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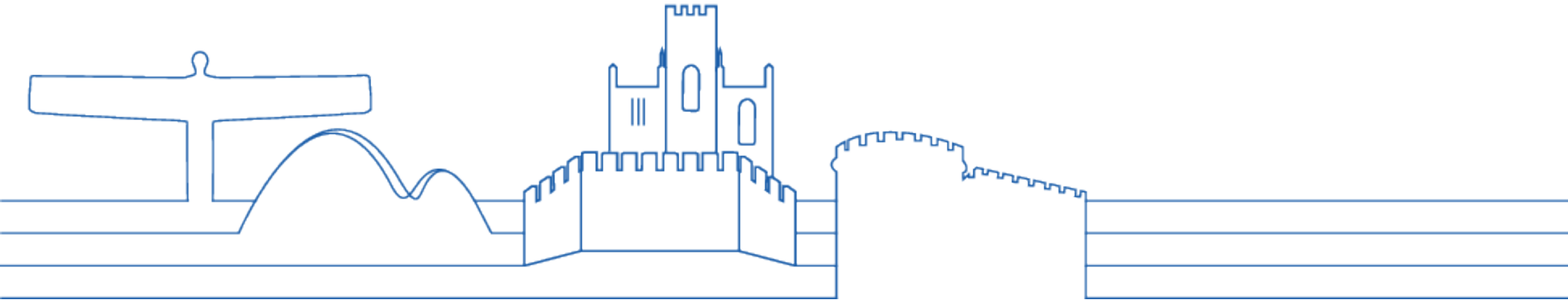
DRAFT

# Towards an Operating Model for NHS North East and North Cumbria Integrated Care Board



# Presentation outline

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- What is an operating model?
- Our objectives
- Design principles agreed through JMEG
- Functions and Decisions Map
- System working example: commissioning
- Place Based Partnerships, role and governance
- ICB Area and matrix management concept
- System Flow Chart
- Next steps

# Suggested Operating Model Framework

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- Values and principles
- People and local communities at the centre of what we do
- Governance and membership of the ICB
- Operating arrangements i.e. ICP, sub ICP, ICB system, geography above place and place
- Functions and where they are delivered
- Next steps, stress, scenario testing etc
- Review and agree governance handbook
- Phase 2 structure work underway
- Shadow ICB in place April to July- focus on board development and readiness to operate from July.

# What is an operating model?

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**One definition:**
An operating model is a visual representation of how an organisation delivers value to its internal and external customers. Operating models are created to help employees visualise and understand the role each part of an organisation plays in meeting the needs of other components [What is an operating model? - Definition from WhatIs.com (techtarget.com)]

## Some key questions for us:

1. How do we set our objectives as an integrated care system?
2. How do we make decisions – and who makes them?
3. How we deploy our people and resources to make these decisions happen?
4. How do we assure ourselves that we are meeting our objectives?

# Our objectives

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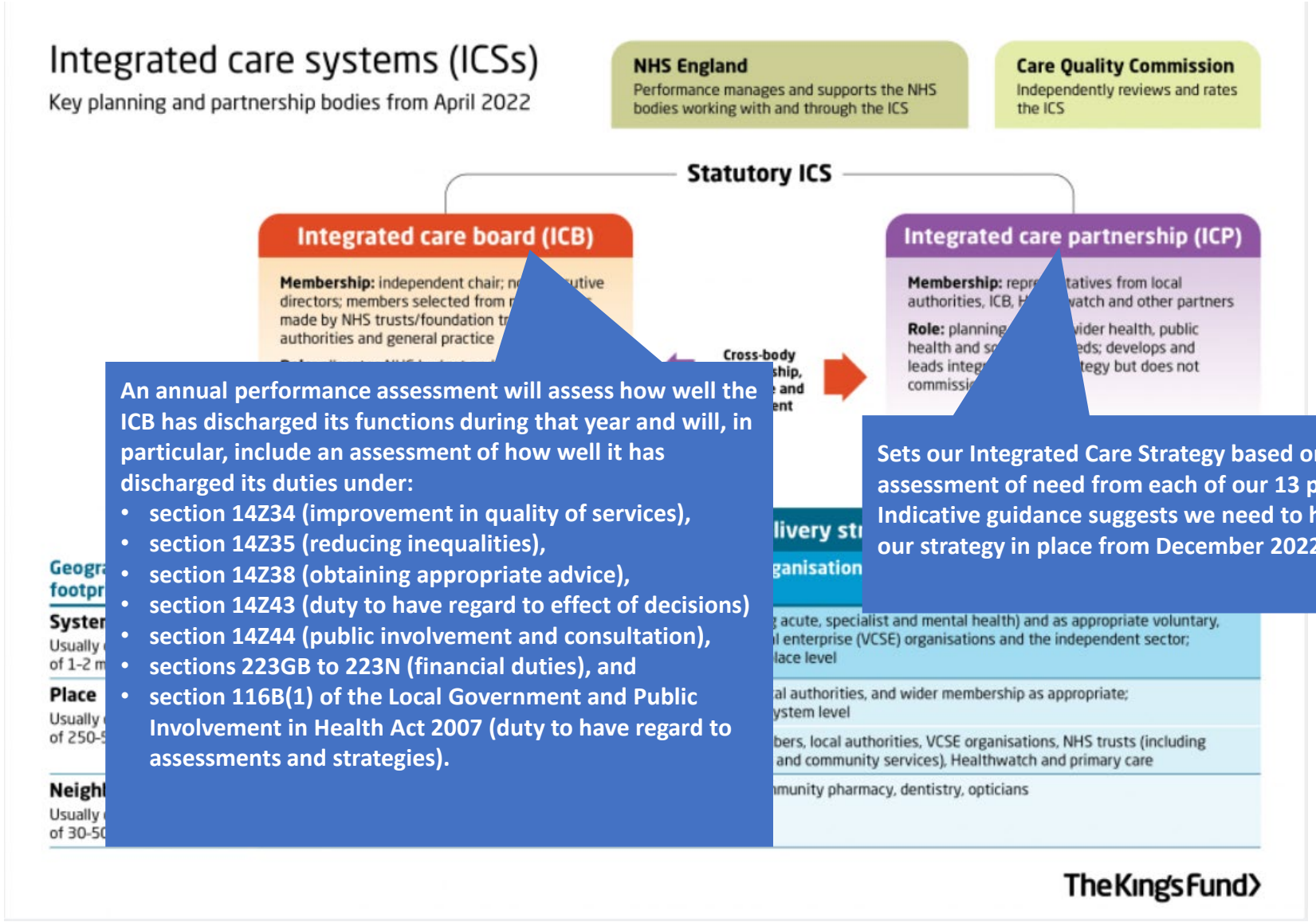

