Mid-Nottinghamshire
Integrated Care Partnership
Creating happier, healthier communities together

Mid Nottinghamshire Integrated Care Partnership(ICP)

Maturity Self Assessment March 2021

Draft for Discussion – version 2

A partner of the
Integrated Care System
Nottingham & Nottinghamshire

MN ICP maturity self- assessment

- Mid Nottinghamshire ICP was formed from the MN Better Together Alliance and has been a collaboration of providers and CCG since 2016
- The MN ICP has 2 provider collaborations currently delivering integrated models of care – MSK and EOL Together.
- The ICP has clear strategic objectives with dedicated leads from across the ICP partners and delivered through collaboration and partnership
- MN ICP has dedicated clinical leadership and a clinically led Transformation Board ensuring clinicians are at the heart of the development and direction of the MN ICP
- MN ICP has a dedicated management support team led by the Programme Director and hosted by Sherwood Forest Hospitals NHS Foundation Trust.

MN ICP maturity self- assessment

* National policy direction in NHSE/I engagement paper and DHSC places significant emphasis on delivery at “place”
* For ICPs to have greater delegated responsibility and accountability from the ICS/ICP, MN ICP must be able to build on existing examples of its capability and demonstrate its competency and capacity to extend this even further into 21/22 and beyond
* ICS/CCGs will need to determine and be assured of the maturity in order to allocate resource, development of outcome based strategic commissioning and to attribute risk and reward for delivery
* The table on the next slide provides MN ICP with a framework to assess it’s maturity and is the same framework adopted by City ICP with the intention of providing the ICS/CCG with a consistent approach to the self-assessment

Mid-Nottinghamshire Integrated Care Partnership Creating happier, healthier communities together	Emerging	Developing	Maturing	Thriving
Common vision and purpose	Recognition that there is a need for a collective vision but limited progress has been made to finalise ICP vision and objectives or embed these across the ICP and within individual organisations	An early shared vision and some defined objectives, starting to build common purpose and a collectively-owned narrative among ICP leadership team	The ICP's vision and purpose is clear, aligned to the programme objectives and can be articulated by partners. Partners are clear on how the work of the ICP will add value to the work being undertaken by the constituent partners that make up its membership	The ICP's vision has a clear relationship to the overarching system vision and objectives, is shared across all members of the partnership and tangibly informs decision making
Operating Model and Risk Management	Agreement in principle between ICP partners to work towards an alliance agreement that will enable the ICP to hold programme / population level budgets and fairly allocate risk and reward	The ICP has an agreed set of principles established to inform the design/re-design of services to deliver joined-up care to cohorts of the population. Agreements in place with strategic commissioners for ICPs to hold budgets and share risk on smaller population / cohort groups. Risk associated with delivery is still held by strategic commissioners	Provider alliance agreement in place. The principles and processes established provide assurance to strategic commissioners that delivery through the ICP will improve outcomes for the population as well as organisational performance. Risk associated with delivery is shared between partners	The ICP has a collectively agreed operating model and form to deliver whole-population, joined-up care. The model enables the ICP to hold population / pathway based contracts that span multiple care settings and multi-year time horizons. Arrangements to assess and share risks and gains across providers are established and supported by transparency around resource availability and allocation within the ICP
Workforce Engagement	Limited input from clinical and other frontline professionals into plans, policies and decision making. Limited established networks across professional groups and care settings	Clinicians and other frontline professional are consulted on relevant programmes however this takes place on an ad hoc basis. Frontline professionals are not always clear on the outcome of the consultation / engagement.	Established engagement with clinical community and other frontline professional across care settings into ICP programmes of work. Frontline professionals are involved in service design / re-design, ensuring that service design is based on best practice and an understanding of practical barriers to integrated working	All plans, policies and decisions of the ICP are based on or informed by engagement with the partnership's clinical community and other frontline professionals. Strong networks amongst care professionals exist across care settings and professional groups are the foundation of this engagement
Care Coordination and Management	The ICP is starting to build local plans for **improving** the coordination of care for its population and is starting to build relationships across partners	Relationships between partners are developing and partners are beginning to work through traditional barriers to care coordination and management outside of formal ICP programmes. The ICP has facilitated the generation of some multi-disciplinary teams to meet the needs of specific populations / cohorts, working across health and care pathways	There is continued development of partnerships across primary care, community services, social care, mental health, the voluntary sector and secondary care that are enabling on-going MDT development. Workforce sharing protocols in place.	The ICP enables the provision of high-quality, coordinated and population-focused care across all health and care pathways
Citizen Ownership and Engagement	There is limited meaningful engagement with citizens. Citizens are not routinely involved in the development of priorities or co-design of services. When citizens are consulted they are not always aware of the outcome of their involvement.	Processes are in place to engage with citizens in the design and delivery of programmes and trusted relationships between citizens and partners are beginning to develop	The ICP has embedded forums and processes for seeking and acting on citizen views in co-designing and delivering care. Expert citizens are involved in programmes and contribute to key decision making	The ICP is routinely involving and engaging citizens in the design and delivery of services to meet the needs of population groups / cohorts. The ICP has established links and relationships with wider community assets and works in partnership with community assets to meet population need
Data, Analytics, Infrastructure and Interoperability	Infrastructure is being developed for population health management including facilitating access to data that can be used easily, developing information governance arrangements & providing analytical support	Basic data sharing, common population definitions, and information governance arrangements have been established that supports the flow of information between services. There is some linking of data flows between social care, primary care, community services and secondary care	There is a data and digital infrastructure in place to enable a level of interoperability within and across the ICP, including wider availability of shared care records. Analytical support, real time patient data and PHM tools are made available for ICPs and PCNs to help understand at risk population cohorts, and to support care design	IT, data system alignment and interoperability exists across ICP partners. To enable the optimal management, coordination and delivery of patient care, information is available to clinicians and service planners across care organisations. Agreed permissions in place for data and information sharing relevant for system insight across care organisations to enable system wide analysis

