WIRRAL

ADULT SOCIAL CARE AND PUBLIC HEALTH COMMITTEE

29 JULY 2021

REPORT TITLE:	**INTEGRATED CARE SYSTEM AND INTEGRATED CARE PARTNERSHIP DEVELOPMENTS - UPDATE**
REPORT OF:	**DIRECTOR OF CARE AND HEALTH**

REPORT SUMMARY

This report sets out the policy context for the development of Integrated Care Systems (ICS) in the NHS in England, specifically highlighting the work to create a Cheshire and Merseyside ICS. The report also sets out the emerging guidance around developing Integrated Care Partnership (ICP) in "place" and specifically in Wirral.

RECOMMENDATION

The Adult Social Care and Public Health Committee is recommended to:

1. Note the report and receive a further verbal update on progress.

2. Receive written reports on the progress of the development of the Integrated Care System and Integrated Care Partnerships at future meetings.

SUPPORTING INFORMATION

1.0 REASON FOR RECOMMENDATION

1.1 This report is for the information of the Adult Social Care and Public Health Committee. It is therefore recommended that the Committee notes the report and receives a further verbal update on progress. In addition, it is recommended that the Committee receives written reports on the progress of this work at future meetings.

2.0 OTHER OPTIONS CONSIDERED

2.1 No other options have been considered.

3.0 BACKGROUND INFORMATION

3.1 Policy Context

3.1.1 Given that the terminology being used in regard to strategic developments in the NHS is new and emerging a definition of the key terms is included in Appendix 1.

3.1.2 On 26th November 2020 NHS England/Improvement (NHSE/I) published *Integrating Care: Next steps to building strong and effective integrated care systems across England*, subsequently referred to as *Integrating Care: Next steps*. This document set out proposals for legislative reform and focused on the operational direction of travel for the NHS from 2021/22 onwards.

3.1.3 On 11th February 2021, the Department of Health and Social Care (DHSC) published the White Paper *Integration and innovation: working together to improve health and social care for all*, which sets out legislative proposals for a Health and Care Bill. The White Paper brings together proposals that build on the recommendations made by NHS England and NHS Improvement in *Integrating care: next steps to building strong and effective integrated care systems across England* with additional ones relating to the Secretary of State's powers over the system and targeted changes to Public Health, social care, and quality and safety matters. On the same day NHSE/I issued four documents including *Legislating for Integrated Care Systems: five recommendations to Government and Parliament*: These documents encouraged Her Majesty's Government to introduce legislation, at the earliest opportunity, to place Integrated Care Systems (ICSs) "on a clear statutory footing, but with minimum national legislative provision and prescription, and maximum local operational flexibility".

3.1.4 On 25th March 2021 NHS England and NHS Improvement published the NHS Operational Planning and Implementation Guidance for 2021/22. This set out that:

- There will be one statutory ICS NHS body and one statutory ICS health and care partnership per ICS from April 2022.
- Clinical Commissioning Group (CCG) functions will be subsumed into the ICS NHS body and some NHS England and NHS Improvement direct commissioning functions will be transferred or delegated to ICSs.

- CCG staff below board level who are directly affected will have an employment commitment and local NHS administrative running costs will not be cut as a consequence of the organisational changes.
- Through strong place-based partnerships, NHS organisations will continue to forge deep relationships with local government and communities to join up health and social care and tackle the wider social and economic determinants of health. To enable this, ICS boundaries will align with upper-tier Local Authority boundaries by April 2022, unless otherwise agreed by exception. Joint working with local government will be further supported by the health and care partnership at ICS level.
- The development of primary and community services and implementation of population health management will be led at place level, with Primary Care Networks as the building blocks of local healthcare integration.
- Every acute (non-specialist) and mental health NHS trust and Foundation Trust (FT) will be part of at least one provider collaborative, allowing them to integrate services appropriately with local partners at place and to strengthen the resilience, efficiency and quality of services delivered at-scale, including across multiple ICSs.
- Clinical and professional leadership will be enhanced, connecting the primary care voice that has been a strong feature of Primary Care Networks (PCNs) and CCGs, to clinical and professional leadership from community, acute and mental health providers, Public Health, and social care teams.

