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:	**29 March 2022**
Subject:	**Integrated Care Partnership**

Summary:
This report provides a summary of the changes announced in December 2021 to the timeline for the establishment of the Integrated Care Board and the impact of this on the wider system. The report also reflects on and includes the guidance issued by the Department of Health and Social Care (DHSC) and the Local Government Association (LGA) in September 2021 regarding Integrated Care Partnerships (ICPs) as reported in the paper of the 7 December 2021.

Actions Required:

1. To note the current position in relation to the development of ICP.
2. To note the information regarding the upcoming ICP planning and development workshop in April 2022.

1. Background

1.1 Context

On 24 December 2021 it was confirmed by NHS England that the anticipated date for the introduction of the new statutory ICS arrangements, which includes the establishment of the NHS Lincolnshire Integrated Care Board (ICB) (into which the CCG's responsibilities will be subsumed), was to be set back from 1st April 2022 to 1st July 2022. As the establishment of the ICP aligns to that of the ICB, the timeframe for the ICP establishment has also changed.

It is important to note that all elements of the relevant guidance remain 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 series of guidance documents released in September 2021, by the DHSC to support the implementation of Integrated Care Systems (ICSs), included Integrated Care Partnership (ICP) Engagement Document: Integrated Care System (ICS) Implementation. This guidance remains in principle the same so on this basis, plans for Lincolnshire continue to progress.

1.2 Purpose of the ICP

The Health and Care Bill introduces a two-part statutory ICS model with an ICB, bringing together the organisations that plan and deliver NHS services within the geographic area covered by the ICS and an ICP, bringing together a broad alliance of organisations related to improving health and care. Together these elements form the ICS.

As previously set out in the report developed for the Health and Wellbeing Board (HWB) on 7 December 2021 (meeting later cancelled), the ICP 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 ICB. The establishment in law of an integrated NHS and local authority model for ICSs will place 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.

1.3 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. Although a revised date of the 1 July 2022 has been issued for the formal establishment of the ICB, to date there has been less clarity on a revised timeline for the ICP. However, the existing guidance does refer to the fact that as the ICP will be jointly established by the

ICB and Local Authority (LA), it cannot therefore be established formally until the ICB is in place from 1 July 2022. The following minimum arrangements will need to be in place when statutory ICBs commence:

- 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

The process to form the ICP will have a large effect on its success: the approach taken at the early stages of development therefore needs to be inclusive and iterative – open to different perspectives and willing to adapt. To enable swift progress once legislative provisions come into place, LAs and existing ICS leaders should be discussing with key partners and exploring options for how they want their ICPs to work. This work is underway in Lincolnshire and key partners are working together to plan our local arrangements within the parameters set out in the guidance.

The wider membership and its administration will become a matter for the ICP itself once is it formally established. Sub-committee structures, linkages with other governance structures and period changes to the ICP membership will need to be agreed as a priority.

1.4 Integrated Care Strategy

An integrated care partnership must prepare a strategy (an "integrated care strategy") setting out how the assessed needs in relation to its area are to be met. NHSE expects that systems will develop their inaugural ICP strategies in 2022/23. However, the guidance is clear that areas do not have to prepare a new Integrated Care strategy if existing Joint Health and Wellbeing Strategies (JHWS) are considered sufficient by NHS, local authority and community partners. For example, if existing strategies set out a vision for improving population health and wellbeing outcomes, through integrated services and commissioning plans, this might be considered sufficient. The establishment of statutory arrangements for ICSs is to build on what is already working in the system and community and working together to make improvements, where possible. However, ICP's integrated care strategies should have regard to the NHSEI Mandate and any guidance issued by DHSC, and explicitly cover the issue of integration and the use of Section 75 arrangements, including pooled funds.

Once formed, the ICP will need to agree our system's approach i.e. how we may wish to develop, refine and formally agree any amendments to our existing JHWS strategy, if it is considered fit for purpose as an Integrated Care Strategy.

1.5 Relationship between the ICP and HWB

The requirement for the HWB remains at an upper tier level to bring together NHS, local authorities, and wider partners to develop a Joint Strategic Needs Assessment (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 multiple 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 cannot 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.

In lower complexity systems where the majority of ICS governance will be conducted at the system level, partners can agree to a common membership of the ICP and the HWB and streamline arrangements for holding meetings to allow different sets of business to proceed in a more coordinated way. There is a desire for our system to remain uncomplicated, efficient, and more integrated as it develops.

2 Current position and next steps

Planning for the Lincolnshire ICS is being progressed by the NHS Senior Leaders Board (SLB) in conjunction with the Better Lives Lincolnshire Leadership Team (BLLLT). As discussed in the previous agenda item, this work is already well under way as are discussions regarding the development of the ICP. Actions via BLLLT are in progress and we are coordinating activity around the decision-making processes that the LA and ICB will need to fulfil in jointly forming the ICP.

In addition, links have been established with other low complexity, coterminous systems in Gloucestershire and Somerset to share learning and experience as plans continue to develop.

2.1 ICP planning and development workshop

The next step on our journey to establishing the ICP is to facilitate further engagement with a broad range of partners to consider the challenges and opportunities as our system develops. Arrangements for an ICP planning and development workshop are in progress. Invitations have been sent to representatives across the system, including the HWB membership and other key representatives. The aim of the workshop is:

- To explore opportunities for how the Health and Wellbeing Board and Integrated Care Partnership will operate in Lincolnshire
- To understand the functions and membership of the two boards
- Reflect on the existing governance architecture and how future arrangements will:

    - improve outcomes in population health and healthcare
    - tackle inequalities in outcomes, experience and access
    - enhance productivity and value for money
    - help the NHS support broader social and economic development.

The December 2021 report suggested that formal proposals, including the ICP terms of reference and governance arrangements would be presented to the HWB in March 2022. However, the changes to the timeline for the formal establishment of the ICB means that this is not possible at this time. The ICP terms of reference will be a matter for the ICP itself, once established but early discussions with key stakeholders will influence future decision making.

The HWB terms of reference were last updated in June 2021 to enable the HWB to take on the functions and responsibilities of the ICP. As the guidance issued in September 2021 confirmed that

the HWB cannot act as an ICP further amendment will be required, and this work must align with the development of the ICP terms of reference. As the HWB is a committee of the Council any changes to the terms of reference will result in a change to the Council Constitution therefore requiring full council decision making. It is recommended that revised HWB terms of reference are presented to the HWB at the meeting on 14 June 2022 and presented to the Council on 16 September 2022. If required, there will be opportunity for this timeline to flex and present to the HWB on 27 September 2022 and full council on 9 December 2022.

3 Conclusion

Discussions regarding the development of the ICP are ongoing across our system however any plans developed remain subject to the passage of the Health and Care Bill through Parliament. In order to continue to progress some sensible assumptions have been made whilst we await the final guidance.

Further work on the establishment of the ICP will be reported and brought back to future Health and Wellbeing Board meetings

4 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.

5 Consultation

Not applicable

6 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

7 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
Health and Social Care	Health and social care integration: joining up care for people,

integration: joining up care for people, places and populations (February 2022)	places and populations - GOV.UK (www.gov.uk)

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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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