ICS development briefing

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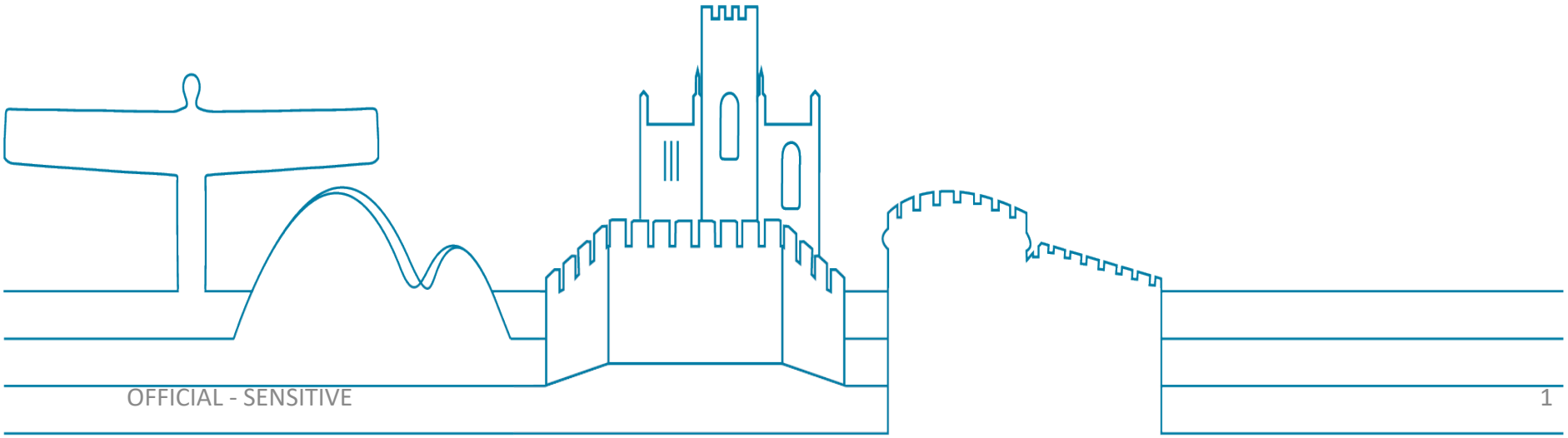
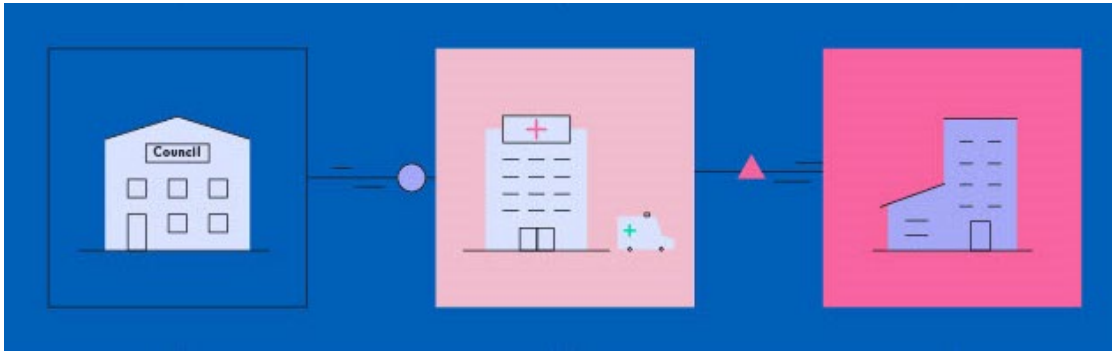