The planning and implementation guidance anticipated that legislation would be introduced into Parliament to enact the proposals in the White Paper. The guidance asked systems to start formally preparing to establish the expected statutory arrangements during Quarter 1 2021/22.

3.1.5 The intention of the Government to bring forward a Health and Care Bill to implement the proposals in the White Paper was announced in The Queen's Speech on 11th May 2021. The background briefing notes to The Queen's Speech state that the purpose of the Health and Care Bill is to:

- Lay the foundations for a more integrated, efficient, and accountable health and care system - one which allows staff to get on with their jobs and provide the best possible treatment and care for their patients.
- Give the NHS and Local Authorities the tools they need to level up health and care outcomes across the country, enabling healthier, longer, and more independent lives.

The background briefing notes articulate that the main benefits of the Bill will be:

- Delivering on the proposals put forward by the NHS in its own long-term plan, while building on the lessons learned from the successful vaccine rollout.
- Making it easier for different parts of the health and care system, including doctors and nurses, carers, local government officials and the voluntary sector to work together to provide joined-up services.
- Removing bureaucratic and transactional processes that do not add value, thus freeing up the NHS to focus on what really matters to patients.
- Enabling the system to most effectively prevent illness, support our ageing population, tackle health inequalities, tailor support to the needs of local

populations, and enhance patient safety and quality in the provision of healthcare services.
- Ensuring the NHS and the wider system can respond swiftly to emerging issues while being fully accountable to the public.

The main elements of the Bill are:

- Driving integration of health and care through the delivery of an Integrated Care System in every part of the country.
- Ensuring NHS England, in a new combined form, is accountable to Government, Parliament and taxpayers while maintaining the NHS's clinical and day-to-day operational independence.
- Banning junk food adverts pre-9pm watershed on TV and a total ban online.
- Putting the Healthcare Safety Investigation Branch on a statutory footing to deliver a fully independent national body to investigate healthcare incidents, with the right powers to investigate the most serious patient safety risks to support system learning.

3.2 Developing Integrated Care Systems

3.2.1 On 16th June 2021 NHSE/I published two documents, *Integrated Care Systems: Design Framework* and *Guidance on the Employment Commitment*. The former document begins to describe future ambitions for:

- the functions of the ICS Partnership to align the ambitions, purpose, and strategies of partners across each system.
- the functions of the ICS NHS body, including planning to meet population health needs, allocating resources, ensuring that services are in place to deliver against ambitions, facilitating the transformation of services, co-ordinating and improving people and culture development, and overseeing delivery of improved outcomes for their population.
- the governance and management arrangements that each ICS NHS body will need to establish to carry out those functions including the flexibility to operate in a way that reflects the local context through place-based partnerships and provider collaboratives.
- the opportunity for partner organisations to work together as part of ICSs to agree and jointly deliver shared ambitions.
- key elements of good practice that will be essential to the success of ICSs, including strong clinical and professional leadership, deep and embedded engagement with people and communities, and streamlined arrangements for maintaining accountability and oversight.
- the key features of the financial framework that will underpin the future ambitions of systems, including the freedom and mechanisms to use resource flexibly to better meet identified needs and to manage financial resources at system level.
- the roadmap to implement new arrangements for ICS NHS bodies by April 2022 to establish new organisations, appoint leadership teams to new statutory organisations and to ensure that people affected by change are offered a smooth transition that allows them to maintain focus on their critical role in supporting recovery from the pandemic.

The *Employment Commitment* is designed to minimise uncertainty and provide employment stability for people who will transfer directly from their employment or engagement directly into the statutory ICS NHS body. During the transition period the Employment Commitment asks affected organisations not to carry out significant internal organisational change and not to displace people. The commitment does not apply to those people in senior/board level roles who are likely to be affected by the new ICS Board structure and will have to go through organisational change as part of the abolition and establishment process.

