Joined Up Care Derbyshire

Developing Derbyshire's Integrated Care System

Stakeholder Engagement Document

Autumn 2021

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Bibliography

NHS England Engagement on ICSs (November 2020)

Government White Paper on Health and Social Care Reform (February 2021)

ICS Design Framework & ICS Design Framework Summary (June 2021)

Draft Legislation (July 2021)

Interim guidance on the functions and governance of the integrated care board (August 2021)

Integrated Care Partnership Engagement Document: ICS Implementation (September 2021)

1. Introduction

The Health and Care Bill introduced in Parliament on 6 July 2021 confirmed the Government's intentions to introduce statutory arrangements for integrated care systems (ICSs) from April 2022. Subject to legislation being agreed each ICS will comprise an:

- Integrated Care Partnership (ICP): the broad alliance of organisations and representatives concerned with improving the care, health and wellbeing of the population, jointly convened by local authorities and the NHS.
- Integrated Care Board (ICB) bringing the NHS together locally to improve population health and care.

In Derbyshire we intend that these new structures will build on, rather than replace, the partnerships that have developed over many years across our system.

As part of developing the membership of the ICP and ICB it is important that we seek your views and build on some of the conversations already underway at the Joined Up Care Derbyshire Board and elsewhere to help further shape the future developments, including establishing the membership of each of these new Boards.

The Integrated Care System

Other important components within the ISC are Provider Collaboratives and Place partnerships. It may be helpful to summarise their role and importance within our system to aid the engagement in the development of the ICB and ICP.

Place-based partnerships are collaborative arrangements that have been formed by the organisations responsible for arranging and delivering health and care services in a locality or community. They involve the NHS, local government and providers of health and care services, including the voluntary, community and social enterprise sector (VCSE), people and communities (people who use services, their representatives, carers and local residents). In many cases they include other community partners with a role in supporting the health and wellbeing of the population and addressing health inequalities, such as housing associations, skills and education services and local business. It is intended that there will be two Place partnerships: one for the city, one for the county.

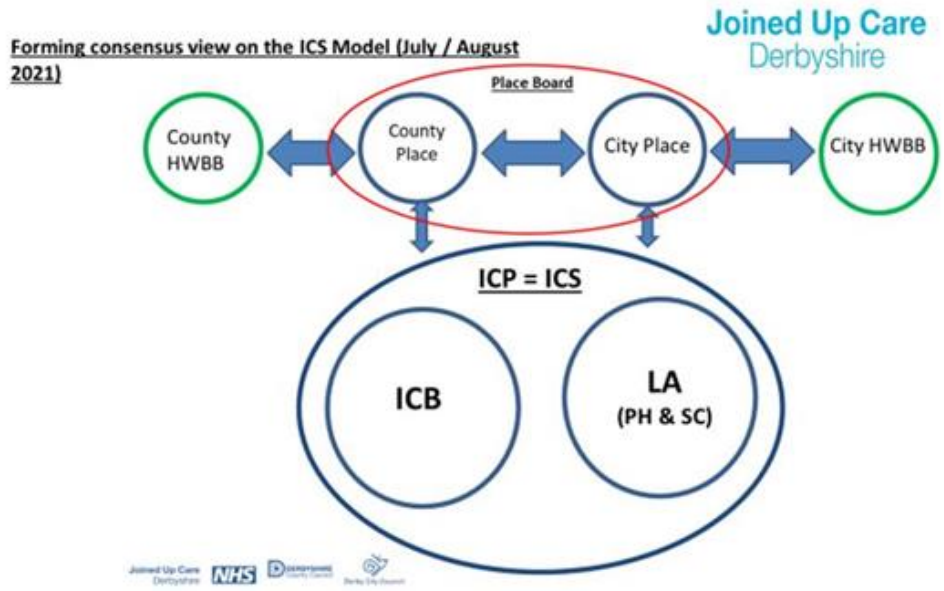
Provider collaboratives are partnership arrangements involving at least two trusts working at scale across multiple places, with a shared purpose and effective decision-making arrangements, to:

- Reduce unwarranted variation and inequality in health outcomes, access to services and experience
- Improve resilience by, for example, providing mutual aid
- Ensure that specialisation and consolidation occur where this will provide better outcomes and value.

