Integrated Care Board:
One year on

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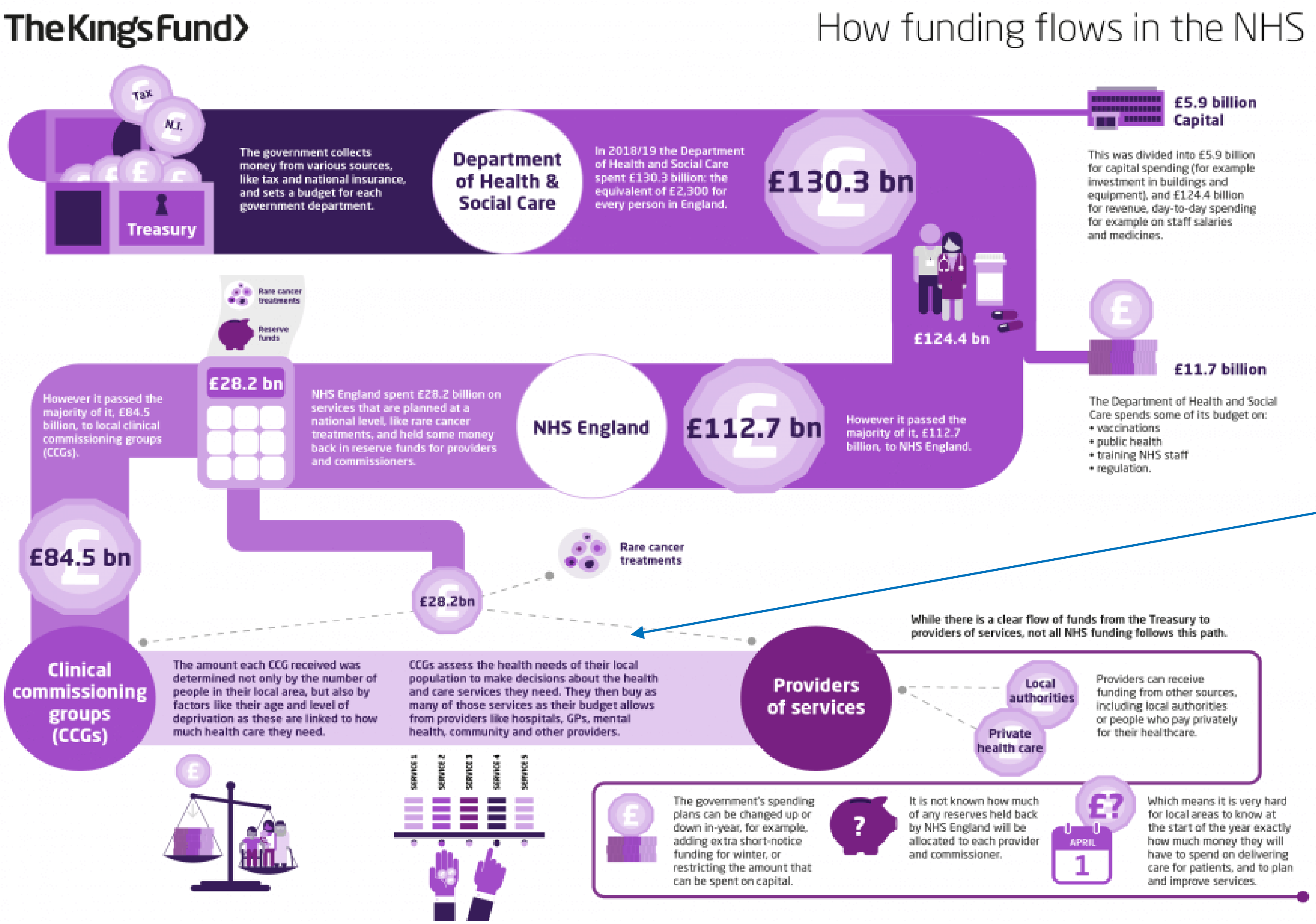
What’s changed? Moving from internal market to integrated care

- Removing the ‘provider / commissioner’ split
- NHS bodies – moving from contractual relationship to partnership
- Bringing all partners round the table – ICB unitary board with membership from providers, Local Authorities and third sector
- Putting our communities and residents in control of decisions
- Placing clinical leadership at the heart of governance
- All partners fully engaged in a whole population health approach
- Decisions around allocation of resources based on need not historic spend

