Northamptonshire
Health and Care Partnership

Northamptonshire Health and Care Partnership Board

Integrated Care System ("ICS") Design

System briefing paper – updated following Partnership Board development session on 17th June

About this paper

This paper sets out an emerging blueprint for our Integrated Care System ("ICS") for consideration and endorsement by organisations and stakeholders in our system. It aims to build on our system's characteristics, and to provide the basis for significantly more integrated services.

How has this blueprint been developed?

- This blueprint is the result of a collaborative piece of work, facilitated by PA Consulting (PA), working closely with the ICS Transition Steering Group (including representatives from across the system), the System Executive Group, and the ICS Health and Care Partnership.
- In developing the blueprint, PA has also held more than 35 discussions with individuals and organisations from across the system to gather their views on how best to develop an ICS for Northamptonshire's context.
- On 17th June, the System Executive Group presented this blueprint to the Northamptonshire Health and Care Partnership development session for discussion. The Partnership signalled agreement that the blueprint represents a good basis to continue to design and build from over the coming months.

What does this blueprint seek to do?

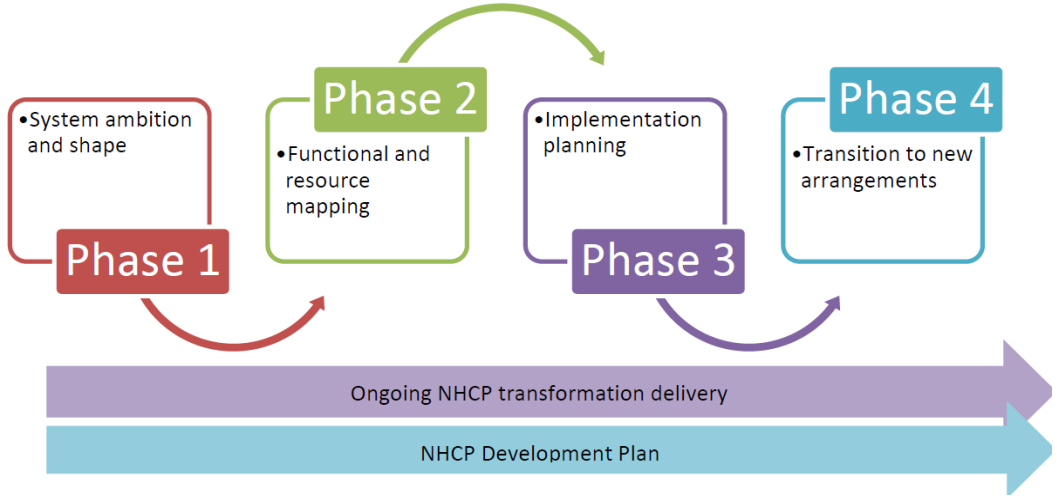
- The blueprint is intended as the start of an ICS design that will help address the sustainability of our system and realise our vision to create a positive lifetime for all, of health, wellbeing and care in our communities. As such, it lays out a number of core building blocks that will anchor further design and development of the system in the coming months.
- It is important to note that this blueprint does not represent a complete system model and there is further work to do to develop the detail that will sit beneath it.

What are system organisations and stakeholders being asked to do?

- We are seeking endorsement of this blueprint as a basis for further development. A list of the recommendations we are asking for endorsement of are included at the end of this deck. This will provide a mandate for further development in the coming months.
- We are also interested to hear feedback and considerations for further development.
- Our aim is to consolidate Board and Member approvals from across the system (and subject to any amends to the blueprint) through formal approval at the Partnership Board planned for late July.

What happens next?

This work is part of a four phase process to April 2022. It marks the conclusion of phase 1



Please note, this paper should be regarded as confidential and not for wider circulation at this time.

Northamptonshire Health and Care Partnership

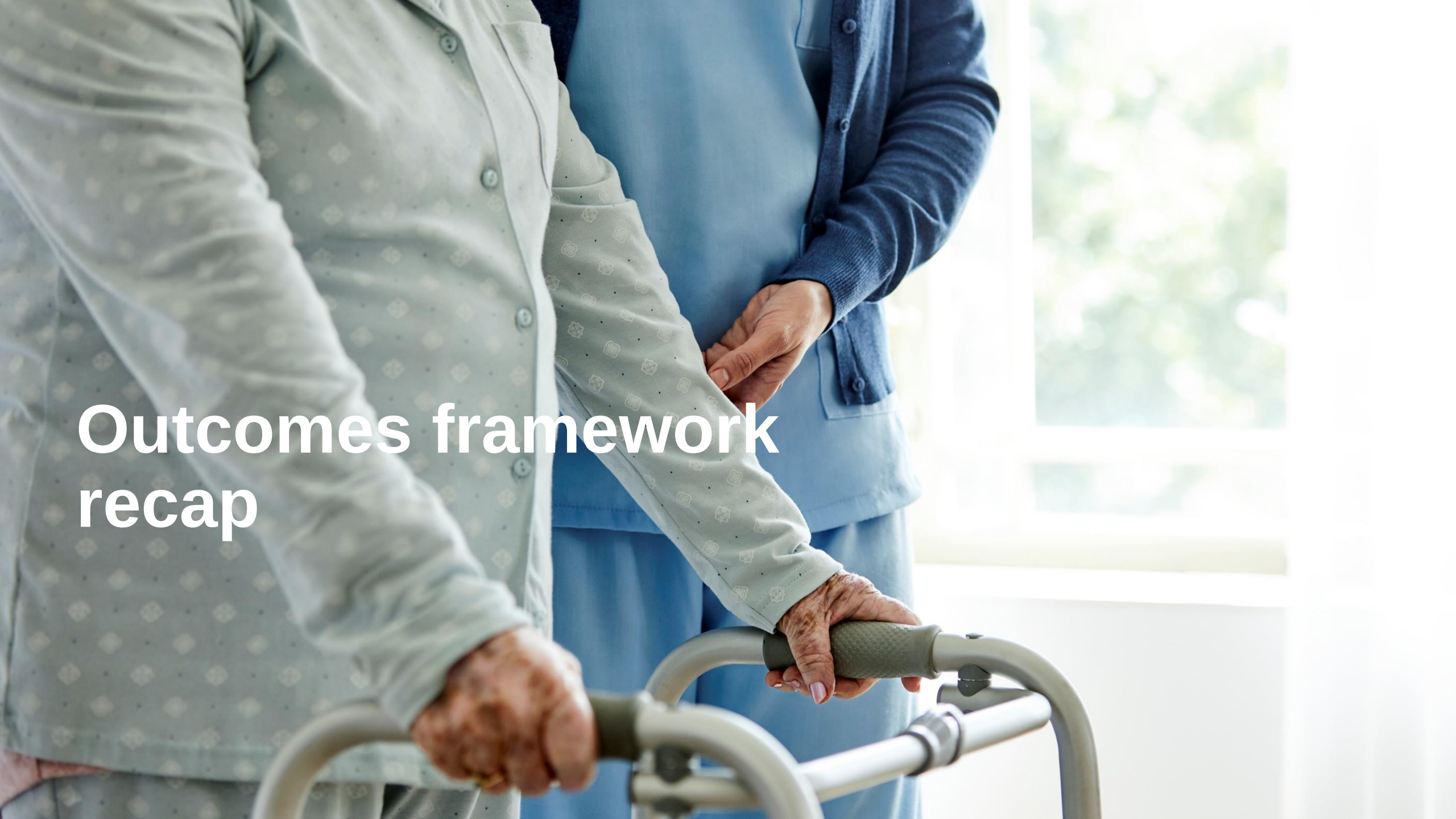
ICS Model Overview

A set of design principles will guide system development. These have been developed from existing NHCP materials and stakeholder discussions.

