

# Integrated Care Partnerships: Policy Implementation Framework

## **1.0 Introduction**

- 1.1 On 18 October 2012 the Minister for Health, Social Services and Public Safety agreed a high level policy direction on the establishment and role of Integrated Care Partnerships (ICPs). This Policy Direction is set out at Annex A of this document.
- 1.2 Section 2.2 of the Policy Direction states “the challenge facing the HSC in Northern Ireland is to enhance the health of our population and deliver high quality and sustainable care whilst ensuring that resources are used as effectively and efficiently as possible.”
- 1.3 The establishment of ICPs is central to meeting this challenge. ICPs are being established by the Health and Social Care Board (HSCB) to support the implementation of Transforming Your Care consistent with the Policy Direction.
- 1.4 In order to provide the foundation for the establishment of ICPs in support of the Policy Direction, the Department has developed a policy implementation framework with which all ICPs should align. This document sets out this Policy Implementation Framework.
- 1.5 The Department will as part of any future evaluation of ICPs and consideration of future policy development, benchmark the operation of ICPs against this Policy Implementation Framework.

## **2.0 Definition**

2.1 Integrated Care Partnerships are multi-sector collaborative networks of health and social care providers that come together to respond innovatively to the assessed care needs of local communities. By purposeful collaboration, they co-ordinate the local application of fully integrated care pathways and develop tailored packages of care initially for frail older people and those – regardless of age - with certain long term conditions namely diabetes, stroke care and respiratory conditions, thereby ensuring that service users receive more effective and efficient care.

### **3.0 Overarching Policy Context**

3.1 The HSCB will ensure that the focus, role, performance and operation of ICPs is adapted and responsive to Ministerial priorities which are expressed through the Programme for Government, Commissioning Plan Direction, Departmental policies and strategies, guidance and standards. As such, the HSCB's annual Commissioning Plan will explain how the work of ICPs supports the delivery of Ministerial priorities, standards and targets.

3.2 As per section 4.6 of the Policy Direction, ICPs operate within the extant policy and statutory framework governing the operation of the integrated health and social care system in Northern Ireland. These requirements are set out in the HSC Framework document of 2011<sup>1</sup>, DHSSPS policies, strategies, standards and guidance e.g. Clinical and Social Care Governance Framework, Controls Assurance Standards, the requirements of professional regulatory bodies, Service Frameworks, and the principles outlined in the Public Health Strategic Framework, and the 'Quality 2020' Strategy. ICPs will be a key enabler for, and will share inter-dependencies with, the wider delivery of Ministerial decisions following the public consultation on 'Transforming Your Care: Vision to Action'.

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<sup>1</sup> [www.dhsspsni.gov.uk/framework\\_document\\_september\\_2011.pdf](http://www.dhsspsni.gov.uk/framework_document_september_2011.pdf)

3.3 The success of ICPs individually and collectively will depend on the extent to which the HSCB, including its Local Commissioning Groups (LCGs), ICPs and those represented within ICPs are able to maximise the use of personnel, services, structures and contracts which are already funded and in place. Every reasonable measure should be taken to utilise existing resources more effectively and efficiently. Where additional resources are felt to be required, these should be sought through normal business case processes.

#### **4.0 Outcomes**

- 4.1 ICPs offer an operational model to facilitate better outcomes for individuals, families and local communities. They must demonstrate a clear commitment to achieving outcomes which enhance service user treatment, care and support in line with Ministerial priorities and the requirements set out in section 3 above.
- 4.2 Evaluation of ICPs will be of key importance and all ICP stakeholders should be made aware of the detail of these requirements from the outset of ICP initiation. The approach to evaluation is set out at section 15 below.
- 4.3 Post project evaluation of the operation of ICPs will be undertaken within one year of the full implementation of ICPs. Taking account of this evaluation, the Department will oversee the overall evaluation of the ICP model as an approach capable of contributing more effectively to Ministerial priorities and Departmental policy through better integration of service delivery.
- 4.4 ICPs will be expected to contribute to the following improvements, and demonstration of these improvements will be expected at evaluation:

- i. Improved patient and client outcomes and experience, especially for those most in need of early intervention, care, treatment and support e.g. at risk by reason of their condition, environment or circumstances;
- ii. Improved and equitable patient and client access to assessment, early diagnosis, treatment, care and support;
- iii. Improved health and wellbeing of local populations including a focus on prevention and earlier intervention and on reducing health inequalities;
- iv. Improved effectiveness and efficiency in HSC systems and processes;
- v. Improved locally-delivered and fully integrated care pathways for service users including an increased focus on health promotion and disease prevention, co-ordinated assessment, earlier diagnosis and effective, co-ordinated care/case management;
- vi. Improved management of long term conditions in the community for children and adults (regardless of age);
- vii. Improved joint working and patient-centred collaboration between primary, community and secondary care (statutory, independent and community and voluntary sectors);
- viii. Shift in share of expenditure from hospital service to the community with an increased share of expenditure focussed on prevention and earlier intervention; and
- ix. Shift in the level of provision of treatment, care and support from the hospital to the primary and community sector and to prevention and earlier intervention where benefits to the wider community can be demonstrated.