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WHERE ARE WE NOW……….	Emerging	Developing	Maturing	Thriving
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WHERE DO WE WANT TO BE 21/22 AND ONWARDS	Emerging	Developing	Maturing	Thriving
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Section 1

Common Vision and Purpose

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Evidence of Maturity

- Relationships and partnerships are well established within the ICP
- The ICP has clear strategic objectives which focus on keeping our population well and focusing on early years, building healthier integrated communities and future opportunities for provider collaborations to support delivery of our objectives
- Programmes of work being developed are aimed at adding value across our partners and not duplication
- The ICP is starting to test itself to determine what its risk appetite is and a recent Board event involving all partners provided a stock take to ensure clarity of vision and purpose across our ICP

Progress Needed

- The ICP needs to establish clear alignment within its objectives to move away from a health lens to ensure synergy between the vision and purpose of all its constituent parts
- The ICP in delivering "place" based models will need to develop models and services that span across all partners including services and financial resources to develop effective provider collaborations and future operating models
- ICP vision and programmes of work embedded into the individual organisational plans to ensure strategic and operational alignment

Next Steps

- Develop an ICP road map for 21/22 and onwards
- Review the ICP membership and involvement in key Boards/Forums and meetings.
- Align Primary Care Locality Team and ICP Management team to develop a single ICP programme building on PCN involvement and engagement in developing the long term vision
- Identify the resources required to deliver key programmes of work identified within the ICP road map
- A single clear communication strategy both internally for the ICP and externally to service users and wider population

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Section 2

Operating Model and Risk Management

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Evidence of Maturity

- Existing Alliance Agreement in place to support the work of the ICP
- MSK Together operating as a provider collaboration but within traditional contracting methodologies
- EOL Together operating as a provider collaboration within a defined capitated budget and operating agreement in place, collaboration involves ICP and non ICP providers
- ICP willingness to build further on this through its emerging delivery models for its objectives

