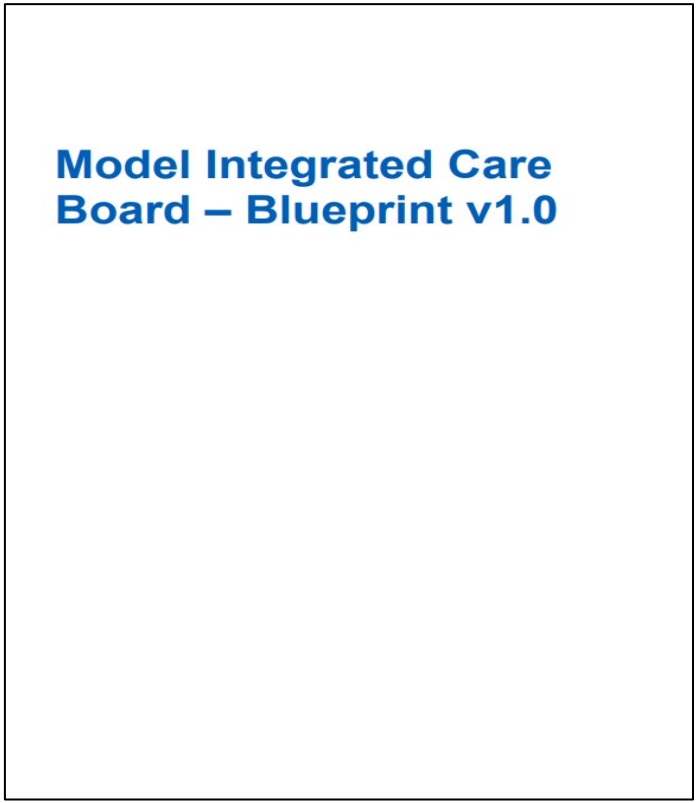
NHS
North East and North Cumbria

May 2025

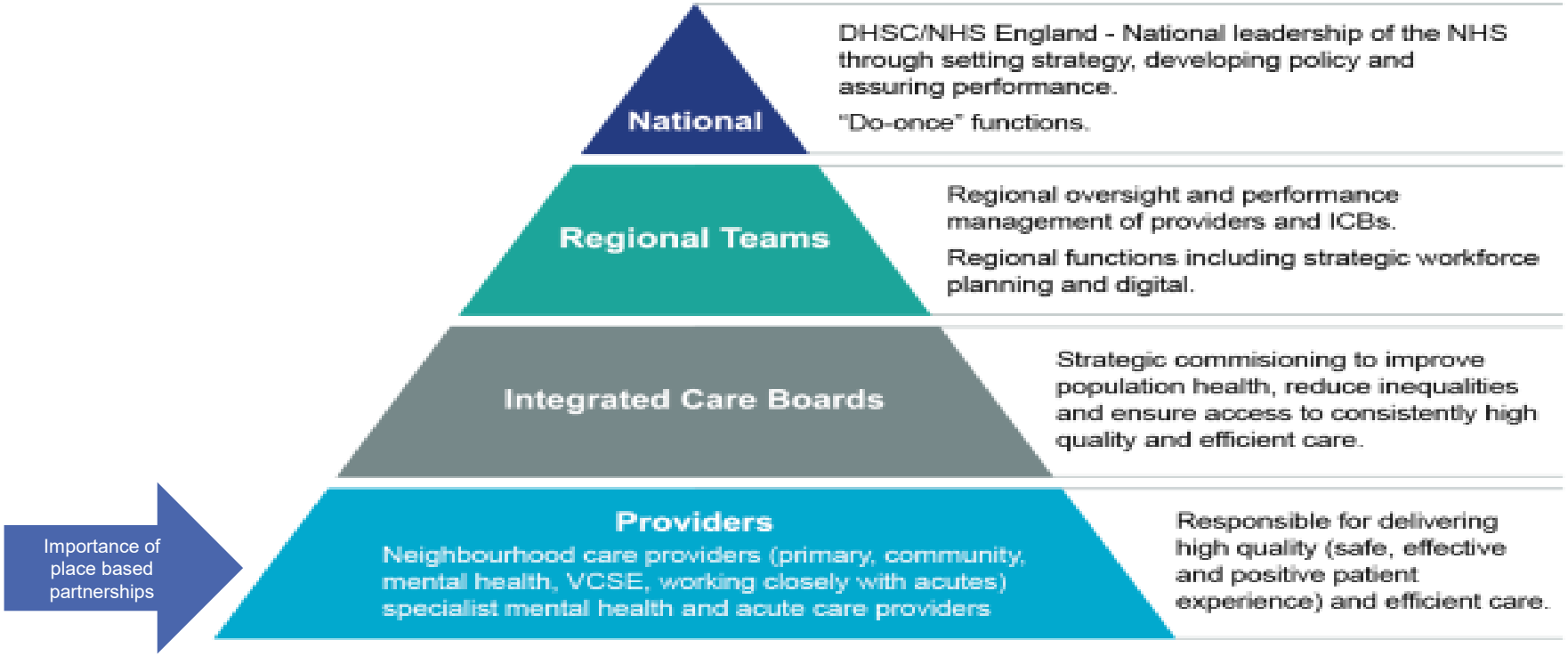
Partner Briefing

Publication ICB Blueprint

- Published early May
- Guide for what we need to do over the coming months
- Provides some signals of what to consider
- Evolving picture
- National mandate to deliver this



How the infrastructure fits together…



Core functions for ICBs…

Model ICB - System leadership for improved population health

1. **Understanding local context**
   Assessing population needs now and in the future, identifying underserved communities and assessing quality, performance and productivity of existing provision

2. **Developing long-term population health strategy**
   Long-term population health planning and strategy and care pathway redesign to maximise value based on evidence

3. **Delivering the strategy through payer functions and resource allocation**
   Oversight and assurance of what is purchased and whether it delivers outcomes required

4. **Evaluating impact**
   Day-to-day oversight of healthcare usage, user feedback and evaluation to ensure optimal, value-based resource use and improved outcomes

ICB functional changes…

Grow

- Population health management, data analytics, predictive modelling, risk stratification, understanding inequalities
- Epidemiological capabilities
- Strategy and strategic planning
- Health inequalities and inclusion
- Neighbourhood health commissioning
- Commissioning clinical risk management
- Commissioning end to end pathway including spec comms and POD
- Vaccinations and screening
- Core payer functions
- Evaluation
- Strategic partnerships

ICB functional changes…

Selectively retain and adapt

- **Quality management** – embed in commissioning cycle and avoid duplication with Providers and CQC
- **Board governance** – look to streamline Boards and reduce headcount at Board
- **Clinical governance** – strengthen focus on embedding management of population clinical risk
- **Corporate governance** – Maintain good governance and look to deliver some functions at scale
- **Core organisational operations** (HR, Communications, internal finance, internal audit, procurement, complaints, PALs) – Look to streamline and deliver some functions at scale

ICB functional changes…

Review for transfer

- **Oversight of provider performance** – transfer to regions
- **EPRR and SCC** – transfer to regions over time
- **High level strategic workforce planning**, development and education and training – transfer to region or national
- **Local workforce development** and training including recruitment and retention – transfer to providers over time
- **Research and Innovation** – transfer to regions over time with ICBs retaining and building strategic partnerships to support population health
- **Green plan and sustainability** – Transfer to providers over time
- **Digital and technology leadership and transformation** – transfer digital leadership to providers over time
- **Data collection and processing** – transfer to national over time
- **Infection prevention and control** – Test and explore options to streamline and transfer some activities out of ICBs

