NHS England
NHS Improvement

Board Meetings held in Common

Meeting Date: **28 March 2019**

Agenda item: **07**

Report by: Dominic Hardy, Director of Primary Care and System Transformation

Report on: **Establishing Integrated Care Systems by April 2021**

Decision Making Responsibility:

NHS England	☐
NHS Improvement	☐
NHS England and NHS Improvement	☐
N/A - joint discussion	☒

Introduction

1. The NHS Long Term Plan (LTP) sets out a commitment that "by April 2021, Integrated Care Systems (ICSs) will cover the whole country". This paper sets out the proposed next steps for establishing and supporting the continuing development of STPs and ICSs, and seeks the Boards' views on these.

Context

2. ICSs are a way of creating shared local responsibility for:

    a) Managing NHS resources more efficiently/effectively to improve quality of care and access to care, improve health outcomes, and reduce inequalities in quality, access and outcomes. This means being able to focus both on delivering financial and performance standards, and addressing the population health challenges within each system;
    b) Building wider partnerships with local government and other community partners to help address wider determinants of health and wellbeing and provide better, more independent lives for people with complex needs; and
    c) Creating the capacity to implement system-wide changes.

3. ICSs work by creating joined-up, patient-centred care at broadly three levels:

    - **Neighbourhood** (c.30-50k populations), with Primary Care Networks as the key delivery unit. Most ICSs now report near full coverage, although these naturally differ in maturity. At minimum, PCNs collaborate to deliver extended access and sharing functions or workforce to reduce day-to-day pressures. The more mature have developed flexible workforce models, integrating with other NHS and local government services and are beginning to provide anticipatory care for people at risk of unnecessary hospitalisation.
    - '**Place'** (up to c.500k populations), which will typically align with local government units, should be the engine room of resource planning, care redesign and population health management for local communities. Most ICSs say that about 80% or more of their work is organised around the place or neighbourhood level.
    - '**Systems'** (c.1m+ populations) discharge responsibilities at a scale larger than places. These include workforce, capital and estates planning, digital, specialised services and reconfiguring the acute care landscape. They oversee a single operating plan and system control total that encompasses CCGs and NHS providers. Systems are increasingly taking responsibility for financial and operational performance across the whole system, supported by new governance arrangements.

4. They bring together health and care professionals to design care that goes further in preventing ill-health, supporting people with long-term health needs and reducing avoidable hospitalisation. This means creating new collaborative relationships between commissioners and providers, replacing unnecessarily transactional relationships and freeing up time and resources to focus on redesigning patient care and improving outcomes. Specifically, in the context of implementation of the NHS Long Term Plan they should take forward the five major practical changes to the NHS service model described in Chapter 1, namely:

    - We will boost 'out-of-hospital' care, and finally dissolve the historic divide between primary and community services;
    - The NHS will re-design and reduce pressure on emergency hospital services;
    - People will get more control over their own health, and more personalised care when they need it;
    - Digitally-enabled primary and outpatient care will go mainstream across the NHS;
    - Local NHS organisations will increasingly focus on population health and local partnerships with local authority-funded services, through new ICSs.

Current position

5. To date, 14 ICSs have been established based on their advanced maturity[1]. Of these, eight are now operating as 'live'[2] ICSs with the remaining six operating in 'shadow' form. While we need to continue to work with all ICSs as they mature and deliver, we also need to broaden our focus to support the other STPs to reach this status.

Next steps

6. The move towards ICSs creates the opportunity for a more collaborative dynamic between systems and NHSE/I. The LTP articulates the vision for ICSs and reinforces their role as the main mechanism to deliver many of the priorities laid out in the Plan. As set out further below, we propose to support the national development of ICSs through four key activities:

   i. developing a maturity matrix to assess STP/ICS progress;
   ii. agreeing a LTP implementation framework to agree priority focus area for each system;
   iii. deploying differentiated national support offers; and
   iv. reinforcing system-based behaviours within NHSE/I.

7. We are developing a **maturity matrix for STPs** and ICSs to show what systems should be able to do at different levels of maturity as they progress towards, and become, ICSs. We envisage that, once final, this should be used to:

   - agree the system priorities for development and the corresponding regional/national support;
   - agree the freedoms and flexibilities that correspond to their level of maturity; and
   - establish a clear set of entry criteria for achieving ICS status.

8. We need to agree now **what the LTP implementation framework will ask of systems, and by when**. As a minimum this should be based on reaching the set of entry criteria to be agreed for achieving ICS status over the next 2 years. We will seek to avoid this becoming a tick box exercise by embedding the matrix into regular touch points with regional and national teams and emphasising that it reflects a continuum of development. We will also re-emphasise that systems must demonstrate progress on the main deliverables on the LTP rather than just focussing on changing the 'wiring' of systems.

[1] There have been two waves of integrated care systems. The first wave of eight ICSs were announced in 2017: Bedford, Luton and Milton Keynes; Berkshire West; Blackpool and Fylde Coast (now Lancashire and South Cumbria); Buckinghamshire; Dorset; Frimley Health; Greater Nottingham (now Nottinghamshire); South Yorkshire and Bassetlaw. They were joined by the two devolution areas, Greater Manchester and Surrey Heartlands. The second wave was announced in May 2018: Gloucestershire STP, Suffolk and North East Essex STP, West, North and East Cumbria STP and West Yorkshire and Harrogate STP.

[2] This denotes their advanced maturity, which is reflected by a more autonomous relationship with national bodies. It also reflects that each of these systems has elected to tie a proportion of their Provider and Commissioner Sustainability Funding to meeting their system control total rather than organisational control totals alone.

9. We will expect each system to work with its regional team to set out its LTP implementation plan during the first part of 2019-20, based on a clear diagnostic process to assess need against the maturity matrix, once agreed. This diagnostic should triangulate STP/ICS feedback, regional team feedback, and quantitative data including the outputs from the bronze diagnostic pack developed by the STP Delivery Unit.

10. At the same time, we need to **create a development offer** that both supports systems to undertake the required organisational development and to deliver the key service changes outlined in the LTP. This development offer needs to be differentiated based on the system's level of maturity and align to the priorities agreed in the their LTP implementation plan. Key elements of this will include:

    - assessing population health management (PHM) maturity, developing a PHM roadmap, and providing intensive support to implement new PHM approaches and infrastructure through the PHM Development Programme.
    - creating a national learning network for health and care professionals, with a focus on developing future leaders, sharing best practice, and developing networks of STP and clinical leads.
    - delivering an accelerator programme that provides intensive hands-on support to a small number of STPs to bridge the gap between being a mature STP and a developing ICS.
    - delivering a national Primary Care Network progamme providing dedicated, intensive support to accelerate the development of PCNs.
    - designing nationally consistent integrated models of care that are delivered locally and delivering time-limited, hands-on support to embed these models of care in a small number of STPs.

11. Finally, we need to **reinforce this approach systematically at a corporate level** and foster a conducive policy, regulatory and financial environment for system development by:

    - constructing a new ICS accountability and performance framework, including streamlining the CCG IAF, provider SOF, and introducing new system metrics;
    - ensuring financial flows support and incentivise system-based collaborative working;
    - developing an 'integration index' to better measure reflect system ambitions around integrated care and population health;
    - developing a single population health dashboard to form a single source of information;
    - agreeing nationally consistent ICS governance structures, specifically the requirements of an ICS governance board, appointments of Independent Chairs and STP Leads; and
    - proposing legislative changes that would further support this direction of travel.

Recommendation

12. The Boards are invited to:

- note and comment on the proposed next steps for establishing and supporting the continuing development of STPs and ICSs.