# Guiding principles for ICB development agreed by JMEG

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- Secure **effective structures** that ensure accountability, oversight and stewardship of our resources and the delivery of key outcomes
- Create **high quality planning arrangements** to address population health needs, reduce health inequalities, and improve care
- Ensure the **continuity of effective place-based working** between the NHS, local authorities and our partners sensitive to local needs
- **'Stabilise, transition, evolve'** throughout 2022-23 – ahead of adoption of formal Place Board models by April 2023
- **Recognise our ICP sub-geographies** as a key feature of our way of working across multiple places
- Design the right mechanisms to drive developments, innovations and improvements in **geographical areas larger than place-level**
- Highlight areas of policy, practice and service design where **harmonisation of approach** by the NHS might benefit service delivery
- Maintain high and positive levels of **staff engagement and communication** at a time of major change and upheaval

# Developing an operating model: DRAFT design principles/givens

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1. Maximise opportunity for standardisation in the interests of efficiency
2. Subsidiarity based on a consideration of Principle 1 above
3. Arrangements must be affordable and within running costs
4. Ensure simplicity and clarity on accountabilities to the ICB

**Key questions for our operating model:**

- Should we just define the ICB's objectives, but leave the delivery arrangements to each Director of Place-Based Delivery?
- If we do this how do the Exec team develop ways of working across the ICB?
- Or, do we develop a more uniform model of place and 'cross-place' working to ensure consistent approaches to delivery across our ICS?
- Or something else ?

