Healthier Futures
Black Country and West Birmingham

Developing the Black Country Integrated Care System

Stakeholder Engagement Document – Autumn 2021

Building Healthier, Happier Communities

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NHS England Engagement on ICSs (November 2020)
Government White Paper on Health and Social Care Reform (February 2021)
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Integrated Care Partnership Engagement Document: ICS Implementation (September 2021)

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 the Black Country we intend that these new structures will build on, rather than replace, the partnerships that we have been working to developed over many years across our system.

The ICP is established between the ICB and local authorities and dialogue is underway to determine the establishment of the future committee.

As part of developing the membership of the ICB it is important that we seek your views and build on the conversations already underway at the Healthier Futures Partnership Board and in other forums to help us further shape the future developments, including establishing the membership of this new NHS Body. Your feedback on this will inform a discussion at our planned development session on the 4th November.

Our Integrated Care System

In addition to the ICB and ICP, other important components within our Integrated Care System are the Provider Collaboratives and Place Based Partnerships. We thought it would be helpful to summarise their role and the importance of these within our system to aid your engagement in the development of our ICB.

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). They often include other community partners that have 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 four Place partnerships in our ICS : one each in, Dudley, Sandwell, Walsall and Wolverhampton

Provider Collaboratives are partnership arrangements involving at least two NHS 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.

Primary Care collaboratives create the opportunity for improving integrated working across the public's front-door to the NHS: transforming the way in which services are organised to improve the sustainability of services; enhancing primary prevention support to the public; offering patients with diverse needs a wider choice of personalised, digital-first health services; and bringing together best practice to improve consistency in access to care, diagnosis and treatment.

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 the key components of our ICS and how they might link with one another. It is not intended to represent a hierarchy but depicts the main connections and inter-

relationships between key parts of our system.

Engagement Period

This document sets out the emerging roles for Our Integrated Care Board and Our Integrated Care Partnership. There are conversations with local authorities to inform the establishment and constitution of our Integrated Care Partnership.

We are now seeking views from all partners to inform the constitution of the ICB. The roles and functions set out within this document are all derived from national guidance documents.

NHS England have produced a Model Constitution as a template for local systems to use to draft their constitution. This includes board membership and appointment arrangements as well as key principles around how the Board will operate to ensure openness and transparency and manage any conflicts of interest. It will serve as a high-level framework, with other key elements of system governance arrangements such as schemes of reservation and delegation, committee terms of reference and delegation arrangements published separately once they are developed.

Whilst this means that much of the content is prescribed, there remains flexibility in our implementation of our future constitution and there are several areas of development on which we wish to engage with you and seek your views. The stages to this engagement are:

Partner organisations are asked to review the guidance documents and the questions posed within this engagement document and submit their responses to info.healthierfutures@nhs.net by 11:59pm on **Sunday 31st October 2021.**

These views will be collated and presented at a workshop on **Thursday 4th November 2021**, to which partners will be invited to help to reach consensus on the direction of travel.

Partners will have a further period to submit any final thoughts by **Wednesday 10th November 2021**.

A draft response will then be submitted to NHS England and NHS Improvement on behalf of the Black Country system by **Wednesday 17th November 2021.** A **draft of our ICB constitution will also be submitted by 3rd December.** There will be opportunity to review and revise the constitution before final submission in February 2022

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
Chief People Officer	Local discretion
Digital Information Officer	Local discretion
Other Executives & Non Executives	To be locally determined
Other Partner Members	To be locally determined

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

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 is a Joint Committee of the ICB and local authorities and their final form will be decided upon once conversations with local authorities have concluded.

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.

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.

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.

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.

Mandatory Requirements for ICPs

The ICP is a statutory joint committee of the ICB and local Councils, 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".

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

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	Informal 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 & 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, including probation services
Acute Care	Housing voices	Offenders health and care voices	Professional Social Work and Care staff	

Future naming conventions and identity

The national guidance on naming our future system was issued on the 13 October. The guidance is included in appendix 2.

We are recommending the following names which we are required to submit to NHS England by the 18th November.