Provider collaboratives work across a range of programmes and represent just one way that providers collaborate to plan, deliver and transform services. Collaboratives may support the work of other collaborations including clinical networks, Cancer Alliances and clinical support service networks. Providers may also work with other organisations within place-based partnerships, which are distinct from provider collaboratives. Place-based partnerships co-ordinate the planning and delivery of integrated services within localities

and alongside communities, while provider collaboratives focus on scale and mutual aid across multiple places or systems.

The below diagram aims to set out key components of the ICS and how they might link with one another. It is not intended to represent a hierarchy but depicts the main connections and relationships between key parts of the system.



2. Engagement Period

This document sets out the emerging roles for the Integrated Care Board and Integrated Care Partnership. We are using this as a summary for our partners to refer to, to help inform their views about how these two elements will be formed. The roles and functions set out within this document are all derived from national guidance documents.

There remains local flexibility in the implementation of ICBs and ICPs and there are several areas of development on which to engage partners and seek your views. The stages to this engagement are:

1. Partner organisations are asked to review the guidance documents and the questions posed within this engagement document and submit their responses to ddccg.communications@nhs.net by **Sunday 31st October 2021.**
2. These views will be collated and presented at a workshop on **Friday 5th November 2021**, to which partners will be invited to help to reach consensus on the direction of travel.
3. Partners will have a further period to submit any final thoughts by **Wednesday 10th November 2021**.
4. A final response is submitted to NHS England on behalf of the Derbyshire system by **Wednesday 17th November 2021.**

The remainder of this document sets out a high-level summary of the functions of the ICP and ICB which provide important context, along with a series of questions that partners may wish to consider in making their response.

3. The role and functions of the Integrated Care Board

Integrated Care Boards (ICBs) will be established as new statutory organisations with responsibility for delivery on a range of statutory functions and will also be the convener of integration within the NHS. They will bring the NHS together locally to improve population health and establish shared strategic priorities within the NHS, connecting to partnership arrangements at system and place.

In summary the functions of the ICB are:

Developing a plan	**Allocating resources**	**Establishing joint working arrangements**
Establishing governance arrangements	**Arranging for the provision of health services**	**Leading system implementation of the People Plan**
Leading system-wide action on data and digital	**Understand local priorities, track delivery of plans, monitor and address variation and drive continuous improvement**	**Ensuring NHS plays a full part in social and economic development and environmental sustainability**
Driving joint work on estates, procurement, supply chain and commercial strategies	**Planning for, responding to and leading recovery from incidents**	**Functions delegated by NHE England**
And any other functions conferred from CCGs		

An initial key step in establishing the ICB as an organisation is to establish its Board. The guidance sets out a statutory minimum as follows and enables local determination of any other roles required on the Board as either voting or non-voting members:

Role (Statutory Min)	**Number**
Chair	1
CEO	1
Non-Executive Directors	2 minimum
Executive Director of Finance	1
Chief Nursing Officer	1
Medical Director	1
Partner Members	3 minimum
Other Executives	To be locally determined
Other Non-Executives	To be local determined
Other Partner Members	To be locally determined

Further information on the duties and roles of the ICB is available at Appendix 1.

4. The role and functions of the Integrated Care Partnership

The Integrated Care Partnership (ICP) will align the ambitions, purpose and strategies of partners across each system. ICPs:

- Are a critical part of ICSs and the journey towards better health and care outcomes for the people they serve.
- Will provide a forum for NHS leaders and local authorities (LAs) to come together, as equal partners, with important stakeholders from across the system and community.
- Will generate an integrated care strategy to improve health and care outcomes and experiences for their populations, for which all partners will be accountable.

The ICP will be established locally and jointly by the relevant local authorities and the ICB. Members must include local authorities (that are responsible for social care services in the ICS area) and the local NHS.

1. The ICP will have a specific responsibility to develop an 'integrated care strategy' for its whole population (covering all ages) using the best available evidence and data, covering health and social care (both children's and adult's social care), and addressing health inequalities and the wider determinants which drive these inequalities.

