# Developing integrated care systems in the West Midlands

## Our local view of “what good looks like”

NHS England

February 2018

# Integrated care for the West Midlands – what are we aiming to achieve?

Working with the national team, we have set up a local development offer which is open to all health and care systems in the West Midlands.

It will be tailored to each system, but based on key capabilities and attributes that enable integrated care delivery – these have been developed nationally and are set out below.

| | | | | |
|---|---|---|---|---|
| **Effective leadership and relationships, capacity & capability** | **Track record of delivery** | **Strong financial management** | **Coherent and defined population** | **Focused on care redesign** |

The development programme will seek to enhance and support the local leaders capacity and capability to make a real difference to the strategic objectives in each place; giving each system the opportunity to assess it's maturity towards designation as an integrated care system whilst enabling each place to move at its own pace.

We have worked with local stakeholders to develop this document which sets out 'what good looks like' for each of the above capabilities. We have built on the nationally developed capabilities to reflect the issues that we are know are particularly relevant to the West Midlands.

We now want to get your views on where your system currently is in developing these capabilities. We will capture your views through a structured interview, using this document as a prompt for discussion.

# Core capability 1: Effective leadership and relationships with the capacity and capability to execute on plans (1/2)

| Detailed criteria | What good looks like |
|---|---|
| 1.1. Strong leadership team, with mature relationships across the system | Place-based leadership is established with capability and capacity to deliver outcomes and manage risks. |
| | Leadership is highly visible with invested time to build and strengthen relationships across all stakeholders, including local authorities, to ensure proactive buy-in from individual organisations and their leaders and to build real health and care integration. |
| | Leaders demonstrate open, transparent and high trust behaviours. |
| | A cross-organisational leadership group is in place that includes representatives from partner organisations, including local authorities, social care providers and primary care leaders. |
| | The role of primary care leadership is clearly articulated and they are a fully engaged partner. |
| | The voice of stakeholders, including patients and the public, is built into the ICS governance arrangement so they have a role in delivery and oversight. |
| | The Health & Wellbeing Board is a key partner in the development of the ICS and is supportive of ICS development. NHS leaders and officers play an active role in H & W Boards to actively progress prevention and address the wider social determinants of well being. |
| 1.2 Clear, shared vision with a credible plan and have a clearly articulated clinical delivery model in place | There is a clear vision which is developed with partners and the public, this is translated into measurable ambitions for outcomes and quality of care. All key partners including staff and patient groups can describe the vision, goals and initiatives relevant to them. |
| | There is a operating model that demonstrates effective integrated care delivery around both population and programs and integrated care teams. This can be articulated to stakeholders at all levels. |
| | Clear clinical and quality governance model that articulates accountability and roles within the system and can be explained to stakeholders and staff. |
| | The ICS is building a cadre of clinical system leaders who understand/share the vision. |
| 1.3. Effective governance model with clear roles and accountabilities – including primary care | There is a clear framework for prioritisation and decision making that aligns with the vision and plan for the system |
| | There is an effective collective decision making and governance structure with clear roles and responsibilities and delegation by statutory boards. Relevant boards have agreed the processes of decision making including delegated authority. There is clarity on decision making between place and levels within the system. |
| | Social care, community health, Chairs, NEDs and local authorities are involved in multiple areas of work and decision making. |

# Core capability 1: Effective leadership and relationships with the capacity and capability to execute on plans (2/2)

| Detailed criteria | What good looks like |
|---|---|
| 1.4 Effective ways of involving clinicians and staff, service users and the public | Clinical leadership (e.g. through a clinical cabinet or a clinical strategy group) will play a role in the delivery and oversight of ICS development and delivery of service strategy and reviews and there is clinical representation at all decision making levels in the system. |
| | Plans are in place to explain and discuss plans with stakeholders on a systematic basis including patient representatives, elected representatives (MPs, councillors), and staff across the system including their representatives. |
| 1.5 Ability to carry out decisions that are made, with the capability to execute on priorities | The ICS has developed an understanding of the skills and capabilities required, there is a program to develop the staff across the system and establish shared expertise and capability. |
| | There is evidence that key priority programs have the capacity invested across the system to drive the improvement and execute on the plan. |
| | Evidence the system is working together to combine functions and resources identify how the system can work more efficiently to unlocking resource between organisations to build the expertise and capacity to deliver on the vision. |

