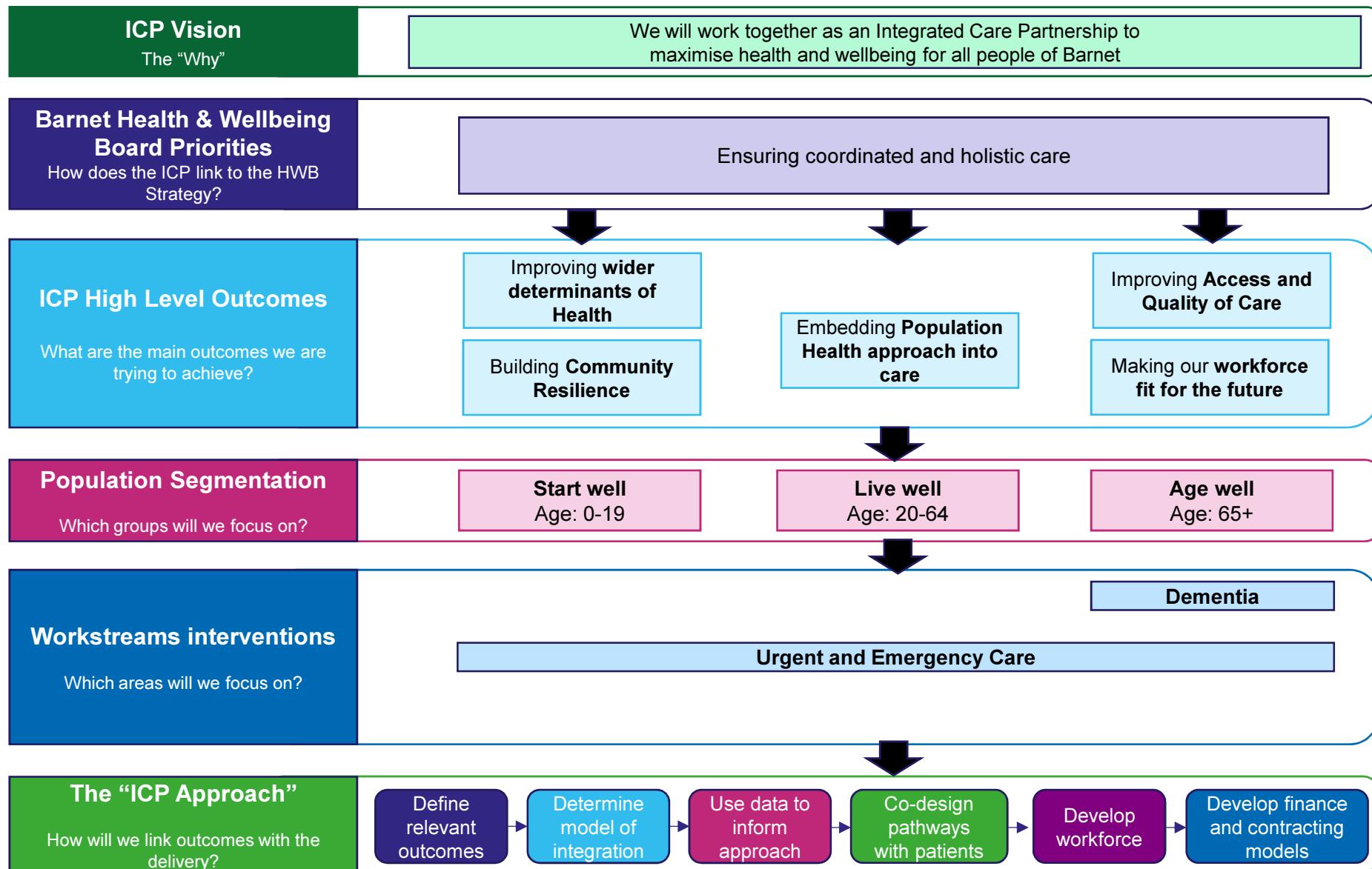


# Barnet ICP Interim Governance Structure



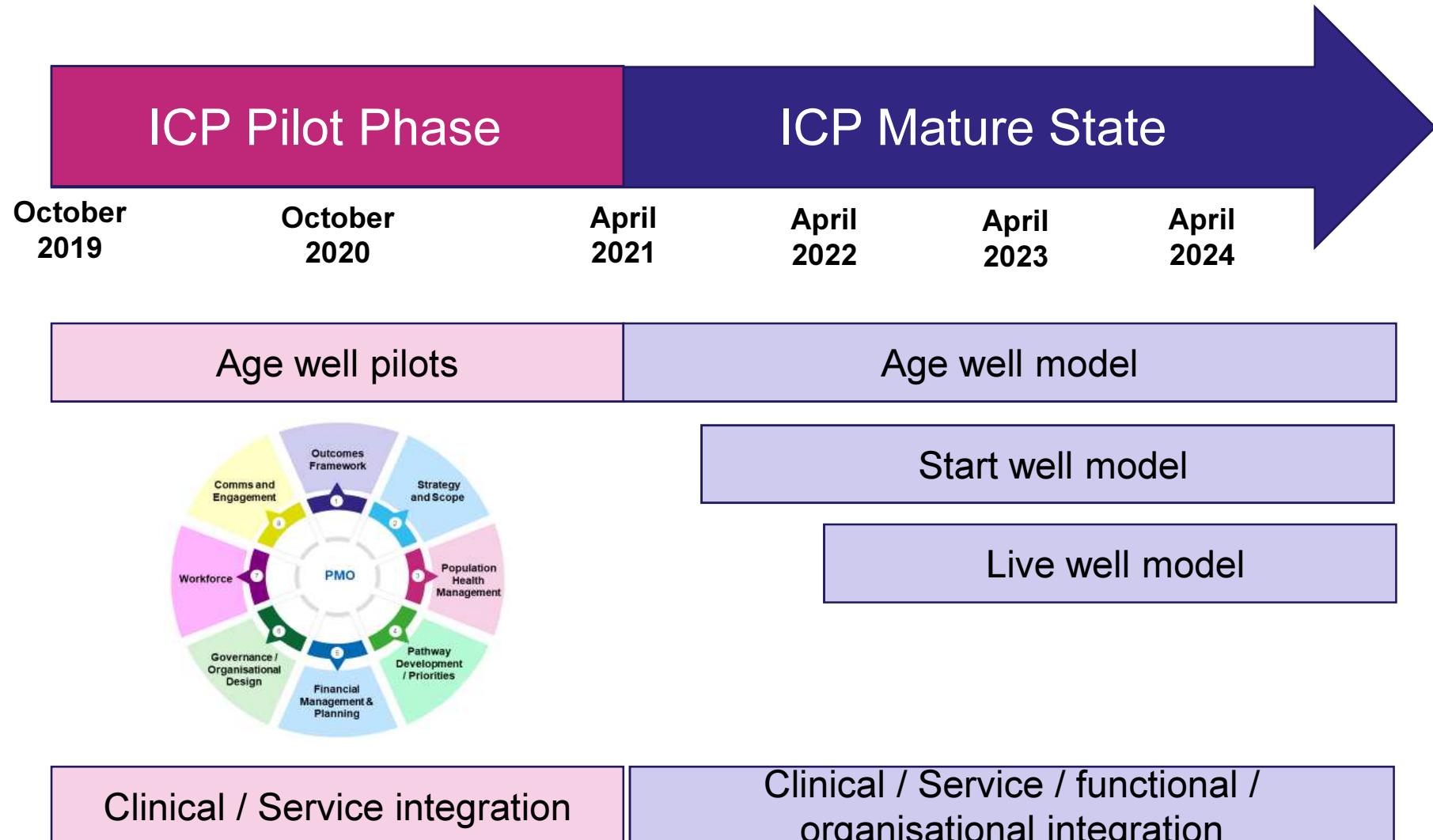
# Barnet ICP development model

Pilot phase to April 2021

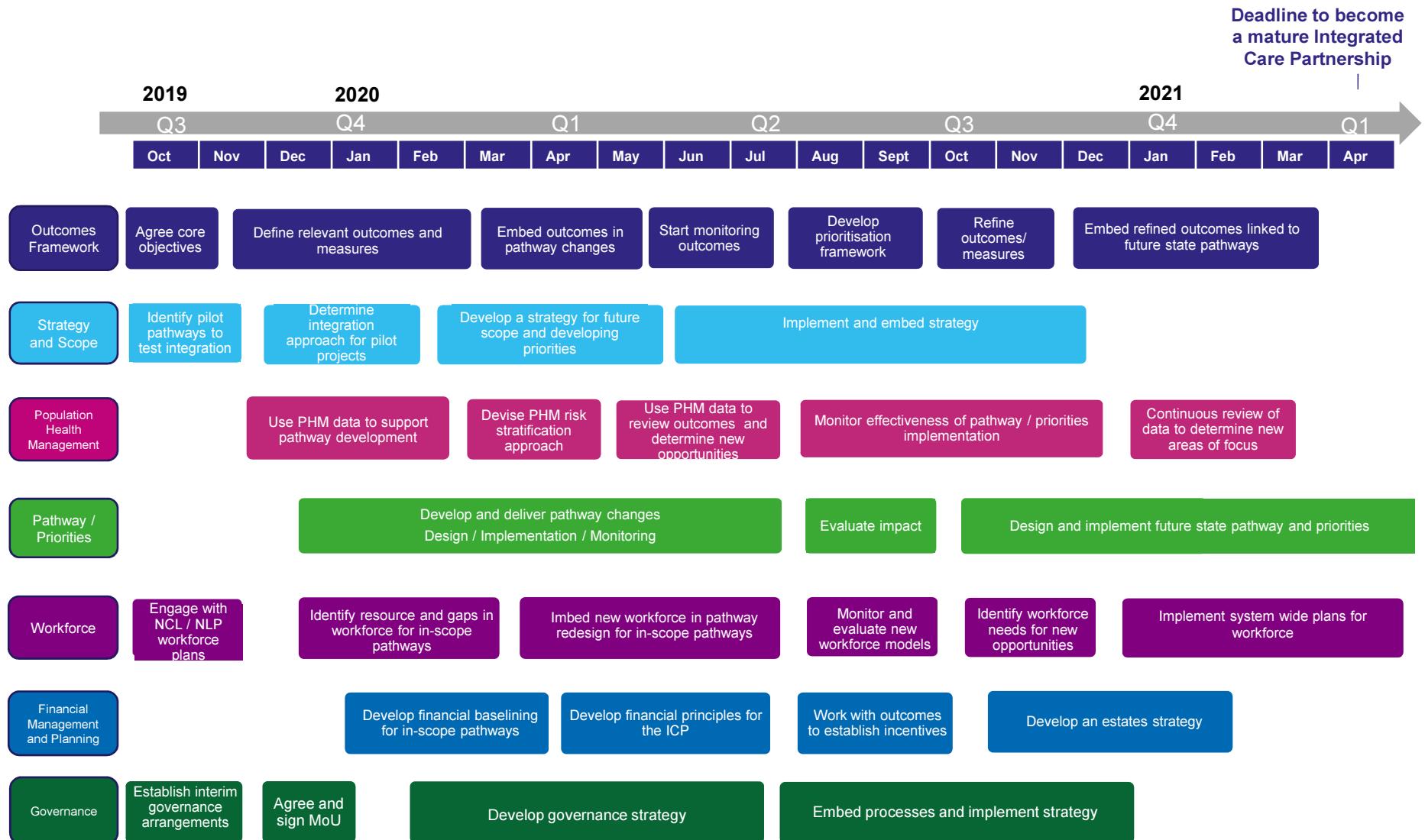




# Proposed Five year approach



# Draft ICP High Level Programme Plan



# Moving towards ICP Mature State



- Barnet ICP will use the ICS Maturity Matrix, developed by NHS England, to monitor development.
- The matrix outlines core characteristics of a mature integrated care system.

## **Key areas that we aim to achieve by April 2021 include:**

- Collaborative and inclusive system leadership;
- Dedicated capacity and infrastructure to enable change;
- Strong system architecture and financial management and planning;
- Population Health Management capability;
- Strong integrated care teams, bringing together PCNs, mental health, social care, community and hospital services; and
- Tangible progress towards delivering national and local priorities.