2. The strategy must set out how the needs assessed in the Joint Strategic Needs Assessment(s) for the ICB area are to be met by the exercise of NHS and local authority functions. This will be complemented by the Joint Health and Wellbeing Strategy prepared by each Health and Wellbeing Board in the geographical area of the ICS.

3. Each ICP should champion inclusion and transparency and challenge all partners to demonstrate progress in reducing inequalities and improving outcomes. It should support place- and neighbourhood-level engagement, ensuring the system is connected to the needs of every community it covers.

4.1 Principles of the ICP

The ICP is expected to highlight where coordination is needed on health and care issues and challenge partners to deliver the action required. These include, but are not limited to:

- Helping people live more independent, healthier lives for longer
- Taking a holistic view of people's interactions with services across the system and the different pathways within it
- Addressing inequalities in health and wellbeing outcomes, experiences and access to health services
- Improving the wider social determinants that drive these inequalities, including employment, housing, education environment, and reducing offending
- Improving the life chances and health outcomes of babies, children and young people
- Improving people's overall wellbeing and preventing ill-health

ICPs will enable partners to plan and develop strategies for using available resources creatively in order to address the longer-term challenges which cannot be addressed by a single sector or organisation alone. The ICP should complement place-based working and partnerships, developing relationships and tackling issues that are better addressed on a bigger area.

Unlike the ICB, there is no minimum statutory membership set out in the guidance and so this can be locally determined, building on good practice and existing partnerships.

4.2 Mandatory Requirements for ICPs

The ICP is a statutory committee of the ICS, not a statutory body, and as such its members can come together to take decisions on an integrated care strategy.

There will be a duty to cooperate on the ICB and local government.

The only members specified are the ICB and LAs in an ICS area, who must come together to establish the ICP. Wider membership should be locally determined, although we expect ICPs to be, at the very least, a partnership between the NHS, LAs and wider community.

The Bill also states that the ICP must "involve the local Healthwatch organisations whose areas coincide with or fall wholly or partly within its area, and the people who live or work in that area".

4.3 Guiding Expectations for ICPs

The Department of Health and Social Care, DHSC, NHS England/Improvement and the Local Government Association have jointly developed the expectations set out below. These are intended to help LAs and designated ICB chairs and Boards maximise the value that ICPs that can give back to local communities. They complement and build on the principles for ICPs set out in NHSEI's ICS Design Framework.

The 5 expectations are:

- ICPs are a core part of ICSs, driving their direction and priorities
- ICPs will be rooted in the needs of people, communities and places
- ICPs create a space to develop and oversee population health strategies to improve health outcomes and experiences
- ICPs will support integrated approaches and subsidiarity
- ICPs should take an open and inclusive approach to strategy development and leadership, involving communities and partners to utilise local data and insights

Further details on this guidance are included at Appendix 2.

4.4 Integrated Care Partnership Membership & Engagement

To further embed place in the long-term health and care strategies that are developed, as a minimum, guidance sets out an expectation that ICPs would have:

- Input from Directors of Public Health, through arrangements agreed by LAs
- Other clinical and professional experts (including primary, community and secondary care) to ensure a strong understanding of local needs and opportunities to innovate in health improvement
- Input from representatives of adult and children's social services – for example by at least one Director of Adult Social Services or Director of Children's Services agreed by the LAs in the ICP area. Input from local social care providers is also needed

- Relevant representation from other local experts, through HWB chairs, primary or community care representatives and other professional leads, for example in social work and occupational therapy
- Appropriate representation from any providers of health, care and related services
- Appropriate representation from the VCSE sector, including of social care, as well as representatives from people with lived experiences of accessing health and social care services in the ICS area, including children and young people
- A representative from Healthwatch to bring senior level expertise in how to carry out engagement and to provide scrutiny

It is not a requirement for all of these stakeholders to be 'members' of the ICP committee. The key is that opportunities for co-production and expert input into ICP strategies are available; this could, for example, be through sub-committees or dedicated public meetings.

