Agenda Item No: 5

Integrated Care System (ICS) - Cambridgeshire County Council position paper

To:	Adults and Health Policy and Service Committee
Meeting Date:	13 January 2022
From:	Executive Director for People & Communities & Director of Public Health
Electoral division(s):	All
Key decision:	No
Forward Plan ref:	Not applicable
Outcome:	To provide a strategic overview of Cambridgeshire County Council's response to the establishment of an Integrated Care System for Cambridgeshire and Peterborough and secure member support for the County Council's approach.
Recommendation:	The Committee is asked to:

a) note the national and local context of the development of the ICS

b) support the principles and priorities set out in section 5.4.

c) note that the Health and Wellbeing Board and the Integrated Care Partnership Committee will be aligned and operate as a 'committee in common' with aligned membership of the Health and Well Being Board and Integrated Care Partnership

d) confirm the criteria at Section 5.7.1 that will be applied to any County Council decisions about ICS integrated services, joint appointments or joint commissioning arrangements.

e) confirm that the Council considers expanding its health policy capacity, to provide advice to members and officers in their work with the ICS.

f) champion the principle of local democratic accountability in the ICS, in accordance with Section 5.8 of the report.

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1.0 Background

1.1 The purpose of this report is to provide a briefing to committee on the Cambridgeshire and Peterborough Integrated Care System (ICS) and secure support for the Local Authority's role in delivering the required outcomes of the ICS. The national and local expectation is that Local Authorities will be key partners in ICS development and delivery and the ICS will be integral to the transformation and integration of health and social care. This will be an evolutionary process which will be developed and built upon in partnership with the NHS. This paper provides a strategic overview and orientation setting out for the Adults and Health Committee the key principles and priorities from a Local Authority perspective. This paper reflects the fact that the establishment of the ICS is at an early stage and the Committee will received regular updates as the ICS becomes more well established.

2.0 Summary position

2.1 The creation of an Integrated Care System for Cambridgeshire and Peterborough takes place in response to the national reforms of health and social care. These reforms sit alongside the recently published Social Care White Paper 'People at the Heart of Care' which sets out a 10-year vision for adult social care and changes to the way social care is funded and how people will contribute to their care costs. The ICS relates to the whole population and is also of direct relevance to the Children and Young People and Communities, Social Mobility and Inclusion Committees. Joint working across these committees will be essential.

2.2 The Local Authority has a statutory role within the structure of the ICS, with unique obligations around democratic accountability but also a potential to contribute through local knowledge, connections and leadership. This includes a public sector ethos and a commitment to involving the voluntary and community sector as well as the local community in key decisions and service developments. Local authority support and leadership working in partnership with the NHS will be crucial, championing the core principles of the ICS and the importance of prevention, population health management, tackling health inequalities and improving health and social care outcomes.

2.3 There will be a duty to collaborate across NHS and local government which will replace existing duties to cooperate. The Local Government Association (LGA) has articulated the local authority contribution to the ICS as ensuring emphasis is given to addressing health inequalities, improving population health and working with the NHS to take decisions that will support health and social care outcomes.

2.4 It is important to recognise that these developments are taking place at a time when all parts of the health and care system continue to operate during a pandemic, in the face of unprecedented demands and pressures on the workforce. The way in which local health and care organisations have worked together throughout the pandemic, developing solutions and working in partnership needs to be recognised and will be built upon by the ICS.

3.0 The national context

3.1 The Kings Fund National Descriptors of an Integrated Care System states '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 (STP's) – 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 and 106 CCGs nationally will be replaced by 42 ICSs, with new footprints set by government. A Cambridgeshire and Peterborough footprint has been mandated by government.

3.2 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

3.3 Collaborating as an ICS should 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

3.4 Clinical Commissioning Groups have the legal duty to develop the Integrated Commissioning Board constitution. For Cambridgeshire and Peterborough this is being led by the ICS designate chair – John O'Brien; and ICS 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).

3.5 **Integrated Care Boards**

Integrated Care Board (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, Non-Executive members and 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.

3.6 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, voluntary, community and social enterprise (VCSE) organisations. They will be responsible for developing the 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. In Cambridgeshire and Peterborough, the Health and Wellbeing Board will play a pivotal role as will the Health and Wellbeing Board Strategy as described later in the paper.

3.7 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 will 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 pharmacies, to work at scale and provide a wider range of services at neighbourhood level.

3.8 **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. There will also be a new planning role for NHS England regional bodies. 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. This will include the inspection of Adult Social Care as part of the ICS as set out in the recently published White Paper 'People at the Heart of Care'.