ICB functional changes…

Review for transfer

- **Safeguarding** – test and explore options to streamline and transfer some activities out of ICBs
- **SEND** - test and explore options to streamline and transfer some activities out of ICBs
- **Development of neighbourhood and place partnerships** to providers over time
- **Primary care operations and transformation** (including primary care, medicines management, estates and workforce support) transfer to neighbourhood health providers over time
- **Medicines optimisation** – transfer delivery to providers over time whilst retaining strategic commissioning
- **Pathway and service development** - test and explore options to streamline and transfer some activities out of ICBs
- **NHS Continuing Healthcare** – Test and explore options to streamline and transfer out of ICBs
- **Estates and infrastructure strategy** – transfer to providers over time, retain strategic commissioning overview
- **General Practice IT** – Explore options to transfer out of ICBs ensuring consistent offer

Delivering ICB cost reductions …

- The document states that ICBs will need to use this guidance to create plans which are affordable within the revised running cost envelope of **£18.76 per head of population**.

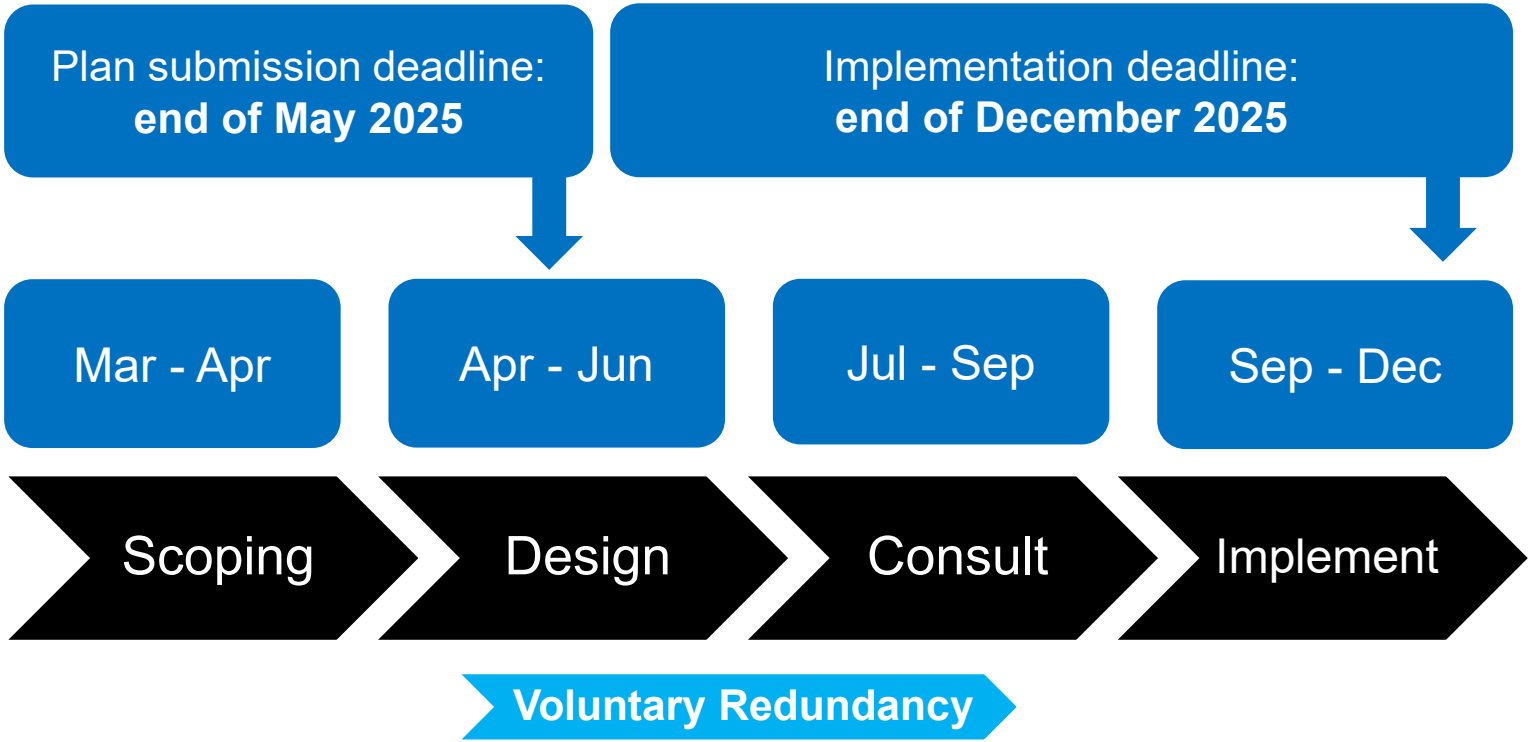
- The reduction in ICB costs to meet this target must be delivered by the end of Q3 2025/26 and recurrently into 2026/27

