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Integrated Care Board

Big primary care conversation – an update from the executive team

Introductions

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- Sam Proffitt, Interim Chief Executive
- Professor Craig Harris, Chief Operating Officer
- Professor Andy Knox, Medical Director

Outline of the session
Professor Andy Knox, Medical Director

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- What is our vision? – Professor Craig Harris, Chief Operating Officer
- Changes to the ICB: Blueprint – Professor Craig Harris, Chief Operating Officer
- Challenges to the ICB – Professor Craig Harris, Chief Operating Officer
- The 10 year plan - Professor Andy Knox, Medical Director
- What does this mean for practices? - Professor Andy Knox, Medical Director
- Questions, summing up and final thoughts – All

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What is our vision?
Professor Craig Harris, Chief Operating Officer

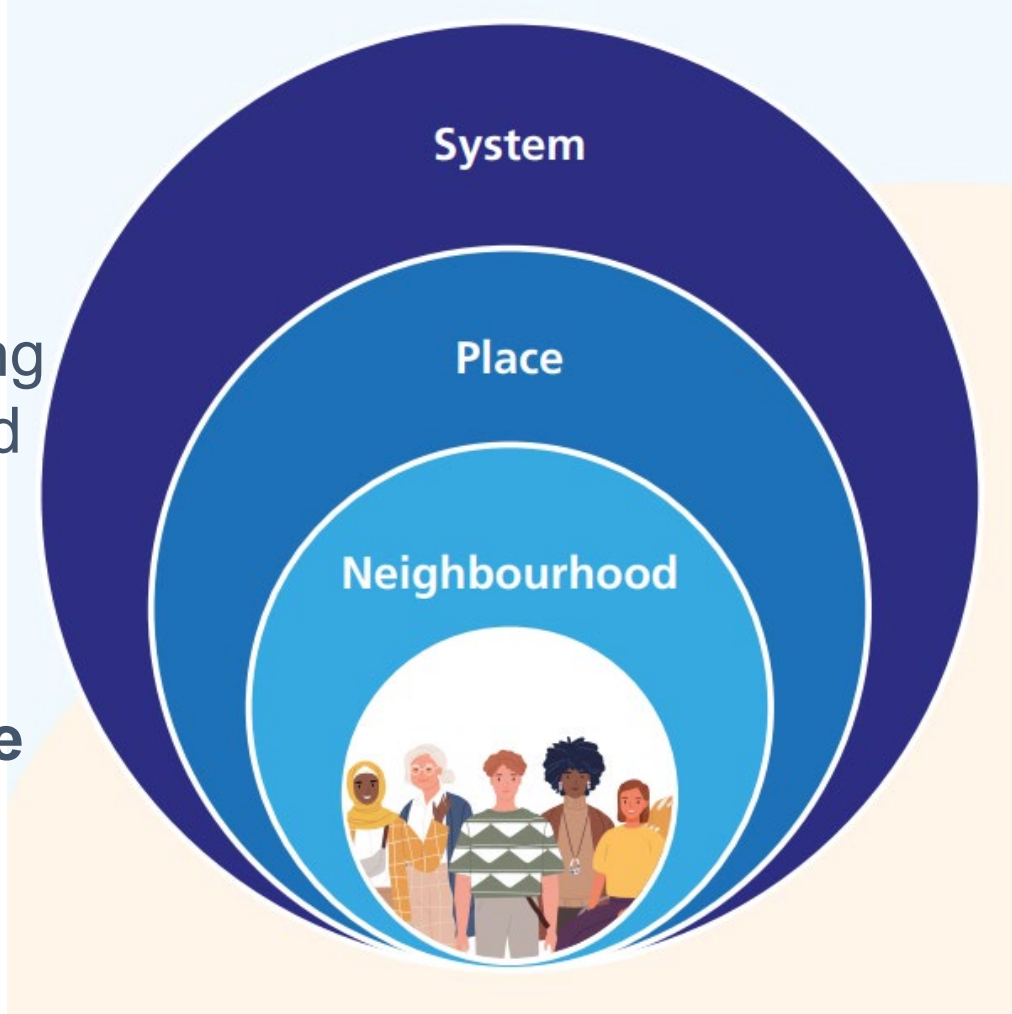
Our vision

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Our vision is to have a high quality, community-centred health and care system by 2035.