# Core capability 2: Strong financial management

| Detailed criteria | What good looks like |
|---|---|
| 2.1 Collective commitment by CCGs and trusts to shared systems of financial planning that demonstrably underpins and enables clinical vision and articulates a transparent process of financial risk management e.g. system control total and process of rectification to variances from plan | Strong financial leadership is in place e.g. lack of recourse to external dispute resolution |
| | Current and future financial assumptions are aligned and co-produced across the system and plans demonstrably triangulate across organisations |
| | Mechanisms and a robust governance structure in place to manage system-wide risk (e.g. Existing local variations to national tariff); or |
| | New contracting methodology is being developed or trialled that aligns with outcome based accountable care developments |
| | Constituent Board level sign up to an agreed plan to manage collective risk (e.g. new payment arrangements) and its formal virement into contracts |
| | Clear articulation of mechanism that will or are used to manage finances in the system. For example, an overview of the combined resources available to achieve the aims of the system; explanation of the way these resources will flow across all organisations in the system; and how these resources are allocated across organisations in the system (sharing costs, risks and rewards). |
| 2.2 Agreement to individual control totals or acceptable proposal for reapportioning system control total | In year financial performance reports show control totals are being met across the system; or |
| | If control totals are not being met, year to date there is a robust plan in place for achieving control totals across the system by the end of the financial year; or |
| | If control totals are not being met, the system is able to articulate how the freedom and flexibility to offset control totals would enable them to deliver their system control total. |
| 2.3 Credible plans for meeting system control total and, where not already achieved, for moving towards system financial balance | There is a robust plan in place for achieving future financial balance across the system including resolving historic debt where appropriate<br>Formal arrangements for aligned and evidence based QIPP / CIP program and governance across partners. |
| 2.4 System financial interdependencies | Evidence that the financial impact on partners of contributing to achievement of constitutional targets is considered, understood and incorporated into the system wide plan |

# Core capability 3: Coherent and defined population

| Detailed criteria | What good looks like |
|---|---|
| 3.1 A meaningful geographical footprint that respects patient flows | A clearly delineated footprint that is congruent with the STP footprint, as a minimum, where possible. |
| | Leaders can demonstrate that accurate, relevant and timely information, including population outcomes, service-line outcomes and programme board outcomes is collected and reported. |
| 3.2 Covers an ICS of sufficient scale (~1million or more) | Ideally the ICS would be congruent with the current STP, or would be wider if there are clear population benefits |
| | If a sub-STP level ICS is proposed there is a detailed explanation of how the ICS across the current STP footprint would be sustainable, will work together in distinct yet complementary ways with clear evidence that the whole current STP footprint supports the proposal; with preferably with plans to cover the whole STP (current Jan 2018 footprint or beyond) over time. |
| 3.3 Where possible is cognisant with local government boundaries | The ICS covers whole Local authority areas/health and well being boards i.e: does not split local authorities between ICS boundaries unless there is evidence that it is in the best interest of the patient |

