CABINET	AGENDA ITEM No. 8
10 JANUARY 2022	PUBLIC REPORT

Report of:	Executive Director People & Communities & Director of Public Health	
Cabinet Member(s) responsible:	Cllr Irene Walsh, Cabinet Member for Adult Social Care, Health and Public Health	
Contact Officer(s):	Wendi Ogle- Welbourn, Executive Director People and Communities	

DEVELOPMENT OF THE INTEGRATED CARE SYSTEM

RECOMMENDATIONS	
FROM: *Wendi Ogle-Welbourn, Executive Director People & Communities*	**Deadline date:** *10th January 2022*
It is recommended that Cabinet: 1. Note the update on the Integrated Care System (ICS); and 2. Endorse the Local Authority's role in delivering the required outcomes of the ICS.	

1. ORIGIN OF REPORT

1.1 This report is submitted to Cabinet following a request from Cllr Irene Walsh, Cabinet Member for Adult Social Care, Health and Public Health.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to provide a briefing to Cabinet on the Integrated Care System (ICS) and secure support for the Local Authority's role in delivering the required outcomes of the ICS.

2.2 This report is for Cabinet to consider under its Terms of Reference No. 3.2.2, *'To promote the Council's role as community leader, giving a 'voice' to the community in its external relations at local, regional and international level, and fostering good working relationships with the Council's partner organisations, Parish Councils and the relevant authorities for Police, Fire, Probation and Magistrates' Courts Services.'*

3. TIMESCALES

Is this a Major Policy Item/Statutory Plan?	**YES**	If yes, date for Cabinet meeting	**N/A**

4. BACKGROUND AND KEY ISSUES

Kings Fund National Descriptors of an Integrated Care System

4.1

Integrated care systems (ICSs) are geographically based partnerships (generally 1 million population) that bring together providers and commissioners of NHS services with local

authorities and other local partners to plan, co-ordinate and commission health and care services. They are part of a fundamental shift in the way the health and care system are organised – away from competition and organisational autonomy and towards collaboration, with health and care organisations working together to integrate services and improve population health. ICSs have been developing for several years, under the banner of Sustainable Transformation Partnerships (STPs). The Health and Care Bill will put them on a statutory footing from April 2022.

Clinical Commissioning Groups will cease to exist, contracts and funding commitments will novate to the ICS.

4.2 The ICS seeks to achieve four aims: -

- Improve outcomes in population health and health care
- Tackle inequalities in outcomes, experience and access
- Enhance productivity and value for money
- Help the NHS support broader social and economic development

4.3 Collaborating as an ICS will help health and care organisations tackle complex challenges, including.

- Improving the health of children and young people
- Supporting people to stay well and independent
- Acting sooner to help those with preventable conditions
- Supporting those with long term conditions or mental health issues
- Caring for those with multiple needs as populations age
- Getting the best from collective resources so people get care as quickly as possible

4.4 Clinical Commissioning Groups have the legal duty to develop the Integrated Care Board constitution. This development is expected to be led by the ICB designate chair – John O'Brien and ICB designate Chief Executive – Jan Thomas.

The statutory ICS will be made up of two key bodies – an integrated care board (ICB) and integrated care partnership (ICP).

4.5 **Integrated care boards**

Integrated care boards (ICBs) will take on the NHS planning functions previously held by clinical commissioning groups (CCGs) and are likely to absorb some planning roles from NHS England. ICBs will have their own leadership teams, which will include a chair and chief executive, and will also include members from NHS trusts/foundation trusts, local authorities, and general practice, selected from nominations made by each set of organisations. In consultation with local partners, the ICB will produce a five-year plan (updated annually) for how NHS services will be delivered to meet local needs. In developing this plan and carrying out their work, the ICB must have regard to their partner ICP's integrated care strategy and be informed by the joint health and wellbeing strategies published by the health and wellbeing boards in their area. Additionally, each ICB must outline how it will ensure public involvement and consultation.

ICBs will also contract with providers to deliver NHS services and will be able to delegate some funding to place level to support joint planning of some NHS and council-led services.