# North East and North Cumbria Integrated Care Board - functions and decisions map

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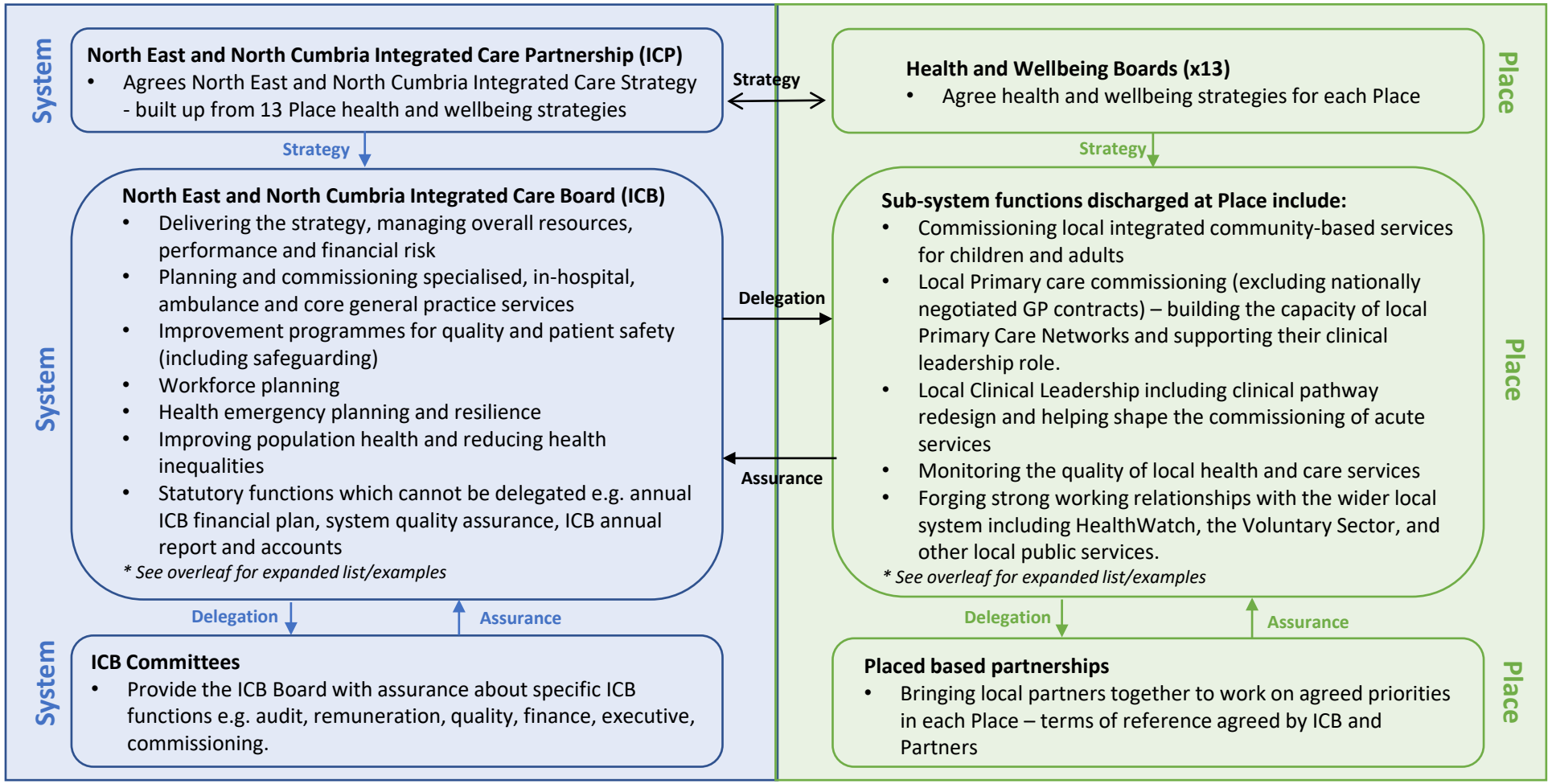

# North East and North Cumbria Integrated Care Board - functions and decisions map

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**ICB functions discharged at system level**

- Setting strategy
- Managing overall resources, performance and financial risk
- Planning and commissioning specialised, in-hospital, ambulance and core general practice services
- Improvement programmes for quality and patient safety (including safeguarding)
- Workforce planning
- Horizon scanning and futures
- Harnessing innovation
- Building research strategy and fostering a research ecosystem
- Driving digital and advanced analytics as enablers
- Health emergency planning and resilience
- Improving population health and reducing health inequalities
- Strategic communications and engagement
- Statutory functions which cannot be delegated e.g. annual ICB financial plan, system quality assurance, ICB annual report and accounts

**Sub-system functions discharged at Place***

- Building strong relationships with communities
- Service development and delivery with a focus on neighbourhoods and communities
- Commissioning local integrated community-based services for children and adults (including care homes and domiciliary care).
- Local Primary care commissioning (excluding nationally negotiated GP contracts) – building the capacity of local PCNs and supporting their clinical leadership role.
- Local Clinical Leadership including clinical pathway redesign and helping shape the commissioning of acute services
- Monitoring the quality of local health and care services – including support to care homes, e.g. infection prevention and control.
- Forging strong working relationships with the wider local system including HealthWatch, the Voluntary Sector, and other local public services.
- Monitor Place based delivery of key enabling strategies.

**In addition, there are formal place-based joint working arrangements between the NHS and Local Authorities which will also be part of the ICB delegated functions; they include:**

- Participation in Health & Wellbeing Boards to develop Joint Strategic Needs Assessments and Joint Health & Wellbeing Strategies
- Joint initiatives to promote health, prevent disease and reduce inequalities
- Joint commissioning and leadership of local services:
  - Continuing Health Care
  - Personal Health Budgets
  - Community mental health, learning disability and autism
  - Children and young people's services (including transitions, Special Educational Needs and Disabilities, Looked After Children)
- Service integration initiatives and jointly funded work, e.g. the BCF & Section 75.
- Fulfilling the NHS's statutory advisory role in adults' & children's safeguarding.
- The provision of updates to local Scrutiny Committees and Lead Members on local health and care services.

** Some of these functions may have a policy or plan developed at a geography above Place for ICB consistency but the function would be delivered and nuanced at Place*

# System level working example: Commissioning by the ICB

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**Proposals developed by the Commissioning workstream:**

- Commissioning is a tool to deliver the ICB's priorities (hence our ICB commissioning sub-cttee)
- ICB commissioning should be simpler than current arrangements
- We should do things once where possible, and avoid duplication
- Our commissioning resources should be used flexibly to support pressure points
- Our clinical networks should support performance and pathway improvement
- We can build on and refine what already works well - e.g. the lead commissioner model
- One contract per provider, with a clear nominated lead
- ICB rules should determine that contracts are handled as close to provider footprints as possible
    - Specialised Services and Ambulance Services at system level
    - Acute and community contracts across relevant places (ICP area level?)
    - BCF and smaller scale VCSE contracts managed at place
- Commissioning, performance and quality management could happen on the same footprints