3.2.2 The Cheshire and Merseyside Integrated Care System (ICS) has established a Development Advisory Group (DAG) to support the implementation timetable and guidance referred to above. The Chief Executive and the Director for Adult Care and Health, Wirral Council and the Chief Officer, NHS Wirral CCG are part of the DAG. This enables Wirral, as a place, to be at the heart of shaping the ICS and to ensure that we are in a position to respond at pace and with clarity to the emerging changes. There is also representation from Wirral in other ICS governance arrangements such as the Partnership Board and Joint Committee of Cheshire and Merseyside Clinical Commissioning Groups.

3.2.3 The ICS has established a number of workstreams of which the DAG will have oversight. These include commissioning, workforce, system performance and oversight, finance, governance, communications and engagement, quality, transformation, digital and data, and estates. The ICS will be assuming the commissioning functions of 9 CCGs in Cheshire and Merseyside and will be working with those CCGs to manage the transition to the new statutory body. The ICS, CCGs and Local Authorities are working together on the future models for the discharge of these commissioning functions from April 2022.

3.2.4 The implementation timetable that the ICS is working to is set out below. This is subject to the Health and Care Bill becoming an Act of Parliament.

Date (2021/22)	**Task**
By end of Quarter 1 (Q1)	Update System Development Plans (SDPs) against the key implementation requirements (functions, leadership, capabilities, and governance) and identify key support requirements. Develop plans in preparation for managing organisational and people transition, taking into account the anticipated process and timetable, and any potential changes to ICS boundaries and the need to transform functions to support recovery and delivery across the ICS.
By end of Q2	Ensure people currently in ICS Chair, ICS lead or AO roles are well supported and consulted with appropriately. Carry out the agreed national recruitment and selection processes for the ICS NHS body chair and chief executive, in accordance with guidance on competencies and job descriptions issued by NHS England and NHS Improvement. This will reflect the expected new accountabilities and responsibilities of ICS NHS bodies.

Date (2021/22)	Task
	Confirm appointments to ICS Chair and chief executive. Subject to the progress of the Bill and after the second 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, in line with the NHS England and NHS Improvement model constitution and guidance. 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.
By end of Q3	Ensure people in impacted roles are well supported and consulted with appropriately. Carry out the recruitment and selection processes for designate finance director, medical director, director of nursing 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 director of nursing 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.
By end of Q4	Ensure people in affected roles are consulted and supported. 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 (in line with our relevant guidance) so that as much of the ICS NHS executive board and other senior leadership is ready (subject to formal decisions on appointments after the legislation is in place/in force). Complete due diligence and preparations for staff and property (assets and liabilities, including contracts) transfers from CCGs and other NHS staff transfers to new ICS NHS body in line with our guidance.

Date (2021/22)	Task
	Commence engagement and consultation on the transfer with trade unions. Complete preparations to shift our direct commissioning functions to ICS NHS body, where this is agreed from 1 April 2022. Ensure that revised digital, data and financial systems are in place ready for 'go live'. Submit the ICS NHS body constitution for approval and agree the 2022/23 ICS MoU with NHS England and NHS Improvement, setting out key elements of how the new ICS NHS body and ICS Partnership will operate in the future, in accordance with guidance to be issued by NHS England and NHS Improvement.
From 1st April 2022	Establish new ICS NHS body; with staff and property (assets and liabilities) transferred and boards in place.

3.3 Developing Integrated Care Partnerships

3.3.1 Throughout the development of the policy on Integrated Care Systems there has been a strong focus on partnerships between organisations to collectively plan, deliver and monitor services within a locally defined 'place'. The document *Integrated Care Systems: Design Framework* makes it clear that, as part of the development of ICSs, NHSE/I expect that place-based partnerships are consistently recognised as key to the coordination and improvement of service planning and delivery, and as a forum to allow partners to collectively address wider determinants of health. Wirral is a place within this framework.

3.3.2 There is no single way of defining place or determining a fixed set of responsibilities that a place-based partnership should hold. All ICSs are expected to establish and support place-based partnerships with configuration and catchment areas reflecting meaningful communities and geographies that local people recognise. The arrangements for joint working at place should enable joined-up decision-making and delivery across the range of services meeting immediate care and support needs in those local places but should be designed flexibly to reflect what works in that area.