## **5.0 Performance Metrics**

- 5.1 The performance of the ICP model will be monitored within the existing arrangements described in section six of the HSC Framework Document<sup>2</sup>.
- 5.2 Each ICP will be required to provide a progress update to the Regional ICP Implementation Team (RIIPT) on a regular basis in a format agreed with the HSCB. This will include appropriate activity indicators which will be required from the outset of ICP establishment to monitor ICP activities and performance.
- 5.3 The HSCB will establish the precise, regionally-agreed metrics which it will use in the performance management of each ICP having taken account of best practice evidence. These metrics will ultimately derive from Ministerial priorities and should include those indicated in section 15 on 'Evaluation'.
- 5.4 The HSCB will be required to determine and report on the specific contribution of ICPs to the achievement of the high level performance metrics and clearly identify the linkages to the activity-related metrics which it has set for ICPs.
- 5.5 The HSCB and its LCGs should ensure that a baseline position in respect of performance metrics is established within six months of the establishment of each ICP.
- 5.6 The HSCB will ensure that ICP support teams work with ICPs, LCGs and the RIIPT to put data collection arrangements in place to meet the six month timescale for baseline and that these are maintained on an ongoing basis to support evaluation as per section 15.

## **6.0 Initial Focus**

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<sup>2</sup> [www.dhsspsni.gov.uk/framework\\_document\\_september\\_2011.pdf](http://www.dhsspsni.gov.uk/framework_document_september_2011.pdf)

- 6.1 As set out in the Policy Direction, initially the focus of ICPs will be on the frail elderly and aspects of long term conditions for all ages, namely diabetes, stroke care and respiratory conditions. This includes palliative and end of life care in respect of these agreed areas.
- 6.2 Subject to these initial work areas being effectively addressed, additional areas of focus may be proposed by the Department, the HSCB/LCGs and/or the ICPs. Departmental priority areas will normally be communicated through the annual Commissioning Plan Direction.

## **7.0 Scope**

- 7.1 As per section 4.8 of the Policy Direction, a typical ICP is established to include membership which serves a shared population of around 100,000 people.
- 7.2 The HSCB will, however, ensure that its arrangements allow for the creation and management of ICPs which may be established to cover a population which straddles more than one LCG area.

## **8.0 Role and Structure**

- 8.1 In line with the definition at section 2 above, ICPs will undertake two key strands of work:

Strand 1: Strategic Level - Local application of fully integrated, Commissioner-approved care pathways to ensure co-ordinated and effective delivery; evaluation of local effectiveness of existing care pathways with a view to service improvement; risk stratification of a defined population of service users; contribution to comparative benchmarking between ICPs; and the sharing of best practice.

Strand 2: Patient level – agreeing the processes for anonymised casework: care planning; case reviews of patients at significant risk of

poor outcomes relating to the condition under consideration, to include the promotion of self-care and independence; improvement in control and prevention of inappropriate acute admission; and information sharing.

8.2 As per section 2.2 of the ICP Policy Direction, ICPs should be constituted and managed to enhance the health of the population and deliver high quality and sustainable care whilst ensuring that resources are used as effectively and efficiently as possible. The anticipated outcomes of ICPs should be clearly articulated from the outset and should align with those set out in this Policy Implementation Framework at section 4 above.

8.3 Building on the Policy Direction, the following principles will underpin the structure and operation of the ICPs:

- i. within an LCG area, and regionally, there is an avoidance of unnecessary duplication in the work which they undertake;
- ii. they are able to provide locally specific advice and input into Strand 1 and 2 work as outlined above;
- iii. local flexibility and innovation in identifying solutions is supported throughout the process;
- iv. they are multi-disciplinary and multi-sectoral bringing together the range of health and social care providers in the area including the HSC Trusts and encompassing representation from service users and a range of stakeholders;
- v. they offer inclusive leadership opportunities;
- vi. they encourage input from subject matter experts from outside of the membership of the ICP, as required;
- vii. they are flexible with membership re-constituted as necessary depending on the priority issues under consideration;
- viii. they work within the appropriate Clinical and Social Care Governance (CSCG) framework, taking account of evidence of

best practice and the requirements of audit and evaluation for projects undertaken; and

- ix. they maintain the principle of the Commissioner/Provider split, and therefore do not undertake a commissioning role.

8.4 The HSCB and its LCGs will put in place arrangements to facilitate and manage continuing communication and information sharing between individual ICPs. These arrangements must ensure a regionally consistent approach, effective knowledge exchange and best practice sharing, and avoidance of both unsuitable divergences in ICP working in different geographical areas, and unnecessary duplication.

8.5 The HSCB will create an ICP support team per LCG area which will service all ICPs within that LCG area. The ICP support team will be organised and managed in order to provide continuity and momentum to the work of the ICPs.

8.6 In order to protect and maintain appropriate commissioner/provider separation, ICP support team staff will be part of the ICP project management structures within the HSCB, reporting to the Transformation Programme Board.

8.7 The ICP support team will work with ICPs to ensure:

- i. consistency of ICPs with extant policy, standards, regulatory and other legal requirements;
- ii. the operation and regulation of ICPs in a way which promotes equity of service across all regions;
- iii. sufficient buy-in from stakeholders in line with the evaluation requirements;
- iv. the participation of independent contractors, including GP practices, within the locality with their relevant ICPs;
- v. incorporation and support of appropriate service user representation within each ICP; and

vi. quick response to and appropriate escalation of emerging issues in line with the Memorandum of Understanding and the Local Accountability Agreement (further details at section 10 below).

8.8 Reporting structures in respect of ICPs and their associated support teams are outlined at Annex B of this Policy Implementation Framework.

## **9.0 Governance**

9.1 The establishment of ICPs does not in any way affect the statutory responsibilities described in the HSC Framework Document.