**Key question: Does this mean high value contract negotiation is done locally and at 'area' level – with sign off at the ICB Commissioning Committee?**

# Place-based working: Expectations in the Integration White Paper

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- While strategic planning is carried out at ICS level, **places will be the engine for delivery** and reform
- Introducing a **single person accountable for delivery** of a shared plan at a local level – agreed by the relevant local authority and ICB
- Expectations for **place-level governance and accountability** through 'Place Boards' or similar to be adopted by Spring 2023.
- **Place governance should provide clarity of decision-making**, agreeing shared outcomes, managing risk and resolving disagreements between partners
- These arrangements should **make use of existing structures** and processes including Health and Wellbeing Boards and the Better Care Fund.
- All places will need to develop ambitious plans for the scope of services and spend to be overseen and section 75 will be reviewed to **encourage greater pooling of budgets**
- ICS will support **joint health and care workforce planning at place level** to meet the needs of local populations, expanding multidisciplinary teams
- **ICSs will provide support and challenge to each place** as to the assessment of need and local outcome selection and plans to meet both national and local outcomes.
- **The CQC will consider outcomes agreed at place level** as part of its assessment of ICSs
- **Place Boards will require shared insight** and a holistic understanding of the needs of their local population, listening to the voices of service users

## Each of our places has:

A **Health and Wellbeing Board** – a statutory committee of each local authority, responsible for assessing local health and care needs (JSNA) and developing a local strategy (JHWBS)

A **non-statutory local partnership forum** of NHS and LA executives –responsible for operationalising the JHWBS, developing local integration initiatives, and overseeing pooled budgets and joint financial decisions (S75, BCF).

Each Place-Based Partnership/Board/Committee will be accountable for the delivery of objectives set out by the ICB. Some of already have the design features and representation to move seamlessly into the new system – but some may need to evolve.

| CCG | Local Authority | Partnership Forum |
|---|---|---|
| Cumbria | Cumbria County Council | North Cumbria ICP Leaders Board |
| | | North Cumbria ICP Executive |
| | | (Whole of) Cumbria Joint Commissioning Board |
| | | (Whole of) Cumbria Health and Wellbeing Board |
| Newcastle Gateshead | Newcastle City Council | Collaborative Newcastle Executive Group |
| | | City Futures Board (formerly Health & Wellbeing) |
| | Gateshead Council | Gateshead Care (System Board and Delivery Group) |
| | | Gateshead Health and Wellbeing Board |
| Northumberland | Northumberland County Council | Northumberland System Transformation Board |
| | | BCF Partnership |
| | | Northumberland Health and Wellbeing Board |
| North Tyneside | North Tyneside Council | North Tyneside Future Care Executive |
| | | North Tyneside Future Care Programme Board |
| | | North Tyneside Health and Wellbeing Board |
| Sunderland | Sunderland City Council | All Together Better Executive Group |
| | | Sunderland Health and Wellbeing Board |
| South Tyneside | South Tyneside Council | S Tyneside Alliance Commissioning Board & Exec |
| | | South Tyneside Health and Wellbeing Board |
| Durham | Durham County Council | County Durham Care Partnership |
| | | County Durham Health and Wellbeing Board |
| Tees Valley | Middlesbrough Council | South Tees Health and Wellbeing Board |
| | Redcar & Cleveland Council | Adults Joint Commissioning Board |
| | Hartlepool Council | Hartlepool BCF Pooled Budget Partnership Board |
| | | Hartlepool Health and Wellbeing Board |
| | Stockton-on-Tees Council | Stockton BCF Pooled Budget Partnership Board |
| | | Stockton-on-Tees Health and Wellbeing Board |
| | Darlington Council | Darlington Pooled Budget Partnership Board |
| | | Darlington Health and Wellbeing Board |

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# Financial delegations to place agreed by FLG and JMEG

