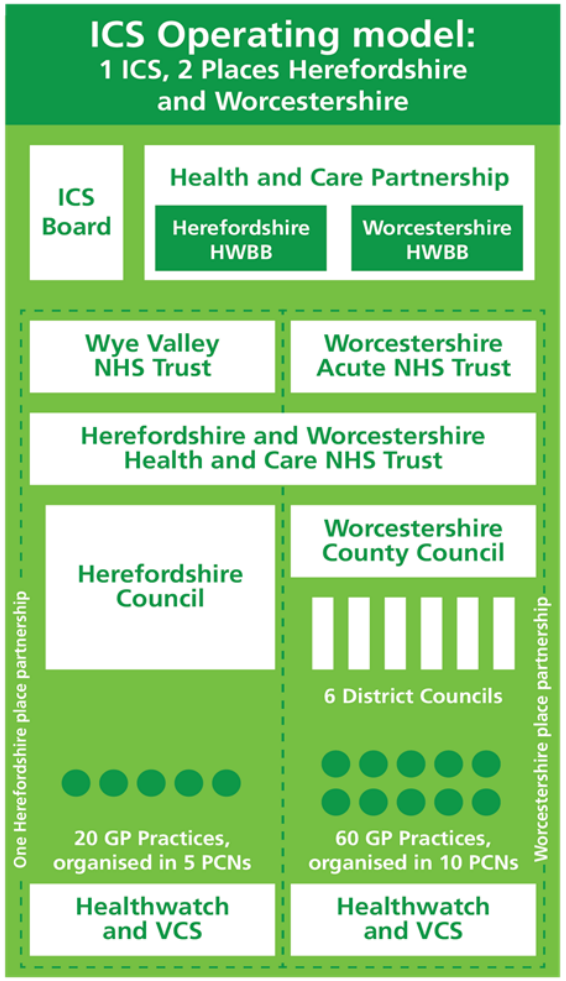
Herefordshire and Worcestershire
Integrated Care System

Integrated care system development

System Design Framework Summary

A brief recap on the H&W Integrated Care System

A variety of NHS Bodies, Local Authorities, Primary Care Providers and other organisations spending more than £1.7bn on providing health and care services to 800,000 people



ICS Partnership

- Each ICS to have a Partnership at system level based on **equal partnership** between NHS and Local Authorities.
- **NHS and Local Authorities to jointly agree** on the chair, their role, term of office and accountabilities.
- **Operate as a forum** (a committee rather than a corporate body).
- Governance to be based on a **consensus model of collective accountability**.
- Will **meet in public** and on-line and publish papers and minutes.
- Will need to **align to local Place-based** arrangements.
- Statutory guidance being developed by **Department of Health and Social Care**, not the NHS.
- **Membership must include NHS** (could be just the ICS NHS Body) and the **upper tier local authorities** providing social care.
- Beyond this, **membership to be locally determined.**
- Role is to **facilitate joint action** to:
    - Improve health and care services.
    - Influence wider determinants of health.
    - Support broader social and economic development.
- Only statutory duty is to **produce an Integrated Care Strategy.**
- Must draw upon the **JSNA** and address both **Children's and Adults Services**.
- **Public Health experts** to play a significant role.
- Should focus on:
    - Improving health and care outcomes.
    - Reducing inequalities.
    - Addressing the consequences of the pandemic.
- Need to **engage people with lived experience** and **traditionally under-represented groups.**

ICS NHS Body

- Will **replace the CCG**, absorbing all its statutory functions and duties in the process.
- Will receive **additional functions delegated from NHSE** around commissioning (primary care, specialised services etc) and assurance / oversight of local provider performance.
- Statutory duties re **safeguarding, children in care and SEND** will apply.
- Other defined functions include:
  - **Develop a plan** to meet the health needs of the population.
  - **Allocate resources** to deliver the plan.
  - **Establish joint working** arrangements to deliver the plan.
  - **Establish governance** arrangements to ensure the plan is delivered.
  - **Arrange for the provision of health services** to enable delivery of the plan.
  - **Lead coordinated action** on enablers such as People (workforce), Digital/Data, Estate, EPRR etc to support delivery of the plan.
- Functions can be **delegated to Place-Based Alliances** or **Provider Collaborations** working together to deliver integrated physical, mental and social health and well being (more to come on these in future development discussions).
- **Accountability for delivery cannot be delegated** from the ICS NHS Body to Place so **robust oversight and assurance arrangements** are needed.
- Will be supported by a **Unitary Board** responsible for ensuring the statutory duties are met.
- ICS NHS **Board minimum membership is defined** (see overleaf) but can by built upon by local agreement.
- **Model constitution** to be provided in due course.
- All board members will have **shared corporate accountability** for delivery, they will **not be delegates of their sector**.
- **Chair and Chief Executive** roles subject to a national recruitment process during the summer.
- Must have an **Audit Committee** and a **Remuneration Committee**. **Committee members** do not need to be members or employees of the ICS NHS Body.
- Can form **joint committees** with NHS Provider Trusts and Local Authorities.
- Need to produce "**functions and decisions map**" to describe how governance will work.