3.9 It is important to recognise the limits of what legislation can achieve. Success will depend on implementation of the integration and prevention agenda, 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 health and care indicates that these changes will take time to deliver results. Listening to patients and communities will also be key to improving services and understanding how efforts to join up health and care are progressing. 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.

4.0 ICS development in other areas, opportunities and challenges ahead

4.1 ICS development is taking place at a similar pace across the Eastern Region and the country, and no ICSs are sufficiently well established to draw any firm conclusions about impact. There will inevitably be variation reflecting local circumstances.

4.2 There is some learning from Manchester where in April 2016, as part of its devolution deal, the Greater Manchester Health and Social Care Partnership (GMHSCP) took direct control of £6bn health and social care budget and assumed responsibility for health and social care across ten metropolitan boroughs. Each has become roughly coterminous with a Clinical Commissioning Group. The boroughs function as the geographical footprint for the place level of system-place-neighbourhood organisation, though they are termed Local Care Organisations (LCOs) rather than ICPs. Each of these oversees a Private Care Network (PCN).

4.3 The GMHSCP was one of the first bodies to try this new means of delivering health and social care, and as such will be one of the first to offer signs of what challenges and opportunities the model may present. It is difficult to draw firm conclusions from Manchester so far, as some metrics have improved and others have worsened, but this is at a time when the NHS and social care have been experiencing significant challenges and increased demand.

4.4 The LGA published 'Achieving integrated care: 15 best practice actions' which draws on evidence from international research and emerging best practice and sets out the following 15 actions which align well with County Council priorities and principles and the work already being undertake on place based working, decentralisation and changing the way we commission care through the 'Care Together' approach.

Realising person-centred coordinated care	Building place-based care and support systems	Leading for integration
1. Risk stratification Identify the people in your area that are most likely to benefit from integrated care and proactive support, and preventative support.	**6. Operational framework** Create an integrated care operational framework that is right for the local area, and which aligns service delivery and service changes to a clear set of benefits for local people.	**11. Common purpose** Agree a common purpose and a shared vision for integration, including setting clear goals and outcomes.
2. Access to information Ensure individuals and their carers have easy and ready access to information about local services and community assets. Also, that they are supported to navigate these options and to make informed decisions about their care.	**7. Integrated commissioning** Use integrated commissioning to enable ready access to joined-up health and social care resources and transform care.	**12. Collaborative culture** Foster a collaborative culture across health, social care and wider partners.
3. Multidisciplinary team training Invest in the development and joint training of multidisciplinary teams (MDTs) to transform their skills, cultures and ways of working.	**8. Shared records** Identify and tackle barriers to sharing digital care records to ensure providers and practitioners have ready access to the information they need.	**13. Resource allocation** Maintain a cross-sector agreement about the resources available for delivering the model of care; including community assets.
4. Personalised care plans Develop personalised care plans together with the people using services, their family and carers.	**9. Community capacity** Build capacity for integrated community-based health, social care and mental health services, focusing on care closer to home.	**14. Accountability** Provide system governance and assure system accountability.
5. Rapid response Provide access to integrated rapid response services for urgent health and social care needs through a single-point.	**10. Partnership with voluntary, community and social enterprise (VCSE) sector** Foster partnerships to develop community assets to provide easy access to a wide range of support.	**15. Workforce planning** Lead system-wide workforce planning to support delivery of integrated care.

4.5 The LGA has also published 'Shifting the centre of gravity: making place-based, person-centred health and care a reality' which describes the shifts that need to be made to achieve the benefits of integration and proposes 6 principles to achieve integrated care:

- Collaborative local leadership to develop a shared vision, culture and values
- Subsidiarity - decision-making as close to communities as possible
- Building on existing, successful local arrangements
- A person-centred and co-productive approach
- A preventative, assets-based and population-health management approach
- Achieving best value.

4.6 With such a major set of changes, it is inevitable that there will be challenges in implementation and associated risks for the County Council itself. It is important to identify and seek to manage those risks in advance. The King's Fund says there is a risk that responsibilities for NHS resources and performance crowd out wider system priorities

and weaken the sense of equal partnership across the NHS and local government that many ICSs have worked hard to nurture. They also point to the 'sweeping powers' of the Secretary of State to intervention local decisions, within the legislation.

4.7 The Social Care Institute for Excellence identifies how the ICS model is based on a new 'shared risk and benefit' system, initially developed in the United States. It is argued that proper objectives to manage cost by preventing the need to access (relatively more expensive) acute care could simply reproduce elements of competition from the existing 'purchaser-provider' split. Research for the NHS in the Midlands and Lancashire shows that there are inherent complexities and hazards in these 'risk and reward' arrangements, which they recommend should be approached cautiously and be carefully evaluated. This clearly would apply the local authority as one of the system partners.