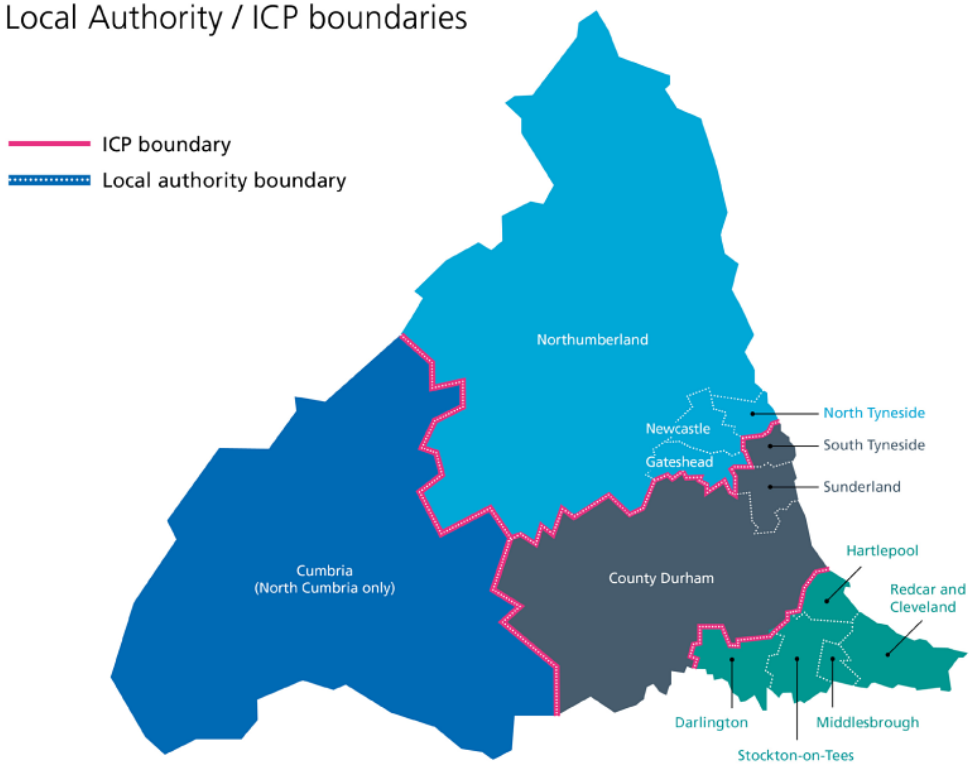
ICSs have four key purposes:

- **improving outcomes** in population health and healthcare;
- **tackling inequalities** in outcomes, experience and access;
- **enhancing productivity** and value for money;
- supporting broader **social and economic development**.



Working at place and system

North East and North Cumbria
Local Authority / ICP boundaries



North Cumbria ICP

Population: 324,000
1 CCG: North Cumbria
Primary Care Networks: 8
1 FT: North Cumbria Integrated Care NHS Foundation Trust (NCIC)
1 Council Area: Cumbria County Council (with 4 District Councils)
North West Ambulance Service

NENC ICS-wide

North East Ambulance Service FT covers: North of Tyne and Gateshead ICP; Durham, South Tyneside and Sunderland ICP; Tees Valley South ICP

CNTW Mental Health FT covers: North Cumbria ICP; North of Tyne and Gateshead ICP; plus part of South Tyneside and Sunderland ICP

TEWV Mental Health FT covers: Tees Valley ICP; plus part of South Tyneside and Sunderland ICP

Newcastle upon Tyne Hospital FT: provider of highly specialised and specialised national and regional services (including transplant, paediatric specialisms and major trauma)

South Tees Hospitals FT: provider of highly specialised north of England and regional services (including cardiothoracic, spinal, cochlear implant neurosciences, gynaecology, urology and major trauma)

North of Tyne and Gateshead ICP

Population: 1.079M
3 CCGs: Northumberland, North Tyneside, Newcastle Gateshead
Primary Care Networks: 22
3 FTs: Northumbria, Newcastle, Gateshead
4 Council Areas: Northumberland, North Tyneside, Newcastle, Gateshead

Durham, South Tyneside and Sunderland ICP

Population: 997,000
3 CCGs: South Tyneside, Sunderland, County Durham
Primary Care Networks: 22
2 FTs: South Tyneside & Sunderland, County Durham and Darlington
3 Council Areas: South Tyneside, Sunderland, County Durham

Tees Valley ICP

Population: 701,000
1 CCG: Tees Valley
Primary Care Networks: 14
3 FTs: County Durham and Darlington, North Tees & Hartlepool, South Tees
5 Council Areas: Hartlepool, Stockton on Tees, Darlington, Middlesbrough, Redcar & Cleveland