ICS Body minimum* membership

Minimum number on the board

10 Unitary Board

Board members have a collective and corporate responsibility for delivering the functions and legal duties of the ICS Body

3 Non Executives
(not holding roles in other bodies)

- Chair
- 2 other independent non-executive directors

3 Executives
(employed by NHS Body)

- Chief Finance Officer
- Chief Nursing Officer
- Chief Medical Officer

3 Partner Members**
(At least one from each of the groups)

- Local authority
- Primary Care Medical Services
- NHS Trust

1 Chief Executive Officer
(Accountable Officer for NHS Funding allocated)

**Further discussions to be had on local membership proposals in July*

***Partner members normally expected to be CEO or nominee and attending as an expert in the field **NOT** as a delegate of their sector, due to statutory duties of the post holder being personal, not representative.*

People and culture

- **New and specific responsibilities** to shape the approach to growing, developing, retaining and supporting the entire workforce across the whole ICS.
- Work with other employers to plan the development and growth of "**one workforce**" across the ICS.
- ICS NHS Body to have **specific responsibilities around delivering the NHS people plan** and expected to **establish a people and workforce capability** to discharge these responsibilities.
- ICS NHS Body expected to demonstrate how it is **driving the EDI agenda and foster a culture of civility and respect**, whilst creating a workforce that is representative of the population.

Specific People requirements:

- **Establish clear and effective governance arrangements** for the people agenda.
- Support delivery of **standardised transactional HR support** across the ICS.
- Ensure action is taken to **promote the health and well being of the workforce** within the ICS footprint.
- Establish leadership structures and process around leadership **development, talent management and succession planning.**
- Develop **integrated and dynamic workforce, activity and finance planning**.
- Develop new ways of working to **optimise staff skills and the use of technology**.
- Contribute to the **wider local social and economic growth** and vibrant local labour market.

Place-based partnerships

- To have a lead role in the **coordination and improvement of service planning and delivery**, and where partners come together to address the wider determinants of health.
- ICS NHS Body to agree with local partners what the membership form and governance structure is, **building on or complementing local arrangements like HWBBs**.
- **Minimum membership** should include:
  - Primary Care provider leadership.
  - Local authorities, including Director of Public Health.
  - Acute, community and mental health service NHS. Providers.
  - Representatives of people who access care and support.
- **ICS NHS Body will remain accountable for resources** allocated to Place-based Partnerships.
- Leadership and governance arrangements therefore need to **support safe and effective delivery** of the ICS NHS Body's functions delegated to Place.
- Expected to take **one of five forms**:
  - Consultative forum.
  - Committee of the ICS NHS Body.
  - Joint Committee of the ICS NHS Body with one or more partners.
  - Individual director of the ICS NHS Body with delegated responsibility.
  - Lead provider at Place.
- Each ICS NHS Body must **clearly set out the role of Place-based leaders** within governance arrangement for the ICSB. This will need to include:
  - **Convening** the Place-based partnership.
  - **Representing** the partnership in the wider governance structures in the ICS.
  - **Potentially taking on executive responsibility** for functions delegated to the Partnership.

The role of providers

- **All providers to be constituent members** of the ICS Partnership with contracts (NHS standard contract or national Primary Care Contract) to be supplemented to support longer term, outcomes based arrangements.
- **Primary Care** should be represented at all levels of decision making, including Place and System.

Primary Care Networks

- **PCNs should work together** to drive improvement through peer support, lead on one another's behalf on transformation programmes and in governance structures at.
- PCN involvement in Place-based partnerships is in **addition to their core function and will need to be resourced** by Place-based partnerships.
- ICS NHS Bodies to **support PCN Clinical Directors through targeted operational support** for their PCNs, such as in data and analytics, HR support and project management.

Voluntary, Community and Social Enterprises

- **VCSE should be embedded as essential partners** at all levels of decision making, including:
    - Governance structures.
    - Workforce planning.
    - PHM work.
    - Service design work.
    - Leadership and organisational development.
- A **national development programme** for engaging the VCSE sector is in place and should be used to support this work.
- A **formal agreement for engaging and embedding VSE input** should be developed.