9.2 An ICP is a collaborative network rather than an organisation and, as such, it does not have any separate statutory existence. The establishment of an ICP does not remove or dilute the statutory governance requirements placed on existing organisations. Individual members of an ICP remain bound by their own statutory obligations in areas such as human rights and data protection; however, the statutory obligations falling to a relevant public authority, such as equality, will default to the HSCB where ICP members do not hold relevant responsibility.

9.3 The HSCB is accountable to the Department for oversight, governance and performance management of each ICP. The governance arrangements between the HSCB/LCGs and an ICP will be set out in a Local Accountability Agreement (see section 10 for further details).

9.4 As per section 4.8 of the Policy Direction, responsibility for commissioning and funding services lies with the HSCB and its LCGs.

9.5 An individual professional participating within an ICP acts as a representative of the organisation s/he represents and is therefore covered by the governance, standards and indemnity arrangements of

that organisation, providing s/he acts within their professional competence and standards of their professional body. Where the individual is an independent practitioner, they are responsible for their own professional conduct, clinical decision making and indemnity arrangements.

- 9.6 Decisions about care remain the clinical or social care responsibility of the practitioner involved, and final decisions rest with individual practitioners. Any decisions emerging from an ICP will be based on best practice guidance and will have guidance rather than requirement status.
- 9.7 If concerns emerge about the practice of a member of an ICP then members should raise this with the relevant ICP support team lead. All members of the ICP have a duty to report their concerns and should expect that these concerns will be taken seriously.
- 9.8 The HSCB and its LCGs will put in place checks and balances to avoid any ICP member benefitting inappropriately from commissioning decisions. Where a participating organisation has a particular interest in a specific aspect of the commissioning/provision of services, they must make a formal declaration of such interest.

## **10.0 Memorandum of Understanding and Local Accountability Agreement**

- 10.1 Through its ICP project support structures, the HSCB will establish arrangements for the selection and management of ICP members. This will include setting out how and when membership should be refreshed.
- 10.2 The HSCB will develop a common Memorandum of Understanding (MoU) and a common Local Accountability Agreement (LAA). The Memorandum of Understanding will govern the interaction between ICP members and will include a fully developed dispute resolution section.

The Local Accountability Agreement will govern the relationship between the HSCB/LCG and the ICP and ensure clarity of governance and accountability arrangements between the HSCB/LCG and the ICP.

- 10.3 The HSCB will be responsible for the ongoing operation and maintenance of the MoU and the LAA.
- 10.4 The MoU will be signed by all ICP members. Where an ICP member steps down from an ICP but re-joins at a later stage, they will be required to re-sign the MoU.
- 10.5 The MoU will require that the participating organisations are fully committed to working with the products and outcomes of ICPs – as endorsed by the Commissioner. Individual members of an ICP will also be required to agree to comply with the working practices which govern the arrangements for ICPs. Signatories to the MoU who are representing another corporate body, act within the remit, governance and statutory requirements of that organisation.
- 10.6 As the project manager for the establishment of ICPs, the HSCB's systems of internal control will extend to and embrace ICPs. This is in addition to the usual commissioner/provider accountability relationship.
- 10.7 The Local Accountability Agreement should provide a mechanism for asserting an appropriate degree of meaningful oversight and governance by the HSCB over the ICP, including but not limited to:
  - i. Arrangements for monitoring the ICPs activities on a continuing basis through an adequate and timely flow of information from the ICP in respect of performance, control, and risk management;
  - ii. Arrangements for ensuring that the work of the ICP is helping to achieve the policy objectives and that resources are being used appropriately to achieve those objectives;
  - iii. Arrangements for reviewing ICPs in line with agreed outcomes and performance metrics;

- iv. Arrangements for whistle blowing and reporting of malpractice concerns;
- v. Arrangements for ensuring equality requirements are adhered to and that the ICP will undertake its work in line with the duty to promote equality of opportunity and good relations as per the statutory requirements of Section 75 of the NI Act 1998;
- vi. Arrangements for ensuring compliance with the requirements of the Data Protection Act 1998 and the Freedom of Information Act 2000;
- vii. Arrangements for ensuring adherence to the statutory duty of quality, Personal and Public Involvement, improving health and wellbeing and reducing health inequality requirements;
- viii. Arrangements for addressing, in a timely manner, any significant problems arising in the ICP including any actions which could infringe the requirements of propriety or regularity;
- ix. Arrangements in respect of the relative roles and responsibilities of the DHSSPS, the HSCB/LCGs, and the ICP including details of provision of clear line of sight and confirmation of the unchanged statutory responsibilities of ICP participants as set out in section 9;
- x. Arrangements for ensuring appropriate risk management approaches are in place including assurance that the ICP will be able to respond flexibly to any service reconfiguration in response to pandemic flu or other emergency requirements;
- xi. Arrangements for ensuring compliance at all times with the requirements of Managing Public Money Northern Ireland;
- xii. Arrangements for the HSCB to ensure that the proposed work of an ICP is aligned with extant policies, strategies, standards, regulatory and other legal requirements and that unnecessary duplication is avoided;
- xiii. Arrangements for ensuring that the commissioner/provider split is protected and arrangements for ongoing monitoring to ensure this is appropriately maintained;

- xiv. Arrangements for making ICP outputs - incorporating good practice - widely available regionally, and locally, to stakeholders once endorsed as fit for purpose; and
- xv. Arrangements in respect of baseline data collection for evaluation, performance metrics and monitoring update reports.

10.8 The HSCB will formally review the arrangements for the governance and accountability of ICPs and their support teams at the end of the project management period.