Interdependence of our ICS

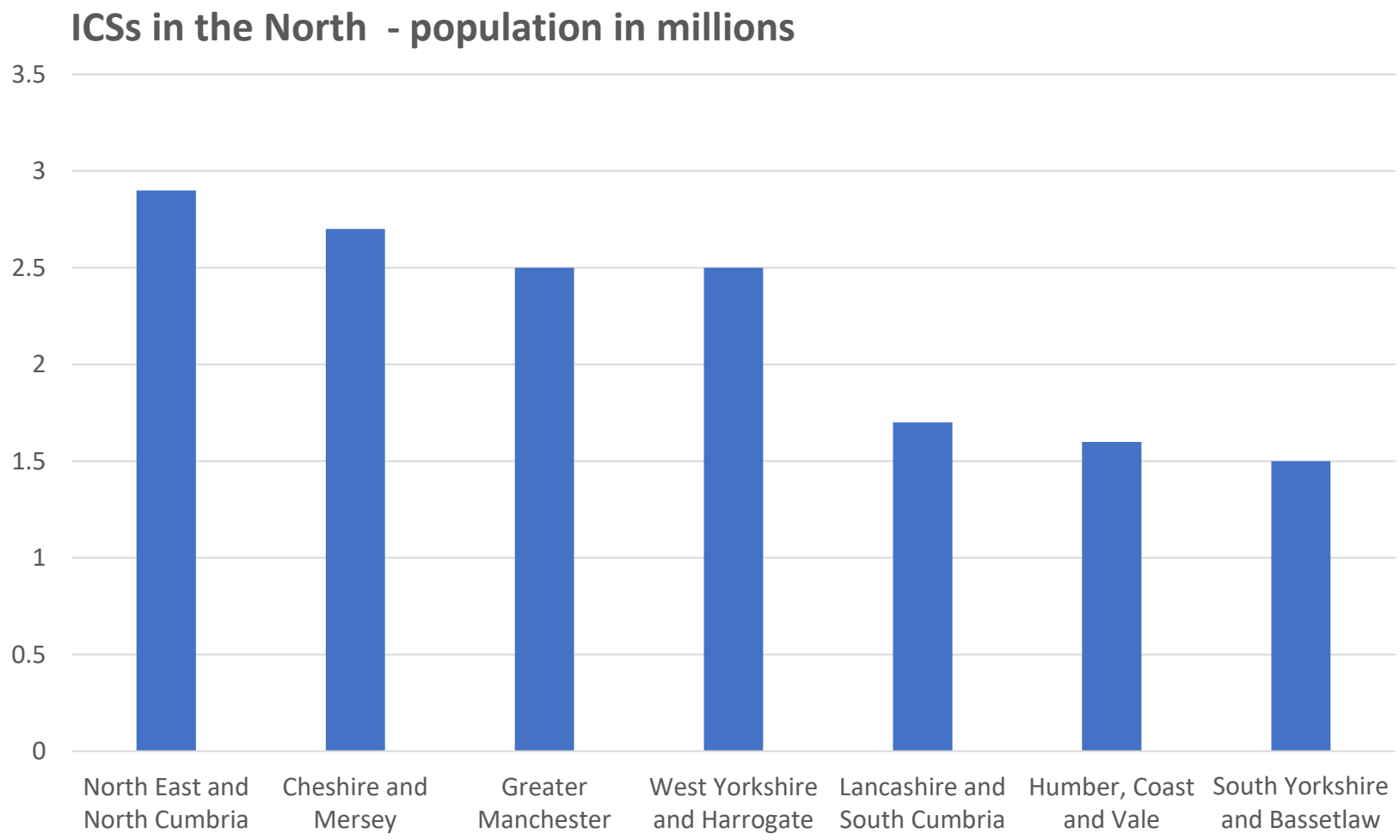
Existing functions at whole North East level

- One ambulance service – NEAS – for the whole of the North East
- One highly specialist tertiary provider (NUTH) – with historic patient flows from Teesside
- One integrated COVID hub and Nightingale Hospital for the ICS
- 16 clinical networks – including the Northern Cancer Alliance
- One Joint CCG Committee for joint policy decisions and strategic commissioning decisions
- Workforce Planning via HENE (Health Education England North East)
- One NHS Digital network – coordinating cyber-security and the Great North Care Record
- One NHS Comms Network to manage our shared campaigns (eg COVID, Winter)
- One Academic Health Science Network (AHSN NE) and Applied Research Collaborative (ARC)
- NHS England/NHS Improvement Locality Team – regulatory and assurance oversight
- One main provider of NHSE delivery support services: NECS (North East Care System Support)