#	**Design Principle** *The design must …*	**Rationale** *In order to …*
1	Be geared towards a set of clear, evidenced, agreed priorities which respond to local needs.	Ensure system design will create a platform that can effectively respond to Northamptonshire's needs.
2	Ensure the needs of the patient / service users are at the centre, with co-production as a critical principle.	Develop a system and service structure that is person, not organisation or funding stream-centred.
3	Provide a mechanisms for placing greater funding, focus and accountability on prevention and self-care, improving the wider determinants of health and tackling the causes of long-term health demand.	Deliver long-term improvements in people's health and wellbeing, reducing health inequalities and contributing to long term value for money and system sustainability.
4	Create a meaningful voice in the commissioning of services for frontline clinicians, patients, service users (and must allow these stakeholders routes to scrutinise and challenge plans).	Create services that are responsive to clinicians and services users.
5	Locate decision-making as close to communities as possible (subsidiarity).	Create a system that is cognisant and responsive to local needs.
6	Incorporate critical partners (including GPs and local government) into governance at all levels, involving them in commissioning decisions at every level.	Build greater understanding of communities within the system and encourage greater responsiveness to these communities.
7	Recognise and build on current structures and what is working well in Northamptonshire, making best use of strengths and assets.	Ensure the system works with what it has, recognises and builds on local assets, enabling it to progress further, faster.
8	Locate specific system functions at the appropriate level (system, place, sub-place) for Northamptonshire's size and characteristics.	Effectively balance the benefits of scale, with a nuanced understanding and responsiveness to local needs – enables best value use of funding.
9	Provide a platform that can deliver collective, integrated and co-ordinated leadership, developing a shared vision and culture and reducing the likelihood of organisational silos.	Create the conditions for alignment of strategic priorities and direction across all key players.
10	Recognise the risks and opportunity cost in establishing new organisational delivery models – pursuing these routes only where there is a compelling evidence base for success.	Reduce the risk of ICS transition and reform and keep costs, lead time and organisational disruption to a realistic minimum.
11	Provide a route to a shared data and digital agenda for Northants, accelerating system-wide data collation, analysis and insight and creating new health and care pathways.	Maximise and benefits that digital and data can bring to the system.
12	Ensure that the delivery of care and support represents the best long-term value for money for the tax payer.	Maximise the value of health and care spending.
13	Comply with all legal and statutory guidelines including guidance on good governance and representation.	Receive approval from NHS and other regulators, and operate within the boundaries of government policy, and best practice.

Summary: The ‘building blocks’ of our ICS blueprint

Our work to date lays out the intended shape of our ICS and the outline building blocks of that. Further work is required to develop the underlying detail of this model and its component parts.



Outcomes framework recap

Our Outcomes Framework will allow us to link specific health, care or wider service interventions with improved outcomes for Northamptonshire citizens

Triple Aim

Outcomes

What is an outcomes framework?	• A resource that links 'interventions' with 'outcomes' and ultimately, 'impact'.
Why is it different to what we do now?	• We focus on 'activities' (e.g. reducing the size of our backlog) or 'outputs' (achieving a national standard) and not always 'outcomes' (e.g. reducing premature mortality from an illness) or 'impact' (e.g. fewer children are carers as a result of parents having a chronic illness). • At best, we take a limited view of data types we would use to evaluate effectiveness. At worst, we could pick and choose the metrics that put our interventions in the best light. • Do we lack objectivity in evaluating programmes locally? Are there inherent biases at play?
Why do we need an outcomes framework now?	• It will help us describe 'why' the system partners are coming together to form an ICS and distil common causes. We know what we're doing and how we go about achieving it, but can we always explain why? • Our Outcomes Framework will develop over time as our understanding of local need develops and we can use Population Health approaches to guide our thinking.
How does it help local people?	• People will be able to see the links between 'what' we are doing and 'why' we are doing them. • It will help contribute to the rationale for why partners are coming together to form an ICS and how we can collectively tackle the 'causes of the causes' in Northamptonshire.
How are we developing it?	• There are many ways we could develop an outcomes framework. Having explored the options, NHCP Partnership Board have asked us to use a 'life-course' approach. This results in us looking at the evidence-based outcomes that require our collective attention using phases of life i.e. pre-birth all the way through to end of life. • At this time, we are using things like the Public Health Outcomes Framework and NHS Rightcare to guide its development. We expect that to evolve over time with inclusion of more datasets to help refine our work. • Once we are clear on the outcomes, we will adopt a logic model approach to develop evidence-based ways of improving the outcomes. • Once drafted, we will need to think through how we collectively prioritise and phase work/inputs required to deliver the outcome.
What *won't* it do?	• It won't list every priority or 'must do'. If you don't see your area of work, it does not mean its not important or that it doesn't need to be addressed, we just have to cut the elephant up into smaller pieces to manage it. • Due to the current limitations on benchmarks and the life-course approach being used, we will invariably not capture every work-stream.
How does it link with Population Health Management?	• The development of an outcomes framework is one key part of developing population health capabilities in Northamptonshire. • In time, Population Health Management will be the 'brain' or 'GPS' of the ICS, guiding the system to understand what needs to be addressed, why and how it might be achieved.