The expectation is for the ICP to have a broad membership and engagement with the organisations and communities it serves. However, this membership should be managed appropriately to ensure that the operations of the ICP remain efficient and effective. Below outlines the key areas who may need to be part of the ICP.

voices for children & young people	patients, service users, & public voices	voluntary, charity & social enterprise	homeless services	Local Enterprise Partnerships
voices from the Children's Board	Black and minoritised voices	Healthwatch	social prescribing services	armed forces
led by and for women's organisations	social care providers and workforce	unpaid carers voices	businesses	police and crime commissioners
disability voices	mental health providers and service users	primary care (GPs, dental, eye care, pharmacy)	employment support services (e.g.,JobcentrePlus)	learning disabilities and autism providers and service users
NHS Trusts	community care	public health voices (e.g., Directors of Public Health)	alcohol and addiction services	Criminal Justice System agencies, inc probation services
Acute Care	housing voices	offenders health and care voices	local authority officers (Children's Services &, Adult Services)	

5. Questions and areas to explore

The questions below aim to seek partner views on the establishment of the ICB and ICP. Please use the form to provide your thoughts and feedback, as this will enable the theming of responses. **Return completed forms to ddccg.communications@nhs.net by 11.59pm on Sunday 31st October.**

Regarding the Integrated Care Board

Question	Partner Response
1. What do you feel has worked well within the JUCD partnership to date, and what hasn't worked so well?	
2. What elements of JUCD do you think must be retained in the new arrangements for the future?	
3. Do partners agree that there needs to be a continuation of and strengthening of co-ownership of system challenges that requires input from all system partners at either ICB and/or ICP?	
4. What are the options for ensuring co-ownership of NHS challenges at the ICB?	
5. What are the options for managing conflicts of interests at the ICB?	
6. Provider collaboratives at Scale are an important part of the NHS reforms. What are the options for hearing the provider collaborative at Scale voice through the ICB?	
7. Provider collaboratives at Place are an important part of the NHS reforms. What are the options for hearing the provider collaborative at Place voice through the ICB?	
8. How could we build on the current JUCD model of having Non-Executive input from provider organisations within the governance structures of JUCD whilst managing any conflicts of interest?	
9. How could we build on the current JUCD model of having Chair input from provider organisations within and leading areas of the governance structures of JUCD whilst managing any conflicts of interest?	
10. The guidance sets out a minimum membership for the Board of the ICB. What is your view on the required membership of the ICB (including thoughts	

on the relative numbers of and types of contributors to) given its significant NHS statutory duties?	

Regarding the Integrated Care Partnership

Question	Partner Response
1. The JUCD approach to date has focussed on the partnership between the NHS, Public Health & Social care. Do you believe this focus should continue or do you believe the focus should change? Based upon your thoughts, what do you believe the role of the Health & Wellbeing Boards should be in this case?	
2. What do we want to retain from the current JUCD partnership in establishing the new ICP?	
3. What has worked well and what has worked less well?	
4. What are the key considerations in establishing the ICP?	
5. Given that the ICP is principally an equal partnership between the NHS and Local Authorities, what should the ICP membership and chairing arrangements be (including the inputs from Unitary, County and District / Borough Councils?)	
6. How will ICP work with HWBs and others to bolster place-based partnerships?	
7. The ICP has a key a role to develop an integrated care strategy for Derbyshire. What would a good strategy comprise of and who would need to be involved?	
8. The ICP doesn't have to be fully in place until September 2022. Would it be supported to develop an interim position for the ICP enabling it to operate during Qrt4 of 2022 whilst continuing to work through the longer-term role for September 22?	
Additional comments?	