# Core capability 4: Track record of delivery

| Detailed criteria | What good looks like |
|---|---|
| 4.1 Evidence of tangible process towards delivering Next Steps on the Five Year Forward View especially redesign of UEC system, better access to primary care, improved mental health and cancer services | Tangible examples of progress made by the ICS and an overview of how the system proposes to support, strengthen and accelerate key service improvement deliverables for 17/18 and 18/19 with detail for each priority area. For example, key deliverables may include:<br>• UEC - Demonstrated improvement towards transforming UEC services in 2017/18 including compliance, or approaching compliance, on 4 hour wait, urgent treatment centres and front door streaming in all A&E departments. On track to improve patient flow and implement 111 online according to local plans, strengthen support to care homes and enhance provision of mental health support in A&E.<br>• Primary care - Collaborative networks of GPs and community services to extend primary care access, expansion of multidisciplinary workforce and the scope and scale of services delivered in the community. Systemic and shared plans for modernisation of premises that include general practice and community teams.<br>• Cancer - Planned interventions to reduce cancer waiting times, increase survival rates, expand screening times to improve detection and early prevention, ensure faster tests and results for symptomatic patients.<br>• Mental Health - Evidence of progress or planned progress against key mental health deliverables set out in the implementation plan for the Five Year Forward View for Mental Health.<br>• Providers and Commissioners have agreed investment and disinvestments required to support delivery |
| 4.2 Delivery of constitutional standards or confidence that by working as a system they are more likely to be recovered | A&E - Evidence of improved A&E wait time targets set out in the Next Steps and plans for further improvement. |
| | Cancer - Evidence of improving cancer 62-day wait targets, or if not achieved yet, evidence of robust plans in place to meet the wait targets. |
| | Mental Health - Meeting mandated mental health standards for psychological therapies, dementia, early intervention in psychosis and children and young people's eating disorders. |
| | Planned Care – Equity of access with robust sustainable plans in place based of demand & capacity modelling |
| 4.3 The system is working collaboratively to deliver against standards and the 5YFV priorities | Evidence of recognition of the contribution of partners to the NHS constitutional targets and NHS contribution to other partners, Public Health Outcomes Framework and Adult Social Care Outcomes Framework e.g. evidence from CQUIN, Health & Well Being board etc. |
| | Evidence decision making is supported by the right capabilities and resources, and the system is building the capacity to execute their plans. |
| | Evidence that system wide intelligence led analytics are integral to the population health planning process |
| | Evidence that transformation funding has been managed and monitored effectively and prioritised to areas of need. |

# Core capability 5: Focused on care redesign

| Detailed criteria | What good looks like |
|---|---|
| 5.1 System has persuasive plans to integrated integration acute care, health and social care | Plans to redesign care delivery through integration between acute, primary, community, mental health and social care to deliver more care in the community and avoid the need for hospitalisation. |
| | Plans to redesign the way secondary care providers work together to reduce unwarranted variation, share assets and resources and use support services more efficiently including networked pathways to drive equity of access and outcome across the STP |
| | A clear plan to invest in digitisation and to harness the advantages of implementing a cross-system digital plan. |
| | Evidence that data and knowledge sharing systems and processes are in place with networks for sharing improvement knowledge and experience |
| | Utilisation and engagement with the JSNA to ensure population health plans are placed based |
| 5.2 Widespread involvement of primary & secondary care with GP practices collaborating through networks | Evidence GP practices are collaborating across practice boundaries, preferably there are primary care networks at a 30-50,000 population level. |
| | Evidence GPs and Consultants are involved in multiple areas of work and ICS decision making, accountable for and leading clinical teams and delivering best value pathways of care. |
| | Evidence of GPs, Consultants and community health, mental health and care services working to deliver integrated primary care. |
| 5.3 Plans to redesign care models and introduce more systematic approaches to population health management | Evidence of a population based care model as defined by tools such as the population health assessment tool. |
| | Evidence the system are pursing population health management principles in their planning and delivery of integrated care recognising the vital role wider partners in locality, place based care delivery models |
| | Clear articulation of how the system is utilising or plan to utilise population health analytics in their ICS, including using the LPF when seeking an outside partner. |
| | Evidence service users, carers and partners from the voluntary sector and local authorities are involved in care redesign. |
| | Plans to work across the system on shared priorities and deliverables for public health and prevention. |
| | Evidence that an embedded, system wide, patient-focused, intelligence driven approach to improvement. |
| | Evidence of redesign being clinically led with robust pathways planning and design |
| | Evidence of clinical engagement at all levels with a robust change management and staff engagement strategy in place |
| | Clearly articulated case for change and the drivers for change, defining the process used to develop principles and the process used for prioritisation. |

# Ranking and Scoring

| Status | Capabilities | Self Assessment Score |
|---|---|---|
| Mature | Implementing all of the components of what good looks like | 5 |
| Making good progress | Implementing a number of the components additional support may be required on specific elements | 4 |
| Fair Progress | Needs Specific attention, plans are in place to address this capability. Support is likely to be needed. | 3 |
| More Progress Required | Requires more work, agreements are not in place and support is required | 2 |
| Not a priority | Work is embryonic and has not been identified as a priority | 1 |