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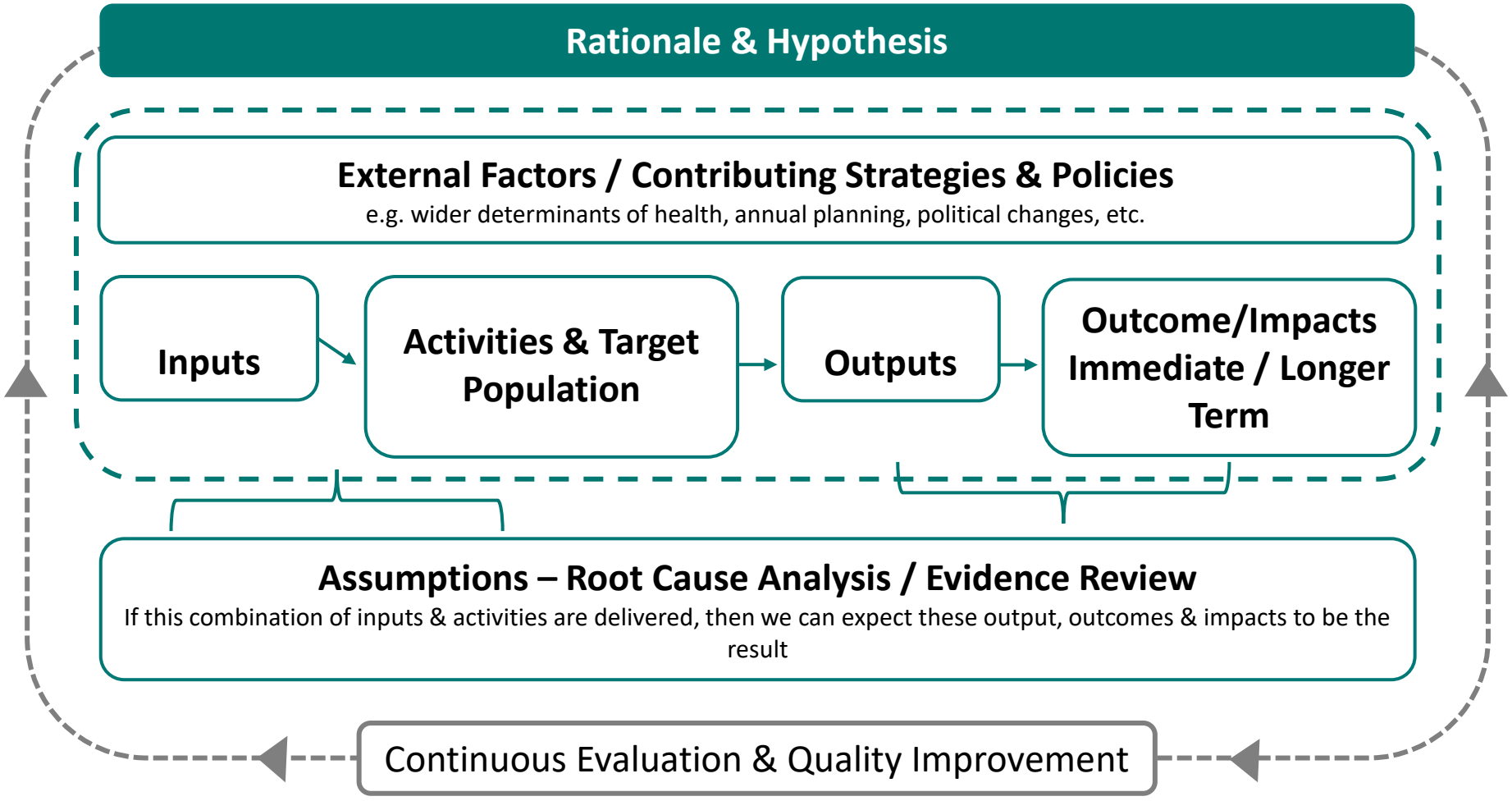
Example Logic Model*

Triple Aim

Outcomes



* Adapted from Nuffield Trust (2020) *Using logic models to evaluate innovations in health care* [online]. Available at: https://www.nuffieldtrust.org.uk/news-item/using-logic-models-for-evaluating-innovations-in-healthcare. Accessed: 17/05/2021

Our DRAFT Outcomes Framework will include agreed key measures across the five key phases of the Life Course

Triple Aim

Outcomes

Early Years

To provide families with the support required to prepare their children for school and wider society

1 Increase childhood vaccination uptake
2 Improve good development by end of reception year

School Age

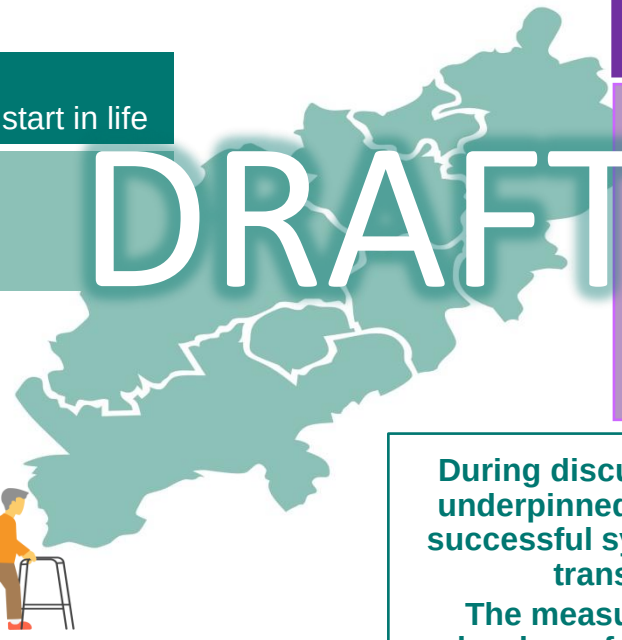
To create home and learning environments which encourage children to achieve their full potential

1 Reduce chlamydia rates in under-18s
2 Reduce under-18 conceptions
3 Reduce 15-19 year olds hospitalised through self-harm

Pregnancy & First Year of Life

To offer all babies born in Northamptonshire the best start in life

1 Reduce smoking at time of delivery
2 increase infant vaccination uptake
3 Increase breastfeeding initiation & continuation



Working Age

To improve the health and productivity of working age people and reduce risk of premature mortality

1 Improve management of diabetes
2 Increase levels of physical activity
3 Increase healthy weight within the population
4 Reduce smoking prevalence
5 Reduce alcohol-related hospital admissions
6 Reduce emergency hospital admissions for self-harm
7 Reduce deaths from COPD
8 Reduce deaths from cancers considered preventable

Older Age

To support people to remain independent into older age and live well to the end of life.

1 Increase vaccination uptake
2 Reduce hospital admissions due to falls
3 Reduce excess winter deaths

During discussion, the Partnership confirmed that a system outcomes framework, underpinned by a public health management approach, will be a critical enabler to successful system integration. Once developed, the framework will help the system transition to a longer-term approach to improving heath outcomes.

The measures listed here are illustrative only and there is further work to do to develop a framework that reflects the our priorities and the aspirations of system partners and citizens.

We anticipate a first draft of this framework will be available for discussion with partners at the end of July

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Collaboratives

Collaboratives are the preferred delivery approach for realising our ambition of outcomes-based services to meet population needs.

- Collaboratives are groups of providers, commissioners and other organisations which work together to deliver a defined set of outcomes (as specified by the ICS statutory body).
- Collaboratives will take on responsibility for service design and transformation (sometimes known as ‘tactical commissioning)’ which is currently exercised by commissioners.
- Collaboratives will be commissioned at a system level, and operate system wide, but operate services which are tailored to meet needs at Place* and neighbourhood level.
- Collaboratives will work closely with representatives from Places and Neighbourhoods, and take a ‘co-production’ approach to service design.
- The majority of citizen, patient, community and staff engagement will take place through collaboratives. We believe this is best focussed on how services are designed and delivered rather than governed.
- Collaboratives will be formed around four system priorities in the first instance. Over time, we will increase the range of services managed through collaboratives.
- We will explore potential for a ‘hub’ model providing support services across multiple collaboratives.
- Our Collaboratives will operate under one of two Collaboration Models – either an Alliance or a Lead Provider.

Further work is required to determine which model will be used for each collaborative, as well as leadership arrangements (for lead provider collaboratives) and/or responsibility for co-ordination of Alliance collaboratives. This will form part of the next stage of work for each collaborative, which is currently being scoped.

*We recognise that ‘place’ is used with different meaning in different contexts. For the purposes of this document, “Place” is used as set out in NHS guidance and documentation as referring to a geographic unit within an ICS – typically containing a population of 250,000 – 500,000.