Appendix 1 - Duties and functions of the Integrated Care Board

Duties of Integrated Care Board – the Bill

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Duties	Duties

• Publish a Constitution
• Maintain and publish register of interests
• Manage conflicts of interest
• Commissioning of health services including
  ○ Hospital
  ○ Dental (other than primary dental)
  ○ Nursing and Ambulance
  ○ Pregnant women and children
  ○ Services for prevention of illness, care and aftercare
  ○ Services required for diagnosis and treatment of illness
  ○ Services for physical and mental health
• Act in a way that promotes the Constitution and raise awareness of it with staff, patients and public
• Exercise functions effectively, efficiently and economically
• Secure continuous improvement in service quality and outcomes
• Reduce inequalities in respect to access and outcomes
• Promote involvement of patients and carers in prevention and treatment of illness
• Promote innovation in the provision of health services
	• Promote education for health service staff
	• Promote integration where improvements in quality and outcomes would be achieved
	• Have regard as to the effect of decisions on patients in England, quality, efficiency and sustainability
	• Involve the public in planning the delivery and range of services
	• Jointly exercise functions with local Health Boards
	• Raise additional income (Health and Medicines Act 1988)
	• Make grants to NHS Trusts or NHS Foundation Trusts, or voluntary organisations
	• Make payments to providers
	• Prepare a five-year plan at the start of each financial year setting out how it will exercise its functions and consult on the plan with the public and taking account of the local Health and Wellbeing strategy
	• Prepare a joint plan setting out capital resource use
	• Prepare and publish an annual report
	• Participate in performance assessment with NHSE annually
	• Provide information to NHSE as and when requested and within the timeframes requested

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Functions of Integrated Care Board (1/4)

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Strategic Planning	
• Establish joint working arrangements with partners that embed collaboration as the basis for delivery of joint priorities within the plan. The ICS NHS body may choose to commission jointly with local authorities, including the use of powers to make partnership arrangements under section 75 of the 2006 Act and supported through the integrated care strategy, across the whole system; this may happen at place where that is the relevant local authority footprint • Establish governance arrangements to support collective accountability between partner organisations for whole-system delivery and performance, underpinned by the statutory and contractual accountabilities of individual organisations, to ensure the plan is implemented effectively within a system financial envelope set by NHS England and NHS Improvement. • Manage functions NHS England and NHS Improvement will be delegating including commissioning of primary care and appropriate specialised services. • Work with other ICS NHS bodies on commissioning more specialised services, emergency ambulance services etc. • Develop a plan to meet the health needs of the population, having regard to the ICP strategy and including restoration of NHS services and performance, in line with national operational planning requirements, and Long Term Plan commitments are met. • ICS NHS bodies will also have statutory duties to act with a view to securing continuous improvement in quality. We expect them to have arrangements for ensuring the fundamental standards of quality are delivered including to manage quality and safety risks and to address inequalities and variation; and to promote continual improvement in the quality of services, in a way that makes a real difference to the people using them	Arrange for the provision of health services in line with the allocated resources across the ICS through a range of activities including: • Putting contracts and agreements in place to secure delivery of the plan by providers with individual providers or lead providers within a place-based partnership or provider collaborative. They will reflect the resource allocations, priorities and specifications developed across the whole system and at place level and will be strategic, long-term and based on outcomes, with providers responsible for designing services and interventions to meet agreed system objectives. • Convening and supporting providers (working both at scale and at place) to lead major service transformation programmes to achieve agreed outcomes, including through joining-up health, care and wider support. The ICS NHS body will facilitate partners in the health and care system to work together, combining their expertise and resources to deliver improvements, fostering and deploying research and innovations. • Working with local authority and VCSE partners to put in place personalised care for people, including assessment and provision of continuing healthcare and funded nursing care, and agreeing personal health budgets and direct payments for care. This may be delegated to individual place partnerships and delivered through integrated teams working in neighbourhoods or across local places, further supporting the integration of planning and provision with adult social care and VCSE organisations • Plan for, respond to and lead recovery from incidents (EPRR), to ensure NHS and partner organisations are joined up at times of greatest need, including taking on incident coordination responsibilities as delegated by NHS England and NHS Improvement

Functions of Integrated Care Board (2/4)

Joined Up Care Derbyshire

Resource management	
• Allocate resources to deliver the plan across the system, including determining what resources should be available to meet the needs of the population in each place and setting principles for how they should be allocated across services, striking the right balance between enabling local decision-making to meet specific needs and securing the benefits of standardisation and scale across larger footprints • The ICS NHS body will agree how the allocation will be used to perform its functions, in line with health and care priorities set at a local level by an independent committee of academics, public health experts, GPs and NHS managers that makes recommendations on the preferred, relative, geographical distribution of resources for health services. Money will flow from the ICS NHS body to providers largely through contracts for services/outcomes, which may be managed by place-based partnerships or provider collaboratives • The ICS NHS board and chief executive (AO) will be ultimately responsible for services under delegation arrangements with place-based partnerships or through lead provider contracts. They will need to put in place proportionate mechanisms to provide assurance on the spending of public money	• Work alongside councils to invest in local community organisations and infrastructure and, through joint working between health, social care and other partners including police, education, housing, safeguarding partnerships, employment and welfare services, ensuring that the NHS plays a full part in social and economic development and environmental sustainability. • Drive joint work on estates, procurement, supply chain and commercial strategies to maximise value for money across the system and support these wider goals of development and sustainability