### **11.0 Patient Care and Information Sharing**

11.1 Information will be shared only on an appropriate basis to ensure good quality health and social care.

11.2 Sharing of clinical and social care information within the ICP will be on the basis of standard parameters around patient/client confidentiality and in line with the Data Protection Act 1998.

11.3 An information governance protocol will be put in place for each ICP to govern the sharing of health or social care information within the ICP.

### **12.0 Value for Money**

12.1 The responsibilities of Accounting Officers under the terms of their appointment and Managing Public Money NI remain in place. In particular, the Chief Executive of the HSCB, as Chief Accounting Officer, should ensure that arrangements for the establishment of ICPs should:

- i. Be capable of demonstrating Value for Money;
- ii. Avoid unnecessary duplication of effort/costs between ICPs; and

- iii. Avoid any double funding of practitioners and service providers who are already being funded to undertake tasks which contribute to the delivery of ICP functions and outcomes.

### **13.0 Project Management Arrangements**

- 13.1 The establishment and development of ICPs will be taken forward through agreed project management arrangements, reporting to the HSCB-led Transformation Programme Board and, as appropriate, to the DHSSPS-led Strategic Planning Group.
- 13.2 A Regional ICP Implementation Project Team (RIIPT) and Regional ICP Implementation Project Board (RIIPB) will be put in place by the HSCB. It is anticipated that these arrangements will remain in place within the HSCB to March 2015 at which point support arrangements for ICPs will be reviewed as part of the overall evaluation.
- 13.3 The HSCB through the RIIPT will oversee ICP project implementation and be accountable to RIIPB which will in turn be accountable to the HSCB-led Transformation Programme Board and the DHSSPS-led Strategic Planning Group.

### **14 Timescale**

- 14.1 ICPs will be established on a phased basis with roll out completed by March 2014.
- 14.2 The HSCB through the RIIPT is required to draw up a Project Initiation Document and a Project Plan with details of key milestones and timescales which map out the work leading up to establishment of ICPs, and also planned key milestones post-ICP establishment.

14.3 Should the ICP deviate from the RIIPT and the RIIPB planned approach, this will be raised initially via escalation to the HSCB as required.

## **15.0 Evaluation**

15.1 The evaluation criteria for ICPs will be outcomes' focused and under six themes: quality; access; financial benefits; engagement; pathway redesign; and future proofing aligned to the outcomes described in section 4. A number of the designated outcomes span more than one of these six themes. Performance metrics will be linked to these themes and outcomes as explained in section 5. ICPs will also need to demonstrate progress against the delivery of the relevant proposals set out in Transforming Your Care.

15.2 It is envisaged that the focus of ICPs will evolve over time. The evaluation criteria may be updated to reflect these changes, appropriate amendments, or new Ministerial priorities. The proposed metrics are attached at Annex C – these are subject to review and further refinement.

15.3 An interim assessment may also be undertaken in the course of ICP implementation in order to review progress to date under each of the evaluation themes.

**Integrated Care Partnerships – Policy Direction  
(Issued to the HSC in November 2012)**

**Section 1**

**Introduction**

- 1.1 Transforming Your Care (TYC), the report of the Review of Health and Social Care in Northern Ireland published in December 2011, recommends the establishment of 17 Integrated Care Partnerships (ICPs). These Partnerships would play a key role in supporting the delivery of the future model of health and social care proposed in the Report.
- 1.2 This paper sets out a proposed policy direction to support the establishment of ICPs and provide an outline of their role and remit, including the principles which should underpin them. The policy outlines how Integrated Care Partnerships can be introduced within the existing statutory context. The establishment of ICPs would be supported by an Implementation Plan, developed by the Health and Social Care Board (HSCB) and the DHSSPS, which will set out in more detail how ICPs would operate within the existing HSC structures.
- 1.3 The policy addresses a number of specific issues:
  - i. Section 2 provides an overview of the need for change underlying ICPs and the issues they will address;
  - ii. Section 3 outlines the existing governance and accountability framework which provides the context within which ICPs would be established and operate;
  - iii. Section 4 considers the function, role and objectives of ICPs and the principles upon which they should be established;
  - iv. Section 5 notes the options for the development of ICPs in the longer term, subject to evaluation and assessment of longer term

viability.

## **2. The Need for Integrated Care Partnerships**

- 2.1 The Transforming Your Care Report sets out the case for change in how Health and Social Care services are provided. The underlying drivers for change identified in the report include:
- A growing and ageing population;
  - The increasing prevalence of long term conditions;
  - Increased demand and over-reliance on hospital beds;
  - Clinical workforce supply difficulties which have put pressures on service resilience; and
  - The need for greater productivity and value for money.
- 2.2 Within this context, the challenge facing the HSC in Northern Ireland is to enhance the health of our population and deliver high quality and sustainable care whilst ensuring that resources are used as effectively and efficiently as possible.
- 2.3 To address this challenge, Transforming Your Care proposes a new model for health and social care, designed with the person at the centre and with health and social care services built around the individual, supporting them to make good health decisions.
- 2.4 Key to the delivery of this new model of care is a more integrated approach to service planning and delivery. Transforming Your Care recommends the establishment of 17 Integrated Care Partnerships which would join together the full range of health and social care services in each area, including GPs, health and social care providers, hospital specialists and representatives from the independent, voluntary and community sector.
- 2.5 ICPs would have an important role in the reform and modernisation of health and social care envisaged under TYC, particularly the “shift left”

of services out of the hospital sector and into the primary and community sector. The main objectives of shift left would be to reduce unnecessary hospital admissions, provide care closer to home, personalise care through empowering patients and service users, and support the movement of services upstream towards the prevention of ill health. ICPs would also support the shifting of resources from hospitals to enable investment in community health and social care services.