Progress Needed

- The ICP needs to contribute effectively to the system operational planning and demonstrate it's willingness to accept risk and accountability associated with delivering system outcomes
- PCN's must be integral to the development of the ICP priorities in developing place based models and building on community assets – engaged and involved
- Emerging models such as care navigation and mental health social prescribing requires the ICP to be responsible for monitoring the performance of the services against the agreed outcomes. This resource does not currently sit within the ICP
- In developing new provider collaborations and provider alliances, ICP partners will need to establish and agree how partners will share risk and reward for delivery across organisational boundaries and where such agreements traditionally are not in place – Health and Local Authority alliance as an example

Next Steps

- The ICP through it's maturity assessment will need to determine the gateways and actions it needs to have in place to transition into a more formalised legal entity to enable it to deliver the new ways of working set out in the White Paper
- The ICP road map will have to demonstrate how the programmes of work will contribute to the quality and financial performance of the system
- Development and delivery of the Care Home Model and Transformation of Community Services provide two opportunities for the ICP to contribute to the operational planning and delivery
- ICS/CCG and ICP need to agree how the transfer of responsibility to the ICP will be facilitated in response to its road map and future priorities
- Through the ICP road map determine how provider and CCG resources can be aligned

Section 3

Workforce Engagement

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- Programmes of work being developed are aimed at adding value across our partners and nor duplication
- The ICP is starting to test itself to determine what its risk appetite is and a recent Board event involving all partners provided a stock take to ensure clarity of vision and purpose across our ICP

Progress Needed

- Awareness of the ICP and the implications of the White Paper needs to be understood more widely across the ICP partner organisations workforce
- Clear agreement across all partners that the ICP will be the future Place based Leadership in response to the White Paper
- The role of the ICP alongside the individual partner organisations needs to be more widely communicated and engaged with, if the ICP is to transition into the Place based leadership of the future
- Bottom up development of future integrated care models involving the workforce at the heart of the delivery is essential to gain "buy in" and confidence in the role of the ICP

Next Steps

- Ensure that the priorities of the ICP include the communication with and the engagement of the wider workforce
- Ensure ICP programmes of work involve and include the right people from the wider workforce to influence and inform models of care and service change
- Work with ICP partners to identify how ICP programmes of work will be resourced ensuring the right subject matter experts are involved and engaged from development through to delivery
- Ensure the Transformation Board as the clinical decision making forum for the ICP is effective and builds on the ICPs clinical community to inform and support decision making

Section 4

Care Coordination and Management

	Emerging	Developing	Maturing	Thriving
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Evidence of Maturity

- The ICP has pockets of evidence and good practice in respect of multi-agency working through EOL, MSK and integrated teams within the PCNs and Community Services with differing levels of maturity
- The ICP has developed a multi-agency approach to the development of a model for care homes that builds on the success of the ECRT model and with multi-agency MDT and delivery at the heart of the model
- The ICP is linked into the development of the D2A pathway where people are working together as a system in developing the MDT approach to support hospital discharge

Progress Needed

- The ICP needs to build on its existing provider collaboration models to support its maturity and confidence in the development of population focused pathways that span across health and non health partners
- The ICP needs to develop its existing MDT approach to establish a consistent maturity and opportunity to ensure the services bring system value
  - EOL 2
  - MSK 2
  - PCN level Integrated teams
- PCN level MDTs need to have an operating model developed to provide consistency, reduce complicated referral methods and extended to include health and social care partners
- There are differing levels of engagement and involvement with the PCNS, PCNs are key providers of the ICP and should be key partners in the ICP development and delivery of the ICP road map and priorities

Next Steps

- Multi-agency group to be formed including Council neighbourhood departments to use available PHM and neighbourhood intelligence to determine key areas of focus for development of PCN and community care and support teams
- The ICP should undertake an asset mapping exercise to understand the collective resources available in each PCN
- The ICP should prioritise its Care Home integrated model and the Transformation of Community services to demonstrate how the ICP is maturing and the onward transition to thriving from 22 onwards
- The ICS/CCG will be required to support the ICP priorities and indicate how and what is required for responsibility for delivery can transition to the ICP