3.3.3 The Cheshire and Merseyside ICS NHS body will want to agree with local partners the membership and form of governance that place-based partnerships adopt, building on or complementing existing local configurations and arrangements such as Health and Wellbeing Boards. At a minimum, these partnerships should involve primary care provider leadership, Local Authorities, including Directors of Public Health, providers of acute, community and mental health services and representatives of people who access care and support.

3.3.4 The ICS NHS body will remain accountable for NHS resources deployed at place-level. Governance and leadership arrangements for place-based partnerships should support safe and effective delivery of the body's functions and responsibilities

alongside wider functions of the partnership. Each ICS NHS body should clearly set out the role of place-based leaders within the governance arrangements for the body.

3.3.5 An NHS ICS body could establish any of the following place-based governance arrangements with Local Authorities and other partners, to jointly drive and oversee local integration:

- *consultative forum*, informing decisions by the ICS NHS body, Local Authorities, and other partners.
- *committee of the ICS NHS body with delegated authority* to take decisions about the use of ICS NHS body resources.
- *joint committee of the ICS NHS body and one or more statutory provider(s),* where the relevant statutory bodies delegate decision making on specific functions/services/populations to the joint committee in accordance with their schemes of delegation
- individual directors of the ICS NHS body having delegated authority, which they may choose to exercise through a committee. This individual director could be a joint appointment with the Local Authority or with an NHS statutory provider and could also have delegated authority from those bodies
- lead provider managing resources and delivery at place-level under a contract with the ICS NHS body, having lead responsibility for delivering the agreed outcomes for the place.

3.3.6 Effective leadership at place level is critical to effective system working, but the specific approach is to be determined locally. The roles of place-based leaders will include convening the place-based partnership, representing the partnership in the wider structures and governance of the ICS and (potentially) taking on executive responsibility for functions delegated by the ICS NHS body CEO or relevant Local Authority.

3.3.7 The ICS NHS body will have the freedom to set a delegated budget for place-based partnerships to support local financial decisions to spend ICS NHS resources. However, it must adopt the principle of equal access for equal need and the requirements to reduce health inequalities. The ICS NHS body should engage Local Authority partners on the ICS NHS resources for the NHS services to be commissioned at place and support transparency on the spending made at place level. It should explain any variation from previous CCG budgets and enable the shared planning or pooling of NHS and Local Authority budgets, including stated minimum NHS contributions to Better Care Fund arrangements. Budget allocated to and managed within a place (under the agreed schemes of delegation) might include:

- primary medical care
- other primary care as delegated/transferred from NHS England and NHS Improvement – dental, pharmaceutical, ophthalmology services
- community services
- community mental health including Improving Access to Psychological Therapies (IAPT)
- community diagnostics
- intermediate care

- any services subject to Section 75 agreement with Local Authority
- any acute or secondary care services that is has been agreed should be commissioned at place-level.

3.3.8 In regard to developing Integrated Care Partnerships (ICPs) in each place, the Cheshire and Merseyside ICS has set out seven expected core features of an ICP:

- *ICP Governance* – clearly defined formal arrangements for place partners to meet and work together to deliver outcomes set by the Health and Wellbeing Board (HWB) and ICS.
- *ICP nominated 'Place Lead'* with remit for integrated working who will connect with the ICS.
- *Shared vision and plan for reducing inequalities and improving outcomes* of local people approved by the HWB (underpinned by local population health and socio-economic intelligence).
- *Agreed ICP development plan.*
- *Defined footprints (e.g. neighbourhoods) for delivery of integrated care*, clinically led by PCNs working with social care, community, mental health, Public Health, and other community groups.
- *Programme of ongoing public and wider stakeholder engagement at place*
- *Integrated approach to commissioning between health and Local Authority* (such as shared posts, joint teams, and pooled budgets) to underpin and support the work of the ICP.

The seven expected core features are described in more detail in Appendix 2.