2.6 Improving how providers work together to the benefit of patients and service users will mean challenging existing systems and processes that impede effective health and social care, thereby ensuring joined up and cohesive care through meeting the need for:

- A multi-disciplinary approach to the planning and provision of treatment and care, co-ordinating how care is planned and delivered;
- Placing the individual at the centre of care and promoting partnership working, both with individual service users and within and across the statutory, independent, voluntary and community sectors;
- Better communication, including detailed, accurate and timely information flow;
- Ensuring safe, high quality treatment and care through taking a holistic approach to improving services;
- Improving the speed of operational decision making; and
- The effective deployment of resources.

2.7 For the individual, this will mean health and social care providers working together to deliver the services needed by local populations. As a consequence, people would benefit from more co-ordinated and streamlined services and be at the centre of decision-making about their care and treatment.

### **3. Strategic and Legislative Context for Establishment of Integrated care Partnerships**

- 3.1 The establishment of Integrated Care Partnerships must be considered within the statutory framework for Health and Social Care in Northern Ireland.
- 3.2 Health and Social Care (HSC) bodies in Northern Ireland exist and operate within the legislative context of the Health and Social Care (Reform) Act 2009 (the 2009 Act). Under the 2009 Act, the Department of Health, Social Services and Public Safety has a statutory duty to promote an integrated system of health care designed to secure improvement in the physical and mental health of people and prevention and diagnosis and treatment of illness. It must also promote social care designed to secure improvement in the social well-being of people.
- 3.3 These duties are fulfilled both by the direct action of the Department and through the operation of its Arm's Length Bodies (ALBs) including the Health and Social Care Board (HSCB), Public Health Agency (PHA) and Health and Social Care Trusts. The 2009 Act sets out the functions of HSC bodies and the parameters within which they operate, including governance and accountability arrangements to support the effective delivery of health and social care in Northern Ireland.
- 3.4 The Framework Document produced by the DHSSPS to meet its statutory requirement under the 2009 Act, sets out the main priorities and objectives of each of the Health and Social Care bodies in carrying out its functions. All of the HSC ALBs covered by the Framework Document are ultimately accountable to the Department for the discharge of their functions set out in their founding legislation.
- 3.5 Central to improving and protecting the health and social well being of the people of Northern Ireland is the commissioning process, led by the

Health and Social Care Board and based on assessment of need, strategic planning, priority setting and resource acquisition. Under the 2009 Reform Act, the HSCB has established 5 Local Commissioning Groups (LCGs), co-terminus with the HSC Trusts, each of which is responsible for planning and resourcing health and social care to meet the needs of its local population. LCGs function as committees of, and are therefore accountable to, the HSCB.

#### **4. Form and Function of Integrated Care Partnerships**

- 4.1 Transforming Your Care envisages Integrated Care Partnerships as having a central role in the reform and modernisation of services and the move to the new future model of care proposed in the Report.
- 4.2 The draft Strategic Implementation Plan developed to support the implementation of the Transformation Programme, includes the initial establishment of ICPs by October 2012. The further roll out to 17 Integrated Care Partnerships would be on a phased basis between autumn 2012 and the end of 2013. The Department's 2012 Commissioning Plan Direction also includes a target to establish Integrated Care Partnerships.
- 4.3 A key consideration in the establishment of ICPs therefore is the need to ensure that they are in place as quickly as possible in order to support the reform and modernisation of HSC services in line with Transforming Your Care and the Strategic Implementation Plan.
- 4.4. The Transforming Your Care Report does not include specific recommendations for how ICPs would function, although it does note the potential for ICPs to be established as free-standing provider organisations in their own right – including the option to become social enterprises or mutual organisations.

- 4.5 To move to such a position to establish ICPs as formal provider bodies would possibly require changes to the existing HSC legislative framework with associated implications in terms of timescales and resources.
- 4.6 It is clear therefore that for ICPs to be established to meet the immediate challenges identified in TYC requires that they are developed within the existing statutory framework and that their role and remit are clearly identified within these parameters.
- 4.7 ICPs would therefore be developed as collaborative networks, bringing providers together in a partnership approach and based on a number of key principles.

#### ICP Principles

- 4.8 The following key principles would underpin the development of ICPs.
- (i) ICPs would not be established as separate legal entities but would be a networked group of service providers within the existing HSC structures;
  - (ii) ICPs would be a collaborative alliance with membership that would include statutory, independent and voluntary and community practitioners and organisations. A key consideration would be the inclusion of the voluntary and community sector in the work of ICPs;
  - (iii) The aim of ICPs would be to focus on identifying how the blockages and barriers to the integration of services might be overcome through re-designing care pathways and improving how services are planned and delivered to the benefit of patients and clients;
  - (iv) Maintaining the principle of the commissioner/provider split, ICPs would not have a commissioning role;
  - (v) Responsibility for commissioning and funding services would continue to lie with the HSCB and its LCG committees;

- (vi) ICPs would be established around natural communities (approximately 100,000 people) and would evolve from and replace Primary Care Partnerships;
- (vii) There should be awareness of the possible dual role of independent contractor members of ICPs and implications for the principle of commissioner/provider spilt i.e. ensuring there is no conflict of interest between those who may be involved in commissioning (through LCGs for example) and their roles as providers in ICPs;
- (viii) ICPs should be clinically led and be based on multi-disciplinary working;
- (ix) They should be operated and regulated in a way that ensures equity of service across all regions.

