LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of Cllr Sue Woolley, Chair, Lincolnshire Health and Wellbeing Board and John Turner, Chief Executive, NHS Lincolnshire Clinical Commissioning Group

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**7 December 2021**
Subject:	**Integrated Care Partnership**

Summary:
This report provides a summary on the recent guidance issued by the Department of Health and Social Care (DHSC) and the Local Government Association (LGA) on Integrated Care Partnerships (ICPs). Along with Integrated Care Boards (ICBs), an ICP will be statutory element of Integrated Care Systems (ICSs).

Actions Required:
To note the current position in relation to the development of ICPs.

1. Background

1.1 Context

In September 2021, the DHSC issued a series of guidance documents to support the implementation of Integrated Care Systems, including Integrated Care Partnership (ICP) Engagement Document: Integrated Care System (ICS) Implementation. This document focuses on the role of the ICP within the statutory arrangements for the ICS. It sets out the key areas for consideration by the local stakeholders responsible for establishing ICPs from April 2022. Elements of the document are subject to change until the Health and Care Bill passes Parliament and receives Royal Assent. A summary of the ICP guidance is provided in Appendix A.

The guidance builds on the principles for ICPs set out in the NHSE's ICS Design Framework (published on 16 June 2021) and should be read alongside wider ICS guidance on the establishment of the Integrated Care Board. The establishment in law of an integrated NHS and local authority model for ICSs places ICPs on a statutory footing and aims to build on exiting partnership arrangements across the system. As a statutory committee of the ICS, ICPs will:

- be required to be established in every system;

- have a minimum membership required in law; and
- be tasked with producing an integrated care strategy for their area.

The expectation is that ICPs will play a critical role in ICSs, facilitating joint action to improve health and care outcomes and influencing the wider determinants of health. It will act as a forum to enhance relationships between the leaders across the health and care system with wider statutory and non-statutory stakeholders. 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; and
- improving the life chances.

ICPs will also be expected to enable partners to plan for the future and develop strategies to enable the use of available resources creatively in order to address the longer-term challenges which cannot be addressed by a single sector or organisation alone. These strategies should reflect the priorities of all partners with a particular focus on the wider determinants of health.

1.2 Timings and Establishment of ICPs

As the ICP is a core element of the statutory arrangements for the ICS it cannot fully function without an ICP being in place. Therefore, subject to the passage of the legislation, each ICS is expected to have at least an interim ICP in place for April 2022. In practical terms, the ICP will be established jointly by the ICB and local authority, so the guidance recognises that the ICP may not be formally established until the ICB designated chair and Chief Executive are in place. Therefore, as a minimum, the following arrangements need to be in place for April 2022:

- ICP chair appointed – the guidance does not set any national expectations for the appointment or remuneration of the ICP chair beyond stating that this should be a fair and transparent process adhering to the normal expectations of appointing public positions and agreed by the ICB and local authority
- a committee of at least statutory members (i.e., the ICB and local authority)
- an agreement between the ICB and local authority on how the ICP will be resourced and supported

From April 2022 the following is needed:

- Sub committees and governance structures confirmed and linkages with other governance structures formalised.
- Agreement on the wider membership of the ICP – the expectation is that full membership will be agreed and the ICP will be fully operational by September 2022.
- Agreement on how the Integrated Care Strategy will be developed and approved - this includes deciding if the existing Joint Health and Wellbeing Strategy (JHWS) fulfils the requirements for an Integrated Care Strategy.

- Work to develop, refine and formally agree the strategy will need to start in earnest from April 2022. The process will need to involve significant engagement and take account of the Joint Strategic Needs Assessment (JSNA).

1.3 Relationship between the ICP and HWB

The requirement for the Health and Wellbeing Board remains at an upper tier level to bring together NHS, local authorities, and wider partners to develop a JSNA and JHWS for their local population. The guidance emphasises the importance of HWBs at a place level whilst, on the other hand, the ICP is designed to support partnerships and integrated working across places at a system level. The guidance refers to the relationship between the ICP and HWB differing from place to place depending on the scope and maturity of partnership working. The emphasis in the guidance assumes that an ICS area contains more than one HWB. Obviously, this is not the situation in Lincolnshire, as the ICS area is coterminous with the HWB.

The guidance makes it clear that the HWB can not act as an ICP, but reference is made to considering how existing arrangements, such as the HWB, provides an opportunity to build greater alignment between different partners and communities and to ensure effective joined up decision making. For example, by agreeing common membership for the ICP and the HWB and streamlining arrangements for holding meetings to allow different sets of business to proceed in a more coordinated way.