Developing our Collaboratives

Example development material from our emerging Mental Health Collaborative

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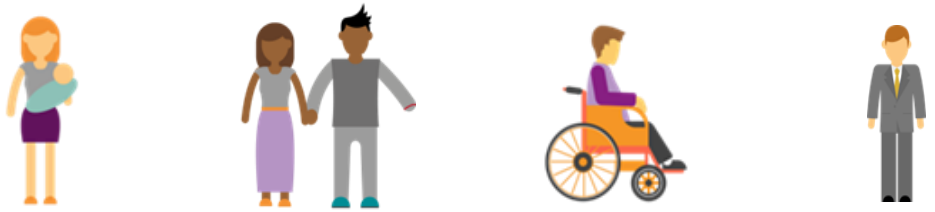
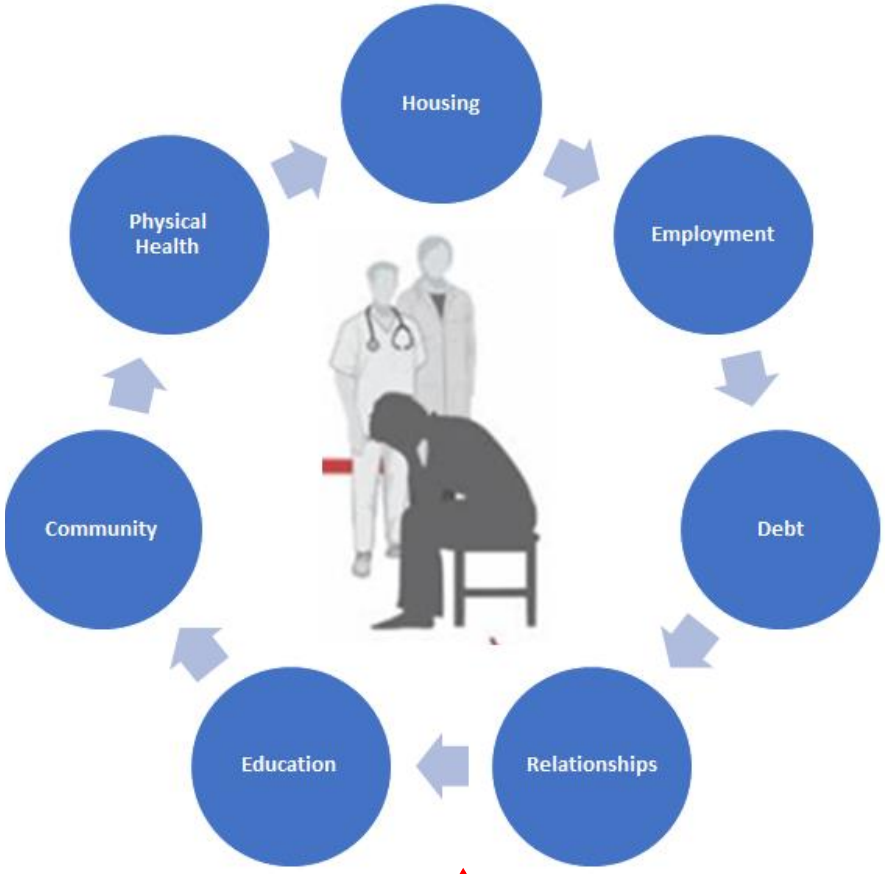
Example – developing the MH collaborative: The need for an integrated response

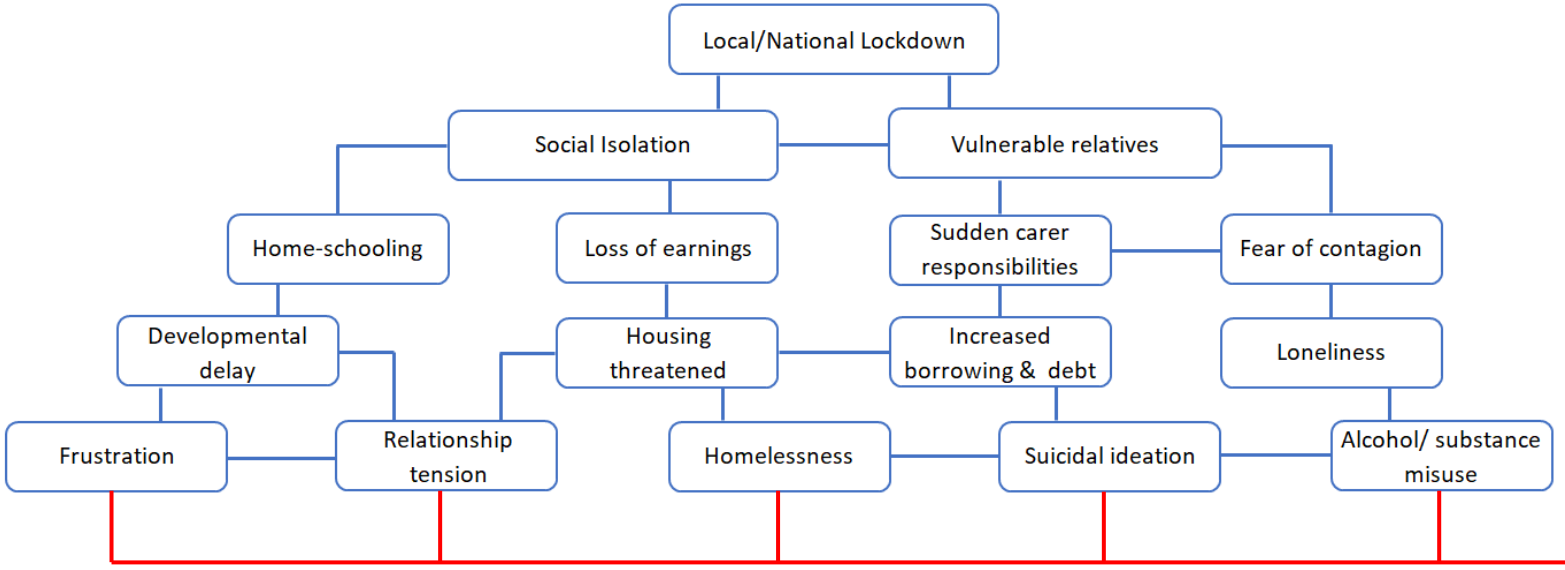
Collabora-tives

Mental Health Collab

Covid-19 highlights the reality of how mental health impacts on every other area of our system. We have developed an Integrated care pathway approach as we cannot separate mental health from wider determinants of health.