Integrated Care System: Healthier Futures: Black Country Integrated Care System (ICS)

Integrated Care Board: NHS Black Country Integrated Care Board (ICB)

Integrated Care Partnership: The Integrated Care Partnership for the Black Country (ICP)

Partner Organisations: [org name] working with partners to create Healthier Futures as part of the Black Country Integrated Care System

Place Partnerships: no guidance on naming in relation to place but we should strive for some consistency. Recommend that we favour the most embedded name 'Walsall together' and apply the same convention across other places where possible and encourage the incorporation of the skyline into identities for commonality.

Provider collaborations: no guidance on naming in relation to provider collaborative but we should encourage caution over any identity creation which deviates from geography and purpose as this will confuse patients/ public

We intend to keep the continuity of the existing Healthier Futures identity and the skyline elements (removing West Birmingham landmarks). This will be a low cost solution, retain elements that are already recognised and also leave room for the future ICP and ICB to make changes if they wish.

Work is also underway to develop a new Integrated Care Board website which will be NHS hosted (.nhs.uk) and use the existing CCG frames and also to refresh our healthier futures website to incorporate the new ICP (.co.uk).

Questions and areas to explore

The questions below aim to seek partner views on the establishment of the Black Country Integrated Care Board. Please use the form to provide your thoughts and feedback, as this will enable the theming of responses. **Return completed forms to info.healthierfutures@nhs.net by 11.59pm on Sunday 31st October.**

Question	Partner Response
What do you feel has worked well within the Healthier Futures Partnership to date, and what hasn't worked so well?	
What elements of Healthier Futures Partnership do you think must be retained in the new arrangements for the future?	

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?	
What are the options for ensuring co-ownership of NHS challenges at the ICB?	
What are the options for managing conflicts of interests at the ICB?	
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?	
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?	
How could we build on the recent Healthier Futures Partnership model of having Non-Executive input from provider organisations within the governance structures of Healthier Futures Partnership whilst managing any conflicts of interest?	
Should we develop a model of Chair input from provider organisations leading areas of the governance structures of Healthier Futures Partnership whilst managing any conflicts of	

interest?	
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?	
Do you support the naming conventions recommended? **If not please explain why and make alternative suggestions**	
Do you support the identity proposal to retain Healthier futures for the ICS and for the ICB to hold NHS identity and use elements of the Black country CCG identity which aligns with the existing Healthier futures visuals (skyline)?	

Appendix 1 - Duties and functions of the Integrated Care Board

Duties of Integrated Care Board – the Bill

Duties	Duties
Publish a Constitution	Promote education for health service staff
Maintain and publish register of interests	Promote integration where improvements in quality and outcomes would be achieved
Manage conflicts of interest	Have regard as to the effect of decisions on patients in England, quality, efficiency and sustainability
Commissioning of health services including	Involve the public in planning the delivery and range of services
Hospital	Jointly exercise functions with local Health Boards
Dental (and other primary dental)	Raise additional income (Health and Medicines Act 1988)
Nursing and Ambulance	Make grants to NHS Trusts or NHS Foundation Trusts, or voluntary organisations
Pregnant women and children	Make payments to providers
Services for prevention of illness, care and aftercare	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
Services required for diagnosis and treatment of illness	Prepare a joint plan setting out capital resource use
Services for physical and mental health	
Act in a way that promotes the Constitution and raise awareness of it with staff, patients and the 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	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

Functions of Integrated Care Board (1/4)

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 the collective accountability between 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	Arrange 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

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.	lead major service transformation programmes to achieve 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, combing 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 planes, 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)

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 executives (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)

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 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.
Establish the appropriate people and workforce capability to discharge responsibilities, including strong local leadership, including: Clear leadership and accountability for the organisations 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	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 Partnerships 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).
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, the other ICSs	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

and with regional workforce teams. Support the delivery of standardises, high-quality transactional HR services (e.g. 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.	sharing arrangements and passporting or accreditation systems. Contribute to wider local social economic growth and vibrant labour market, through collaboration with partner organisations, including care home sector and education and skills providers.

Functions of Integrated Care Board (4/4)

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	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.

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.	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: ICS naming conventions guidance

We have developed naming conventions for Integrated Care Boards (ICBs), Integrated Care Systems (ICSs) and Integrated Care Partnerships (ICPs) that are subject to passage of the Health and Care Bill.