The old world before integration – CCGs and the internal market



CCGs assess the health needs of their local population to make decisions about the health and care services they need. They then ***buy*** as many of those services as their budget allows from providers like hospitals, GPs, mental health, community and other providers

Integrated care systems (ICSs)

Key planning and partnership bodies from July 2022

NHS England
Performance manages and supports the NHS bodies working with and through the ICS

Care Quality Commission
Independently reviews and rates the ICS

Statutory ICS

Integrated care board (ICB)

Membership: independent chair; non-executive directors; members selected from nominations made by NHS trusts/foundation trusts, local authorities, general practice; an individual with expertise and knowledge of mental illness

Role: allocates NHS budget and commissions services; produces five-year system plan for health services

Cross-body membership, influence and alignment

Integrated care partnership (ICP)

Membership: representatives from local authorities, ICB, Healthwatch and other partners

Role: planning to meet wider health, public health and social care needs; develops and leads integrated care strategy but does not commission services

Influence

Influence

Partnership and delivery structures

Geographical footprint	Name	Participating organisations
System Usually covers a population of 1-2 million	**Provider collaboratives**	NHS trusts (including acute, specialist and mental health) and as appropriate voluntary, community and social enterprise (VCSE) organisations and the independent sector; can also operate at place level
Place Usually covers a population of 250-500,000	**Health and wellbeing boards**	ICS, Healthwatch, local authorities, and wider membership as appropriate; can also operate at system level
	Place-based partnerships	Can include ICB members, local authorities, VCSE organisations, NHS trusts (including acute, mental health and community services), Healthwatch and primary care
Neighbourhood Usually covers a population of 30-50,000	**Primary care networks**	General practice, community pharmacy, dentistry, opticians

The King's Fund

And what's different

- no separate commissioning organisation and much less transactional procurement and contracting activity
- partnerships at place and between providers focussed on improvement and integration
- decision-making distributed between partnership forums at ICS level, across providers, and in places

The integrated care board

Its main functions

- Broadly, the main functions of the ICB will be to:
- **support delivery of the integrated care strategy;**
- **hold overall accountability for addressing health inequalities;**
- **define ambitions and expectations – outcomes, care standards; and**
- **allocating resources**

Who participates and how the board's authority is exercised

- Subject to legislation, most of the CCG's statutory functions were conferred on the ICB on 1 April 2022
- The board comprises members prescribed by NHS England and others appointed by local consensus. The prescribed member are:
  - Chair
  - A minimum of two other independent non-executive members
  - Chief Executive
  - Chief Finance Officer
  - Director of Nursing
  - Medical Director
  - At least one member drawn from each of: local NHS trusts and foundation trusts, local general practice, and local councils
- The NEL ICB has a significant degree of **flexibility** in how it discharges or delegates its responsibilities
- It has more flexibility than the CCG to delegate functions to **NHS trusts**, including a joint committee of trusts
- It is also able to delegate functions to **place-based partnerships**
- The ICB will continue to be held to account by NHS England for how delegated functions are discharged. It will need to monitor how delegation is operating and whether it remains appropriate

Reserved functions

- There are some functions that the ICB will not be able to delegate to providers, such as conflicts of interest management
- Regulations will specify which functions may not be delegated. For these functions the ICB will be able to ask organisations to carry out activities in support of the function, so long as decisions relating to that function are taken by the ICB
- There will be other functions that the ICB will choose to reserve to itself, where a 'do once' approach is required for coherence and efficiency
- These include functions like commissioning the national core primary care contract and preparing annual accounts and the annual report