4.9 A critical underlying principle to health and social care in Northern Ireland, and a key context in the development of ICPs, is the separation of commissioners and providers, an arrangement designed to promote a patient and client-centred system. In taking forward the establishment of Integrated Care Partnerships, a core principle underpinning their development is that they would not be commissioners of services. Their role and function would be solely on the delivery/provider side.

4.10 On this basis, the role of Integrated Care Partnerships would include:

- (i) Exploring new and innovative approaches to improving care pathways, to include piloting, testing and evaluating new ways of working and to enable the upstream investment required to delay and defer chronic disease onset.
- (ii) Co-ordinating the delivery of important HSC projects, such as the Electronic Care Record;
- (iii) Driving improvements in effectiveness and efficiency in HSC systems and processes;

- (iv) Improving patient outcomes and experience through better communication and networking between primary, community and secondary care;
- (v) Reducing avoidable hospital admissions and the number of bed days for the frail elderly through better integrated care and a tangible “shift left” from the hospital to the primary and community sector;
- (vi) Supporting a focus on health promotion and disease prevention;  
and
- (vii) Enabling a shift in expenditure from hospital service to community.

4.11 It is anticipated that initially much of the focus of ICPs would be on the frail elderly and aspects of long term conditions, namely diabetes, stroke care and respiratory conditions. However, it is envisaged that over time ICPs would have the scope to address local priorities for service delivery improvement in line with identified local need and the direction of the Local Commissioning Group.

#### Primary Care Partnerships

4.12 The development of Integrated Care Partnerships would be informed by the work of existing Primary Care Partnerships (PCPs). PCP pathfinders were established by the HSCB in 2010 to trial primary care led approaches to new models of care and/or elements of new models. Practitioners working in the pathfinders were involved in the development of care pathways, including vertical integration with hospital specialists and horizontal integration with community nursing and other staff.

4.13 Primary Care Partnerships pathfinders have been established across all 5 LCG areas and have addressed a diverse range of projects including dermatology, oral nutritional supplements, access to

ultrasound diagnostics, medicines management and mental health.

The pathfinders were evaluated independently by the Beeches Management Centre against 6 specified criteria:

- Clinical quality
- Access
- Financial benefits
- Engagement
- Pathway redesign and
- Future proofing.

4.14 The evaluation (conducted in April 2011 and December 2011) was generally positive with all of the Pathfinders evidencing good process outcomes and a number demonstrating measureable improvements.

4.15 Although lessons learned from the work of PCPs provide a useful foundation, the establishment of ICPs would ensure a more integrated approach crossing all sector boundaries. By including the whole spectrum of providers, ICPs would be able to improve services and maximise outcomes for patients and clients through a more co-ordinated and integrated approach to care.

4.16 ICPs working in this way would also be influenced by the approach to service improvements already successfully applied through Managed Clinical Networks.

## **5. Longer Term Options for ICPs**

5.1 In the longer term, consideration may be given to how ICPs might move to become formal service delivery organisations in their own right, including the potential for ICPs to become social enterprise or mutual organisations. As already indicated however, this would move beyond existing policy and as such would require significant change, including formal consultation and the possible need for new legislation

that would allow ICPs to be established as formal provider organisations in their own right, which would take a number of years to achieve.

- 5.2 However, these issues do not need to be addressed in the immediate context – the current focus is to achieve enhanced patient care by more integrated service delivery across the HSC. It is not proposed therefore that further analysis of structures is undertaken at this point in time.