4.6 **Integrated Care Partnerships**

Integrated care partnerships (ICPs) will operate as a statutory committee, bringing together the NHS and local authorities as equal partners to focus more widely on health, public health and social care. ICPs will include representatives from the ICB, the local authorities within their area and other partners such as NHS providers, public health, social care, housing services and voluntary, community and social enterprise (VCSE) organisations. They will be responsible for developing an integrated care strategy, which sets out how the wider health needs of the local population will be met. This should be informed by any relevant joint strategic needs

assessments (see below). In developing its integrated care strategy, the ICP must involve the local Healthwatch, the VSCE sector, and people and communities living in the area. ICPs will not directly commission services.

4.7 Partnership and delivery structures

A number of partnership and delivery structures will operate within an ICS at system, place, and neighbourhood level.

NHS providers will work together at scale through provider collaboratives, new partnerships operating across ICSs to improve services. Provider collaboratives, which may involve voluntary and independent sector providers where appropriate, are expected to be operating across England by April 2022 and will agree delivery objectives with partner ICSs.

Health and wellbeing boards (HWBs) are formal committees of local authorities that bring together a range of local health and care partners to promote integration. They are responsible for producing a joint strategic needs assessment and a joint health and wellbeing strategy for their local population.

Place-based partnerships operate on a smaller footprint within an ICS, often that of a local authority. They are where much of the heavy lifting of integration will take place through multi-agency partnerships involving the NHS, local authorities, the VCSE sector and local communities themselves.

Primary care networks (PCNs) bring together general practice and other primary care services, such as community pharmacy, to work at scale and provide a wider range of services at neighbourhood level.

4.8 National bodies

The NHS organisations within ICSs, including ICBs, NHS trusts and foundation trusts, will be accountable to NHS England for their operational and financial performance. The Care Quality Commission (CQC) will independently review and rate the quality of partnership working within ICSs, alongside its existing responsibilities for regulating and inspecting health and care services.

4.9 *'It is important to recognise the limits of what legislation can achieve. Success will depend on implementation, with behaviours and relationships that support collaboration needing to be developed, nurtured, and modelled right across the health and care system, including within national bodies. Evidence from previous attempts to integrate care indicates that these changes will take time to deliver results – local and national leaders need to make a long-term commitment to change and avoid the past mistake of moving swiftly on to the next reorganisation if desired outcomes are not rapidly achieved. Listening to patients and communities will also be key to improving services and understanding how efforts to join up care are progressing.'* (The Kings Fund).

As a local authority we are well placed to advocate on behalf of our residents and ensure the public are well informed and can inform the development of our local ICS.

5.0 Local Development of ICS

Noted below are the proposed arrangements locally for the Integrated Care System. What we are trying to fix is:

- the lack of join up in the health and care system
- fragmentation and competition
- reducing duplication and waste
- inefficiencies

The aim is to develop health and care pathways that are easy for residents and patients to navigate and that support them to remain living and working in their local communities. Where they do need to access specialist health and care this is for the shortest time possible.

Covid has shown that where barriers are removed and communities engaged, we are able to work better together.

5.1 **Glossary:**

ICB = integrated care board (Cambridgeshire & Peterborough) = strategic commissioning
ICPC = integrated care partnership committee (Cambridgeshire & Peterborough) = Integrated Care Strategy/Plan.
ICP North = integrated care partnership for the North (Huntingdonshire, Fenland, Peterborough – North West Anglia Foundation Trust hospital footprint) = community, primary care, elective, urgent and emergency care, cancer, and personalised care including continuing health care.
ICP South = integrated care partnership for the south (Cambs South, City, East – Cambridgeshire University Hospital footprint) = community, primary care, elective, urgent and emergency care, cancer, and personalised care including continuing health care.
Children & Maternity Collaborative (Cambridgeshire & Peterborough – Cambridgeshire Community Services Foundation Trust (CCS) footprint) = all provision and commissioning for children
Mental Health and Learning Disability Collaborative (Cambridgeshire & Peterborough – Cambridgeshire & Peterborough Foundation Trust (CPFT) footprint) = all provision and commissioning for adults with learning difficulties and mental health needs
HWBB = Health and Wellbeing Board