NHS Trusts

- Expect that ICS NHS Bodies will ask **NHS Trusts to take on traditional commissioning responsibilities**.
- **Success of NHS Trusts will be increasingly judged against their contribution to the objectives of the ICS**, in addition to providing safe and effective care. This will include:
    - Delivering their contribution to **system financial balance.**
    - Improving quality and outcomes and **reducing inequalities across the whole system.**
    - **Contribution to the triple aim.**
- **Provider selection regime no longer requires competition** when commissioning NHS services where the ICS NHS Body is satisfied with the services delivered. Procurement remains and option when it is not.

Provider collaborations

- **All providers must be formally part of a Provider Collaboration**, specifically to agree plans for:
  - Inclusive service recovery.
  - Restoration.
  - Transformation.
  - Improve quality, efficiency and outcomes.
  - Address unwarranted variation and health inequalities.
- It is for providers to work together to decide on the best governance model for their collaboration, but expected to **be one of the following:**
  - Provider Leadership Board.
  - Lead Provider.
  - Shared Leadership or Group.
- ICS NHS bodies can contract with providers individually or with Provider Collaboratives.
- Further guidance to be published.

Working with people and communities

- Engagement seen as the **bedrock for tacking health inequalities**.
- ICS NHS Body will have a **legal duty to involve local people** in planning and commissioning arrangements.
- Arrangements need to be **more than allowing "commentary"** on services.
- A series of design principles have been specified and ICS NHS Bodies are required to **produce a local strategy** setting out how they will implement those principles.
- The strategy should also include:
  - How to support **involvement in decision making**
  - How to **gather intelligence about experience** and aspiration and clear arrangements for using these insights in decision making and quality governance.
- More guidance to follow.

Quality governance

- **Statutory duty** will include needing to act with a view to securing continuous improvement in quality. This will need to include:
  - Ensuring **fundamental standards** in quality are met.
  - Identifying **quality risks and safety risks.**
  - Identifying **inequalities and variation.**
  - **Promoting continual improvement** in the quality of services.
- Expected to **build upon existing arrangements** by ensuring that quality functions are properly resourced and can lead effective System Quality Groups.
- Must ensure that **Clinical and Professional leads have sufficient capacity** to participate in quality oversight and improvement.

Clinical and professional leadership

- Need to develop a model of **distributed leadership** and a culture that enables clinical leadership to thrive.
- This includes ensuring that **clinical and professional leaders have protected time and resource** to carry out system roles, are fully involved decision makers and have a central role in strategy.
- Groups should be more than doctors and nurses, **they should reflect wider social care and the VCSE sectors**. Should be inclusive at every level of the ICS.
- Further guidance on building effective clinical and professional leadership models will be provided and will reflect:
  - Building structures and mechanisms to **connect clinical and professional leaders** at all levels.
  - A **learning culture** supporting collaboration and innovation.
  - **Protected time** to engage in system leadership activities.
  - Support for leadership development to **enable work across professional and organisational boundaries.**
  - **Transparent approach to recruiting and selecting leaders** to promote equality of opportunity, professionally and demographically diverse talent that represents the population.
- Will need to use a self-assessment tool and a peer review approach to inform the right plan for improvement.

Accountability and oversight

- **NHSE will approve the ICS NHS Body constitution** and hold it to account for delivery of its statutory duties through its Chair and Chief Executive.
- Providers of **NHS Services remain accountable** for:
  - **Quality, safety and use of resources** and compliance with their provider license.
  - **Delivery of services** or functions commissioned from them or delegated to them by the NHS ICS Body.
- Where an Executive of an NHS Provider sits on the ICS NHS Board, **they will be accountable in that capacity for the performance of the ICS NHS Board** and must act in the interests of the ICS NHS Board not their employing organisation.
- **Conflict of Interest guidance** to underpin the operational arrangements such as these are being developed.
- **An MOU for 2021/22 and another for 2022/23** will need to be agreed between the ICS NHS Body and NHSE to ensure effective accountability and oversight arrangements are in place.
- A **System Oversight Framework** with four levels ranging from (1) Freedom and flexibility to (4) Mandated, enhanced national interventions is being used. **H&W ICS is expected to be (3) Enhanced support and oversight**.
- In future **ICS NHS Bodies will be expected to lead on oversight of local performance**, but this will remain a statutory responsibility of NHSE and arrangements will stay essentially the same as now.
- **NHSE will retain responsibility for taking regulatory action** against providers.
- Public accountability and oversight will be delivered through **meetings in public and published minutes**.
- **NHSE is working with CQC and DHSC** to agree the process for reviewing and assessing systems.