4.8 There are also questions as to provisions in the legislation to remove the statutory duties to provide NHS hospital care in each area, and emergency care for everyone present in an area. The King's Fund also identified concerns about proposed integrated care provider contracts, (a new contractual form allowing commissioners to award a long-term contract to a single organisation to provide a wide range of health and care services to a defined population), with campaigners arguing that this could lead to health and care services coming under the control of private companies. The NHS Long Term Plan subsequently set an expectation that integrated care provider contracts would be held by public statutory providers. The British Medical Association also raised concerns that contracts could be handed to the private sector without proper scrutiny and argued that the new system should prioritise the NHS as the preferred provider, free from competition and privatisation.

4.9 The Health Foundation refers to the disadvantages in past major reorganisations of the Health Service, the major disruption which can be created and the risk of the benefits of integration being overstated. They also point to the difficulty of introducing these changes at a point when the Health Service if facing the critical pressures caused by the Covid Pandemic. The ultimate challenge is that the outcome is not organisational integration, but one which leads to service users feeling that their care is genuinely personalised and joined up.

5.0 Local Development of Cambridgeshire & Peterborough ICS

5.1 Below is a glossary to inform Section 5 of the report:

- 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
- 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 Development of local governance arrangements

5.2.1 The Cambridgeshire & Peterborough ICB will be a statutory board that oversees the day-to-day running of the NHS locally. It will manage a single pot of NHS funding, for which it is directly accountable, and will develop a plan to meet the health needs of the population within the ICS.

5.2.2 While individual organisations within the ICS will continue to have direct responsibility for the staff in their own organisations, the ICB will be responsible for delivering the people functions for staff employed directly by the ICB, 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.

5.2.3 ICBs 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 ICS. The ICB 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 at the appropriate Committee.

5.2.4 ICB members will include the Chair and Chief Executive of the ICS, partner members including the local authority, NHS Trusts and Foundation Trusts, primary care (GP), Director of Finance, Medical Director, Director of Nursing and four independent non-executive members. The Local Authority representatives will be the Director of Public Health and the Executive Director People and Communities. The DPH will be a non-voting member while

the Executive Director of People and Communities will be a voting member. It is important to note that this is a significant development which has been facilitated by the coterminous arrangement that we have across Cambridgeshire and Peterborough, which many ICSs do not benefit from.

5.2.5 The Integrated Care Partnership Committee (ICPC) is a statutory body in its own right, which the ICB has established jointly with Cambridgeshire County Council and Peterborough City Council. The ICPC is responsible for the development of an Integrated Care Strategy. The ICB must have regard to this strategy when developing its own plans. The terms of reference for the ICPC and the ICB Constitution will be aligned to ensure that the ICS effectively meets health and care needs across our area and that as an ICS 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'.

5.2.6 The ICPC - Integrated Care Partnership Committee; will have a wide system membership to reflect the local landscape of key partners and bring in the resident voice e.g., Healthwatch, VCS, local authorities, police, combined authority.

5.2.7 Two area Integrated Care Partnership (ICP) – North and South, based around acute hospitals - will have a Managing Director. Performance of the ICPs who will report into the Integrated Care Partnership Committee and ICB. We have senior officers on the North and South ICP's. There are also several thematic groups that are supporting the development of the ICS. The local authority has corporate representation on:

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

5.2.8 As a local authority we should and are expected to play a lead role in ICP development; 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 communication and liaison 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 years spent in good health. However, we know that the pandemic has seen people presenting with more complex and acute needs, so we do not underestimate the scale of the challenge.

5.3 The development of the draft constitution for the ICS and the County Council response

The draft constitution for the Cambridgeshire and Peterborough Integrated Care System including the Integrated Care Board and Integrated Care Partnership Committee has recently been consulted upon. This will not become statute until the passing of the Health and Care Bill in April 2022. The County Council has welcomed the opportunity to comment and responded to this as a key stakeholder and stressed the importance of making the ICP as equivalent to the ICB in status and influence as possible, pursuing an 'equal partnership

model' in the governance of the ICS, with an equal balance of power between the NHS, local government and other partners and building in the principle of subsidiarity and aligning the Health and Well Being Board and the Integrated Care Partnership.