Functions of Integrated Care Board (3/4)

Joined Up Care Derbyshire

People	Functions
• Deliver against the themes and actions set out in the NHS People Plan and the people priorities in operational planning guidance. Play a critical role in shaping the approach to growing, developing, retaining and supporting the entire local health and care workforce. Adopt a 'one workforce' approach and develop shared principles and ambitions for people and culture with local authorities, the VCSE sector and other partners. • Establish the appropriate people and workforce capability to discharge responsibilities, including strong local leadership, including: ➢ clear leadership and accountability for the organisation's role in delivering agreed local and national people priorities, with a named SRO with the appropriate expertise (registered people professional (CIPD accredited) or with equivalent experience) ➢ demonstrate how it is driving equality, diversity and inclusion, foster a culture of civility and respect, and develop a workforce and leadership that are representative of the population they serve • Establish clear and effective governance arrangements for agreeing and delivering local strategic and operational people priorities. This will include ensuring there are clear lines of accountability and streamlined ways of working between individual organisations within the system, with other ICSs and with regional workforce teams • Support the delivery of standardised, high-quality transactional HR services (eg payroll) across the ICS, supported by digital technology. • Ensure action is taken to protect the health and wellbeing of people working within the ICS footprint, delivering the priorities set out in the 2021/22 planning guidance and in the People Promise	• Establish leadership structures and processes (including leadership development, talent management and succession planning approaches) to drive the culture, behaviours and outcomes needed for people working in the system and the local population, in line with the Leadership Compact • Undertake integrated and dynamic workforce, activity and finance planning based on population need, transformation of care models and changes in skills and ways of working – reflected in the system people plan and in the ICS Partnership's Strategy • Plan the development – and where required, growth – of the one workforce to meet future need. This should include agreeing collaborative recruitment and retention approaches where relevant, planning local educational capacity and opportunities, and attracting local people into health and care employment and careers (including creating long-term volunteering opportunities) • Develop new ways of working and delivering care that optimise staff skills, technology and wider innovation to meet population health needs and to create flexible and rewarding career pathways for those working in the system. This should be enabled by inclusive employment models, workforce sharing arrangements and passporting or accreditation systems • Contribute to wider local social and economic growth and a vibrant local labour market, through collaboration with partner organisations, including the care home sector and education and skills providers

Functions of Integrated Care Board (4/4)

Joined Up Care Derbyshire

Digital and Data	
• Lead system-wide action on data and digital: put in place smart digital and data foundations to connect health and care services and transform care to put the citizen at the centre of their care • Use joined-up data and digital capabilities to understand local priorities, track delivery of plans, monitor and address variation and drive continuous improvement in performance and outcomes • Have a renewed digital and data transformation plan that is embedded within the ICS NHS body plan and details the roadmap to achieve 'What Good Looks Like'; and enables a cross system approach to transformation, so that changes to models of care and service redesign involve digital and data experts working with partners from all relevant sectors. • Have clear accountability for digital and data, with a named SRO with the appropriate expertise, (registered professional or with equivalent experience), underpinned by governance arrangements that have clear oversight and responsibility for digital and data standards and requirements for the ICS and enabling partner organisation programmes and services.	• Invest in levelling-up and consolidation of infrastructure, linked to the future ICS reference target architecture and data model, adopting a simplified cloud-first infrastructure that provides agility and frictionless cross-site working experience for the workforce. Implement a shared care record, that allows information to follow the patient and flow across the ICS to ensure that clinical and care decisions are made with the fullest of information. • Ensure adherence by constituent partners to standards and processes that allow for interoperability across the ICS, and alignment to forthcoming national guidance. • Enable a single co-ordinated offer of digital channels for citizens across the system and roll out remote monitoring technologies to help citizens manage their care at home. • Cultivate a cross-system intelligence function to support operational and strategic conversations, as well as building platforms to enable better clinical decisions. This will require ICSs to have linked data, accessible by a shared analytical resource that can work on cross system priorities. • Agree a plan for embedding population health management capabilities and ensuring these are supported by the necessary data and digital infrastructure, such as linked data and digital interventions.