5.2 We are pleased that the Integrated Care Board has proposed adopting the ten principles set out by NHS England (see below) for working with people and communities as this supports the local authority's priorities and principles:

1. Put the voices of people and communities at the center of decision making and governance, at every level of the ICS.
2. Start engagement early when developing plans and feedback to people and communities how it has influenced activities and decisions.
3. Understand your community's needs, experience and aspirations for health and care, using engagement to find out if change is working.
4. Build relationships with excluded groups – especially those affected by inequalities.
5. Work with Healthwatch and the voluntary, community and social enterprise sector as key partners.
6. Provide clear and accessible public information about vision, plans and progress to build understanding and trust.
7. Use community development approaches that empower people and communities, making connections to social action.
8. Use co-production, insight, and engagement to achieve accountable health and care services.
9. Co-produce and redesign services and tackle system priorities in partnership with people and communities.
10. Learn from what works and build on the assets of all ICS partners – networks, relationships, activity in local places.

5.3 In addition to the above principles, we will advocate and negotiate with our partners in the ICS to adopt strategies and plans that support:

- Social Value as the key driver in the development, delivery, and commissioning of services across the health and care sector.
- Democratic accountability.

- Shifting resource towards prevention, community-based solutions, and moving of resources from acute to community, ensuring that resources are spent efficiently to deliver the best outcomes per pounds spent.
- Measurably improving health and wellbeing outcomes and reduce health inequalities for the population.
- A 'Population Health Management' approach and agree what we all mean by this and what actions we can take to pursue this.
- Transparent decision making and accountability to the public.
- Promoting and adopting co-production and participation as a default approach to developing new services making full use of the local authorities Partnership Boards that are run by Healthwatch and any other appropriate forums e.g. trust partnership boards.
- Delivery of real progress through Integrated Neighbourhoods and make the links to the local authority's work on Think Communities and place-based approaches.
- Local Authorities and ICS funds are best used to provide services that are best value, seamless and deliver cost-efficient outcomes.
- Continuation of integrated services where we think this will improve outcomes and sustain/ increase NHS investment in those services that are already jointly commissioned or provided through S75 agreements e.g. occupational therapy, integrated community equipment service and assistive technology.
- Identifying new opportunities where the Local Authority could become the lead provider e.g. discharge to assess pathways.

5.4 **The draft constitution for the Cambridgeshire and Peterborough Integrated Care System including the Integrated Care Board and Integrated Care Partnership Committee is being developed – this will not become statute until the passing of the Health and Care Bill in April 2022.**

NHS Cambridgeshire & Peterborough Integrated Care Board will be a statutory board that oversees the day-to-day running of the NHS locally. It manages a single pot of NHS funding, for which it is directly accountable, and will be developing a plan to meet the health needs of the population within the Integrated Care System.

While individual organisations within the Integrated Care System will continue to have direct responsibility for the staff in their own organisations, the Integrated Care Board is responsible for delivering the people functions for staff employed directly by the Integrated Care Board, and for the NHS staff who work in their local area. This includes clinical and non-clinical people working in primary and community care (such as general practice, dentistry, optometry, and community pharmacy), secondary and tertiary care.

The Integrated Care Partnership Committee is a sub - committee of the Integrated Care Board, which the Integrated Care Board jointly with local authorities has established. The Integrated Care Partnership Committee is responsible for the development of an integrated care strategy. The Integrated Care Board must have regard to this strategy when developing its own plans. The terms of reference for the Integrated Care Partnership Committee and the Integrated Care Board Constitution will be aligned to ensure that health and care needs of people across our area are effectively met and that as an Integrated Care System we deliver on our agreed vision 'All together for healthier futures – working together to improve the health and wellbeing of our local people throughout their lives'.