## **6. Conclusion**

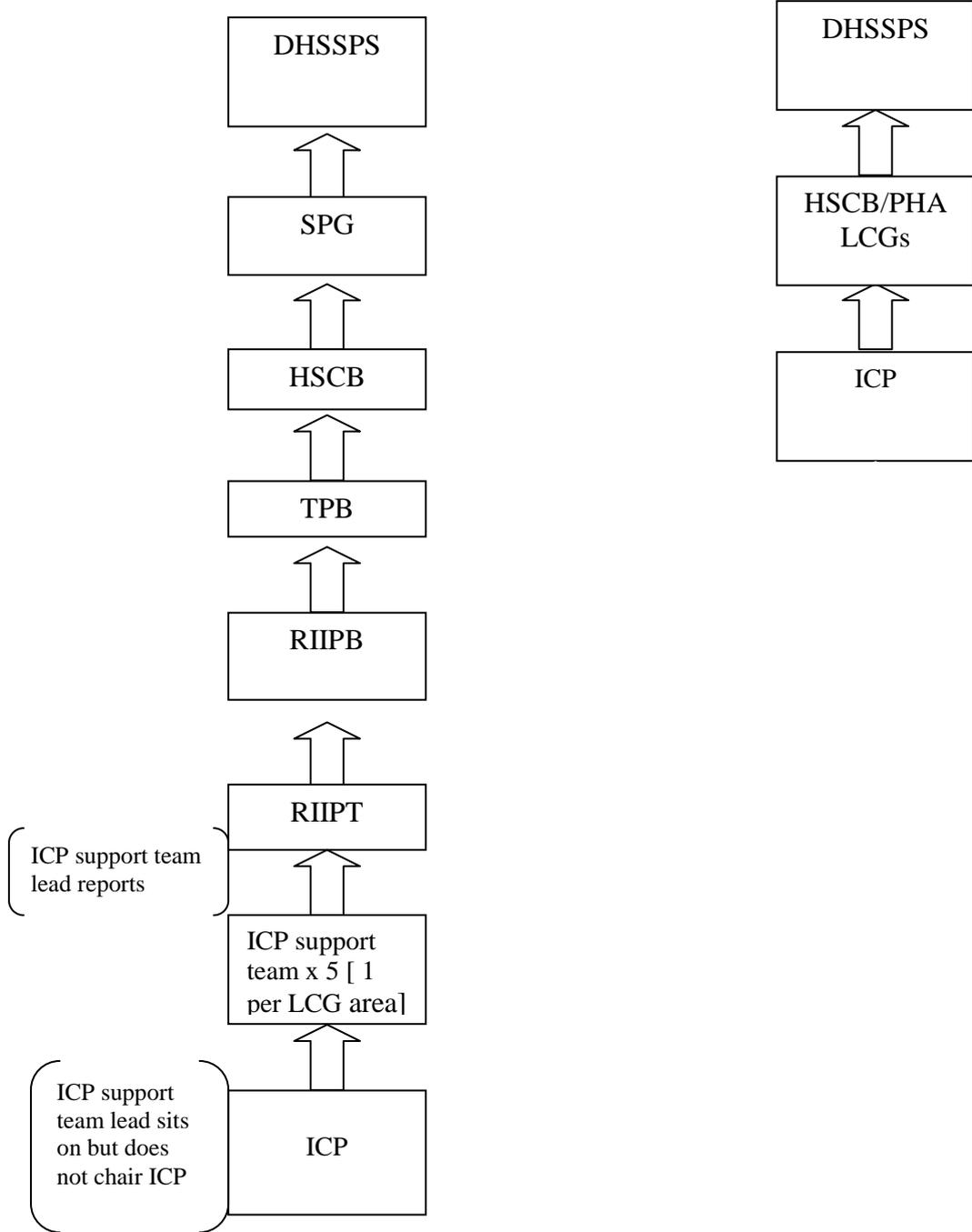
- 6.1 It is proposed that Integrated Care Partnerships would be established as collaborative networks, joining together the full range of health and social care services in each area including family practitioners, community health and social care providers, hospital specialists and representatives from the independent and voluntary sectors. ICPs would have no statutory basis and member organisations would operate within their existing governance and accountability arrangements.
- 6.2 There would continue to be a clear distinction between commissioners and service providers working collaboratively as Integrated Care Partnerships. Existing commissioning arrangements would continue to apply as would current management and accountability arrangements. ICP member organisations would continue to deliver services in line with operating processes as set out in the Health and Social Care (Reform) Act 2009 and the Framework Document.
- 6.3 ICPs would be clinically led and although it is envisaged that General Practitioners would have a key leadership role to play, clinical leadership should not be seen as exclusive to General Practitioners so that opportunities for leadership development should be available to other health and social care professionals.

- 6.4 ICPs would operate in line with an Integrated Care Partnership Implementation Plan and Memorandum of Understanding currently being developed by the Health and Social Care Board and would be subject to the agreement of the DHSSPS.
- 6.5 Clear evaluation criteria would be developed against which the effectiveness of ICPs could be assessed after a period of at least 2 years from the establishment of the first tranche of ICPs anticipated in autumn 2012. It is likely that these evaluation criteria will be based on those set in place to evaluate the effectiveness of PCPs (para 4.13 above). This evaluation would inform the longer term status and role of ICPs, including for example the potential to be established as formally constituted provider organisations.

ICP Reporting Structures – Note this is a simplified illustrative diagram

Interim Project Management Reporting Structure

Service Delivery Reporting Structure



## ANNEX C

*The metrics below have a focus on evaluation. In addition, it is expected that the activities of individual ICPs will be monitored and reported on a regular basis as they develop.*

### ICP EVALUATION FRAMEWORK – PROPOSED PERFORMANCE METRICS

*The metrics are subject to review and further refinement*

The proposed evaluation criteria for ICPs are set out below under six themes: quality; access; financial benefits; engagement; pathway redesign; and future proofing. A number of strategic level outcomes have been identified against these themes with associated performance metrics. The table below identifies the main outcomes expected against each of the themes, although it is recognised that outcomes and performance metrics are inter-linked and each is likely to align to more than one theme.

#### **Evaluation: Themes, Outcomes and Metrics**

*Please note that references to data collection 'by LCG area' will take GP practice registration as the key data source in each instance*

<b>Evaluation Theme</b>	<b>Outcomes</b>	<b>Proposed Metrics</b>	<b>Quantitative</b>	<b>Qualitative</b>	<b>Data collected by</b>	<b>Suggested frequency of Reporting against Metrics</b>
<b>1-6</b>						
<b>1.Quality</b>	<i>i. Improved patient and client outcomes and experience, especially for those most in need of early intervention care, treatment and support,</i>	<i>1a. Service user feedback on their experience of receiving targeted care, treatment and support and their views with regard to the 'joined up' nature of treatment/support.</i>	√	√	HSCB	6 monthly