Appendix 2 – Guidance for the creation of Integrated Care Partnerships

ICPs are a core part of ICSs, driving their direction and priorities

- ICPs will be influential, driving forces within ICSs
- The roles of the ICP and the ICB are distinct and complementary in supporting the objectives of the ICS. The ICP is where the ICB, LA, and wider community come together
- ICBs and LAs will establish the ICP and be statutory members, in partnership with wider system stakeholders
- ICSs will ensure the constitution and governance of the ICB and ICP is aligned, and agreed by local government and other partners
- ICBs and LAs will have regard for the ICP's integrated care strategy when developing their plans and priorities and should consider how assurance can be provided to the ICP on delivery
- Leadership and accountability are important in the relationship between ICBs and ICPs

ICPs will be rooted in the needs of people, communities and places

- ICPs will be strongly connected to the places within their ICS area through co-production with their communities, strong citizen engagement and strategies informed by data and evidence.
- ICSs (both the ICB and the ICP) will be required to take account of HWB strategies and Joint Strategic Needs Assessment (JSNA) in developing their plans, to avoid duplication of effort.
- It will be up to ICPs to work with HWBs and other place-based partnerships to determine the integrated approach that will best deliver holistic and streamlined care in their communities
- To embed the link to people, communities, and places, ICPs should also consider how existing governance arrangements, such as HWBs, could provide the opportunity to build greater alignment between different partners and the community, and ensure effective, joined-up decision-making.

ICPs create a space to develop and oversee strategies to improve health and care outcomes and experiences

- ICPs will set priorities for improving system-wide health and care outcomes and experiences for everyone, while also championing the principle of subsidiarity and empower local decision making.
- ICP priorities should be informed by local population wants and needs, and specific communities identified through population health management data.
- ICPs should consider how they can better work together in and across place-based partnerships to deliver these priorities.
- ICPs will promote the mobilisation of resources and assets in the community and system, and across place-based partnerships; mobilisation of assets should look beyond the traditional boundaries of anchor institutions such as the NHS in finding solutions, and share these solutions with the ICB and LAs, who will be responsible for funding and operationalising delivery.
- ICPs will be in a unique position to identify opportunities for wider partnerships to strengthen our collective approach to improving longer-term health and wellbeing outcomes.

ICPs will set the strategic direction for integration through a shared vision and purpose

- Integrated provision: people receive seamless care across health, social care, housing, education and other public services (including those delivered by independent providers), and between different NHS providers.
- Integrated records: For example, using shared electronic care records for non-clinical and back-office functions as well as NHS services
- Integrated strategic plans: For example, bringing NHS and public health experts together to make a joint plan for improving health outcomes in their area. This could complement or form part of the ICP mandatory responsibility to produce an integrated care strategy
- Integrated commissioning of services: Strengthening the partnership between LAs and the ICB to enable them, and other partners, to work together in areas such as mental health, learning disability, autism, older people, public protection and reducing offending where there are health considerations

- Integrated budgets: and the delegation of functions into place(s), supporting the principle of subsidiarity and facilitating integration. For example, using Section 75 arrangements to manage or support pooled budgets across the NHS and LAs or in place-based partnerships for children or adults
- Integrated data sets: Where all partners can contribute and have access to inform planning and the delivery of services for the benefit of communities

ICPs should take an open and inclusive approach

- The ICP will have a key leadership role to play in setting the tone and culture for each system. The culture should champion co-production, diversity, equality and inclusiveness, recognising that the challenges they are trying to solve are complex, and require input from a range of people, include community associations and residents themselves.
- ICPs should develop a structured, and meaningful, approach to co-production with people with lived experience and consider accountability of their approach.
- ICPs should be open and engaging, agreeing arrangements for transparency and local accountability, including meeting in public with meaningful minutes and papers being made easily accessible.