3.3.9 Work has commenced in Wirral to create an Integrated Care Partnership involving the Local Authority, NHS and wider partners in health and care. The work is being guided by six core principles:

- Organise services around the person to improve outcomes.
- Maintain personal independence by providing services closest to home.
- Reduce health inequalities across the Wirral population.
- Provide seamless and integrated services to patients, clients, and communities, regardless of organisational boundaries.
- Maximise the "Wirral £" by the delivery of improvements in productivity and efficiency through integration.
- Strengthen the focus on wellbeing, including a greater focus on prevention and Public Health.

3.3.10 There are four key work streams in the development of an ICP for Wirral. These are:

- Integrated governance, including Health and Wellbeing Board development.
- Developing provider collaboration.
- Developing integrated commissioning.
- Communications and engagement.

3.3.11 Each area of work is resourced by system partners, financially and with people. At the time of writing the implementation timetable and tasks for this work is still emerging. It is recommended that a verbal update on progress is provided to the

Health and Wellbeing Board on 20th July 2021. It is recommended that the Health and Wellbeing Board receives written reports on the progress of this work at future meetings.

4.0 FINANCIAL IMPLICATIONS

4.1 None as a result of this report but the financial implications of developing an Integrated Care Partnership for Wirral within the Cheshire and Merseyside ICS are being considered as part of the planning for these changes.

5.0 LEGAL IMPLICATIONS

5.1 The Health and Care Bill, subject to Parliamentary process, will further support the implementation of the NHS Long Term Plan and give ICSs statutory roles. Further guidance will be forthcoming from NHSE/I to support the transition to the new arrangements from April 2022. This is in addition to the recently published *Integrated Care Systems: Design Framework* and *Guidance on the Employment Commitment*. Work to develop an Integrated Care Partnership for Wirral will consider the legal implications around workforce, resources, governance, and legal accountabilities.

6.0 RESOURCE IMPLICATIONS: STAFFING, ICT AND ASSETS

6.1 There is a direct impact of these changes on staff employed by CCGs, including NHS Wirral CCG, and NHS England/Improvement. It is anticipated that there will be a national human resources framework within which these proposed changes will be managed. This is in addition to the recently published *Integrated Care Systems: Design Framework* and *Guidance on the Employment Commitment*. Work to develop an Integrated Care Partnership for Wirral will need to consider the opportunities that may exist in regard to staffing, ICT, and assets in the future.

7.0 RELEVANT RISKS

7.1 The system changes outlined in this report will have risk management frameworks as part of their implementation. The Council will help to mitigate risks through the ongoing development of a risk log, which is overseen by a multi-functional project team that gains insight into all areas of risk and puts mitigating actions in place to reduce the impact of risk.

8.0 ENGAGEMENT/CONSULTATION

8.1 Engagement will need to take place in regard to the system changes outlined in this report.

9.0 EQUALITY IMPLICATIONS

9.1 Public bodies have a legal requirement to make sure their policies, and the way they carry out their work, do not discriminate against anyone. An Equality Impact Assessment is a tool to help public services identify steps they can take to ensure equality for anyone who might be affected by a particular policy, decision, or activity. Plans will be underpinned by local population health and socio-economic

intelligence. The Council will work in partnership with local and regional partners to develop place-based partnership arrangements necessary to deliver improved outcomes in population health by tackling health inequality.

An Equality Impact Assessment has been completed for this project and can be found here: The Integrated Care Partnership Programme - May 2021 (wirral.gov.uk)

10.0 ENVIRONMENT AND CLIMATE IMPLICATIONS

10.1 None as a result of this report.

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APPENDICES

Appendix 1 Terminology Definitions
Appendix 2 Seven Core Features of an Integrated Care Partnership