<b>Evaluation Theme 1-6</b>	<b>Outcomes</b>	<b>Proposed Metrics</b>	<b>Quantitative</b>	<b>Qualitative</b>	<b>Data collected by</b>	<b>Suggested frequency of Reporting against Metrics</b>
	<p>eg at risk by reason of their condition, environment or circumstances.</p> <p>ii. Improved health and wellbeing of local populations including a focus on health promotion and on reducing health inequalities.</p>	1b. Service user satisfaction with the effectiveness of education, information and support programmes for those with long term conditions.	√	√	HSCB	6 monthly
		1c. Performance against best practice disease-specific outcome measures as specified in the Commissioning Specification for each ICP priority focus.	√	√	HSCB	Annually
		1d. Comparison of admission rates by rurality and deprivation for each ICP priority focus by LCG area.	√		HSCB	Quarterly
<b>2.Access</b>	<p>i. Improved and equitable patient and client access to assessment, early diagnosis, treatment, care and support.</p> <p>ii. Improved effectiveness and efficiency in HSC systems and processes.</p>	2a. Measurement of activity at 'decision points' in care pathway as per individual Commissioning Specifications (specific measurement points under consideration).	√		HSCB	Quarterly
		2b. Referrals to outpatients for each ICP priority focus (i) by deprivation and rurality by LCG area, and (ii) for each LCG area.	√		HSCB	Quarterly
<b>3.Financial Benefits</b>	<p>i. Shift in share of expenditure from hospital service to the community with an increased share of expenditure focussed on prevention and earlier intervention.</p>	3a. Shift of expenditure from hospital to community-based services [link to IPD E13 and PfG priority 5].	√		HSCB	6 monthly
		3b. Resource release in health and social care directly attributable to ICPs.	√		HSCB	6 monthly
		3c. Shift of expenditure to prevention and earlier intervention.	√		HSCB	6 monthly

<b>Evaluation Theme 1-6</b>	<b>Outcomes</b>	<b>Proposed Metrics</b>	<b>Quantitative</b>	<b>Qualitative</b>	<b>Data collected by</b>	<b>Suggested frequency of Reporting against Metrics</b>
<b>4.Engage-ment</b>	<i>i. Improved joint working and patient-centred collaboration between primary, community and secondary care (statutory, independent and community &amp; voluntary sectors).</i>	<i>4a.Evidence of multi-disciplinary and multi-sectoral engagement in ICPs e.g. meetings, records of attendance.</i>		√	HSCB	6 monthly
		<i>4b.Self-reports from ICP members of improved communication and networking between professions and across all sectors.</i>		√	HSCB	6 monthly
		<i>4c.Evidence via care pathways and case management of multi-sector and multi-professional contribution to, and management of, patient/client treatment and care.</i>	√	√	HSCB	6 monthly
<b>5. Pathway Redesign</b>	<i>i. improved locally-delivered and fully integrated care pathways for service users including an increased focus on health promotion and disease prevention, co-ordinated assessment, earlier diagnosis and effective, co-ordinated care management.</i>	<i>5a.Level of use of personalised and fully integrated care pathways with clear multi-sectoral and multi-disciplinary co-ordination enabling home based management as appropriate [link to IPD C5, C6].</i>	√		HSCB	Quarterly
		<i>5b.Measurement of activity at referral points in care pathway as specific to each ICP priority focus For example: - level of home based management as appropriate [link to IPD B18, C5, C6, CPD 18] - level of use of residential or other intensive care packages - level of use of step up/step down services - level of use of supported living opportunities - level of use of appropriate education, information and support programmes.</i>	√		HSCB	Quarterly
	<i>ii. improved effectiveness in HSC systems and processes</i>					
	<i>iii. improved management of long term conditions in the</i>					

<b>Evaluation Theme 1-6</b>	<b>Outcomes</b>	<b>Proposed Metrics</b>	<b>Quantitative</b>	<b>Qualitative</b>	<b>Data collected by</b>	<b>Suggested frequency of Reporting against Metrics</b>
	<i>community for children and adults (regardless of age).</i>	<i>5c. Overall length of stay in an acute setting [link to CPD 21; IDP E2; E3].</i>	√		<i>HSCB</i>	<i>Quarterly</i>
<i>5d. Level of delayed discharges [Link to IPD E2].</i>		√		<i>HSCB</i>	<i>Quarterly</i>	
<i>5e. Number of unplanned admissions to hospital for people with those long term conditions specified within ICPs' remit [link to CPD 18, 19].</i>		√		<i>HSCB</i>	<i>Quarterly</i>	
<i>5f. Level of emergency re-admissions within 30 days [link to CPD 6, 8, 19; IPD B26].</i>		√		<i>HSCB</i>	<i>Quarterly</i>	

<b>Evaluation Theme 1-6</b>	<b>Outcomes</b>	<b>Proposed Metrics</b>	<b>Quantitative</b>	<b>Qualitative</b>	<b>Data collected by</b>	<b>Suggested frequency of Reporting against Metrics</b>
<b>6.Future Proofing</b>	<p><i>i. Shift in the level of provision of treatment, care and support from the hospital to the primary and community sector and to prevention and earlier intervention where benefits to the wider community can be demonstrated.</i></p> <p><i>ii. Improved management of long term conditions in the community for children and adults (regardless of age).</i></p> <p><i>iii. Improved health and wellbeing of local populations including a focus on prevention and earlier intervention and on reducing health inequalities.</i></p> <p><i>iv. Improved and equitable patient and client access to assessment, early diagnosis, treatment, care and support.</i></p>	<p><i>Measurements in relation to the trends demonstrated in the evaluation themes 1-5 will be considered in combination in evaluating the ‘future proofing’ theme.</i></p>	√	√	HSCB	As indicated earlier in this table

*Please note: Future measurement opportunities remain under consideration. Options may include: QOF indicators, measurement of waiting time for AHP referrals and further metrics as care pathways evolve.*

*Abbreviations:*

*PFG – Programme for Government*

*IPD – Indicator of Performance Direction*

*CPD – Commissioning Plan Direction*