5.4 Priorities and Principles

It is proposed that we will pursue the following priorities and seek to work with ICS partners to adopt strategies and plans that support:

- The real living wage for all health and care workers
- Social Value as the key driver in the development, delivery, and commissioning of services across the health and care sector
- Transparent decision making and accountability to the public
- Supporting 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
- Promoting and adopting co production and participation as a default approach to developing new services making full use of the LA Partnership Boards that are run by Healthwatch and any other appropriate forums such as Parent Carer Forums
- Delivery of real progress through Integrated Neighbourhoods and make the links to the local authority work on Care at Home, place-based approaches, and decentralisation
- Further development of the integrated management and delivery of the Learning Disability Partnership and seek opportunities to further extend and embed this with the local authority as the lead provider
- Support for the Council's own commitment towards social and environmental criteria, local purchasing and developing in-house services where this will deliver the best outcome
- 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 eg Discharge to Assess pathway
- Developing a single health and care record and finding way to share information in a way that will improve outcomes and is legally compliant

5.5 How the ICS will work with people and communities

5.5.1 The Integrated Care Board has proposed adopting the following ten principles set out by NHS England for working with people and communities as this supports the local authority's priorities and principles:

- Put the voices of people and communities at the centre of decision making and governance, at every level of the ICS.
- Start engagement early when developing plans and feedback to people and communities how it has influenced activities and decisions.

- Understand your community's needs, experience and aspirations for health and care, using engagement to find out if change is working.
- Build relationships with excluded groups – especially those affected by inequalities.
- Work with Healthwatch and the voluntary, community and social enterprise sector as key partners.
- Provide clear and accessible public information about vision, plans and progress to build understanding and trust.
- Use community development approaches that empower people and communities, making connections to social action.
- Use co-production, insight, and engagement to achieve accountable health and care services.
- Co-produce and redesign services and tackle system priorities in partnership with people and communities.
- Learn from what works and build on the assets of all ICS partners – networks, relationships, activity in local places.

5.5.2 These principles are very welcome and are congruent with the County Council's ambitions in relation to decentralisation and delivering services at the most local level. This can be seen in the proposals to change the way in which we commission domiciliary care through 'Care Together', work on Think Communities and the County Council's focus on promoting independence and supporting people to stay at home. The County Council has a strong track record in both adults and children's services of strong collaboration through long-standing joint work with all parts of the local NHS including primary care, Cambridge and Peterborough Foundation Trusts and Cambridgeshire Community Services.

5.6 Most Capable Provider and Provider Collaboratives

5.6.1 To award NHS contracts to partners for delivery of substantial functions in return for significant funding, there needs to be a process that assures the ICB that the receiving organisation and their partners have the capacity and capability to hold the clinical and financial risk. The CCG are adapting the proven 'Most Capable Provider' Framework, to use as a governance process.

5.6.2 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. The ICB will undertake a 'Capable Provider' process to decide who is best to deliver functions. Detailed guidance is currently being drawn up about this and how the most capable provider will be identified.

5.6.3 NHS England has produced significant guidance on the approaches, capabilities and roles of various organisations in the development of Provider Collaboratives. The guidance is clear in all examples that the host, lead or provider contractually responsible is an NHS trust or foundation trust. The role of Local Authorities is to be part of the Provider Collaboratives, but there is not a role to be the host. There is provision to discharge functions to the local authority via a Section 75 agreement and this will be important to enable us to continue to build on our existing integrated services for Learning Disability, Mental Health, Occupational Therapy, Community Equipment and Tech Enabled Care.

5.6.4 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.
- **Mental Health/Learning Disability Collaborative** (led by Cambridgeshire & Peterborough Foundation Trust) and **Childrens and Maternity Collaborative** (led by Cambridgeshire Community Services) has some overlaps that need to be worked through, but as they already have ICS approaches in place these will continue.

5.6.5 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. The Director of Children's Services and Executive Director People and Communities are co-leading the Children's Collaborative development. The Director of Adult Social Care is involved in the development of the Mental Health/Learning Disability Collaborative. These are at an early stage of development and are where detailed plans are being developed in partnership 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.

5.7 Criteria to inform decisions and decision-making processes that impact on County Council responsibilities and services

5.7.1 The creation of the ICS will create opportunities for the integration of health and social care and opportunities will arise to support this way of working. It will be important to apply some agreed criteria that support delivery of the Local Authority priorities and principles, reduce organisational barriers and improve outcomes for our residents when considering opportunities which could include joint posts, joint commissioning arrangements or integrated services. The following criteria are proposed to inform decision making:

- Evidence that outcomes will be improved
- Congruence with County Council priorities
- Operating in line with the statutory and legislative framework for social care
- Supporting the improvement in quality, practice and outcomes that will form the basis for the external assurance of all social care services
- Improving and strengthening the County Council's focus on promoting independence and managing increased levels of demand on Council services
- Supporting the development of a place based or neighbourhood approach and the County Council's commitment to decentralisation.