- Generating savings cannot be a cost shift to a provider/partner unless overall there is the saving, for example, a provider takes on an ICB operated service and therefore requires **circa 50% less cost in line with the £18.76 running cost envelope**

The ask for the coming months…

- Deliver ICB cost reductions plans and realising the savings
- Manage the impact on staff
- Design leadership structures of ICBs
- Manage risk during transition through safe governance
- Expectations for safe transition of transferred functions

High level programme plan…



Cost reduction ask…

- NHS England is setting a broadened spend cap for ICBs, covering running costs plus programme staff spend, of **£18.76** per head of population
- NENC has proportionately one of the **smallest reduction targets** of the 42 ICBs, due to our current costs being lower than most

Current:

£100.307m

(£27.69 per head)

Future:

£67.969m

(£18.76 per head)

Reduction:

£32.338m

(32%)

Potential impact on staff…

Current budget staff WTE	Potential staff WTE reduction (32%)	Current vacancies WTE
1,048	336	116*

- Numbers **include** staff transferred from NECS on 1 April 2025
- *Assuming no further recruitment at all, we would need to further reduce our wholetime equivalent staff in post by at least **220** and up to **270** if we need to fill some critical service posts - for example, the safeguarding and all ages continuing care teams
- For example, there are **48 WTE vacancies** in nursing posts

- **NB – new operating model may mean changing roles for many more**

ICB statutory duties

- Promote the NHS Constitution
- Exercise functions effectively, efficiently and economically
- Improvement in quality of services
- Reducing Inequalities
- Promote involvement of each patient
- Patient Choice
- Obtain appropriate advice
- Innovation
- Respect of research
- Promote education and training
- Promote integration
- Have regard as to wider effect of decisions
- Climate change

In addition, there are separate duties as a category 1 responder under the Civil contingencies Act and various safeguarding legislation