Everything we do is for the benefit of improving the health and wellbeing of the population and our people.

We are committed to **integrating health and care services** to **improve outcomes**, **reduce health inequalities** and **enhance productivity and value for money**.



Our Vision

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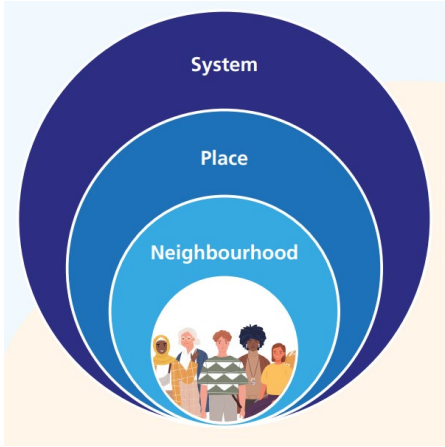
- Our vision is to have a high quality, community-centred health and care system by 2035.
- ‘Community-centred’ means a focus on keeping our communities well rather than a 'sick care' model which we recognise currently.
- An emphasis on prevention, wellbeing and healthy communities rather than solely on a specific health issue and/or clinical visit of a patient.
- A shift towards delivering care in the home and community over a person’s lifetime, taking into account the context of family, community and the holistic person at the centre of the care and making best use of digital technology.
- Everything we do as a partnership is focused on improving the health and wellbeing of our population and to move towards a more equitable health and care system.

When we are successful…..

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We will have a high quality, community-centred health and care system

- The health and wellbeing of our population and our people will be demonstrably higher.
- Health inequalities will have reduced.
- We will be financially balanced, spending less on reactive treatment and more on things that enable people to stay healthy longer.
- People will be more empowered and better able to access the services they need and want.
- Lancashire and South Cumbria will be a great place to work.





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Changes to the ICB - blueprint
Professor Craig Harris, Chief Operating Officer

The Model ICB Blueprint

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- The Model ICB Blueprint builds on NHS England's letter to trust and system leaders issued at the start of the financial year.
- The letter set out two key expectations for ICBs:
  - a 50% reduction in their running costs, and
  - a shift towards positioning ICBs as strategic commissioners, central to delivering the ambitions of the 10 Year Health Plan.
- The blueprint provides an additional level of detail on how ICBs are expected to evolve and sets out which of their functions may in future be transferred to providers.
- It defines the system leadership role of ICBs in improving population health, reducing inequalities, and ensuring access to high-quality care.

The Model ICB Blueprint

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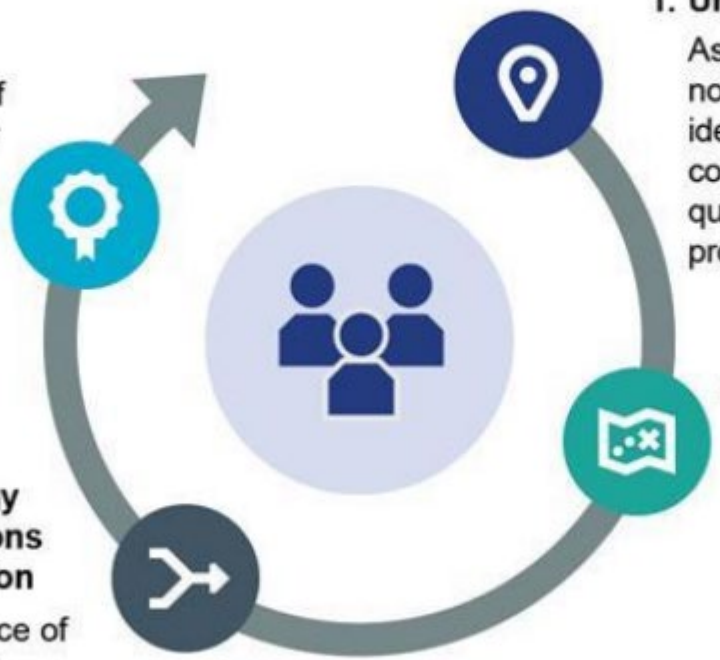
- ICBs are tasked with improving population health and ensuring access to consistently high-quality services.
- They will be accountable for ensuring the best use of their available resources, which should be used strategically with long-term population health outcomes in mind.
- Overall, the blueprint positions ICBs as system leaders, responsible for setting a population health strategy and acting as “healthcare payers” to maximise value from available resources.
- The refreshed role for ICBs is set out as part of a refreshed system architecture in which:
  - DHSC/NHS England provide national leadership and “do once” functions;
  - regional teams provide oversight and performance management of ICBs and providers and take on functions such as strategic workforce planning and digital provision;
  - ICBs become strategic commissioners; and
  - providers are responsible for the delivery of care.
- As strategic commissioners ICBs are expected to fulfil four core functions:
  1. Understanding the local context.
  2. Developing a long-term population health strategy.
  3. Delivering the strategy through payer functions and resource allocation.
  4. Evaluating impact.