5.7.2 It is important that when thinking about integration we draw on past learning to inform future partnership working to improve outcomes. The Local Authority has experience of developing integrated services when over ten years ago, all staff and budgets associated with Older People, Mental Health and Learning Disability Services were transferred to the NHS. There were some benefits but the County Council made a decision to transfer all the Older People's staff and budgets back in house due to concerns about financial control and professional direction. A decision was made to continue with the integrated models for Learning Disability, Mental Health and Occupational Therapy. This process showed that relying on structural change is not enough on its own.

5.7.3 We continue to have a pooled budget for learning disability which is currently under review and a jointly funded Tech Enabled Care Service and a joint contract for Community Equipment. It will be necessary to agree how these arrangements continue to be developed within the ICS framework. Integrated services are all governed through a Section 75 arrangement which enables the NHS or the Local Authority to delegate functions to each other. As part of this governance the effectiveness and outcomes are under constant review and where needed changes are made. There is a clear process for giving notice if the arrangement is no longer working in the interests of either party.

5.8 Accountability and democratic participation in the ICS decision making processes

5.8.1 Local health partners are committed to the objective of good accountability for decisions made by the ICS, recognising accountability to the NHS and to the national objectives of the NHS Long-Term Plan, but which the NHS Confederation says should be only 'one component' of accountability to a broader based local strategy for improving the health and wellbeing of the local population.

5.8.2 Accountability involves system actors taking responsibility for their actions and recognising the need to explain and be answerable for them. This applies at many levels including to employees, internal partners, regulators and to patients, people and communities. It also involves seeking to ensure transparency, through decision-making processes which are as simple, accessible and made in public as possible.

5.8.3 The local authority has a crucial role to play in ensuring local democratic accountability is properly fulfilled within the system. This will involve the County Council in enhancing its scrutiny function to recognise that it is likely to engage in increasing partnership arrangements within the system and must retain appropriate scrutiny and overview for actions taken. The priorities and principles set out in this paper will be used to guide officers and member representatives involved. This includes ensuring that decisions which potentially have significant or strategic impact on the authority's own responsibilities or finances will continue to be subject to prior approval by elected members and to subsequent review. This is also important to maintain accountability for councillors themselves to the local electorate.

5.8.4 The Local Government Association (LGA) has advocated that local government must be treated as 'equal partners' in the ICS, which otherwise risks the "danger of missing the real prize of collaborative place-based leadership to achieve greater investment in prevention and community-based health and wellbeing services." The LGA position informs the proposals in this paper to seek to ensure that the Health and Wellbeing Board continues to be regarded as the forum that has lead responsibility for ensuring the development and agreement of the joint strategic needs assessment and the joint health and wellbeing strategy for our local population

5.8.5 The LGA together with NHS Clinical Commissioners also recommend that ICS bodies should adopt a 'subsidiarity' principle, in which decision-making is as close to communities as possible. Seeking to ensure place-based partnerships at local level within the ICS are included as far as possible in the Council's own evolving plans for decentralisation, can both help avoid unnecessary duplication and assist engagement with local communities.

5.8.6 Unanimous agreement between the local authorities and health partners was established at the October development day on 'Working together as a System' to bring the work of the Health and Wellbeing Board(s) as close together with the ICP Committee as possible, setting out a 'Committee in Common' approach. Agreement was unanimous on the establishment of one plan and one set of priorities.

5.8.7 The Integrated Care Partnership Committee and Health and Wellbeing Boards must take place in public, ensuring 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.

5.8.8 The local authority officers who are members of the ICB will be championing the social care agenda and Joint Administration's (JA) priorities. At the same time, it is recognised that the ICS financial envelope is accountable to NHS England and there are national requirements and targets on how money is spent. (not to mention the deficit that must be dealt with as well) The local authority will use our financial resources and relationships to influence priorities where appropriate.

5.8.9 The four priorities established at the HWBB/ICP October development day affirms the Joint Administration's 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

5.8.10 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 set targets and develop and deliver the outcomes' supported by appropriate KPIs.

5.8.11 To promote parity of esteem across health and social care and equality of voice we will advocate a rotating chair arrangement between Local Authorities and the NHS for the HWB/ICP Committee.

5.8.12 Health Scrutiny will, as it does now, be able to request evidence of performance against the ICS plans – this would likely be focused on the difference we are making as an ICS to the lives and outcomes of our residents. Again, this is in public and therefore providing transparency. It will be necessary to identify resource implications of effective Scrutiny and if additional resources are needed to explore whether there is any internal capacity that can be redirected to support effective Scrutiny or to seek resources through the business planning process.