BACKGROUND PAPERS

- NHS Five Year Forward View (2014), https://www.england.nhs.uk/five-year-forward-view/
- NHS Planning Guidance (2017), https://www.england.nhs.uk/publication/delivering-the-forward-view-nhs-planning-guidance-201617-202021/
- NHS Long Term Plan (2019), https://www.longtermplan.nhs.uk/
- Designing Integrated Care Systems (ICSs) in England (2019), https://www.england.nhs.uk/wp-content/uploads/2019/06/designing-integrated-care-systems-in-england.pdf
- Integrating Care: Next steps to building strong and effective integrated care systems across England (2020), https://www.england.nhs.uk/wp-content/uploads/2020/11/261120-item-5-integrating-care-next-steps-for-integrated-care-systems.pdf
- *Integration and Innovation: working together to improve health and social care for all*, White Paper (2021), https://www.gov.uk/government/publications/working-together-to-improve-health-and-social-care-for-all.
- *Legislating for Integrated Care Systems: five recommendations to Government and Parliament* (2021), https://www.england.nhs.uk/publication/legislating-for-integrated-care-systems-five-recommendations-to-government-and-parliament/
- NHS Planning Guidance (2021), https://www.england.nhs.uk/operational-planning-and-contracting/
- The Queen's Speech 2021 – Background Briefing Notes, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/985029/Queen_s_Speech_2021_-_Background_Briefing_Notes..pdf
- *Integrated Care Systems: Design Framework* and *Guidance on the Employment Commitment* (2021), https://www.england.nhs.uk/publication/integrated-care-systems-design-framework/

SUBJECT HISTORY (last 3 years)

Council Meeting	Date
Health and Wellbeing Board	20 July 2021 16 June 2021
Partnerships Committee	9 November 2020 13 January 2021 29 June 2021
Adult Social Care and Public Health Committee	2 March 2021 7 June 2021

APPENDIX 1 TERMINOLOGY DEFINITIONS

Integrated Care Systems (ICS): Bring together NHS organisations, local government, and wider partners at a system level to deliver more joined up approaches to improving health and care outcomes. All areas of England will be covered by an ICS by April 2021 and on a statutory footing by 2022. Cheshire and Merseyside is an ICS area.

Place: is a defined area within an ICS, typically aligned with Local Authority boundaries. In Cheshire and Merseyside there are 9 places aligned with each Local Authority. Wirral is one such place.

Neighbourhood: a defined area within a Place that is typically co-terminus with a Primary Care Network or other recognised local community footprint.

Integrated Care Partnerships (ICP): term used to describe **place-based** joint working between NHS, local government, community services and other partners. Each Place will determine how it organises itself as an ICP and how these arrangements relate to the Health and Wellbeing Board (HWB). HWB continue to have statutory role for improving health and wellbeing of local population, using Joint Strategic Needs Assessment (JSNA) to set local priorities. HWBs are a key component of the ICS and a key role for the ICS is to support place-based working and the development of ICP arrangements.

What is Purpose of an ICP? ICPs will deliver the local priorities set by the HWB and system priorities set by the ICS, by organising how local services and partners can work better together. ICPs will drive improved outcomes and address the inequalities identified by the HWB. They can use enablers such as integrated commissioning, BCF, population health data and improved digital technology to enable this work.

Provider Collaboratives: NHS-Led Provider Collaboratives will include providers from a range of backgrounds, including the voluntary sector, other NHS trusts and independent sector providers. Provider Collaboratives will work closely with established partnerships called Integrated Care Systems, which include NHS organisations, local Councils, and others, to support improved commissioning of services for people within the same population footprint. They will also work alongside service users, carers, and families.

There are key principles which underpin the Provider Collaborative model:

- Collaboration between Providers and across local systems
- Experts by Experience and clinicians leading improvements in care pathways
- Managing resources across the collaborative to invest in community alternatives and reduce inappropriate admissions/care away from home
- Working with local stakeholders
- Improvements in quality, patient experience and outcomes driving change
- Advancing equality for the local population

APPENDIX 2 SEVEN CORE FEATURES OF AN INTEGRATED CARE PARTNERSHIP

1. ICP Governance – clearly defined formal arrangements for place partners to meet and work together to deliver outcomes set by the Health and Wellbeing Board (HWB) and ICS.