The Model ICB Blueprint

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To deliver their purpose, ICBs focus on the following core functions:

Model ICB - System leadership for improved population health



1. **Understanding local context**
   Assessing population needs now and in the future, identifying underserved communities and assessing quality, performance and productivity of existing provision

2. **Developing long-term population health strategy**
   Long-term population health planning and strategy and care pathway redesign to maximise value based on evidence

3. **Delivering the strategy through payer functions and resource allocation**
   Oversight and assurance of what is purchased and whether it delivers outcomes required

4. **Evaluating impact**
   Day-to-day oversight of healthcare usage, user feedback and evaluation to ensure optimal, value-based resource use and improved outcomes

The Model ICB Blueprint

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- Our ICB has been identified as being required to make **47 per cent** running cost savings, which equates to a total net saving of £35.1 million.
- We have been asked by NHS England to do this by December 2025/26.
- A draft Model ICB Blueprint was shared by NHS England on 2 May: Draft Model ICB Blueprint
- The core role of the ICB is strategic commissioning, and they want to see a significant reduction in oversight.
- The executive team has been working to redesign the ICB with support from senior leaders from across the organisation.
- The aim of this is to design an organisation which fits the national target per head of the population (which is now £19.00 due to the pay award).
- We are not expecting there will be changes to the geographical footprint of our ICB.
- We have not received any information about a national model redundancy scheme or whether this will be funded.

The Model ICB Blueprint

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- To remain compliant with the 2022 Health and Care Act every ICB board is required to have a chair, chief executive, and three partner members (nominated by GPs, trusts, and local authorities), plus one board member with expertise in mental health.

- In addition, the ICB model constitution requires that ICB boards include at least two non-executive board members, a finance director, nursing director and medical director. Changes to ICB constitutions require NHS England agreement and ICBs are encouraged to discuss any relevant changes they would like to make to their board executive leadership with their regional team.

- NHS England's winter planning requirements are that ICBs continue to provide system co-ordination which gathers real time situational awareness of operational pressures. ICBs are required to nominate a winter director with the specific accountable role of convening executives from across providers in a system to mitigate pressure between providers.

- ICBs remain responsible for EPRR and system control centres over winter and must ensure they continue to operate effectively.

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Challenges to the ICB
Professor Craig Harris, Chief Operating Officer

Challenges to the ICB

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- Organisational change and workforce
- Financial
  - NOF 4 and IAG – what they are and what they mean in practice
  - System wide position
  - ICB position
  - Trusts position
- Waste Reduction Programme
  - Difficult decisions
- Even greater focus on performance and quality

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The 10 Year Plan
Professor Andy Knox, Medical Director

10 YEAR PLAN – shift 1

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From hospital to community: the neighbourhood health service designed around you



10 YEAR PLAN – shift 1

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Hot off the press

- GMS will remain in place. Government has committed to longer term reform of the GMS contract – we anticipate this will be a multi-year process. However, in the meantime, GMS remains.
- The PCN DES will also remain. Any shift to a neighbourhood contract will be voluntary – so for those not wanting to move, they will remain with GMS / PCN DES.
- NHSE are still working through the contractual form for the neighbourhood contract. Their aim is to create a contract that:
  - Is an overlay or sits alongside GMS – so practices will not be asked to 'give up' GMS in order to take up a neighbourhood contract.
  - Has less bureaucracy / form filling that the current GMS and PCN DES arrangements
  - Has more flexibilities around staff and resourcing that the current GMS and PCN DES contract
  - Provides a contractual level for neighbourhood health services