5.8.13 The key areas where health and the local authority currently have joint accountabilities and have joint KPIs 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)

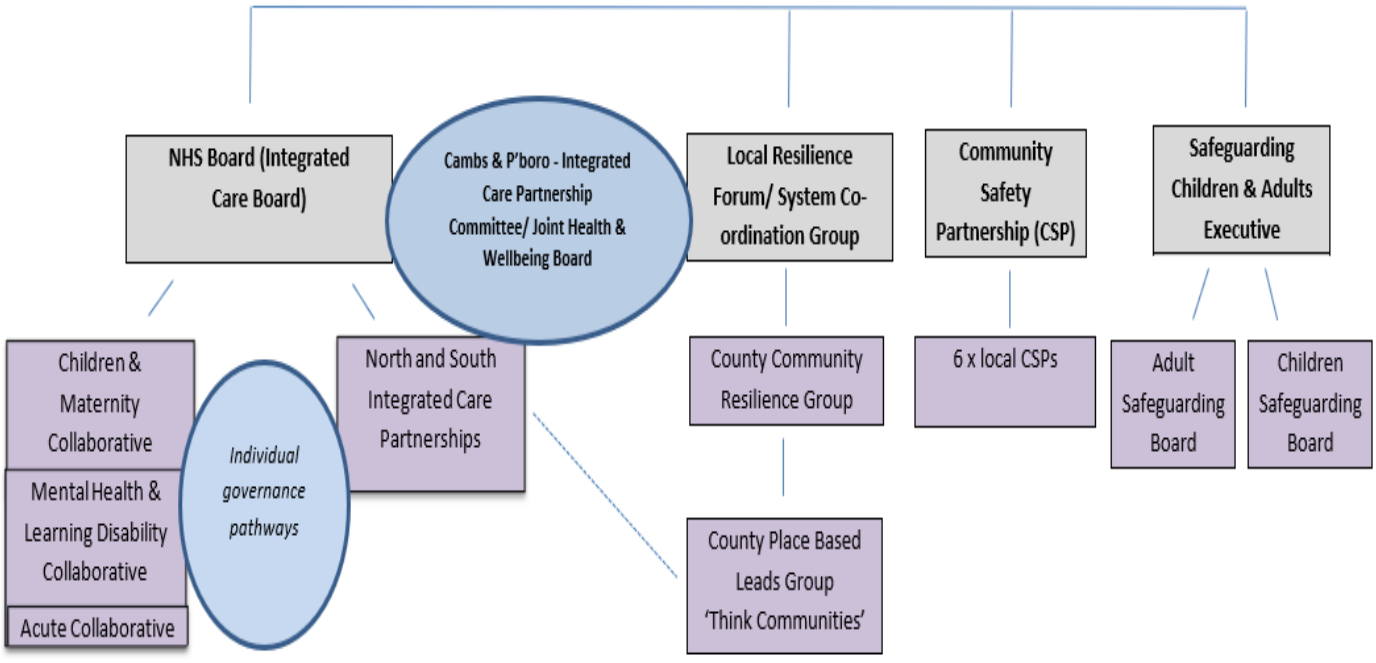
- Joint commissioning (making sure we are not competing for resources and we are securing the resources that meet need and represent value for money, including social value)
- Special educational needs and disabled children and children with complex needs
- Supporting those with mental health and learning difficulties to live independently

5.8.14 In these areas we align budgets or have S75 agreements (where we give the money to health to deliver services on our behalf or 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 ICPs and Collaboratives. Performance will be reported into the Integrated Care Partnership Committee/HWBB and Integrated Care Board. In addition, much of this work is reported into service committees as well. (Adults & Health and Children & Young People) Health Scrutiny will be asking for evidence of impact on residents.

5.8.15 At present health and LA business planning processes do not align, the LA start and end 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, this is signed off at the HWBB. This is an area for development in the ICS.

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

CAMBRIDGESHIRE AND PETERBOROUGH STATUTORY GOVERNANCE STRUCTURE



6. Alignment with corporate priorities

6.1 Communities at the heart of everything we do
There are no significant implications for this priority.

6.2 A good quality of life for everyone
There are no significant implications for this priority.

6.3 Helping our children learn, develop and live life to the full
There are no significant implications for this priority.

6.4 Cambridgeshire: a well-connected, safe, clean, green environment
There are no significant implications for this priority.

6.5 Protecting and caring for those who need us
The creation of an Integrated Care System for Cambridgeshire and Peterborough takes place in response to the national reforms of health and social care. These reforms sit alongside the recently published Social Care White Paper 'People at the Heart of Care' which sets out a 10-year vision for adult social care and changes to the way social care is funded and how people will contribute to their care costs. The ICS relates to the whole population and is also of direct relevance to the Children and Young People and Communities, Social Mobility and Inclusion Committees. Joint working across these committees will be essential.