Integrated Care Board members include the Chair and Chief Executive of the Integrated Care System, partner members including the local authority, NHS Trusts and Foundation Trusts, primary care, (GP's) Director of Finance, Medical Director, Director of Nursing and four independent non-executive members.

5.5 The Integrated Care Partnership Committee will have a wide system membership to reflect the local landscape of key partners and bring in the voice of residents, e.g. Healthwatch, VCS, local authorities, police, combined authority etc. It is expected that the local authority's Integrated Care Board officers (suggested Director of Public Health and Executive Director People &

Communities) will be championing the local authority's priorities and raising Member representations.

5.6 Integrated Care Boards will be able to agree with specified other statutory organisations (NHS & Foundation Trusts and Local Authorities) that they will exercise their functions on behalf of the Integrated Care Board or jointly with the Integrated Care Board. The Integrated Care Board will remain legally accountable for any arrangements made regardless of any delegations made. From a local authority perspective any delegation would need to be agreed by the Council.

5.7 The Integrated Care Board will undertake a 'Capable Provider' process to decide who is best to deliver functions.

To award contracts to partners for delivery of substantial functions in return for significant funding, there needs to be a process that assures the Integrated Care Board that the receiving organisation and their partners have the capacity and capability to hold the clinical and financial risk. The Clinical Commissioning Group are adapting their proven 'Most Capable Provider' framework to use as a governance process.

The Most Capable Provider approach covers a range of areas and asks the receiving parties to explain how they will discharge their accountability, and more importantly drive a strong culture of delivery and transformation that improves outcomes for our citizens.

At a high level, the assumptions of the NHS on who may be capable providers are:

- **North & South Places** (led by North West Anglia Foundation Trust & Cambridgeshire University Hospital) deals with all the community, primary care, elective, urgent and emergency care, Cancer, and personalised care including continuing health care.
- **Strategic commissioning** focuses on population health, citizen-based data, strategic planning, and outcomes setting.
- **MH/LD collaborative** (led by Cambridgeshire & Peterborough Foundation Trust (CPFT)) and **Childrens and Maternity collaborative** (led by Cambridgeshire Community Services (CCS)) has some overlaps that need to be worked through, but as they already have ICS approaches in place these will continue.

There is provision to discharge functions to the local authority via a Section 75 agreement.

This process is at a very early stage and likely to evolve over an eighteen-month period. We need to consider the areas that we as a local authority might want to lead on.

5.8 Senior officers from organisations such as the acute sector, community health, primary care, VCS, and local authority are working together in the development of the North and South partnerships (ICP's) and the Children & Maternity and Mental Health & Learning Disability Collaboratives. These are at an early stage of development and are where detailed plans are being developed to drive the prevention agenda and integrated service delivery wrapped around groups of GP practices, (primary care networks) or in the case of children and young people, schools. As a local authority this is where we would want to play a lead role; ensuring local services are joined up for our residents and developed and understood in the context of the communities they live and work in and wrapped around primary care and community services. This is where communications with local Councillors will be important.

The local authority will be advocating a focus on population health management and investment in prevention and neighbourhood or place-based approaches. Investing in prevention will lead to better efficiencies through more cost-effective interventions and an increase in the years spent in good health. However, we know that the pandemic has seen people presenting with more complex and acute needs, so this will take time to turn around.

5.9 In the future, the aspiration maybe to develop joint roles across health and care to support this way of working. The North and South partnerships (ICP's) will have a Managing Director. Performance of the ICP's/Collaboratives will report into the Integrated Care Partnership Committee and Integrated Care Board. The Director of Children's Services and Executive Director People and Communities are co-leading the Children and Maternity Collaborative development. The Director of Adult Services is involved in the development of the Mental Health/Learning Disability Collaborative. We have senior officers on the North and South Integrated Care Partnerships.