10 YEAR PLAN – shift 1

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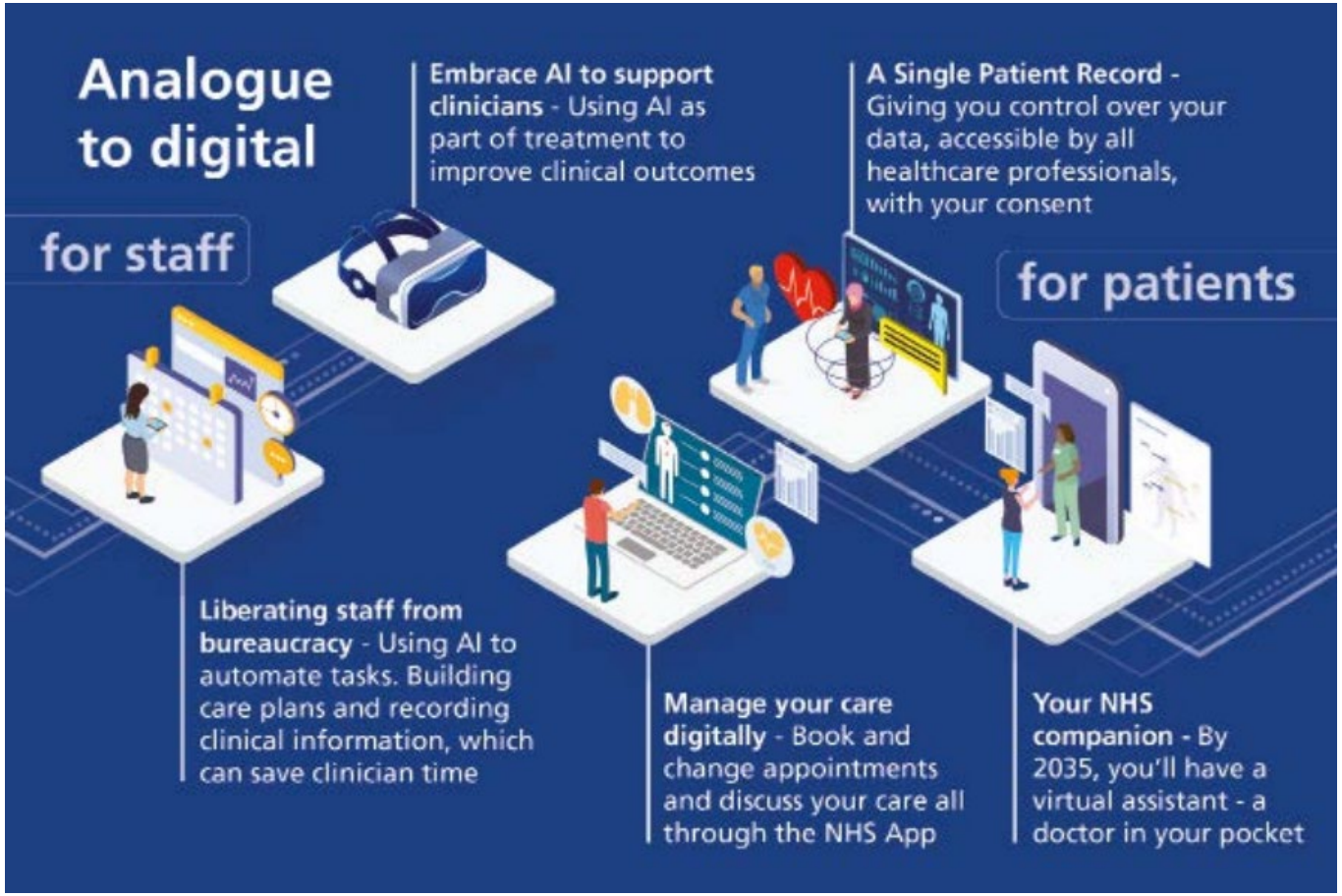
Hot off the press

- NHSE are also looking for the contractual form to potentially enable other benefits.
- NHSE's aim is to consult on a draft of this new contract after the summer with GPCE and more broadly.
- NHSE expects the contract to be most appealing to single practice PCNs and highly collaborative multi-practice PCNs looking to lead neighbourhood health service delivery.