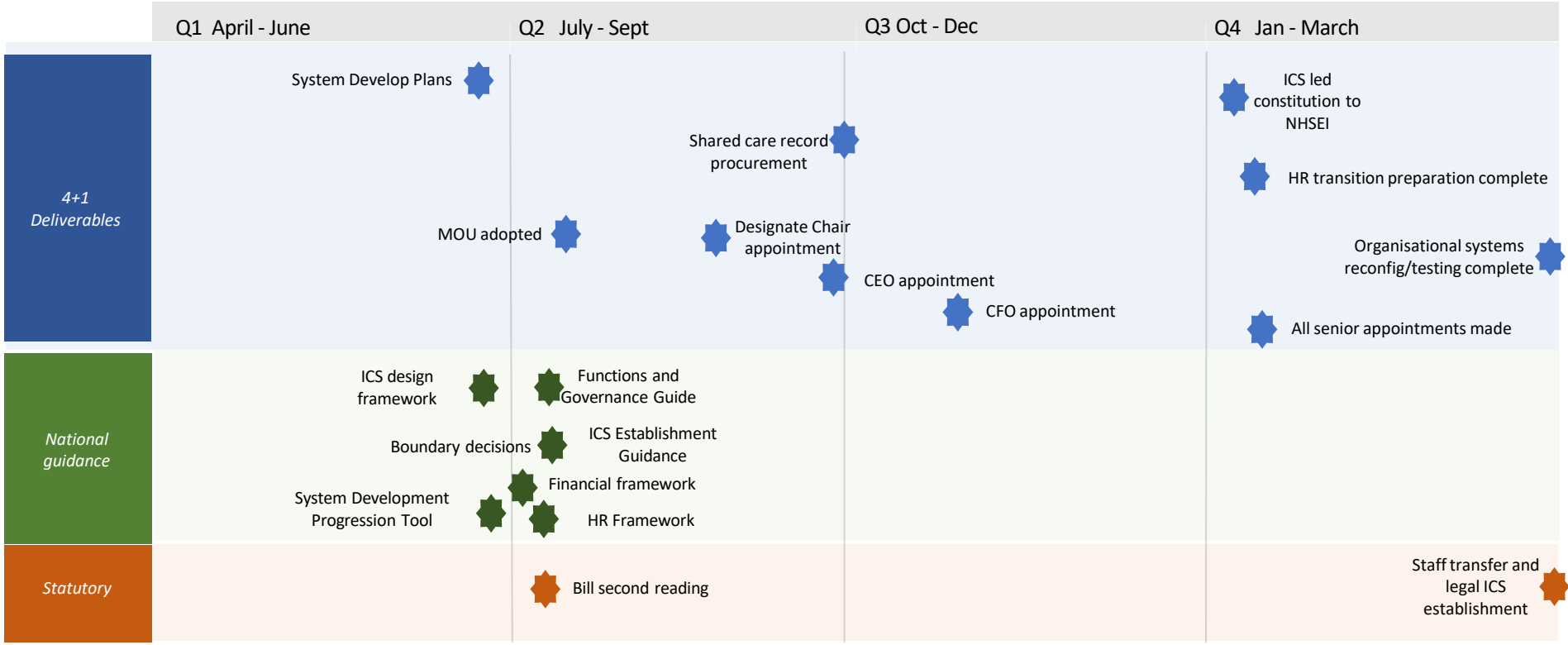
Partner networks at whole North East level

- Public Health England North East – plus the NE Tobacco and Alcohol control offices
- North East Directors of Public Health Network
- North East ADASS and ADCS networks
- VONNE (Voluntary Organisations Network North East)

Scale of our ICS



National ICS development timeline



The Health and Care Bill - overview

- Designed to reform the delivery of health services and promote integration between health and care, repealing the 2012 Health and Social Care Act.
- Promotes integration rather than competition and includes the specifications of integrated care systems (ICSs), with distinct statutory functions for the **integrated care board (ICB)** and **integrated care partnership (ICP)**.
- Increases the Secretary of State's powers over various aspects of the NHS's operation, notably including local service reconfigurations.
- Powers are introduced for NHSE (notably including commissioning functions) to be exercised by Integrated Care Boards.
- The government may direct NHSE (and subsequently ICSs) to use particular allocations of funding for the purposes of service integration.
- These reforms cannot be considered in isolation and their success will rely upon several factors not contained within the bill. The future of social care, for example, remains uncertain.