1.4 Next Steps

Planning for the Lincolnshire ICS is being progressed by the NHS Senior Leaders Board (SLB) in conjunction with the Better Lives Lincolnshire Executive Team (BLLET). As discussed in the previous agenda item, planning for the implementation of the ICB is already well under way and are now at a stage for discussions to start on the development of the ICP. The local desire is to keep the governance arrangements as simple as possible and to ensure they work for Lincolnshire. Therefore, to ensure Lincolnshire can meet the minimum requirements for an ICP by April 2022, engagement with partners will need to take place in earnest between now and February 2022 to progress the development of the ICP. Potential areas for consideration include:

- How do we structure the ICP/HWB governance?
- How will the arrangements be resourced and supported, including who will provide secretarial support?
- What is the overlap of membership between the HWB and ICP?
- What is the process for electing the ICP chair?
- Is the current JHWS fit for purpose to meet the needs for an Integrated Care Strategy – if not, what arrangements need putting in place to develop an Integrated Care Strategy during 2022?

Formal proposals, including the ICP terms of reference and governance arrangements will be presented to the HWB at the meeting in March 2022.

2. Conclusion

Subject to the legislation completing its progress through Parliament, ICS will become statutory from April 2022. Alongside the establishment of the ICB, Lincolnshire will also be required, as a minimum, to have an interim ICP in place by this date. The ICP needs to be fully established by September 2022.

3. Joint Strategic Needs Assessment and Joint Health & Wellbeing Strategy

The Council and Clinical Commissioning Group must have regard to the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy.

Both the ICB and ICP will be required to take account of the JHWS and JSNA in developing their plans.

4. Consultation

Not applicable

5. Appendices

These are listed below and attached at the back of the report	
Appendix A	Integrated care partnership (ICP) – initial expectations for the role of ICPs within Integrated Care Systems

6. Background Papers

Document	Where this can be accessed
Integrated Care Systems: Design Framework (June 2021)	https://www.england.nhs.uk/wp-content/uploads/2021/06/B0642-ics-design-framework-june-2021.pdf
Integrated Care Partnership (ICP) engagement document: Integrated Care System (ICS) implementation (September 2021)	https://www.gov.uk/government/publications/integrated-care-partnership-icp-engagement-document/integrated-care-partnership-icp-engagement-document-integrated-care-system-ics-implementation

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APPENDIX A

INTEGRATED CARE PARTNERSHIP (ICP) – initial expectations for the role of ICPs within Integrated Care Systems

1. Principles of ICPs

The ICP will work, foremost, on the principle of a statutorily equal partnership between the NHS and local government to work with and for their partners and communities. The focus of the ICP will be on building shared purpose and common aspiration across the whole system. The guidance invites local systems to consider the following 10 principles:

1. Come together under a distributed leadership model and commit to working together equally.
2. Use a collective model of decision making that seeks to find consensus between system partners and make decisions based on unanimity as the norm, including working through difficult issues where appropriate.
3. Operate a collective model of accountability, where partners hold each other mutually accountable for their shared and individual organisational contributions to shared objectives.
4. Agree arrangements for transparency and local accountability, including meeting in public with minutes and papers available online.
5. Focus on improving outcomes for people, including improved health and wellbeing, supporting people to live more independent lives and reduce health inequalities.
6. Champion co-production and inclusiveness throughout the ICS.
7. Support the Triple Aim (better health for everyone; better care for all and efficient use of resources); the legal duties on statutory bodies to co-operate and the principle of subsidiarity (that decision making should happen at the most local appropriate level).
8. Ensure place-based partnership arrangements are respected and supported, and have appropriate resource, capacity and autonomy to address community priorities.
9. Draw on the experience and expertise of professional, clinical, political and community leaders and promote strong clinical and professional system leadership.
10. Create a learning system, sharing evidence and insight across and beyond the ICS, crossing organisational and professional boundaries.

2. Opportunities for ICPs

The government's guidance is not prescriptive as ICPs will be a dynamic element of the ICS and will need to build on the assets that already exist in the community and wider system. The creation of ICPs is expected to present the opportunity to:

- build on existing governance structures such as Health and Wellbeing Boards, and support newly forming structures to ensure governance and decision making are proportionate, support subsidiarity and avoid duplication across the ICS;
- drive and enhance integrated approaches and collaborative behaviours at every level of the system;
- foster, structure and promote an ethos of partnership and co-production, working in partnership with communities and organisations within them;
- address health challenges that the health and care system cannot address alone such as tackling health inequalities and the underlying social determinants that drive poor health outcomes;
- continue working with multiagency partners to safeguard people's rights and ensure people are free from abuse or neglect and not deprived of their liberty; and
- develop strategies that are focused on addressing the needs and preferences of the population including specific cohorts such as babies, children and young people, or ageing populations.

