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NHS Providers

NHS Providers briefing: Designing Integrated Care Systems in England and the Maturity Matrix

This week NHS England and NHS Improvement (NHSE/I) published *Designing integrated care systems (ICSs) in England: an overview on the arrangements needed to build strong health and care systems across the country*. The document includes a description of the possible functions of partnerships at different levels of population within an ICS and emerging regional and national arrangements to support and oversee systems. It also includes, the new maturity matrix intended to help system leaders to assess their own progress and a chart of the proposed freedoms and flexibilities that NHSE/I plan to award to mature systems. This briefing provides a summary of the information within the document and NHS Providers view.

Key points

- The publication of this document is helpful in articulating NHSE/I's expectations of an ICS in more detail along with criteria for their development
- However, we are concerned that the language used throughout the document often fails to accurately reflect the realities of the current legal framework in which the statutory bodies within an ICS partnership remain accountable for delivery. We believe it is possible to describe ICSs and the mechanisms which underpin them accurately and with due reference to the current legal framework, without diluting the aims and ambitions of system working
- Key information, helpfully included in the publication includes:
    - The levels of vertical integration are described as;
    - Neighbourhood – 30,000 – 50,000 population
    - Place – 250,000 – 500,000 population
    - System – 1 – 3 million population
    - Region – NHS England and NHS Improvement oversight and support
- There are four criteria of development for systems within the maturity matrix, across five criteria
    - System leadership, partnerships and change capability
    - System architecture and strong financial management and planning
    - Integrated care models
    - Track record of delivery
    - Coherent and defined population
- STPs will be judged to be ICSs when they satisfy the criteria under the 'Developing ICS' heading.

Neighbourhoods

Neighbourhoods with populations of 30,000 – 50,000, are described as the 'cornerstone of integrated care.' The footprints of neighbourhoods will be based on natural geographies, population distribution and the footprints of existing structures. The neighbourhood level of care will be made up of GPs, care homes and home care, pharmacists, community and mental health teams and the voluntary sector. A key aim of neighbourhood level care will be to deliver care as close to home as possible.

A key mechanism at this level will be primary care networks (PCNs), enabled by the new GP contract. The document states that PCNs will be able to reduce pressure on the system by offering extended hours access to GPs and sharing functions and staff, using new technology and tools such as social prescribing, and population health data.

Places

Populations of 250,000 to 500,000 are described as 'places', with the footprint likely to match local council boundaries or existing natural geographies within which services are already delivered. It will include clusters of PCNs, one or more acute hospitals, care homes, mental health and community providers, local government and health and wellbeing boards, and voluntary or community organisations.

The two key aims of 'place level' care will be to address clinical care redesign and population health management. The document does not reference that population health management is often also delivered at neighbourhood level. The document suggests that place level organisations could collaborate through an NHS alliance agreement, or memorandum of understanding which indicates a lack of robust governance and accountability arrangements.

Systems

The system level covers a population of 1 to 3 million and is intended to provide strategic leadership for the ICS. The document suggests that this will include oversight of operational and long-term transformation priorities, financial performance against a system control total. It suggests that system leadership teams will have responsibility for the delivery of high quality services, reducing unwarranted clinical variation, health inequalities, workforce planning, capital strategy, estates and digital infrastructure, and the development of the lower levels (place and neighbourhood). The document proposes that system leaders will take collective responsibility for financial and operational performance through a system wide board enabled by new governance arrangements.

Regions

The document proposes that NHS E/I's seven new regional teams, led by the regional directors, will be responsible for holding systems to account and have the power to intervene. ICSs will agree

objectives with the regional directors, and then be held accountable against those objectives. As ICSs mature, the document suggests that system regulation be passed to the system to manage and regional directors will take on a role of a critical friend. This means that regulation arrangements will vary by system. Learning and improvement will be treated as a supportive continuum of development, as opposed to the application of penalties for poor performance.

Maturity Matrix

Five domains, four stages

We would encourage members to view the full table included in NHSE/I's document itself. The maturity matrix will define system progression as emerging, developing, maturing ICS or thriving ICS against the following five criteria.

- System leadership, partnerships and change capability
- System architecture and strong financial management and planning
- Integrated care models
- Track record of delivery
- Coherent and defined population.

Freedoms and Flexibilities for 2019 – 20

This table outlines the freedoms and flexibilities provided to systems at each stage (emerging, developing, maturing ICS or thriving ICS) in four areas;

- Oversight
- Finance
- Planning
- Support.

NHS Providers view

NHS Providers welcomes greater detail on NHSE/I's aspirations and expectations of systems, including the publication of further information on the national bodies' plans to introduce system oversight, the maturity matrix, and the freedoms and system partnerships could access as they mature. The case study material included in this publication is also very helpful and testament to the positive and constructive collaborations which are developing in support of system working across the country

We also agree with the premise in the document that successful system working depends on building constructive, transparent and trusting local relationships between key partners. However, we are disappointed that the language used in this publication frequently fails to accurately reflect the fact that accountabilities continue to rest in the component statutory bodies (providers, CCGs, local authorities) which form local systems (ICSs and STPs). We feel strongly that it is possible to describe existing accountabilities within local systems accurately without detracting from any of the ambitions

of system working to drive improvement and more integrated service delivery for local populations. The articulation within this document suggests that further thinking will be required to help system partners to develop appropriate governance, risk management and engagement mechanisms.

NHS Providers welcomes the move towards the model of self-assessment and peer review which is reflected in the maturity matrix, alongside statutory regulatory frameworks, over time. It is helpful to see that the development of constructive, trusting, local relationships sits at the heart of this model. However, we are keen to understand how the maturity matrix will operate in practice, how judgements against the criteria will be reached and how the maturity matrix will sit alongside regulation and oversight.

We also welcome the flexibility for more advanced (maturing, thriving) partnerships to voluntarily agree additional freedoms with colleagues in the regional teams. Given the variability in how quickly STPs are progressing across the country it is important that all STPs and ICSs can access appropriate support to continue their journey at an appropriate pace. In developing these freedoms and flexibilities, it will also be essential for NHSE/I to ensure consistency of approach between system oversight and the potential for regulatory intervention in individual providers if performance is seen to slip. The agreement of any system level freedoms and flexibilities will not of course diminish trusts' statutory responsibilities for financial and performance management or the accountabilities of other statutory bodies (CCGs and local authorities) within the system.

We look forward to working with NHSE/I to help support their communications to trusts and their partners on the aims and implementation of system working.

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