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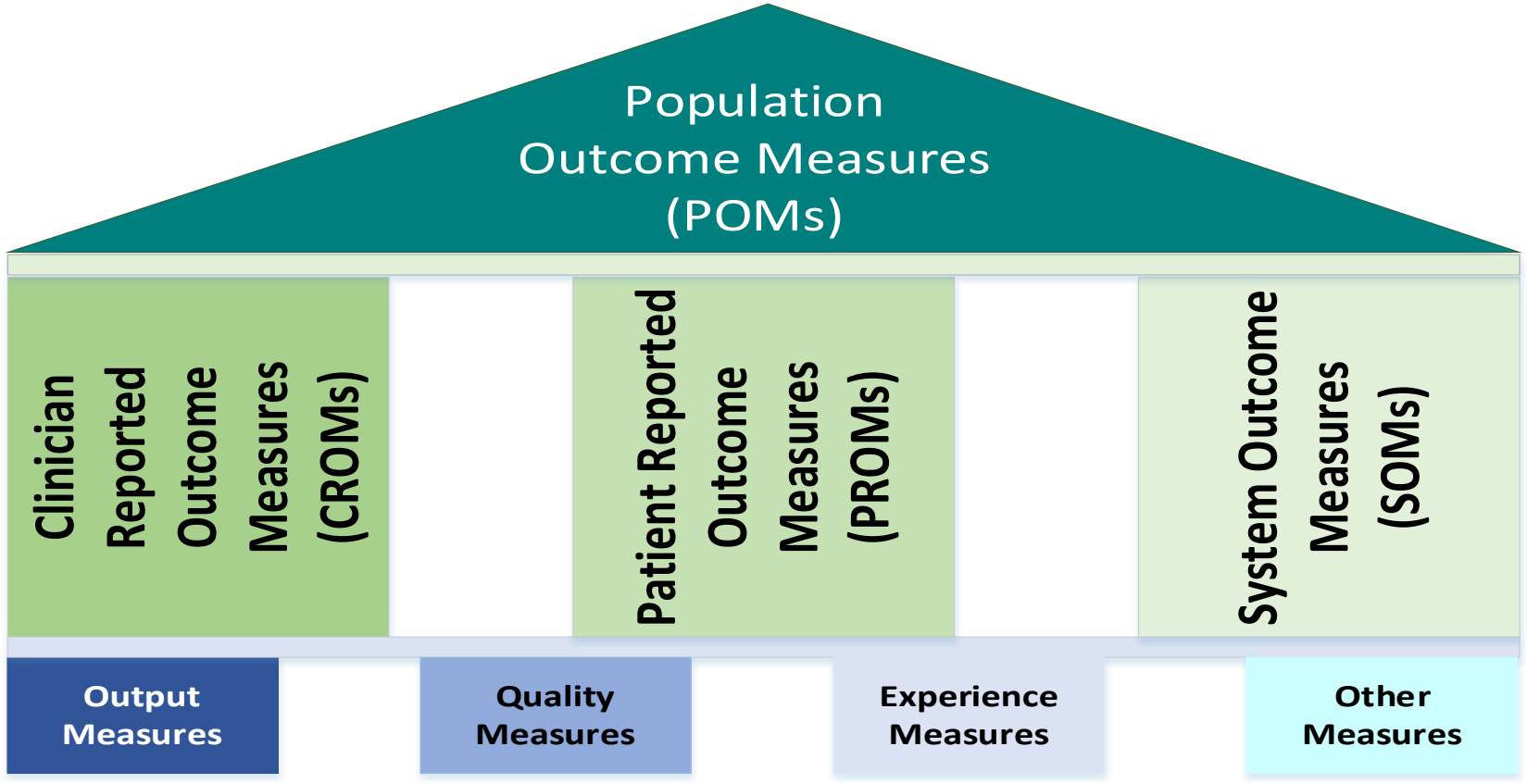
Example – developing the MH collaborative: Outcomes Framework

Collabora-tives

Mental Health Collab

The following outcomes framework, originally drafted in 2018, was used for the design and management of outcomes within this contract:

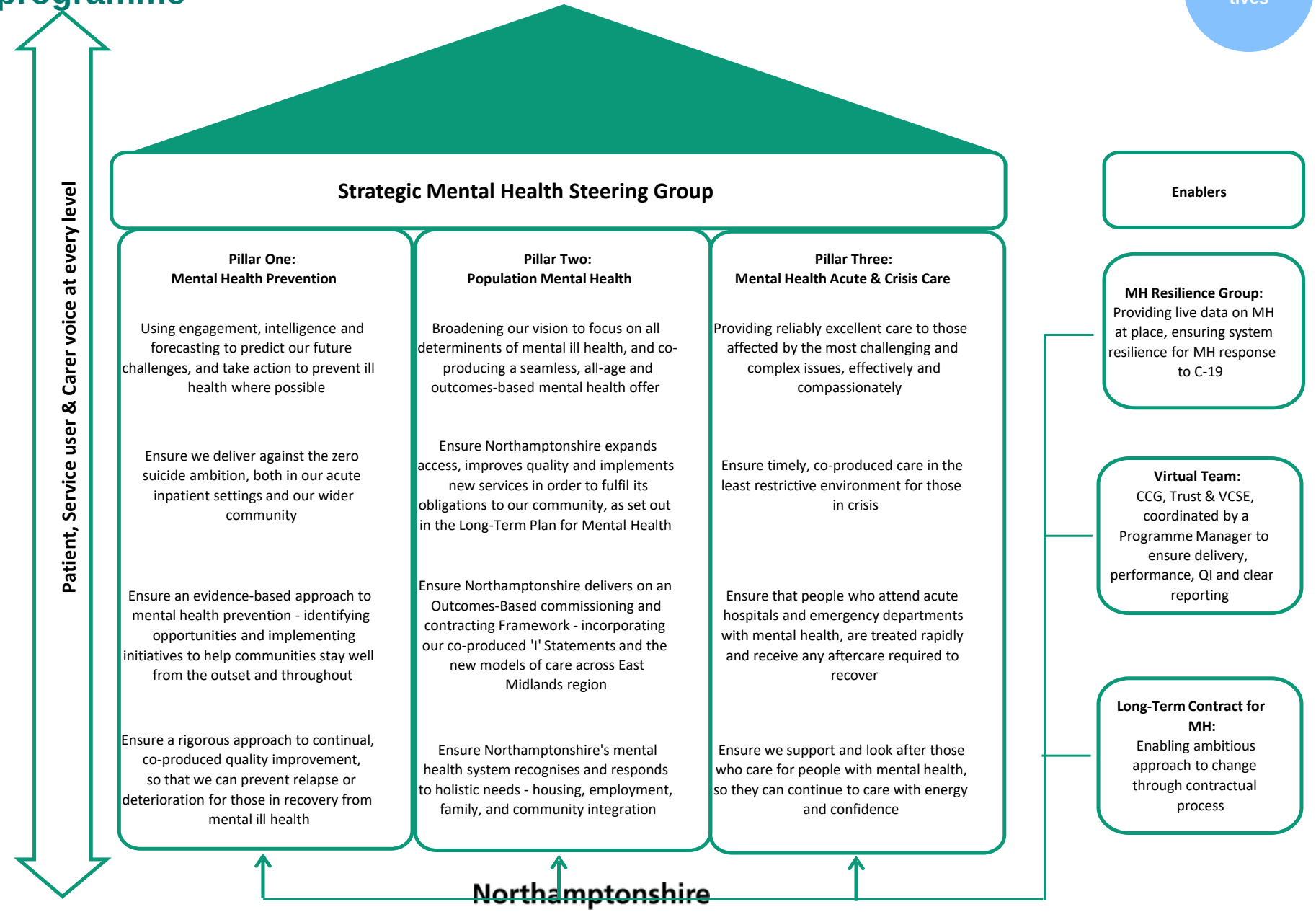


In essence, information of all types is essential but is of most impact if designed to support the achievement of Population Outcome Measures