7. Significant Implications

7.1 Resource Implications
There are no significant implications within this category.

7.2 Procurement/Contractual/Council Contract Procedure Rules Implications
There are no significant implications within this category.

7.3 Statutory, Legal and Risk Implications
The report above sets out the implications for this priority in section 5.7

7.4 Equality and Diversity Implications
There are no significant implications within this category.

7.5 Engagement and Communications Implications
There are no significant implications within this category.

7.6 Localism and Local Member Involvement
There are no significant implications within this category.

7.7 Public Health Implications
This will support promotion of public health

7.8 Environment and Climate Change Implications on Priority Areas:

7.8.1 Implication 1: Energy efficient, low carbon buildings.
Positive/neutral/negative Status: neutral
Explanation: No direct impact

7.8.2 Implication 2: Low carbon transport.
Positive/neutral/negative Status: neutral
Explanation: No direct impact

7.8.3 Implication 3: Green spaces, peatland, afforestation, habitats and land management.
Positive/neutral/negative Status: neutral
Explanation: No direct impact

7.8.4 Implication 4: Waste Management and Tackling Plastic Pollution.
Positive/neutral/negative Status: neutral
Explanation: No direct impact

7.8.5 Implication 5: Water use, availability and management:
Positive/neutral/negative Status: neutral
Explanation: No direct impact

7.8.6 Implication 6: Air Pollution.
Positive/neutral/negative Status: neutral
Explanation: No direct impact

7.8.7 Implication 7: Resilience of our services and infrastructure and supporting vulnerable people to cope with climate change.
Positive/neutral/negative Status: neutral
Explanation: No direct impact

Have the resource implications been cleared by Finance? Yes
Name of Financial Officer: Justine Hartley

Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by the Head of Procurement? Yes/No (email sent 05.01.22 awaiting confirmation)
Name of Officer: Henry Swan

Has the impact on statutory, legal and risk implications been cleared by the Council's Monitoring Officer or LGSS Law? Yes
Name of Legal Officer: Fiona McMillan

Have the equality and diversity implications been cleared by your Service Contact? Yes
Name of Officer: Charlotte Black

Have any engagement and communication implications been cleared by Communications? Yes/No (email sent 05.01.22 awaiting confirmation)

Name of Officer: Matthew Hall (been part of the Chair & Vice Chair discussions)

Have any localism and Local Member involvement issues been cleared by your Service Contact? Yes
Name of Officer: Charlotte Black

Have any Public Health implications been cleared by Public Health?
Yes
Name of Officer: Jyoti Atri (been part of the Chair & Vice Chair discussions)

If a Key decision, have any Environment and Climate Change implications been cleared by the Climate Change Officer?
Yes
Name of Officer: Sarah Wilkinson

8. Source documents guidance

8.1 Source documents

The King's Fund
https://www.kingsfund.org.uk/publications/integrated-care-systems-explained
https://www.kingsfund.org.uk/publications/health-and-care-bill-key-questions

The British Medical Association
https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/integration/integrated-care-systems-icss

Social Care Institute for Excellence Research for the Better Care Fund
https://www.scie.org.uk/integrated-care/better-care/guides/sharing-risks-benefits/challenges

The Health Foundation
https://www.health.org.uk/news-and-comment/consultation-responses/integrating-care%253A-next-steps-to-building-strong-and-effectiv

NHS Midlands and Lancashire Commissioning Support Unit
https://www.strategyunitwm.nhs.uk/sites/default/files/2018-06/Risk%20and%20Reward%20Sharing%20for%20NHS%20Integrated%20Care%20Systems%20-%20180605_0.pdf

NHS Confederation
https://www.nhsconfed.org/news/considerable-uncertainty-over-ics-accountability-new-report-finds

Royal College of Nursing
https://www.rcn.org.uk/professional-development/accountability-and-delegation

Local Government Association
https://www.local.gov.uk/parliament/briefings-and-responses/lga-response-nhs-england-and-nhs-improvement-consultation

APPENDIX 1:

The following table refers to the CCGs response entitled 'You Said we Did'- the relevant sections have been extracted.

