Annex A

Using the national ICS model of Neighbourhood / Place / System

1. **Primary Care Networks** (PCNs) will be the key delivery unit for integrated care at a **Neighbourhood** level. These PCNs would consist of primary care practitioners in the widest sense (not just GPs but also pharmacists, nurses, mental health staff, social care staff, occupational therapists and others) joining up to provide wrap-around care to people.

- PCNs would operate at a grouping that serve between approximately 30-50,000 people and will be based on the GP list of registered patients.

- For some services, it would be necessary to co-ordinate and aggregate the activities of these PCNs at a level greater than the 30-50,000 population but at a level less than the 250-500,000 population (Place). However the co-ordination, management and performance management of these PCNs would not require a “one-size-fits-all” and potentially inflexible solution.

- PCNs might need to cluster into larger groups, perhaps by using the frameworks of existing Federations or partnerships, where there was an issue that required them to work collectively. This sort of collaboration would be facilitated by the ICP in agreement with their PCNs.

- Whilst the proposed *activities* (which are yet to be finalised) of what has previously been described as Locality Integrated Care Providers (LICPs) would continue to be required, there was an agreement in the interests of efficiency and effectiveness not to proceed with these LICPs as a *hard organisational structure*.

2. Turning to a **Place** level, **Integrated Care Providers** (ICPs) will have responsibility for:

- Managing a capitated budget for all health and care in their area
- Delivering on the strategic objectives set by the ICS Board as tailored for their area
- Directing the resources needed to deliver this – increasingly moving to be a geographically oriented provider with a mixture of acute, community and primary provider within them.

The ICP would be made up of, and governed by, a partnership of the key constituent organisations including PCNs, acute, community, social care and mental health providers and potentially a wider group of stakeholders with interests in tackling the wider determinants of health. ICPs would have freedom within a framework to deliver on the objectives set by the ICS Board and would be the key drivers of the overall health and care delivery.

The ICPs would take up the functions and activities of co-ordinating and supporting all the partner organisations (including PCNs) as the main engine room for the delivery of the ICP objectives.

In line with the desire to allow for flexibility in the construction of the management of PCNs, it was recognised that there is a requirement to deliver a specific solution that respects the particular health and care needs of the citizens of the City of Nottingham. This therefore may have implications for the construction of ICPs and a meeting will be arranged to consider this further in the next 2 weeks.

3. At a **System** level, the **ICS Board** (which is proposed to be set up in shadow form by December this year and to come into full existence by April 2019) would have responsibility for:

- Setting the strategic direction of the system and articulating the outcomes expected and priority areas
- Allocate the capitated budget to the ICPs
- Increasingly take on the current assurance and performance management functions of NHSE/I.