Example – developing the MH collaborative: Structure of the MH Collaborative Transformation programme

Collabora-tives

Mental Health Collab



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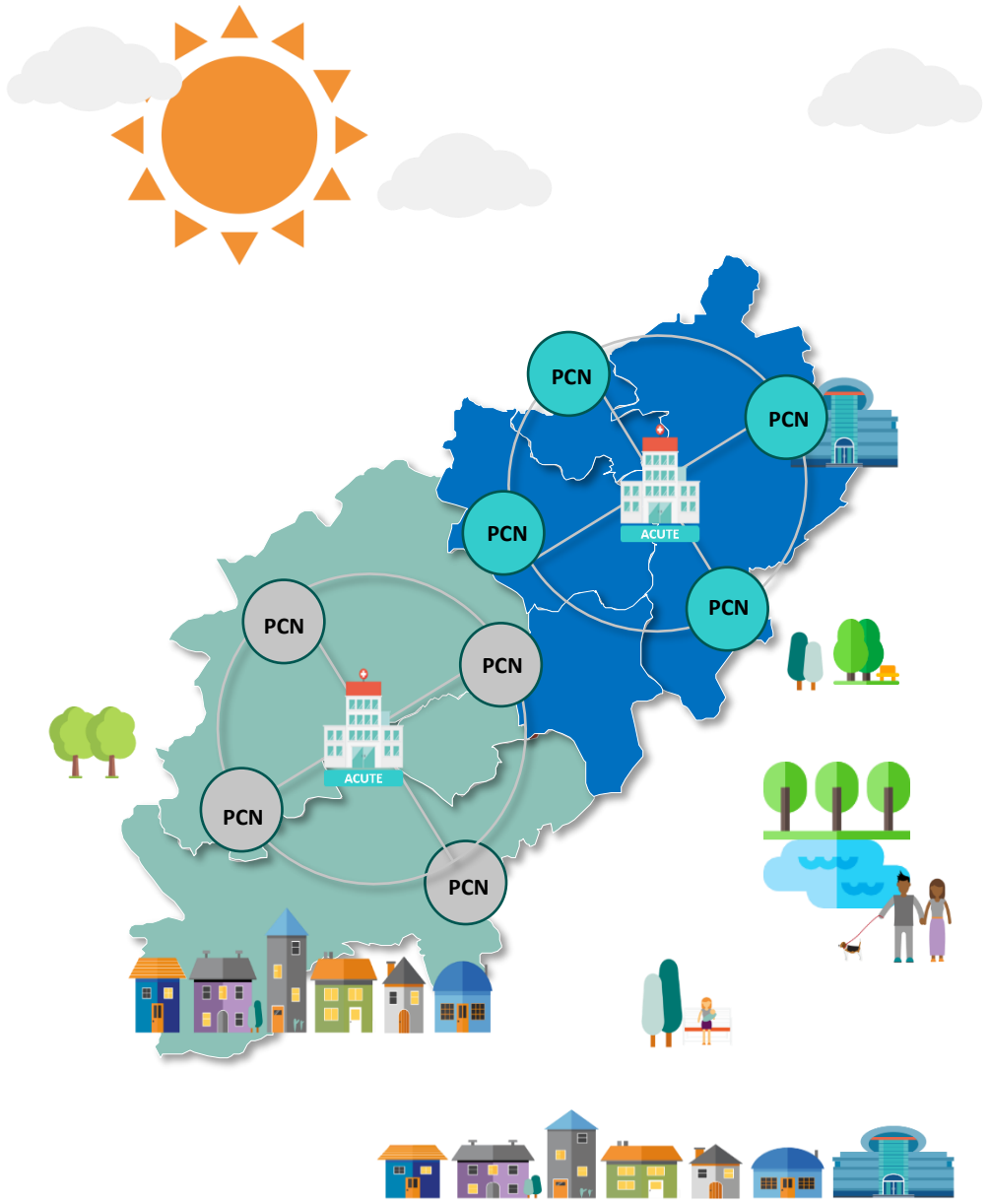
Place and Health and Wellbeing Boards

Our Ambition for places

Discussed at Partnership board in May 2019

- Peoples' wellbeing at the heart of what we do.
- Health & Wellbeing Strategy focused on Improved population health and reduced Health inequalities.
- Earlier intervention and prevention.
- A network of connected services working as collaboratives to deliver agreed outcomes
- Improved long term condition management.
- Care closer to home.
- Systems and processes easy for residents to navigate.
- Place based budgets and commissioning.
- Shared Care Records and care plans
- Enhanced care home support
- Better use of the Northamptonshire pound through shared resources and assets.
- Combined estates strategy and fit for purpose Infrastructure.



What we want to achieve

At a neighbourhood level we want to create integrated hubs delivering a range of services that meet local needs and outcomes set out in place based Health and Wellbeing Strategies

Discussed at Partnership board in May 2019

OBJECTIVE 1
Create Neighbourhood Community hubs delivering public services and care.

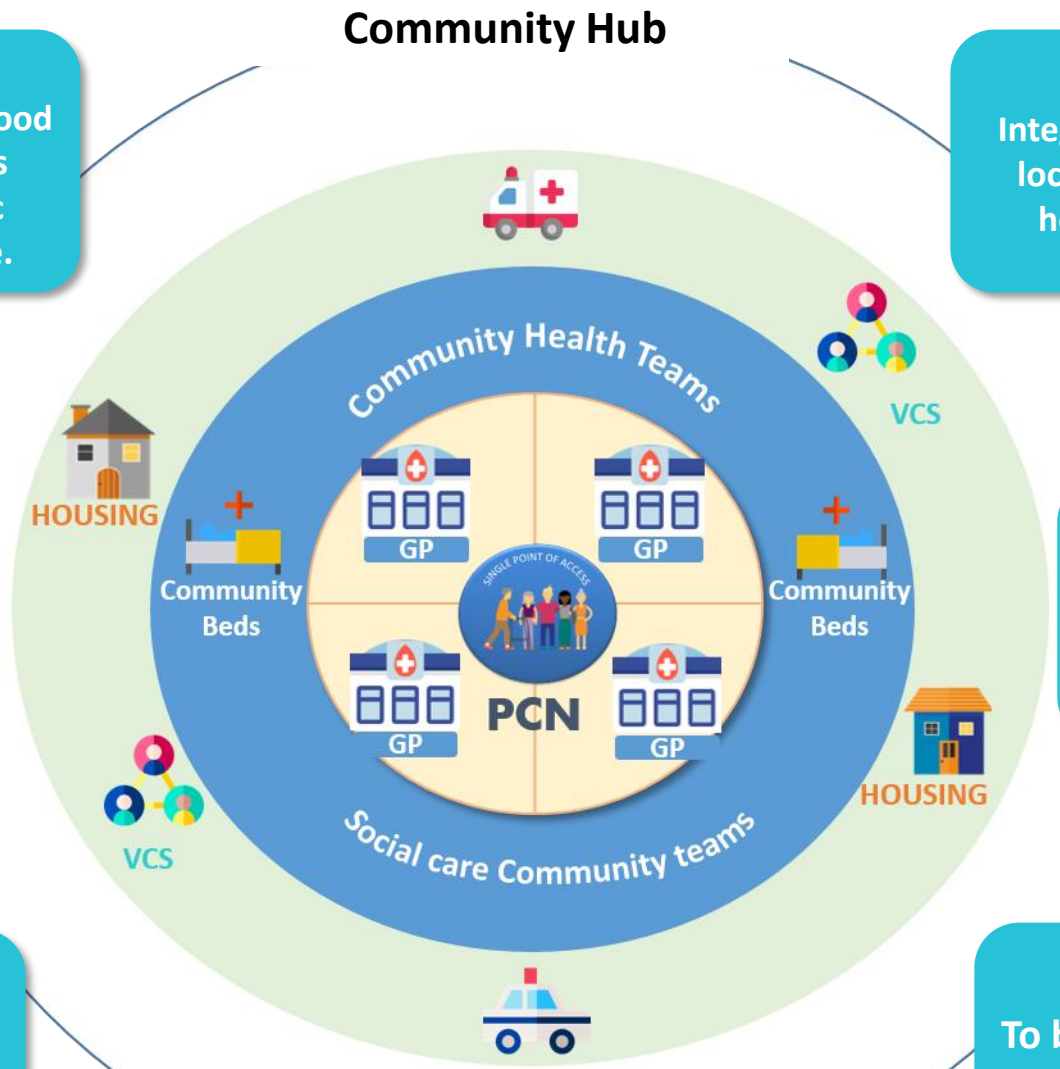
OBJECTIVE 2
Help people remain well for longer and provide better self-care support.