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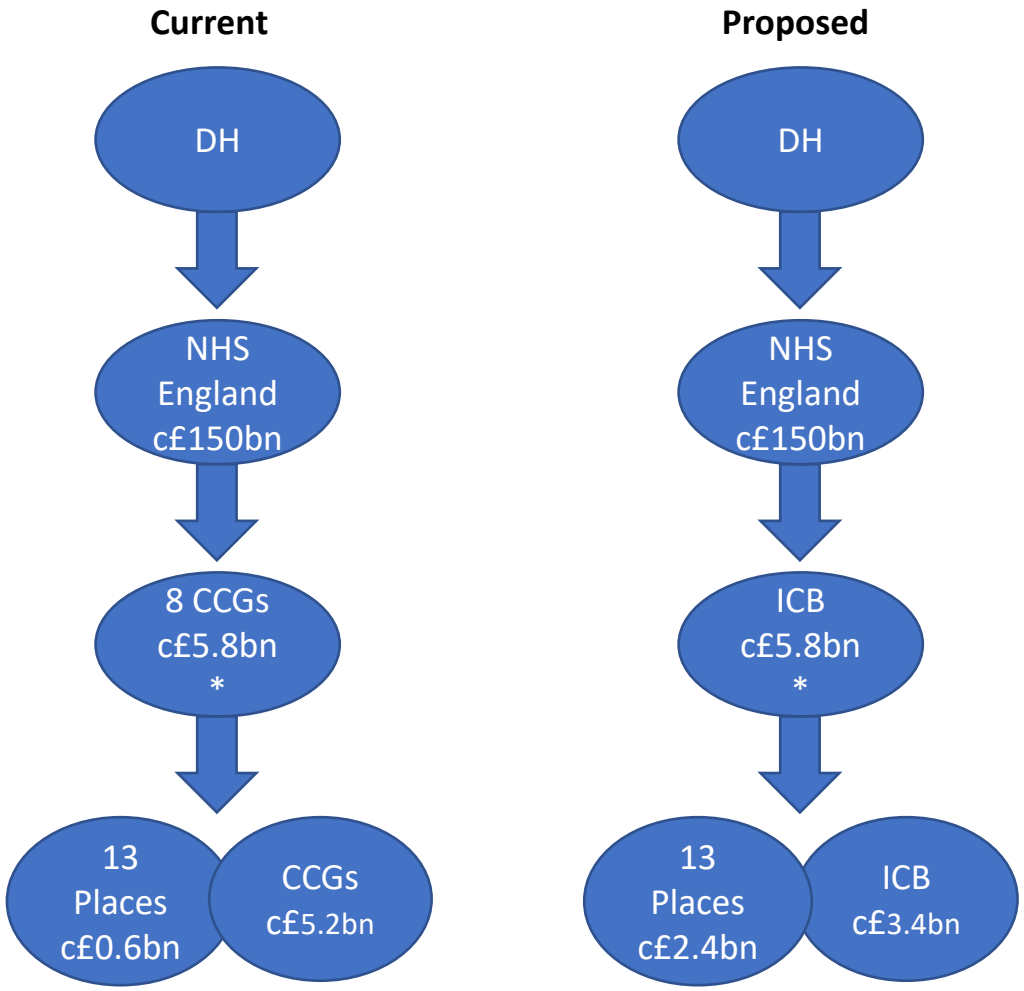
- The Finance Leadership Group recommended increasing the current allocation of resources overseen at Place
- Currently joint financial arrangements at place tend to focus predominantly on the *Better Care Fund* and those services closely aligned with it – e.g. the joint-funding of care packages, safeguarding, and elements of community and primary care.
- From 1 July 2022, Place-Based Partnerships will be responsible for all long-term care packages, community-based services, local primary care services and VCSE provision.
- Place Based Partnerships will therefore need robust governance to manage a more significant level of resource.

**These are indicative allocations at this point**



# ICB Exec placed based delivery concept

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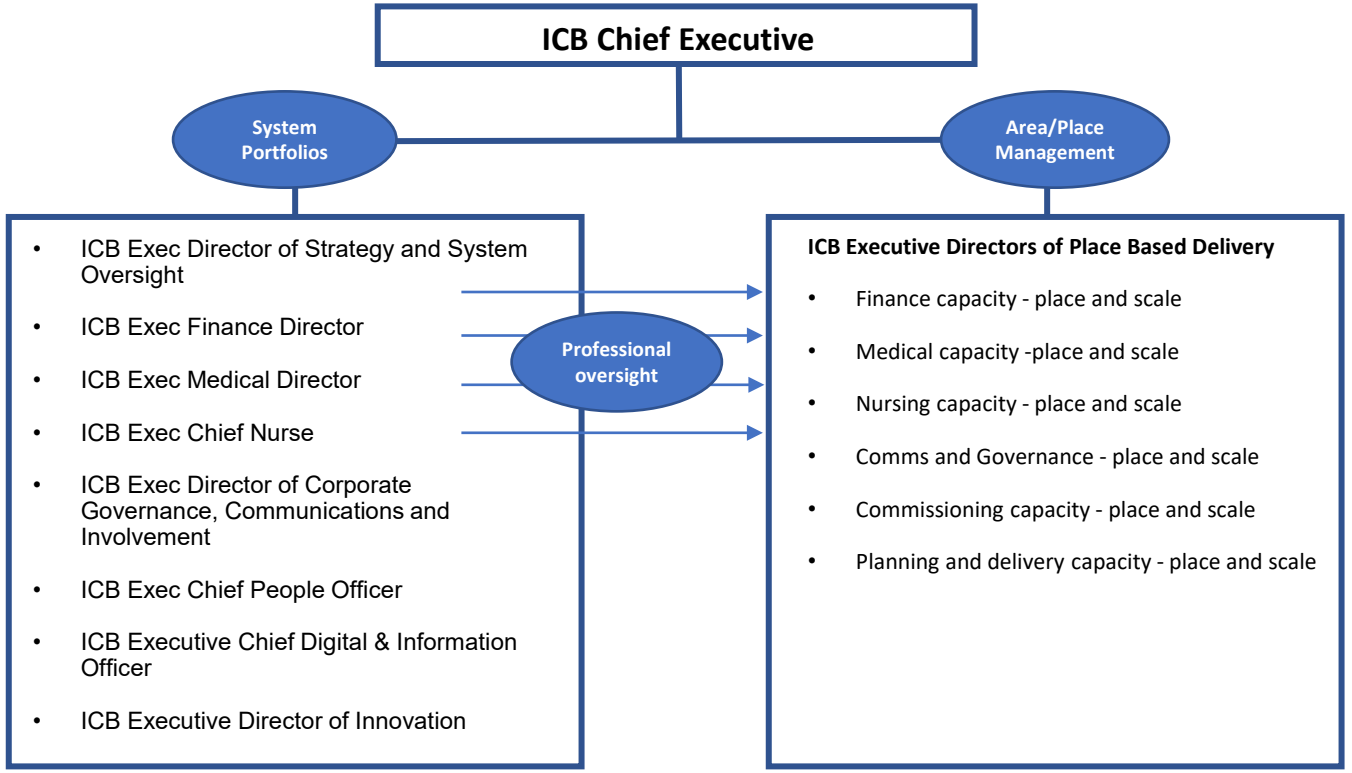
**Role**