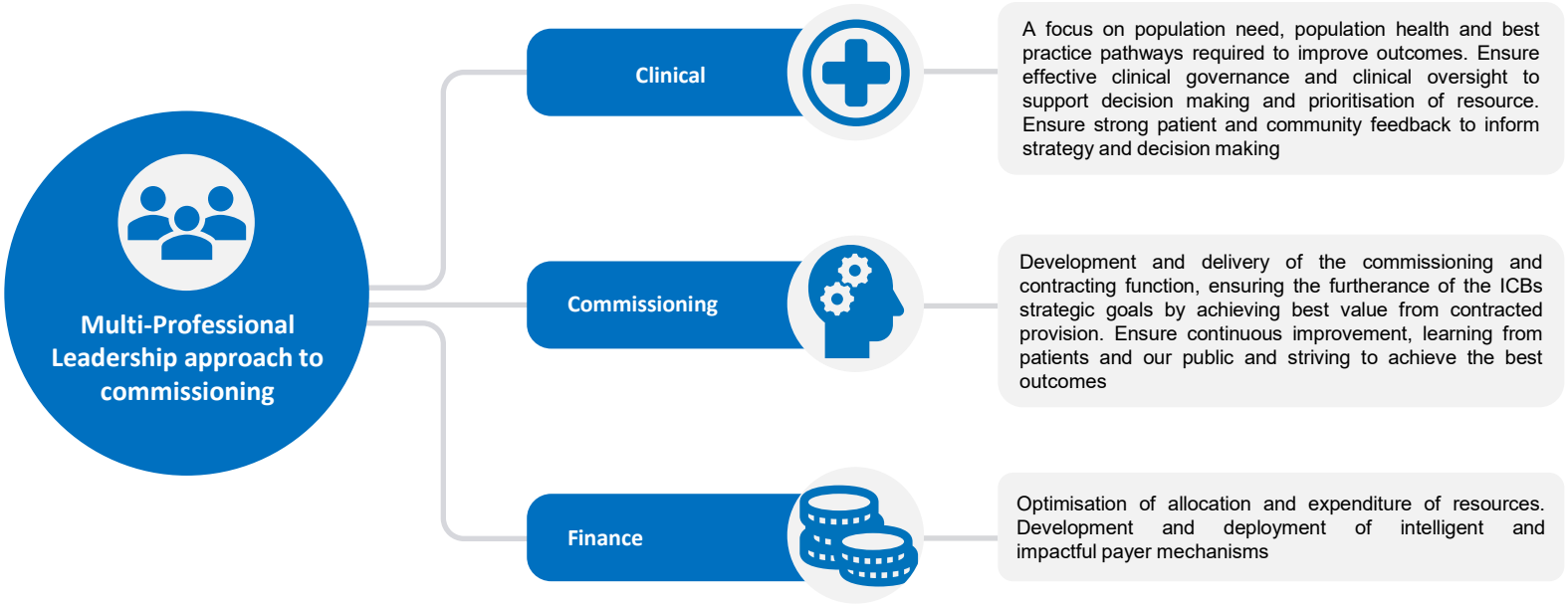
- We need to be cognisant of such duties as the ICB can not delegate ‘accountability’ of such functions without there being a change in the Health and Social Care Act

Initial thoughts regarding operating model…

Multi-Professional Leadership Approach…

The ICB will provide system leadership for population health, set evidence based and long-term population health strategy and work as an intelligent healthcare payer to maximise the value that can be created from its available resource. This involves investing in, purchasing and evaluating a range of services and pathways required to ensure access to high quality care, and in order to improve outcomes and reduce inequalities within its footprint.

To achieve this, the ICB will implement a Multiprofessional Leadership approach to commissioning. This will involve the collaborative efforts of leaders from clinical (medical, nursing and AHP), commissioning, and finance at all levels including at an Executive Director level, working together to lead a multi professional commissioning approach to ensure delivery of the aims and objectives of the organisation.



High level organisational approach…

Multi-professional approach acting as an expert enabler to guide, support and ensure the organisation takes a population health management approach to reform and acts as an intelligent healthcare payer. This will include key functions such as medical and nursing oversight, business intelligence, planning and finance

Multi-professional approach to deliver overarching organisational strategy, acting as the engine room of the organisation. Key functions such as commissioning, contracting, medical and nursing, quality and finance will work collaboratively and in a connected way

Multi-professional approach to ensure the organisation is compliant, accountable and safe and that we strive to work with our communities to hear, learn and use this knowledge to further our commissioning approaches. Including the key functions of governance, communications, involvement, engagement, HR and organisational development

Coming weeks…

- Still evolving therefore things could change or be nuanced
- End of May submission is focussed on ensure we deliver the financial ask
- Structure of ICB will likely be consulted on in July with staff.
- Will have redundancies – just awaiting timings of this
- Further local and specialist (VCSE, POD etc) engagement to take place with a ‘workshop in a box’ specifically focused on those areas to consider to transfer – this will need to include how we will interface with local organisations.
- Continue to work with Combined Authority, NHS and LA CEOs as this work progresses

Place Committee Workshop Questions – 6th June

1. Do you agree with the list of functions to be transferred, is there anything you believe should be removed/added?
2. Rank the list to transfer in priority order
3. What is the resource expectation aligned to the transfer?
4. Given this means the relationship at ‘Place’ is with Providers (including primary care and VCSE partners) and Local Government, who should be taking the lead convening role?
5. When could the transfer of this Place responsibility happen?
6. What needs to be in place to facilitate the transfer to a “ready and willing” receiver?