5.10 There are several thematic groups that are supporting the development of the ICS, the local authorities have representation on:

- Governance
- Digital
- Communications
- Transformation
- Finance
- Workforce

5.11 Members will be able to fulfil their democratic accountability via the Cambridgeshire and Peterborough Integrated Care Partnership Committee; (much like the partnership board Members sit on now). It is a requirement that the Integrated Care Partnership develop an integrated care strategy, which sets out how the wider health needs of the local population will be met, being cognisant of the Joint Strategic Needs Analysis.

5.12 There has been agreement between the local authorities and health to bring the work of the Health and Wellbeing Board(s) as close together with the Integrated Care Partnership Committee as possible.

5.13 Agencies and organisations, including local authorities, NHS, combined authority, Health Watch, and the voluntary sector came together in a workshop in October. Local authority Members and health colleagues opened discussions about their joint desire to merge as closely as possible the work of the Health and Wellbeing Boards and Integrated Care Partnership Committee. Everyone agreed the development of one plan and one set of priorities. The Integrated Care Partnership Committee and Health and Wellbeing Boards must take place in public and therefore this ensures transparency. Relevant decisions that need to be taken at the Integrated Care Board will be shared at the Integrated Care Partnership Committee to ensure the Integrated Care Board is fully aware of the wider partners' views.

5.14 The local authority officers who are members of the Integrated Care Board will be championing the social care agenda and Council's priorities. However, it must be recognised the financial envelope is the NHS's, not local authority's, and there are national requirements and targets on how NHS money is spent. (not to mention the NHS deficit that must be dealt with as well) The local authority will use its financial resources and relationships to influence priorities where appropriate.

5.15 The development of four priorities at the Health and Wellbeing Board/Integrated Care Partnership Committee workshop is a good example of where the local authorities were able to exert influence over priorities that support the desire to focus on population health management, prevention, and inequalities:

- Our children are ready to enter education and exit, prepared for the next phase of their lives.
- Create an environment to give people the opportunities to be as healthy as they can be.
- Reducing poverty through better employment and better housing.
- Promoting Early intervention and prevention measures to improve mental health and wellbeing.

Our Director of Public Health will lead on the delivery of these priorities, in collaboration with priority leads. We are working with partners to identify leads to develop and deliver the outcome, supported by appropriate key performance indicators.

5.16 To promote parity of esteem across health and social care and equality of voice we will advocate a rotating chair arrangement for the Health and Wellbeing Board/Integrated Care Partnership Committee.

5.17 Health Scrutiny will, as it does now, be able to request evidence of performance against the Integrated Care System plans – this would likely be focused on the difference we are making as an Integrated Care System to the lives and outcomes of our residents. Again, this will be in public and therefore provide transparency.

5.18 The key areas where Health and the local authority currently have joint accountabilities and have joint key performance indicators include:

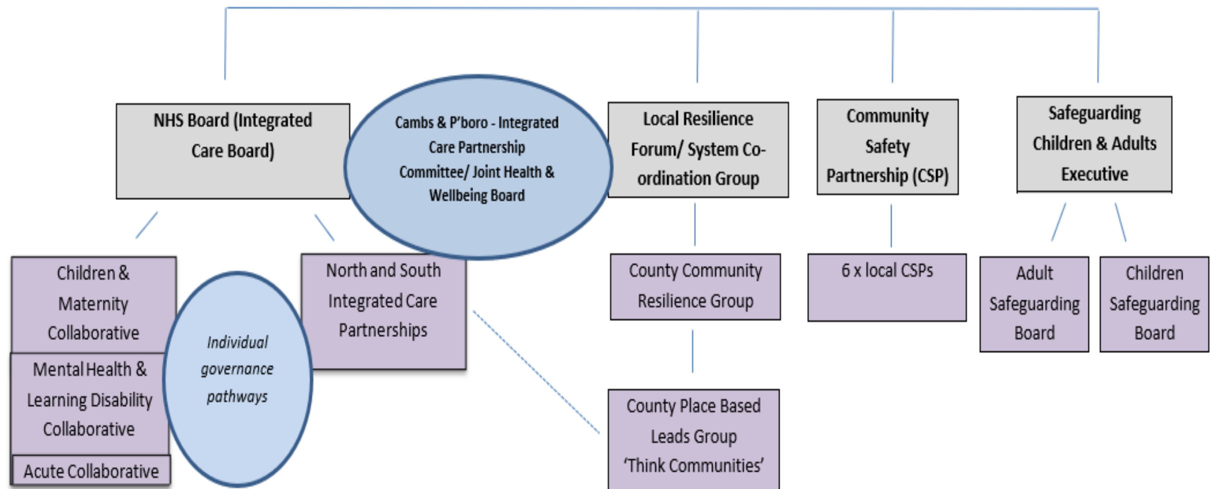
- Discharge to assess. (ensuring timely discharge from hospital into appropriate setting and services)
- Avoiding hospital admissions. (health and care professionals working together to prevent the need for residents to go into hospital)
- Joint commissioning. (making sure we are not competing for resources and we are securing the resources that meet need and represent value for money, including social value)
- Special educational needs and disabled children and children with complex needs.
- Supporting those with mental health and learning difficulties to live independently.