Section	You said	We did
Introduction	Add a reference to a commitment to a user centred health and care system	We have added this reference at paragraph 1.1.4
Introduction	Set out in simple language, what we are trying to fix in the system	We have amended the text at 1.1.4 and 1.1.5 to make this clearer. We have used simple language subject to where legal and statutory requirements are set out
Board size and composition	Suggestion that an additional space on the Board be made available for the Local Authority/Director of Public Health	We have allocated an additional regular participant place on the Board for the Director of Public Health and this was included in our submission to NHSE on the Board size and composition
Board size and composition	Suggestion that an additional space on the Board be made available for Healthwatch to be a regular participant	We are continuing to have discussions internally and with Healthwatch and NHSE on where Healthwatch can add the most value to our ICS decision-making discussions
Appointments process	Confirm that APMS organisations are excluded from being partner members	A new disqualification criteria has been added at 3.2.3, as follows: A person whose involvement with the private healthcare sector or otherwise could reasonably be deemed to risk undermining the independence of the NHS
Appointments process	Suggestion that there should be equal representation from all responsible local authorities	The ICB is a unitary Board - there are no representatives on the Board, each member brings their sector perspective. The local authorities are able to jointly nominate the member drawn from the local authorities. No further changes will be made
Governance	An additional disqualification must apply for anyone with any financial or personal interest in a "for profit" company that provides health, care, or diagnostic services or that	As above, this has been added to the revised constitution for all ICBs

Section	You said	We did
	provides equipment used by the NHS, to avoid any potential conflict of interest	
Governance	The exclusion of private health providers in senior positions or at decision making meetings for the commissioning of services/spending of public money	This is now covered by a new disqualification criteria for the ICB, as above. The ICB Conflicts of Interest policy also provides a robust mechanism to ensure that we use NHS money wisely, providing best value for taxpayers and accountability to our patients for the decisions we take
Accountability and Transparency	The current CCG allows for questions from the public to be submitted and answered. The ICS should at least offer the same level of public scrutiny and provide an option for public participants to speak to their questions. Specify the process.	The Board and its committees will have to make decisions transparently, holding meetings in public and publishing the papers. We consider that the arrangements at 9.1.7 provide this flexibility but we have added an additional reference at Appendix 2 4.3.3 and will provide further detail on the process in the Governance Handbook
Communication and engagement	PPG network should be more widely used for communications and gathering input and feedback from the public	We have added further detail at sections 7 and 9 on how we will work with people and communities
Communication and engagement	Support wider and deeper involvement of local people in decision making and a commitment to specific action to seek and support involvement from those communities experiencing the greatest health inequalities	We have included this in the principles at section 7.2.1 and 9.1.5

Section	You said	We did
Communication and engagement	Provide and publish a mechanism whereby interested members of the public can "sign up" to be notified of consultations	This will be available on the ICS website
Scrutiny and decision-making	Specify that the default provider will always be an NHS provider where one is available or offered and the NHS Provider Selection Regime for competitive tendering will only be actioned if there is no NHS provider available	We cannot commit to defaulting to an NHS provider under the current guidance – only that we will use providers to deliver NHS services in a transparent way, in the best interests of patients, taxpayers and the population. No further changes will be made
ICP	Suggest an addition that the Board will seek to uphold the ICP's integrated care strategy wherever possible. And to merge as far as possible the ICP Committee and Health and Wellbeing Board agendas and develop one plan and one set of priorities	We have amended the text at 1.1.7 to read: 'The terms of reference for the ICP, and the Health and Wellbeing Board will be aligned with this Constitution' The detail on the arrangements to align the ICP Committee and HWB agendas/plans/priorities will be covered in the TOR of reference for the ICP and HWB rather than this constitution
Reporting	Add to the requirement to report on the implementation of the Health and Wellbeing Strategy to also cover the ICP Integrated Care Strategy	This has been added at 7.5.3. We have maintained the reference to the two strategies (HWB strategy and ICP strategy) although we can of course in practice deliver this as a single, aligned strategy
	Add reference to the ICP sub-committee	The ICB Constitution refers to ICB committees and sub committees. The ICP is not a committee of the Board, but rather a statutory committee of the ICS formed jointly with the local authorities. As such, the LA and the ICB are co-owners and equal partners in the ICP

Section	You said	We did
	Suggestion to add; • a commitment to build in the principle of local democratic accountability wherever possible; • an ‘equal partnership model’ being adopted in the ICS, fostering mutual respect between health, local authority and voluntary and community sector partners; • Consideration of a public service ethos and social value focus • building in the need to balance health prevention and social care outcomes	We have highlighted mutual respect and the value that each partner brings at 1.1.2 Social value is embedded as part of our contracting and procurement policies. The ICS will comply with the About Public Services (Social Value) Act 2012 Under which we are required to consider how the services we commission and procure might improve the economic, social and environmental well-being of the area. As the constitution relates specifically to the ICB, and is a high-level document, the points relating to local democratic accountability and social care outcomes will be included within other ISC supporting material where the points can be further expanded on