- Responsible for delivering both the ICB's strategic priorities and those agreed at place – tackling variation, driving up quality and improving outcomes

**Guiding principles for consideration**

- Efficient and cost neutral deployment of our CCG staff
- Harmonising approaches and being as efficient as we can across the ICB while maintaining the strength of place-based working
- Do we need to look at how we manage our resources equitably across our whole ICB ?
- Do we need to ensuring a more consistent model of NECS support for each ICB Area ?

# Matrix Management?




*NB Area Director portfolios TBC*

# System Flow Chart

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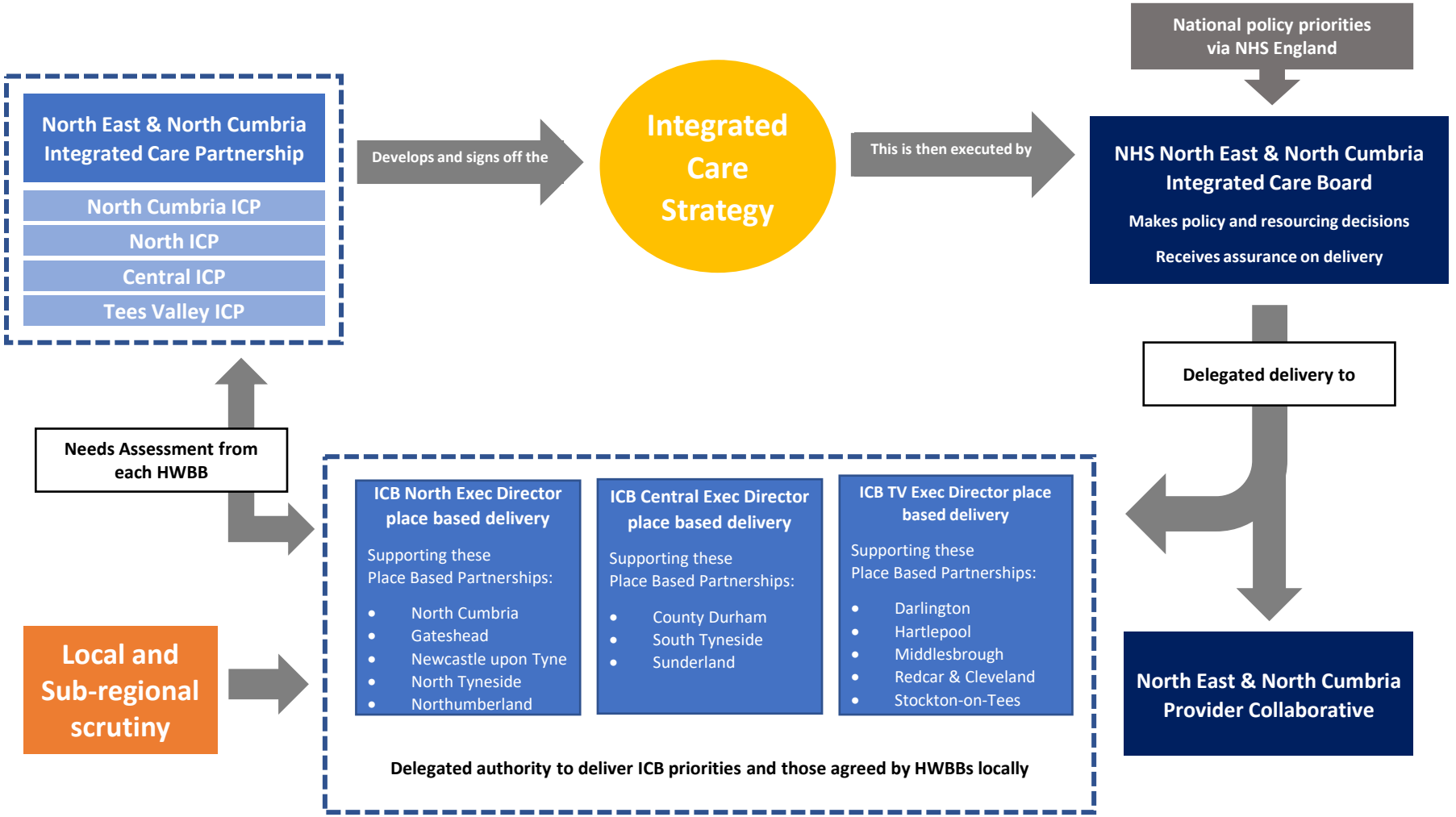
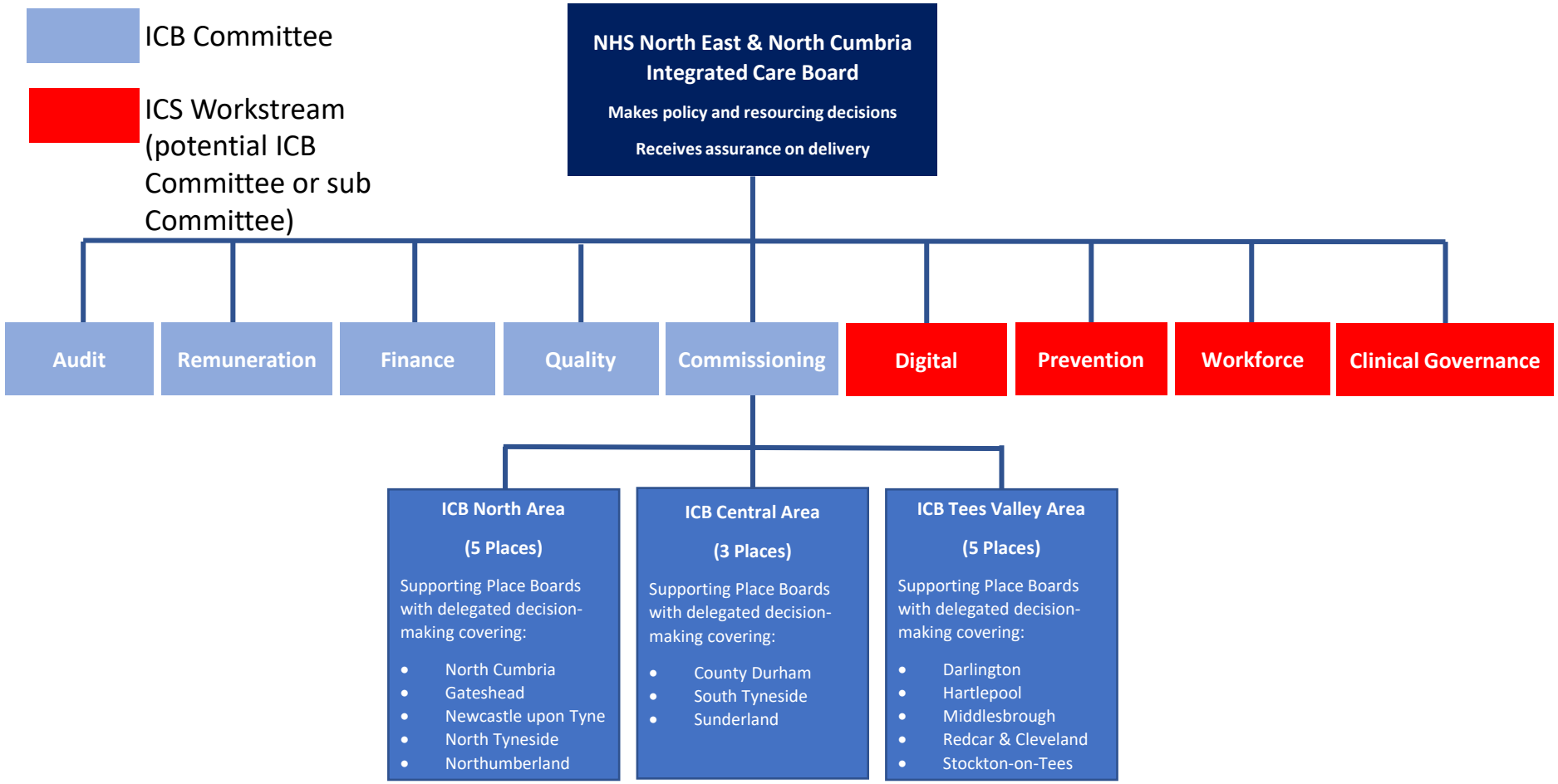
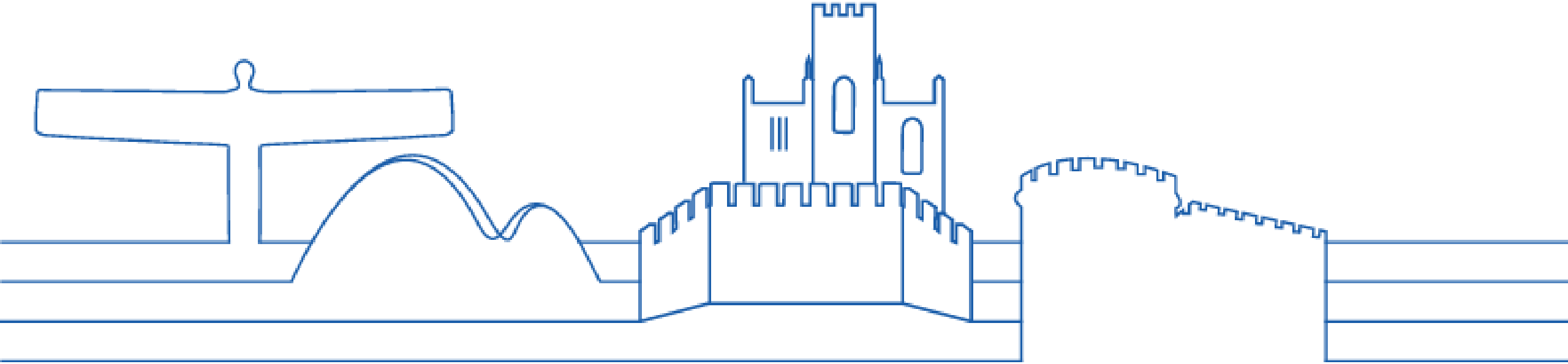