We have sought views on these from the LGA, the eight systems of the Policy Design Workshop, RDSTs, ICS Comms Leads and the Integrated Care Delivery Partners' Group (which includes the NHS Confed and NHS Providers). Amendments have been made to take on board the feedback we have received.

Overall those who responded stressed the need for simplicity and continuity wherever possible and that names should mean something to local people. In the naming convention below we are specific around required names for ICBs but flexible on names for ICS and ICPs. We do not expect or suggest any major re-branding exercises.

We need to confirm the legal names of ICBs to enable financial, contractual and digital implementation arrangements to progress in line with the establishment timeline.

Actions requested

Please amend/complete the attached template and return it to your regional team (who sent you this communication) by 18 November.

If you are considering using a different geographical descriptor for your ICB, please contact your regional team by 29 October to discuss what you are proposing.

We have pre-populated the attached template indicating what the legal name of each ICB would be under the naming convention set out below and what we understand to be the current geographical descriptor. Please amend/complete the columns in the template to:

- Confirm or amend the current geographical descriptor
- Confirm your proposed Integrated Care Board (ICB) legal name
- Feedback on your proposed public name of the ICB if known at this stage
- Feedback on what you intend to call your ICS if known at this stage
- Feedback on what you intend to call your ICP if known at this stage

NB Where you are proposing that your ICB has a different name to that set out in the attached template, we need to hear from you by 18 November with the details. The default position is that the ICB name set out in the attached template will apply with effect from 1 April 2022.

Naming Conventions

Integrated Care Board

The principles for determining the names of Integrated Care Boards are as follows:

(1) ICBs should have a consistent identity that includes a geographical descriptor
(2) Using the NHS prefix makes clear that the ICB is a statutory NHS organisation and supports accountability for decisions
(3) Having a public identity which differs from the legal name is possible (referring to an organisation as a Board can be confusing for staff and others – see below for suggested solution)
(4) The ICB name should mean something to local people

We therefore expect ICBs to be named "NHS + geographical descriptor + ICB"

Example solutions:

- *Legal name: NHS Greater Elsewhere Integrated Care Board (ICB)*
- *Public identity: NHS Greater Elsewhere, part of the Greater Elsewhere Integrated Care System*

Integrated Care System

The principles for determining the names of Integrated Care Systems are as follows:

(1) ICSs needs a name which means something to local people
(2) The name should include the same geographical descriptor as the ICB but there is no requirement to use the NHS identity
(3) The name should be inclusive i.e. seen to be relevant to all partners
(4) Simplicity and continuity are important considerations in determining the name and we anticipate that many systems will continue to use their established names where these have ownership across all partners

Example solutions:

- *Greater Elsewhere Integrated Care System*
- *Greater Elsewhere Health and Care Partnership*
- *One Greater Elsewhere (if this is an established, well-understood name)*

Integrated Care Partnership

The principles for determining the names of Integrated Care Partnerships are as follows:

(1) Systems should decide how best to approach the name of their ICP
(2) This is a statutory committee bringing together partners, rather than a statutory organisation and needs to fit with the broader name of the system and be as clear as possible about the role of ICP and its relationship with other structures
(3) Descriptions should mean something to local people

Example solutions:

- *The Integrated Care Partnership of the Greater Elsewhere Integrated Care System*
- *Greater Elsewhere Integrated Care Partnership*
- *Greater Elsewhere Health and Care Partnership*

Further guidance

- All organisations in the system (ICB, NHS orgs, local authorities) should be clear publicly that they are part of the ICS, stating this on their website for example.
- ICSs should clearly communicate to stakeholders the role of each part of their system and their operating model.
- ICSs should use the word “partnership” with care as use in several contexts may create confusion.
- We do not propose to provide guidance on naming in relation to place-based partnerships. ICSs should be cautious about creating new local identities associated with place-based partnerships. Local decisions on this should be agreed by the ICS to ensure consistency and clarity across the patch.
- We do not propose to provide guidance on naming in relation to provider collaboratives.
- Expectations on branding arrangements for the ICB will be in line with those currently in place for CCGs.