Place-based partnerships – NEL example

What and who

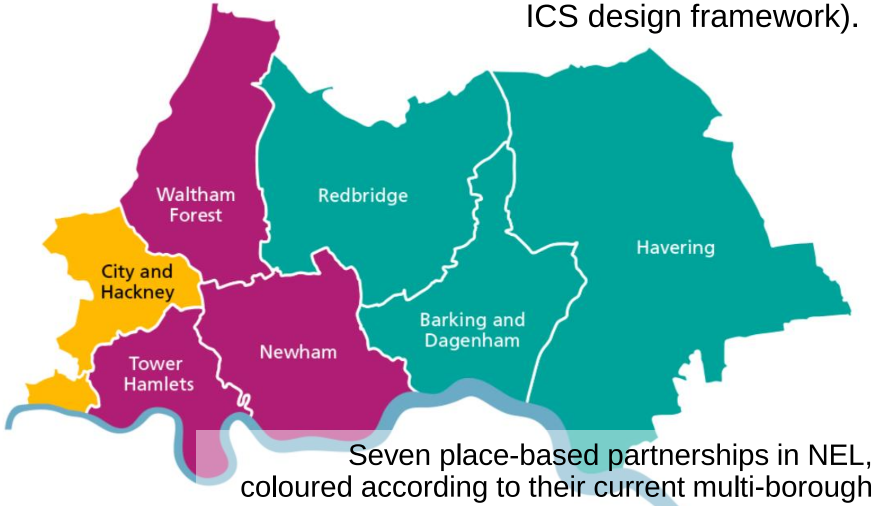
- A place-based partnership is a forum for health and care organisations, residents, and patients operating at borough level to **co-ordinate and improve service planning and delivery** and to collectively **address the wider determinants of health**
- Across the core Barts Health footprint, they are:
  - Tower Hamlets Together;
  - the Newham Executive Group; and
  - Waltham Forest Integrated Care Board.
- NHS England's ICS design framework requires that in future all such partnerships comprise at least:
  - primary care provider leaders;
  - local authorities, including directors of public health;
  - providers of acute, community and mental health services; and
  - representatives of people who access care and support.

System role

- The role of place-based partnerships in an ICS is not nationally defined.
- NEL's partnerships describe their values, purpose, and functions in multiple ways. They are also already delivering local plans with a range of priorities and objectives, rooted in the needs of each place.
- Our ICS will not prescribe the priorities and focus of its pace-based partnerships. Rather, we will explore the development of a set of broad but common expectations of them: the *what* rather than the *how*.
- Examples are:
  - developing an in-depth understanding of local needs;
  - connecting with communities;
  - jointly planning and co-ordinating services;
  - driving local service transformation;
  - focusing on the wider determinants of health;
  - mobilising communities and community leadership;
  - harnessing partners' economic influence as anchor institutions;
  - supporting the best use of financial resources;
  - supporting local workforce development and deployment; and
  - driving improvement through oversight of quality and performance.

The ICS design process

- The ICS design process will secure agreement between the ICB and the partnerships on:
  - autonomy of operation in the place-based partnerships;
  - the conditions on which this autonomy can be exercised; and
  - local governance forms (from the options in the ICS design framework).



Seven place-based partnerships in NEL, coloured according to their current multi-borough collaborative working arrangements

Provider collaboratives

- Provider collaboratives use their scale and local relationships to support the following objectives:
  - reductions in unwarranted variation in access, experience, and outcomes;
  - reductions in pan-ICS health inequalities;
  - greater system resilience, including mutual aid, better management of system-wide capacity, and alleviation of immediate workforce pressures;
  - better recruitment, retention, development of staff and leadership talent;
  - consolidation of low-volume or specialised services; and
  - efficiencies and economies of scale.

- Each collaborative will agree its priorities and workplan with the ICB.
- These will be based on a process that addresses the four areas below.
- The provider collaboratives will lead delivery of their workplans, with support and assurance from the ICB.
- Integrating councils into the work of the provider collaboratives will be critical.

function	1 health and wellbeing outcomes	→ what improvements to care services and population health management will we prioritise over the next twelve months?
function	2 system management	→ which system functions will we undertake together in order to improve outcomes and overall effectiveness?
form	3 people	→ who from across the ICS is needed to make this happen?
form	4 leadership and governance	→ how should the collaborative be led – both clinically and managerially – to best achieve its objectives?

- The latest guidance on provider collaboration sets out three governance models:
  - a provider leadership board model (essentially, committees in common for aligned decision making);
  - a lead provider model; and
  - a shared leadership model.
- The acute and mental health collaboratives will agree between themselves, and then with the ICS, which form of governance best supports the collaboratives to achieve their objectives
- National guidance anticipates that providers and provider collaboratives will take on some planning and transformation functions from the CCG, to help drive more rapid improvements to care

One Year On – highs and lows

Challenges

- Operating environment:
  - NHS financial challenge
  - Local Authority finances (different issues add complexity – discharge, CHC etc)
  - Industrial action
  - RCA reductions
- Legacy of sovereignty – ICS working vs regulatory oversight
- New ways of working – managing the transition

Opportunities

- Place based solutions
- Shared resources
- Common purpose
- Greater focus on, and participation from, our resident population