10 YEAR PLAN – shift 2

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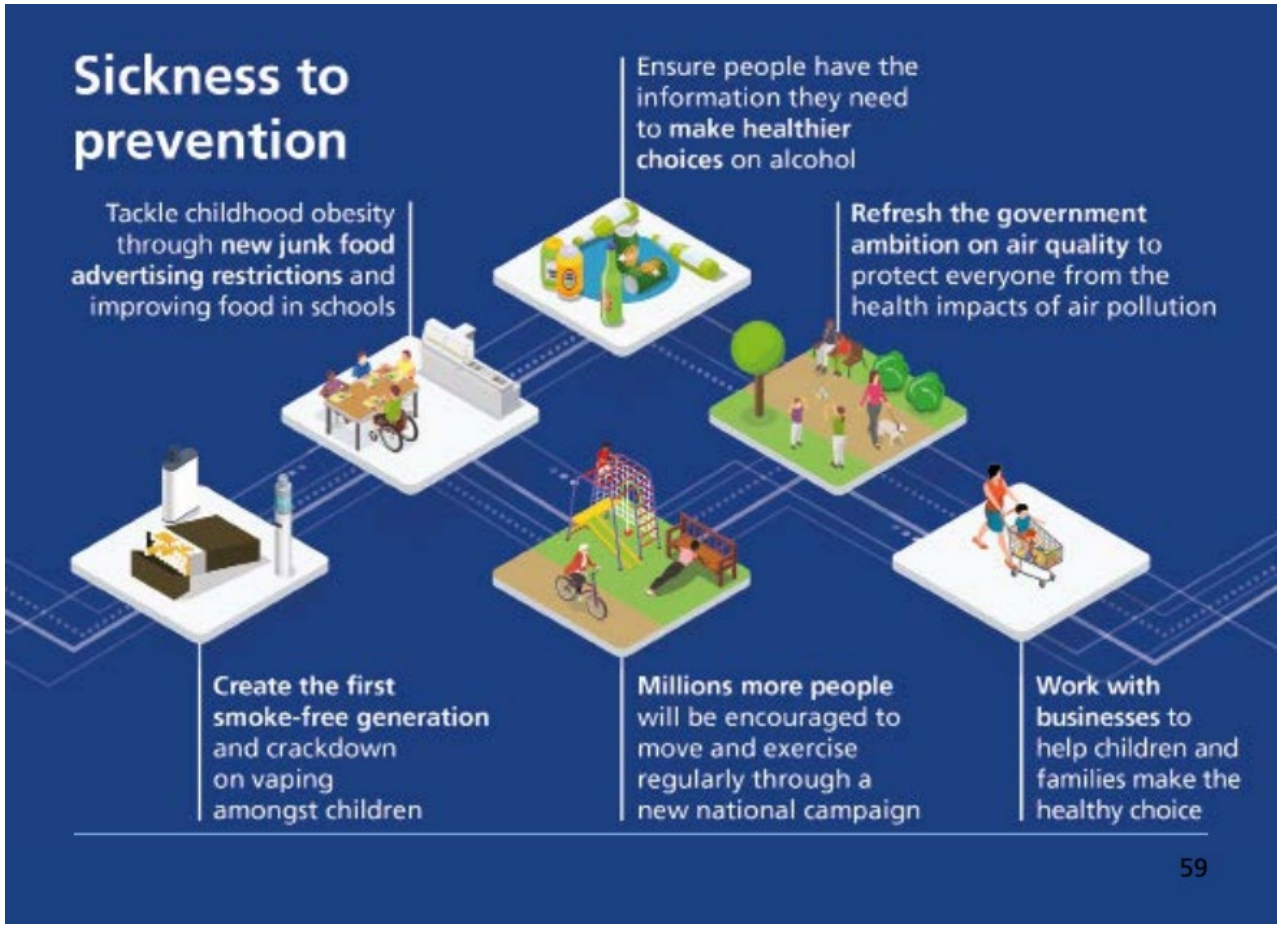
From analogue to digital: power in your hands – this will be the focus of a future webinar



10 YEAR PLAN – shift 3

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From sickness to prevention: power to make the healthy choice – this will be the topic of a future webinar