Key elements of an ICS

From the national ICS operating framework:

ICSs comprise all the partners that make up the health and care system working together via:

- an ICS NHS body overseen by an **Integrated Care Board**, an organisation bringing the NHS together locally to improve population health and care.
- an **Integrated Care Partnership** – a body comprising local organisations and representatives concerned with improving the care, health and wellbeing of the population, jointly convened by local authorities and the NHS

Other Important ICS features are:

- **place-based partnerships** between the NHS, local councils and voluntary organisations, residents, people who access services, carers and families – these partnerships will lead design and delivery of integrated services.
- **provider collaboratives**, bringing NHS providers together across one or more ICSs, working with clinical networks and alliances and other partners, to secure the benefits of working at scale.

Integrated Care Partnership

- The ICP will be established locally and jointly by the relevant local authorities in the ICS area and the ICB, with mutual agreement on its terms of reference, membership, ways of operating and administration.
- Chair is jointly selected by NHS and local authority; can be same chair as ICB – approach to be determined locally.
- Members must include all local authorities and the local NHS (represented at least by the ICB).
- The ICP will have a specific responsibility to develop an **'integrated care strategy'** for its whole population (covering all ages) using the best available evidence and data – including patient experience. The ICP strategy will need to cover health and social care (both children's and adult's social care), health inequalities and the wider determinants which drive these inequalities.

Expectations of ICPs

Key expectations

- No intent to produce detailed guidance for ICPs, but all systems will need to have at least Interim ICPs by April 2022.
- ICPs should be founded on the principle of equal partnership across the NHS, local government, and the communities they serve.
- They should be open an inclusive, setting the tone and culture for each system
- There should be a dynamic relationship between the ICB and the ICP. The ICB helps to form the ICP and to have regard to its strategy.
- ICPs should be strongly connected to existing governance structures such as HWBs and place-based partnerships, and their JSNAs and local strategies
- ICPs will create a dedicated space for the NHS, local government, and local communities to tackle the issues that no one organisation can address alone:
  - Improving healthy life expectancy;
  - Supporting people to live fulfilling and independent lives for longer;
  - Improving people's overall wellbeing;
  - Addressing health and wellbeing inequalities.
  - Exploring the wider connections between health and socio-economic development, housing, environment, education and transport

ICP membership options

Membership

- ICSs may appoint a single Chair of the ICP and ICB
- The only core members will be the ICB and Local Authorities in an ICS area
- ICPs can build their membership over 3-6 months, but will likely include:
  - Representatives from each of our 13 Local Authorities – e.g. HWBB chairs, Lead members with Heath and Care portfolios, and/or Senior Officers
  - Directors of Public Health
  - Key Health Sectors – e.g. Primary, Community, Acute Care
  - Key Networks – e.g. the ADASS, ADCS and DsPH network chairs
  - Independent representatives of people and communities, e.g. HealthWatch
  - Voluntary Sector – e.g. via VONNE
  - Universities and other education and skills providers

Integrated Care Board (ICB)

- ICBs will (i) bring the NHS together locally to improve population health (ii) establish shared strategic priorities within the NHS and connecting to partnership arrangements at system and place.
- The ICB must **develop a plan to meet the health needs of the population** (all ages) within the area, having regard to the Partnership strategy. The ICB must involve each relevant Health and Wellbeing Board in preparing or revising the plan.
- It is expected that the ICB will be able to delegate functions to statutory providers, place-based partnerships or provider collaboratives to enable this.

ICB Governance

- Our CCGs will need to propose an **ICB Constitution** for approval by NHSE that should confirm, ICB governance and board membership, functions and arrangements for managing conflicts of interest
- ICBs will need to publish a **Scheme of Reservation and Delegation (SoRD)** setting out (i) those functions that are reserved to the ICB (ii) those functions that have been delegated to an individual or committees (iii) those functions delegated to another body or to be exercised jointly with another body.
- ICBs must also develop a **Functions and Decision Map** by the end of Q4 that:
  - is locally defined.
  - sets out where decisions are taken and outlines the roles of different committees/partnerships.
  - is easily understood by the public.