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Section 5

Citizen Ownership and Engagement

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Evidence of Maturity

- The ICP holds it's Board in public and actively involves its citizens to input into the role of the ICP
- The CVSs, and Healthwatch are members of and involved and engaged with the Board
- One of the key ICP objectives (No2) is the integration and collaboration with the voluntary sector in the design, development and delivery of ICP programmes of work
- In response to the ICP objectives the CVS have organised two events focusing on Diabetes and Learning Disabilities as two key priorities for the ICP population
- The Board in February undertook a stock take on its vision involving the citizens and CVS representatives ensuring their voice was heard in the next steps for the ICP

Progress Needed

- Connectivity between the Citizens Board chaired by the Local Authority and the developing ICP programme is essential to ensure the citizen voice is heard
- Programmes of work such as the Bellamy Estate project should be integral to the work of the ICP with opportunities to develop further across our ICP building on existing community assets and determining what is required to meet the wider population need

Next Steps

- ICP road map established to incorporate the voices of citizens represented at the Board and agreed as a collective goal for **all** ICP partners
- CVS events to be held in March and use findings and feedback from the events to influence the ICP priorities
- Build on and use learning from the joint ICP and CVS submission for charitable funding that will be used to support 70% of voluntary services adversely affected by the pandemic to restart and 30% new voluntary services to support the population to recover from the pandemic

Section 6

Data, Analytics, Infrastructure and Interoperability

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Evidence of Maturity

- Applicable across all 3 ICPs
- Population Health Management (PHM) is well established at Integrated Care System Level with ICPs identified as 'client groups' – data packs are provided to ICPs
- ICP delivery programmes were based on local population need within those specific pathways
    - End of Life
    - MSK
    - Care Navigation
    - Mental Health Social Prescribing
- Data and information sharing protocols are established between individual organisations and in some programme areas however there are not information sharing agreements at ICP level

Progress Needed

- Whilst it is resource intense there is a need to build or develop a single data hub within the ICP to under pin and inform the ICP priorities
- While Population Health Management information is collected at ICS level the areas of focus are not neatly aligned to ICP programme priorities. The ICP needs to be in a position to influence areas of focus so that information is more useable
- Data and information tools such as GPRCC and e-healthscope are well established to bring together key aspects of health and social care however different data systems means that information is not always aligned
- There is a need to make better use of data and information that is collected outside of health and local government
- Current use of date is often specific and in response to the pathway being reviewed and whilst effective, the ICP should look at data and intelligence to inform and identify the pathways and services for development or review

Next Steps

- The ICP to undertake and asset mapping exercise to determine opportunities for resources to be deployed to form an ICP hub at local level
- Work to be undertaken with ICS PHM team to make PHM data packs more 'user-friendly' for ICPs
- Plans are being developed to merge the work of the PHM team and the data cell to establish an Intelligence Hub which will allow for integrated performance information to be produced alongside population health needs.
- ICP partners are working with the PHM team to input data and information that is collected outside of health and local government capture 'wider determinant' information impacting on health outcomes, e.g. people living alone

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Self Assessment Summary

- 4 of the 6 self-assessment stages identify Mid Notts ICP as Maturing
- 2 of the 6 self-assessment stages identify the MN ICP as Developing
- The self-assessed maturity of the MN ICP enables the ICP to use its road map to set out some clear next steps that will transition the ICP into a thriving ICP
- The self-assessment has set out some clear priorities for the ICP that should inform or are required to enable the development of the road map
    - ***The role of the PCNs and greater integration into the ICP***
    - ***Building on community assets to build PCN neighbourhood integrated models including social care***
    - ***How we use data***
    - ***How we move forward in implementing further some of the work already established or being developed - EOL/MSK/D2A/CARE HOMES MODEL***
    - ***The requirement for the ICS/CCG to set out how it will support the transition of responsibility to the ICP***
    - ***Resources required to support the transition***