Finances and funding flows

- Financial allocation to the ICS NHS Body **will include a running cost allowance**.
- **Funding allocations will continue to be made in a similar way** based on a formula assessing population need, using target allocations and pace of change approaches.
- **ICS NHS Body will determine on allocations to Place**, but existing tools will be adapted to enable ICS NHS Bodies to be able to inform allocations to Place.
- **Capital allocations** for the system will be made to the ICS NHS Body.
- **Funds will mainly flow through contracts** with providers, to be managed through Place-based Partnerships or Provider Collaborations.
- **Financial allocations within the ICS should be made with tackling health inequalities** in mind and should take account of the ICSP strategy and HWBB Strategies.
- **Mental Health Investment Standard and the Primary Medical and Community Health Services funding guarantee** will apply to the ICS NHS Body.
- **ICS NHS Body CEO ultimately remains accountable** for resources allocated across the ICS.

- **Financial collaboration between partners** to be supported through:
  - Setting a **system financial target** that all NHS bodies must have due regard to the agreeing a **System Collaboration and Financial Management Agreement**.
  - Agreeing an **aligned incentive and payment model** to ensure that finances follow positive or negative variations from expected activity levels.
  - **System Outcome Framework** taking account of how well local organisations work together.
  - **Updated Code of Governance** and new guidance issued under the **Provider License** to support providers to work more collaboratively.
  - **A common duty on all NHS Bodies** with regard to the Triple Aim and a common imposition of duties regarding system financial balance.

Data and digital

- A framework called "**What Good Looks Like**" will be used to define expectations for ICS NHS Bodies on digital and data.
- ICS NHS Bodies must have:
  - **Renewed system data and digital plan**
  - **Clear accountability for data and digital development** and a named SRO.
  - **Plans to level up investment** across the ICS and plans to move to Cloud-based infrastructure.
  - **Shared Care Record.**
  - Arrangements to ensure that **providers adhere to agreed standards** and process for interoperability.
  - A plan for a **coordinated offer for digital channels for citizens** and a roll out of remote monitoring technologies.
  - An approach to **cultivate a cross system intelligence function** with linked data accessible by a shared analytical resource.
  - Plans to **embed PHM capabilities** throughout the ICS.

Managing the transition to ICS

- Change will be guided by the **employment commitment**.
- **Accountability for managing the change process will be with the current CCG and ICS Leadership**, with increasing involvement of the new leaders.
- ICS NHS Body needs to **make arrangements to manage the transition** and ensure there is capacity in place for the implementation of the new ICS NHS Body.
- Transition plans should **take account of the organisational development implications** of the new arrangements.

ICS key milestones

End of Q1 PREPATION	End of Q2 IMPLEMENTATION	End of Q3 IMPLEMENTATION	End of Q4 TRANSITION
• Update System Development Plans against the key implementation requirements and identify key support requirements. • Develop plans in preparation for managing organisational and people transition	• National recruitment and selection processes for the ICS NHS body chair and chief executive, in accordance with guidance issued by NHSEI. This will reflect the expected new accountabilities and responsibilities of ICS NHS bodies. • Confirm appointments to ICS Chair and Chief Executive. Subject to the progress of the Bill and after the 2nd reading these roles will be confirmed as designate roles. • Draft proposed **new** ICS NHS body MoU arrangements for **2022/23**, including ICS operating model and governance arrangements • Plan for CCG teams to only operate at sub-ICS level where the SDP confirms that the ICS plans to establish a significant place-based function at that footprint. • Begin due diligence planning.	• Carry out the recruitment and selection processes for designate Finance Director, Medical Director, Nursing Director and other board level role in the NHS ICS body, using local filling of posts processes. • Confirm designate appointments to ICS NHS body Finance Director, Medical Director and Nursing Director roles and other board and senior level roles. • ICS NHS bodies and ICS Partnerships to be ready to operate in shadow form. • Engagement on local ICS Constitution and governance arrangements for ICS NHS body and ICS Partnership.	• Continue the recruitment and selection processes for all other designate ICS NHS body senior roles, including place-level leaders and non-executive roles, using local filling of posts processes. • Confirm designate appointments to any remaining senior ICS roles • Complete due diligence for staff and property transfers from CCGs and other NHS staff transfers to new ICS NHS body • Commence engagement and consultation with trade unions. • Complete preparations to shift direct commissioning functions to ICS NHS body, where this is agreed from 1st April 2021. • Ensure that revised digital, data and financial systems are ready for ‘go live’. • Submit the ICS NHS Body Constitution for approval/agree the 2022/23 ICS MoU with NHSEI