OBJECTIVE 3
highly responsive, effective local and personalised services

OBJECTIVE 4
Integrate services around local community need: housing, social care, health....

OBJECTIVE 5
Optimise our shared Assets and Resources to effect better outcomes and meet local need

OBJECTIVE 6
To become a sustainable system.



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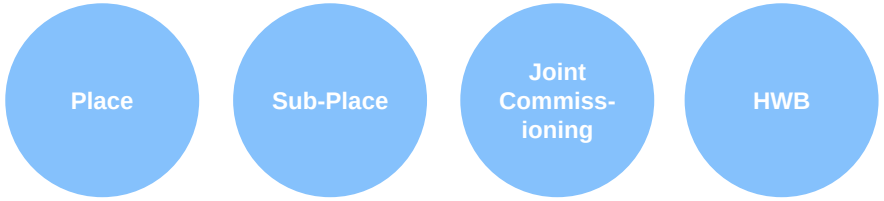
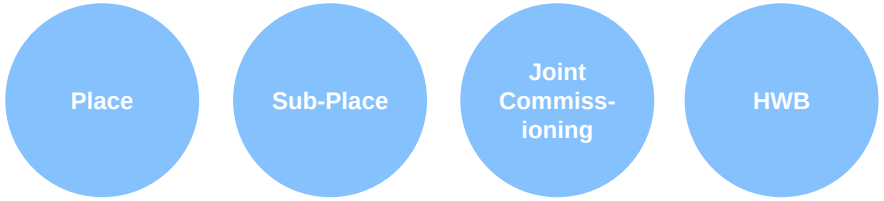
Health and Wellbeing Boards ("HWBs") will anchor ICS arrangements at place-level, continuing with their current functions and oversee place-level commissioning.



- Our ICS will have two "Places" – aligning with the footprints for the new Unitary Authorities.
- Our two HWBs will maintain their current roles and responsibilities around needs analysis, strategic planning and scrutiny.
- ICSs will require an overall system strategy to be developed by the ICS Partnership. The recommendation is that this joint strategy should incorporate our two (planned) Joint Health and Wellbeing Strategies – producing a single, system-wide strategic plan for meeting health, care and wider wellbeing needs across the County.
- The Joint Business Intelligence team will work with the Health and Wellbeing Boards to create a Joint System Needs Analysis (combining two place-based JSNAs) and System Strategy, to be ratified by the Partnership. This work and the resulting documents will remain sensitive to the different needs and characteristics of our two places.
- Joint commissioning for integrated health and care services will continue to take place at Place level (through Better Care Fund and current joint programmes). The ICS strategic commissioner and Local Authority commissioners will develop joint arrangements for each Place, in order to undertake this activity.
- Precise arrangements for HWB involvement will take shape in coming weeks as we engage with the HWBs to shape and articulate their role.

Neighbourhood (sub-place) arrangements will be crucial building blocks in the system, and will be where a good deal of integration is seen and felt.



- ‘Neighbourhood’ arrangements will be needed as a basis of effective integration and tailoring of services to local needs.
- We have a range of organisations and providers operating at this level including PCNs and others.
- Sub-place arrangements (potentially developed from the current locality boundaries, amended where needed) will help enable two way communication and coordinate strategy and programmes for neighbourhoods.
- We will support our Places to develop more local arrangements within each Unitary area, as an explicit work stream during the next phase of design work.
- Our collaboratives will work at a system level, and operate system wide, but operate services which are tailored to meet needs at place and neighbourhood level. They will co-design services in consultation with Place, Sub-Place and general practice representatives, as well as through staff, patients and citizen engagement.

These arrangements require further development in the next phase of work – based around local conversations in each of our Places.

ICS Body and ICS Partnership

A new ICS Statutory Body to bind partner organisations together

- New statutory organisation responsible for:
    - Developing a plan
    - Allocating resources
    - Establishing joint working and governance arrangements
    - Arranging of the provision of services through contracts
    - People plan
    - Data and digital
    - Estates
    - Emergency planning
- Will take on the functions of CCGs plus additional delegated by NHSE&I
- Will be supported by a strategic commissioning/management support function, including the transfer of CCG staff and Commissioning Support Unit arrangements
- It will also provide the Northamptonshire link to East Midlands specialist services planning.

ICS Statutory Board: Membership

- The ICS Statutory Body will have a new unitary board with shared corporate accountability for delivery of the functions and duties of the ICS
- The board will be the senior decision making structure for the ICS body
- The (small) size of our system means that we have an opportunity to build a Board which includes the most comprehensive possible range of NHS and Local Authority partners working across the County.
- Minimum membership will include:
    - Independent Chair plus at least 2 other independent NEDs
    - Chief Executive plus other directors (inc Finance, Nursing and Medical)
    - Partner members from NHS Trusts, local authorities and general practice
- The Board will have a formal constitution and need to establish its own committee structure
- Expected to move into shadow operating mode following designate appointment aligned to progress of legislation

The precise membership, ways of working and decision-making arrangements for the ICS statutory body will be determined in the next phase of work – building on this as a starting point. This will include ensuring effective links between the Board, our Places and our Collaboratives.

Our ICS Partnership will draw insights and expertise from our Health and Wellbeing Boards in order to exercise its statutory functions.