ICB key functions

- **Developing a plan** to meet the health needs of the population
- **Allocating resources** (revenue and capital) to deliver the plan and agree contracts with providers
- Establishing **joint working** and **governance** arrangements between partners
- Leading **major service transformation programmes** across the ICS
- Implement the **NHS People Plan**
- Leading system-wide action on **digital and data**
- Joint work on **estates** and **procurement**
- Leading **emergency planning and response**

ICB statutory duties

Duty to ….

- Promote the NHS Constitution
- Obtain professional advice in the prevention, diagnosis or treatment of illness, and the protection or improvement of public health
- Improve the quality of services
- Promote integration
- Reduce inequalities
- Promote effectiveness and efficiency
- Promote patient choice
- Promote patient involvement
- Promote education and training
- Promote research and innovation
- Have regard to wider effect of decisions

Other ICB commissioning functions

Expectation is that from April 2022 ICBs will:

- assume delegated responsibility for Primary Medical Services (excluding 7A Public Health functions);
- take on delegated responsibility for Dental (Primary, Secondary and Community), General Optometry, and Pharmaceutical Services (including dispensing doctors and appliance contractors); and
- establish mechanisms to strengthen joint working between NHS England and Improvement and ICSs, including through joint committees, across all areas of direct commissioning

By April 2023, all ICBs will have:

- taken on delegated responsibility for Dental (Primary, Secondary and Community), General Optometry, and Pharmaceutical Services;
- taken on delegated commissioning responsibility for a proportion of specialised services (subject to system and service readiness) with national standards and access policies set nationally
- worked collaboratively with our organisation to determine whether some Section 7A Public Health services, and Health and Justice, Sexual Assault and Abuse Service commissioning functions will be delegated, with decisions on the appropriate model and timescale.

ICB Membership

- **The ICB will be the senior decision-making structure for the ICS NHS body, providing strategic leadership. All members of the board will make decisions as a single group with collective accountability for delivery of the ICS's functions and duties and the performance of the organisation. In most cases they will include:***

- **Independent Chair** plus a minimum of two other independent non-executive directors. (These individuals will normally not hold positions or offices in other health and care organisations within the ICS footprint.)
- **Chief Executive**
- **Director of Finance**
- **Director of Nursing**
- **Medical Director**

- at least one member drawn from **NHS trusts and foundation trusts** who provide services within the ICS's area
- at least one member drawn from **general practice** within the area of the ICS NHS body
- at least one member drawn from the **local authority**, or authorities, with statutory social care responsibility whose area falls wholly or partly within the area of the ICS NHS body.

(*subject to statutory confirmation)

Place-based partnerships: governance options

- **Consultative forum**, *informing* decisions by the ICB, local authorities and other partners
- **Committee of the ICB** with delegated authority to take decisions about the use of ICS NHS body resources
- **Joint committee of the ICB** and one or more statutory provider(s), where the relevant statutory bodies delegate decision making on specific functions/services/populations to the joint committee
- **Individual directors of the ICB** having delegated authority, which they may choose to exercise through a committee
- **Lead provider** managing resources and delivery at place-level under a contract with the ICB

Current place governance

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 and Wellbeing Board)
	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 Cttee
		South Tyneside Health and Wellbeing Board
Durham	Durham County Council	County Durham Care Partnership/Joint finance Group
		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

ICP engagement Events

1 July

2 July

13 July

15 July

Key stakeholders in our ICS

- Health and Wellbeing Boards
- Primary Care Networks
- NHS Foundation Trusts
- Provider Collaborative
- Clinical Networks
- HealthWatch and other patient voice organisations
- VCSE organisations – e.g. VONNE
- NHS England's regional teams
- Universities and research networks

Next steps

- Executive Design Group meetings to take place in September/October
- Focus of these sessions:
  - Feedback and key themes from the ICP engagement sessions
  - Overview of national ICS guidance
  - System governance – agreeing the membership of the twin boards
  - Place working models – what works well, what could be repurposed
  - Schemes of delegation – functions and resources at place and ICP level
  - Agreeing the ICS operating model – how to reach consensus and ratify our proposals
- Development of ICS operating model and Constitution for approval by NHS England
- Ongoing due diligence work on CCG close down and staff and property transfer to new system