# Accountability to the ICB



# Proposed engagement



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## Some key questions to consider

- Given the proposed split of system and place-based functions agreed by JMEG, what key functions need to be managed within the ICB's corporate services?
- Based on the proposed functions and their allocation at place and system do you foresee any major safety, reputational or delivery issues
- Do you feel the mapping covers all of the functions you would expect to see in the area you work in and if not what is missing
- Do you think the proposed ICB committee structure is logical, what areas do you feel we may need to consider using sub committees for eg Primary care delegated
- What opportunities are there to further strengthen our place-based working arrangements with our partners? For example, pooling budgets, or joint workforce planning.
- Given the expectation in the Integration White Paper for place-based leadership and governance, what place-based infrastructure would be required to support this and can this only be delivered at place or across places
- How can we build on existing lead commissioning arrangements within our ICS? And could certain commissioning functions be carried out within our ICS sub-regions, and if so what?

# Engagement with leadership groups

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- ICB team to share proposals with;
  - Joint CCG Committee (for CCG chairs)
  - CCG COOs group
  - CCG Executive committees
  - ICS Workstreams
  - Key partners and stakeholders
  - ICS Management Group

# Engaging CCG governing bodies and staff

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- To be led via Accountable Officers
- Governing bodies to be formally presented to with feedback collated.
- Accountable Officers to brief staff verbally and then provide a link to a questionnaire
- All staff to have the opportunity to feedback via the questionnaire created via Comms
- Questionnaire to be available by 1st March
- Comms will provide a syndicated email for Accountable Officers to use as they see fit

# Engaging Local Partner PCNs, GPs, FTs, LAs,

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- Accountable Officers to engage local partners to garner feedback
- To include PCNs, GPs, FTs, LAs, Healthwatch, Voluntary Sector
- Briefings should be set up
- A link to a questionnaire will be provided to be issued to partners for completion

# Feedback

- To be collated and reported on
- Recommendations made on any changes required
- Report to be shared with the Programme Board 25th March
- To be presented to 1st ICB Shadow Board

# Next steps?

- Engage with our colleagues on the detail of the proposed operating model in February and March  (questionnaire to be available first week in March)
- Test the proposed model against a range of scenarios, including:
  - serious quality and financial performance issues
  - major service reconfiguration
  - high cost care packages
  - reducing health inequalities
- Review our Scheme of Reservation and Delegation to ensure alignment with operating model
- Review ICB committee roles and structures, and the governance of our ICS workstreams, with our Exec Directors as they are appointed.
- Conclude CCG staff mapping, and consider how our staff are best deployed to support the final agreed model
- Review current NECS SLA, and consider rebalancing how this support is best deployed across our system

# Appendix 8
# Five principles for placing effective clinical and professional leadership

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1. Ensure that the full range of clinical and professional leaders from diverse backgrounds are integrated into system decision-making at all levels, supporting this with a flow of communications and opportunities for dialogue.
2. Nurture a culture that systematically embraces shared learning, supporting clinical and care professional leaders to collaborate and innovate with a wide range of partners, including patients and local communities.
3. Support clinical and care professional leaders throughout the system to be involved and invested in ICS planning and delivery, with appropriate protected time, support and infrastructure to carry out this work.
4. Create a support offer for clinical and care professional leaders at all levels of the system, one which enables them to learn and develop alongside non-clinical leaders (eg managers and other non-clinical professionals in local government and the VCSE sector), and provides training and development opportunities that recognise the different kind of leadership skills required when working effectively across organisational and professional boundaries and at the different levels of the system (particularly at place).
5. Adopt a transparent approach to identifying and recruiting leaders which promotes equity of opportunity and creates a professionally and demographically diverse talent pipeline that reflects the community served and ensures that appointments are based on ability and skillset to perform the intended function

# Views?  Questions?