ICS Partnership

- All ICSs will be required to have a Partnership at system level established by the NHS and local government as equal partners
- Its role will be to align system outcomes, purpose and ambition for the population through an Integrated Care Strategy.
- Significant local flexibility in how Partnerships are set up and operate in each ICS
- Our ICS Partnership will be made up from the membership of our two Health and Wellbeing Boards and our ICS statutory Board.
- The Partnership will meet twice per year, in order to (i) consider progress against our Outcomes Framework over the past year, and (ii) agree a systemwide health and care strategy (or an update to the existing strategy, as appropriate) to improve population outcomes. This then forms the key mandate for the ICS statutory board, our Places and our Collaboratives.
- This focussed role, membership and meeting arrangements will ensure that the Partnership adds value over and above both the ICS Statutory Body and our Health and Wellbeing Boards, and also that it avoids involvement in operational business which duplicates other forums.

The precise remit of the ICS Partnership – and its relationship to other parts of the system - will be developed during the next phase of work. This will include considering whether the ICS Statutory Body Independent Chair should also chair the ICS Partnership.

Endorsement required from Boards

Endorsement required

This paper sets out a proposal for the key building blocks of our ICS design. Within this, there are a number of elements on which we are seeking explicit approval from Boards across the system. This will ensure that we have explicit approval to the overall direction of travel, and a clear mandate for developing the model in ore detail during the next phase of work.

Boards are therefore asked to **endorse** the following:

ICS design element	Items requiring endorsement from Boards, ahead of the next phase of work to develop the detail
Collaboratives	1. Collaboratives will be formed around four system priorities. 2. Collaboratives will be commissioned at a system level, and operate system wide, but operate services which are tailored to meet needs at Place and neighbourhood level. 3. Our Collaboratives will operate under one of two Collaboration Models – either an Alliance or a Lead Provider. Further work is required to determine which model will be used for each collaborative, as well as leadership arrangements
Place arrangements and Health and Wellbeing Boards	4. Our ICS will have two places – aligning with the footprints for the new Unitary Authorities. 5. ICSs will require an overall system strategy to be developed by the ICS Partnership. We propose that this will incorporate our two (planned) Joint Health and Wellbeing Strategies – producing a single, system-wide strategic plan for meeting health, care and wider wellbeing needs across the County. 6. Joint commissioning for integrated health and care services will continue to take place at Place level (through Better Care Fund and current joint programmes). The ICS strategic commissioner and Local Authority commissioners will form joint arrangements for each Place in order to undertake this activity.
Neighbourhood (sub-place) arrangements	7. 'Neighbourhood' arrangements will be needed as a basis of effective integration and tailoring of services to local needs. We will support our Places to develop the neighbourhood arrangements which best work for them, as an explicit work stream during the next phase of design work. 8. Our collaboratives will operate services which are tailored to needs at Place and neighbourhood level. They will co-design services in consultation with Place, Sub-Place and general practice representatives.
ICS Statutory Body and ICS Partnership	9. The (small) size of our system means that we have an opportunity to build a Board which includes the most comprehensive possible range of NHS and Local Authority partners. *This means that our ICS statutory Board will be able to take a 'whole system' perspective, and will therefore play a relatively larger role – and our ICS Partnership a relatively smaller role – within our overall system governance arrangements when compared to other, larger systems. The precise membership and ways of working for the ICS statutory body will be determined in the next phase of work.* 10. Our ICS Partnership will be made up from the membership of our two Health and Wellbeing Boards and our ICS statutory Board. 11. The Partnership will meet twice per year, in order to (i) consider progress against our Outcomes Framework over the past year, and (ii) agree a systemwide health and care strategy (or an update to the existing strategy, as appropriate) to improve population outcomes. This then forms the key mandate for the ICS statutory board, our Places and our Collaboratives. 12. The precise remit of the ICS Partnership – and its relationship to other parts of the system - will be developed during the next phase of work. This will include considering whether the ICS Statutory Body Independent Chair should also chair the Partnership Board.

Next Steps

Next steps: Building a roadmap to guide further design and development (Draft)

We are in the process of designing a roadmap to guide further design, development and transition activities. The diagram below outlines the process we are following.

OUR APPROACH

1 Structure the roadmap.

Map out the strategic layer of the roadmap:

- Identify key outcomes (2022 and 2024) and milestones
- Identify key streams of work, splitting key delivery streams and enabling / cross-cutting workstreams
- Identify early wins/deliveries.

2 "Must do's" for April 2022.

Align system leadership on the requirements of the White Paper in terms of scope, implications and a common language.

Use sessions with the regional and national team to secure in depth understanding of emerging guidance.

3 Priority workstreams and phasing through to April 2022 and beyond.

Overlay workstreams and requirements to achieve April 2022 state and end state of April 2024.

The system will need to be clear on transition states on the journey towards end state.

4 Outline roadmap.

The roadmap will:

- Set out clear and comprehensive workstreams and accountabilities along with decision points
- Be actionable and focused on delivering against priorities
- Clarify how stakeholders will be engaged.

5 Scenario testing.

Stress test the model and the roadmap against key scenarios and consider how the roadmap will flex and adapt in the face of changes to the external environment.

6 Next steps.

Develop the immediate next steps and scope key pieces of work to support future phases of the transition programme, including an estimate of required resources.

Workstreams (Draft and in development)

The table below sets out a draft workstream structure for the Programme – this is indicative only and currently in development. We have drawn from example transition plans from health and local government and discussed the division of workstreams with CCG colleagues.

ICS Development Workstreams		
Workstream	**Purpose**	**Contents (indicative)**
1. Strategy and Design	Develop ICS strategy and detailed operating model – building on discussions to date	• Needs analysis and outcomes framework • System strategy • Strategic commissioner – design / op. model. • ICS governance and decision-making – detailed design and implementation
2. Place and sub-place model	Develop role and footprint for sub-places. Clarify how Place / sub-place / collaboratives will work together.	• Place / subplace function • Joint commissioning arrangements • Health and Wellbeing Boards, • Form and ability to act • Interface with Collaboratives
3. CCG transition	Ensure effective transition from CCG to ICS arrangements (including but not only ICS statutory body)	• Functional mapping • Transfer of CCG services • Transfer of contracts • Organisation structure for ICS stat body
4. Collaboratives development	Mobilise collaboratives to begin working (in suitable form) from April 2022.	• ICAN • Elective • CYP • Mental health
9. Transition management	Ensure programme is delivered to required quality and timescales	• Programme / project management • Assurance / reporting • Managing risks, issues and dependencies

Cross-cutting and support workstreams		
Workstream	**Purpose**	**Contents (indicative)**
5. Enabling functions for ICS and collaboratives	Ensure support services maximise capability and effectiveness across the system	• Support services (clinical and corporate). • Technology, digital, data and intelligence. • Estates and Infrastructure. • EPRR.
6. Strategic Finance	Ensure financial underpinnings for system working and new service models	• Systemwide finance baseline. • ICS financial strategy (including risk/gain share and incentive structures). • System budget-setting for 2022/23.
7. People	Ensure leadership and staff capability to work in new ways. Ensure effective staff transition	• Leadership. • Organisation development and capability. • People strategy. • HR.
8. Communications	Maintain whole-system alignment and buy-in to changes.	• Internal communications (staff) • External stakeholder participation / engagement and system comms
		• Transition resource and capability development • Coordinate additional cross-cutting support – legal etc

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