- Arrangements for ICPs must outline how link with local HWB who retain statutory role for local population health and are key to the ICS. Some Places may want the Health and Wellbeing Board to be the nominated 'ICP Board' other Places may want to establish an 'ICP Board / Committee' as a sub-group of the HWB.
- ICPs should include a breadth of place partners extending beyond health & social care, e.g. housing, voluntary sector, police.
- ICPs will have a governance framework that sets out:

    i. core members represented on the Partnership Groups,
    ii. the organisations and services that are part of the wider partnership, and
    iii. how the ICP will work with and alongside existing partnership structures (e.g. safeguarding boards, community safety partnerships, Local Enterprise Partnerships etc) to deliver on the aims of improving the quality of life and reducing inequalities.
    iv. ICPs should consider developing formal 'place agreements / MOUs' that each partner signs with agreed objectives / outcomes
    v. ICPs should bring together statutory and non-statutory organisations and communities
    vi. ICPs will need to link to ICS (how will be determined as ICS evolves)

- An ICP should be able to describe and present it's governance arrangements and it should be agreed by all partners

2. ICP nominated 'Place Lead' with remit for integrated working who will connect with the ICS.

- The Place lead should be endorsed by members of the ICP and be able to represent Place within the ICS.
- The Place lead will be a main point of contact for the ICS executive team and will sit on a Place Collaborative Forum and may be asked to represent Place on other ICS forum as system architecture and governance is developed further.

3. Shared vision and plan for reducing inequalities and improving outcomes of local people approved by the HWB (underpinned by local population health and socio-economic intelligence).

- The ICP will need a shared vision and plans / strategies aimed at reducing inequalities & improving outcomes, these plans may already exist e.g. H&WB and 5-year Place Plans. In addition, the work of the ICP is also likely to contribute to wider Place plans that support broader social and economic development.

- This will be underpinned by local population health and socio-economic intelligence
- Using their JSNA, ICPs will have a sound understanding of the characteristics of their population and the local drivers of inequality. There will be a requirement to use 'real time' population health data (supported by case finding and risk stratification) at Place to determine how to best deliver services and address local needs on a personal, neighbourhood and whole Place level.
- Plans and strategies will be created using robust engagement with local people – including minority groups and those whose voices are seldom heard.

4. Agreed ICP development plan

- The ICS will develop an ICP assurance / maturity framework, ICPs will need development plans to support their progress against this framework.
- An 'Organisational Development plan' will be required that sets out how staff from all of the ICPs partners (working at all levels) will be engaged in the vision of the Place and supported to work in an integrated collaborative culture that embeds cross system partnership working.
- As staff are asked to start working differently there will need to be a structured and significant programme of development in place to support implementation at each stage.

5. Defined footprints (e.g. neighbourhoods) for delivery of integrated care, clinically led by PCNs working with social care, community, mental health, Public Health, and other community groups.

- Each Place should have agreed 'neighbourhood' footprints (ideally based on recognised local communities) where there will be partnerships between voluntary sector and other community groups (e.g. faith groups), schools and other local agencies who can influence health and wellbeing. There should be strong partnership working between these neighbourhood services / groups and PCNs, in many areas there will be co-terminosity with PCNs and established community footprints.
- PCNs will provide 'clinical' leadership for their registered population and work with social care, community, mental health and voluntary sector on the design and delivery of integrated health and care services at a neighbourhood level linking this to wider place agendas such as economic growth, community safety and education.

6. Programme of ongoing public and wider stakeholder engagement at place

- Communications teams from each partner in the ICP need to be working closely together to deliver a programme of communications and engagement that is based on common messages and the shared ICP vision. There should be one nominated communications link from each ICP to work with the ICS communications team on how ICP and ICS messages can be coordinated across Cheshire and Merseyside.
- The local population should be able to influence and co-produce local services to best meet their needs.

- Each ICP will need an infrastructure to ensure there is ongoing and wide stakeholder and public engagement and a joint ICP engagement plan. This plan will address how to include seldom heard and minority voices.

7. Integrated approach to commissioning between health and Local Authority (such as shared posts, joint teams, and pooled budgets) to underpin and support the work of the ICP.

- As legislative reform is clarified, Places (CCGs & LAs) need to work with ICS on the transition of commissioning functions and development of new operating models. A move towards shared leadership of health & care commissioning, joint posts and pooled budgets at Place would be welcomed.
- 'Commissioning' at Place should be an enabler for the ICP to transform local services, improve outcomes and address inequalities. Integrated commissioning teams should be part of the ICP arrangements and work to support provider collaboration and service re-design.