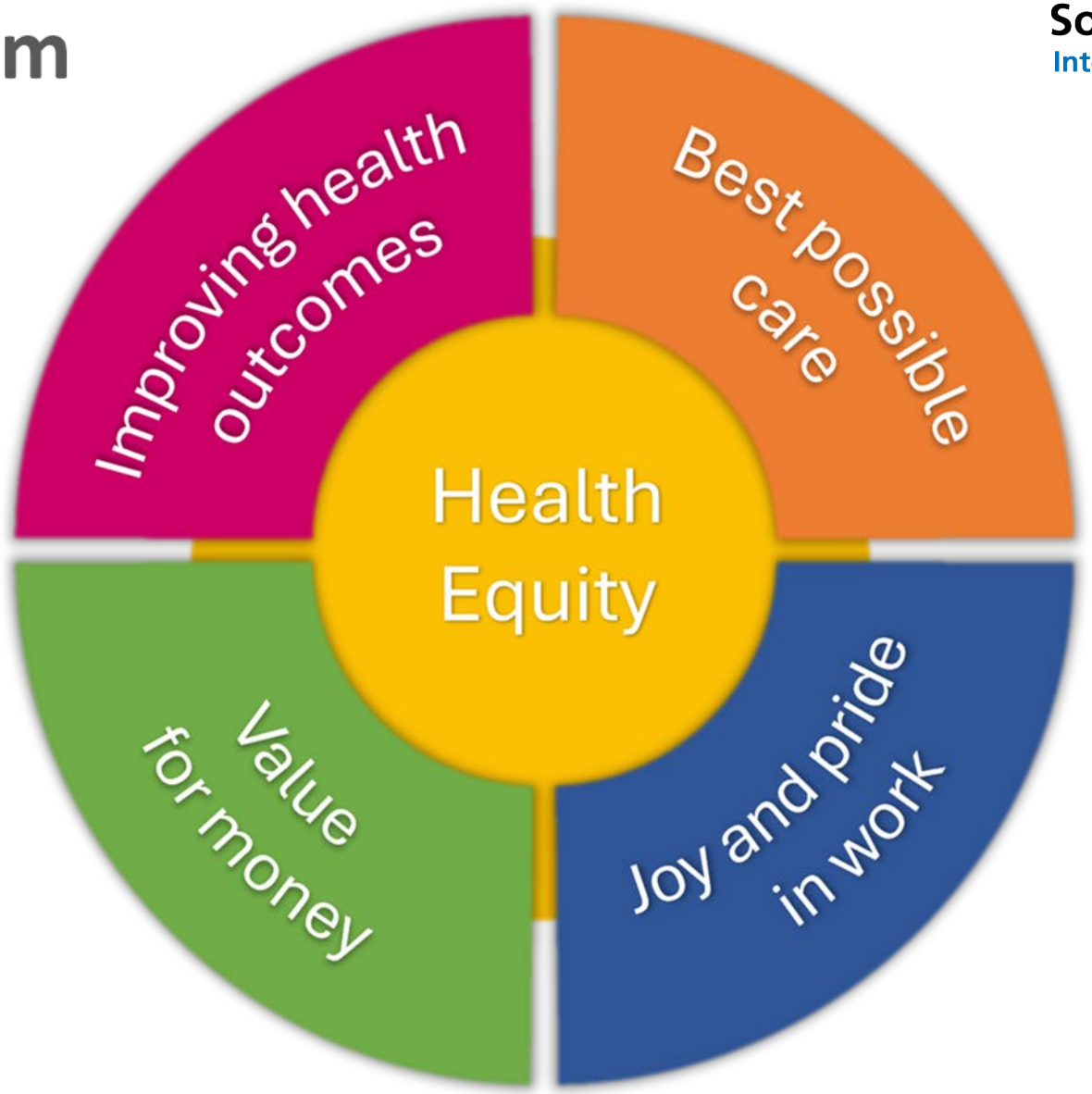


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What does this mean for practices?
Professor Andy Knox, Medical Director

3-4-5-6-7

The Quintuple Aim



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3-4-5-**6**-7

The Population Health Hexagons

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Predict – Using data, insight and ongoing dialogue with communities to identify early issues likely to lead to ill health

Recover – Working with people and carers to enable those recovering from illness to live as full a life as possible, or receive excellent and equitable palliative care

Prevent – Taking action with people and communities to improve lifestyles, social circumstances and our environment to improve health and wellbeing

Manage – Ensuring equitable access to the best possible healthcare at the earliest opportunity

Detect – working proactively in integrated teams to find people who have a condition which increases their risk of ill health



Protect – Working with people with known conditions/risk factors to reduce their risk of ill health

Data and Intelligence | Community participation | Resource (Finance, Skills, People)

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Questions, summing up and final thoughts

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