5.19 In these areas we align budgets or have S75 agreements (where we give the money to health to deliver services on our behalf) or S76 agreements (where health gives us money to deliver on their behalf) and develop joint strategies and plans. Much of this work is now being taken forward by the North and South ICP's and Collaboratives. Performance will be reported into the Integrated Care Partnership Committee/Health and Wellbeing Board and Integrated Care Board. In addition, much of this work is reported to appropriate Cabinet Members and Scrutiny Committees. It is expected that Health Scrutiny will be asking for evidence of impact on residents.

We will build on these current arrangements.

5.20 At present health and local authority business planning processes are not chronologically the same - the local authority starts and ends the business planning process in advance of health; health does not get agreement of their settlement until April – May each year. The only example of joint business planning is the Better Care Fund, which is signed off at the Health and Wellbeing Board. This is an area for development in the Integrated Care System.

5.21 The structure below seeks to describe how the new Integrated Care System governance interplays with other statutory boards across the Cambridgeshire and Peterborough footprint.



6. CONSULTATION

6.1 It is a requirement to consult widely on the development of the ICS. There are a number of public and professional engagement events taking place and planned. Between now and when the ICS comes into being legal in April 22 the public and professional views will continue to be sought and used to inform the ICS constitution, strategy and plan.

7. ANTICIPATED OUTCOMES OR IMPACT

7.1 What we are trying to fix is:

- the lack of join up in the health and care system
- fragmentation and competition
- reducing duplication and waste
- inefficiencies

The aim is to develop health and care pathways that are easy for residents and patients to navigate and that support them to remain living and working in their local communities. Where they do need to access specialist health and care this is for the shortest time possible.

Covid has shown that where barriers are removed and communities engaged, we are able to work better together.

8. REASON FOR THE RECOMMENDATION

8.1 Local Authorities will have a legal requirement to co-operate with the NHS in the development and delivery of the ICS. It is therefore important that Members and the public understand what this legal requirement is and what it means in practice for the local authority.

9. ALTERNATIVE OPTIONS CONSIDERED

9.1 No other options considered – It is imperative that Members and the public are informed and understand the local authority's legal accountabilities.

10. IMPLICATIONS

Financial Implications

10.1 There are no financial implications arising from the recommendations in this report and can be delivered via existing resources.

Legal Implications

10.2 The Health and Care Bill when passed in April 2022 will place a legal responsibility on the council (as described in this report) to co-operate with the NHS on the delivery of the ICS.

Equalities Implications

10.3 The ICS seeks to address the health and social inequalities within our population.

Carbon Impact Assessment

10.4 No assessment completed. However the ICS is in the process of developing it's Green Plan and will be working with all agencies and organisations that make up the ICS in doing this.

11. BACKGROUND DOCUMENTS

Used to prepare this report, in accordance with the Local Government (Access to Information) Act 1985

11.1 The Kings Fund - https://www.kingsfund.org.uk/projects/positions/integrated-care

12. APPENDICES

12.1 None.