3. Mandatory requirements for ICPs

The ICP will be a statutory committee of the ICS, not a statutory body, and as such its members come together to take decisions on an integrated care strategy, but it does not take on the functions from other parts of the system. DHSC has chosen to minimise the level of prescription around ICPs in the primary legislation allowing local flexibility on the structure and operation of the ICP. However, the 5 guiding expectations set out in the NHSEI ICS Design Framework for ICPS are:

a) ICPs are a core part of ICSs, driving their direction and priorities - to create the dynamic relationship and collaborative leaderships between the ICB and ICP the guidance expects:

- ICBs and LAs will establish the ICP and be statutory members, in partnership with wider system stakeholders
- ICSs will ensure the constitution and governance of the ICB and ICP is aligned, and agreed by local government and other partners
- Partners responsible for delivering the priorities of the ICP's Integrated Care Strategy will also be members of the ICP and therefore able to hold each other to account
- ICBs and LAs will have regard for the ICP's Integrated Care Strategy when developing their plans and priorities and should consider how assurance can be provided to the ICP on delivery
- ICBs, LAs and other partners should share intelligence with the ICP in a timely manner to ensure the evolving needs of the local health service are widely understood and opportunities for at scale collaboration are maximised
- Leadership and accountability are important in the relationship between the ICB and ICP. Some ICSs may choose to appoint a single chair of the ICB and ICP whilst others may choose to have 2 chairs. The model is for local determination.

b) ICPs will be rooted in the needs of people, communities and places – to help places continue to improve outcomes, ICPs should build on work already done at place level and encourage decisions to be taken as close as possible to the communities and people they affect. The Bill builds on the important role for HWBs at place level, which will remain legally distinct from ICPs. Both the ICB and ICP will be required to take account of the JHWS and JSNA in developing their plans. Membership and system roles of the HWB and ICP is flexible to best suit local circumstances. As a minimum the guidance expects ICPs to have:

- input from Directors of Public Health and other clinical/professional experts to ensure a strong understanding of local needs
- input from representatives of adult and children's social services. Input from local social care providers will also be needed
- relevant representation from other local experts, through HWB chairs, primary and community care representatives and other professional leads
- appropriate representation from any providers of health, care and related services
- appropriate representation from the VCSE sector and from people with lived experiences of accessing health and social care services
- a representative from Healthwatch to bring senior level expertise in how to do engagement and to provide scrutiny.

It is not a requirement for all of the above 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 be through sub committees or dedicated public meetings.

c) ICPs create a space to develop and oversee strategies to improve health and care outcomes – ICPs will set priorities for improving system wide health and care outcomes, while also championing the principle of subsidiarity and empowering local decision making. The ICP and place based partners will need a mechanism to determine which issues are dealt with where and be informed by local population wants and needs, and specific communities identified through population health management data.

d) ICPs will support integrated approaches and subsidiarity – the ICP will be in a position to identify opportunities for wider partnerships to strengthen the collective approach to improving longer term health and wellbeing outcomes. The ICP is expected to actively champion integrated approaches and look for opportunities to embed and accelerate joined up strategies.

ICPs will set the strategic direction and workplan for organisation, financial, clinical and informational integration. For example:

- shared vision and purpose
- integrated provision – so that people receive seamless care across health, social care, housing, education and other public services and between different NHS providers
- integrated records – for example using shared electronic care records
- integrated strategic plans – for example, bringing NHS and public health experts together to make a joint plan for improving health outcomes
- integrated commissioning of services – strengthening the partnership between LAs and the ICB
- integrated budgets – for example using Section 75 arrangements to manage or support pooled budgets across the NHS and LAs
- integrated data sets – which all partners can contribute and have access to in order to inform planning and the delivery of services

It will be up to ICPs to work with HWBs and other place-based partnerships to determine the integrated approach that will best deliver holistic and streamlined care. Further guidance on the duty to co-operate will be issued at a later date to support ICPs and the wider system in meeting this expectation.

4. NEXT STEPS

ICSs are being asked to take forward the following five steps in partnership with local government:

i. Recognise that it is for the NHS and LAs – as the statutory partners in each ICS – to start the process jointly of creating an ICP in preparation for legislation
ii. Reach agreement between NHS and LA leaders as to how the ICP will be established and a secretariat resourced, at least during the 2021/22 transition year
iii. Ensure that the statutory ICP partners come together as required to oversee ICP set up, including engagement with stakeholders
iv. Appoint an ICP chair designate, taking account of national guidance on functions and ensuring there is a transparent and jointly supported decision-making process
v. Determine key questions to be resolved for that particular system but not limited to the following:
    - What kind of chair would best galvanise the system behind its common aims and what is the process for appointment?
    - Who might constitute an ICP committee that might galvanise the ICS and how should those individuals be chosen?
    - What would be required to deliver an inclusive approach to engagement, in terms of methods, resourcing and public reporting?
    - To what extent can existing structures be used or adapted to create the ICP so as to build on what happens already?
    - To what extent do existing ICS plans meet the requirement for a health and care strategy and how might they be refreshed?
    - How might the ICP meet the ten principles set out in Section 1 of this Appendix?

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