# Theme 2: Integration

## Direction of travel

There is a positive progression for integration, but unclear focus is a risk to achieving integrated commissioning, shared outcomes and improved alignment to tackle health inequalities.

## Summary of strengths

- There are many examples of integration and teams working well together. For example:
    - The pan-Dorset safeguarding decision-making structures
    - community-based integrated teams in primary care
    - integration of place and health and wellbeing boards.
- Across the system, there was a clear focus on developing relationships to enable system working.
- The Dorset Care Record supports service integration and information sharing.
- ICB senior leaders managed the transition from clinical commissioning group to ICB well, and there are structures to engage relevant stakeholders.
- The ICB has invested in creating the GP Alliance to support ongoing GP involvement in decision-making.

# Areas for development

- There is scope to develop cohesion in system leadership and align priorities. Some relationships are still developing, and there are instances of organisational priorities limiting integration, particularly at place-level.
- Operational level connections between providers were frequently based on individual, existing, relationships rather than integration of services.
- It is not clear who is responsible and accountable for the system-level pan-Dorset children and young people agenda.

# Summary findings for quality statements under the Integration theme

This theme includes these quality statements:

- Safe systems, pathways and transitions
- Care provision, integration and continuity
- How staff, teams and services work together

## Quality statement: Safe systems, pathways and transitions

### Key messages

ICS partners were striving to work together to improve alignment between the health and care sectors to improve population health outcomes and mitigate risk. System leaders were aware of pathway challenges within the system and had started to implement plans to address these to ensure continuity of care when people moved between services. ICS leaders and operational staff understood their populations, including health inequalities and barriers to good health. Some arrangements had been made to refine care pathways, but legacy arrangements remained in place for most, and there was a need for further integrated commissioning to progress shared pathway ownership and development.

Dorset ICS ambitions and objectives for improving people's care journeys are documented in multiple system strategies. However, in practice, most of these aspirations were in early stages. There were projects with evidence of initial successes; many of these were provider-led, rather than system-led.

Multi-agency partners reported considerable efforts and investment across a diversity of programmes to improve discharge from hospital. At the time of our assessment, data showed 90% of people aged 65+ are still at home 91 days after discharge from hospital to reablement or rehabilitation services, which is better than the England average of 82%.

Although in early stages, there was a pan-Dorset focus on providing joined-up care through integrating hospital discharge processes for mental health patients into suitable housing in partnership with a housing association charitable trust. This includes housing officers connected to a patient as soon as the patient is identified as homeless, and 8 step-down beds assigned to homeless individuals ready for discharge where no housing is available.

There are shared efforts to improve community safety, with local authorities and the ICB developing a serious violence plan and joint commissioning on domestic violence support and prevention. Practitioners reported a good history of integration and working together to reduce domestic violence, with shared learning and training for partner organisations.

GP representatives told us system-level discussions about pathway design tended to be dominated by secondary care issues and limited integration between health and local authority partners stifled innovation. As a result, they felt workload pressures and risks had transferred to the primary care setting with limited recognition of this impact. Staff in other sectors also identified parity of esteem as a challenge to integrated pathways, with perceived inequities in attention and resource allocation across different services.

## Quality statement: Care provision, integration and continuity

### Key messages

Within Dorset ICS there is understanding of the diverse health and care needs of the population. There is a clear and ambitious five-year strategy with a long-term vision to improve health and wellbeing, reduce health inequalities, maximise value for money and contribute to wider social and economic development. System leaders and operational staff recognised the importance of partnership working and provider collaboratives as integral to improving services, and there was clear ambition to integrate community and voluntary, community or social enterprise (VCSE) partners.

There were some good examples of ICB and system-led work, which have made a positive difference.

The ICB and system partners have access to rich population-wide data and have started to interrogate this information. However, the necessary priority to establish system infrastructure and relationships meant that transformation initiatives to tackle health inequalities were less developed. System leaders were not always able to articulate the impact of system-level work on improving the lives of local people.

System leaders had a strong commitment and vision for investing in communities, prevention and early help. They recognised the tension to address immediate challenges and focus on the future. The ICB has taken steps towards pooling human resources and aligning roles to place-based partnerships.

At the time of our assessment there were approximately 380 pilots and projects ongoing across the ICS. ICB leaders acknowledged the need for a 'stock-take' of this activity to ensure all pilots are aligned with the 5 ICS priorities, with clear objectives, measurable impact and ability to upscale. Work was being undertaken to review and consolidate projects and new governance and accountability structures were to be established.

There was some involvement of communities and places in resource allocation, but processes for including user voice in decision making were in early development. There were some examples of co-production with people who use services and ICS partners demonstrated efforts to engage some people and communities. While there was evidence of listening to people who use services and seeking feedback, many system partners reported engagement rather than a strategic approach for genuine co-production.

Patient and service user representative groups told us the ICB and ICP were keen to involve user voice in decision-making and gather people's views and this was an improvement, but there were still barriers.

VCSE leaders gave examples of working with the ICS to make changes in provision to meet the needs of people in Dorset. ICB leaders recognised the potential of VCSE organisations to contribute to commissioning decisions, and there were formal mechanisms for the inclusion of their collective voice in system decision making and transformation with VCS Assembly representatives on the ICB board.

## Quality statement: How staff, teams and services work together

### Key messages

System leaders were collaborating with partners to improve quality and efficiency to deliver more seamless services. Some progress has been made to establish integrated commissioning and co-location of services, but it was too early to assess the impact this would have on residents and ensure they only needed to ‘tell their story’ once.

Stakeholders across the system told us there are structural inequalities across the county, with differences in service provision in each place for the same conditions or presentations, for example in stroke response, which resulted in differential experience and outcomes. ICB and ICP strategy documents recognised these concerns with plans to address them, for example a Better Care Fund to support places to improve care and support for older people, and co-ordinating health and local authority plans for adult social care and housing.

The ICS Clinical Plan aims for an active move to prevention and early intervention. There is a clear focus on ensuring people's health and social care needs are considered as a whole, instead of multiple conditions and supporting people to manage their own conditions where possible. This includes focused investment to tackle inequalities in areas of deprivation and the greatest need.

The ICB is exploring pilot projects in use of technology for remote interventions, such as apps to monitor the health of people who have recently left hospital. These plans are based on Core20PLUS5 priorities to help people stay independent.

The Dorset Joint Forward Plan states the ICS intention to use population health management tools to focus support for earlier diagnoses and interventions. The ICS has invested in bespoke solutions for digital integration and it aims to create a unified approach to health and social care data in Dorset. These systems and data sharing mechanisms are in early development but indicate progress towards shared use of data. Data is available within the system, but there is not yet an overarching and cohesive plan to use it to address local health inequalities.

Different providers and organisations in Dorset used different user information and patient record systems, which did not always link to each other and could not be accessed by all providers. This meant there were challenges for practitioners in accessing people's comprehensive records and this hindered seamless information sharing between different sectors. Solid professional connections were used to overcome barriers to information access.