Workshop Outputs

1. **Do you agree with the list of functions to be transferred, is there anything you believe should be removed/added?**
   I. Yes, the list is broadly fine, but more detail on some of the functions would be welcome
   II. There were some functions identified that groups struggled with the need for e.g., IPC as there was existing resources in local providers that could facilitate this function.
   III. Some functions could come over relatively painlessly as existing expertise and skills could lead them e.g. estates

2. **Rank the list to transfer in priority order**
   I. Neighbourhood Health & Primary Care were ranked as the key areas of priority. However, it was noted that quite a few of the other functions were key to the successful delivery of neighbourhoods and primary care e.g. estates, digital, GPIT, SEND, safeguarding etc. In essence, the view was, to do the 'priority things', almost all of the identified functions needed to transfer.
   II. Medicines Optimisation – there were mixed views on this, as some saw this as an opportunity to align primary and secondary prescribing and as an area of opportunity for efficiency gain. Others felt this was best held at an regional level.
   III. Green plan & sustainability and IPC were felt to be functions that could be undertaken quite readily from existing services

3. **What is the resource expectation aligned to the transfer?**
   I. All tables were of the view that there would need to be an appropriate resource transfer from the ICB to support the delivery of these functions at a local level. This should be determined based upon the national capacity and capability framework that is referenced in the blueprint. It was acknowledged that there was some expertise and resource at a place level that could align to some of this work, but expertise and experience (or lack of) were identified as risks (e.g. primary care operations, GPIT etc)
   II. View was that alignment of ICB resources would augment existing place resources and could provide economies of scale at a local level e.g. pathway redesign, operations management, estates
   III. Digital was identified as a major gap amongst NHS organisations, but it was felt opportunity existed in working more closely with the LA on this aspect.

4. **Given this means the relationship at 'Place' is with Providers (including primary care and VCSE partners) and Local Government, who should be taking the lead convening role?**
    I. This was quite a contentious point, but in the feedback sessions it was clear that there is significant appetite amongst all local partners to do something across Sunderland. STSFT, CNTW and the LA all expressed interest in being the 'lead' but also all recognised that there is opportunity to do something more aligned e.g. a joint committee/ACO.
    II. Was recognised that this conversation needed much more time to be spent on it, but the ATB work of the past had given them a strong foundation upon which to build.
    III. Some reservations from primary care and VCSE members in the room 're having an 'equitable voice' in the governance and future arrangements.

5. **When could the transfer of this Place responsibility happen?**
    I. All three tables agreed that there needs to be a level of ambition to doing this sooner rather than later – April 2026 was mooted as a date to start 'shadow running' with April'27 as a potential 'go-live'. It was recognised much of this would depend upon resource allocation, the 10yr plan and the development and availability of 'capacity and capability' frameworks as per the Blueprint.
    II. It was clear from conversations that delegation of budgets and day-to-day [tactical] commissioning responsibilities would need to be clarified. If the ICB is a strategic commissioner of services, how and where does the tactical commissioning get done and how does the management of this happen?

6. **What needs to be in place to facilitate the transfer to a "ready and willing" receiver?**
    I. Agreement amongst partners of the 'neighbourhood health provider' form e.g., ACO, lead provider, joint committee
    II. Agreement of shadow running and go-live dates
    III. Clarity from an ICB perspective as to what is entailed in delivering each of the transferring functions (capacity & capability, sign-off etc)
    IV. Clarity from the ICB as to how resource will be aligned to support the transfer.
    V. Agreement amongst partners on the governance to implement this programme of work e.g. revisit place committee ToR to support creation of a 'neighbourhood board'.

Thank you