Integrated Care Partnership engagement document

The Department of Health and Social Care (DHSC) published the Integrated Care Partnership (ICP) engagement document on 15 September 2021. This briefing summarises the document, which was developed with NHS England and NHS Improvement (NHSE/I) and the Local Government Association (LGA), and provides our initial analysis of the role and expectations of ICPs. Please contact senior policy manager Georgia Butterworth (georgia.butterworth@nhsproviders.org) if you have any comments or questions.

Key points

- This engagement document expands on the role that ICPs will play within statutory arrangements for ICSs, including producing an integrated care strategy for their area, agreeing collective objectives and facilitating joint action on health outcomes and the wider determinants of health. It positions ICPs as a critical part of ICSs and builds on NHSE/I's ICS design framework to provide more detail on the expectations of ICPs, as well as the timing of implementation.
- It aims to help systems prepare to establish ICPs from April 2022 and consider what arrangements might work best in their area, including agreeing the ICP's resourcing, membership and priorities. The document also explores opportunities for ICPs, such as addressing system-wide challenges and driving integrated approaches and collaborative behaviours.
- All systems are expected to have at least interim ICPs up and running for April 2022. DHSC hopes that all ICPs will be able to build their membership "to a steady state" by September 2022, and expects the development of integrated care strategies to continue from April 2022.
- Integrated care board (ICB) chairs designate are expected to ensure that systems undertake the following five steps:
  1. The NHS and local authorities start the process this month of creating an ICP in preparation for legislation.
  2. NHS and local authority leaders agree by October 2021 how the ICP will be established and a secretariat resourced at least during 2021/22.
  3. Statutory ICP partners come together as required to oversee ICP set up, including engagement with stakeholders, by November 2021.

4. ICP chairs designate are appointed by a transparent decision-making process by February 2022. DHSC does not propose to set national expectations for the appointment, remuneration or person specification of the ICP chair.
5. Key questions for the system to resolve are determined by April 2022.

- DHSC provides further detail on how ICPs and place-based partnerships will work together to deliver their priorities, including the need for a mechanism to determine which issues are dealt with where in the system. DHSC states that the ICP should not try to overrule or replace existing place-based plans. The document also explores the relationship between ICBs and ICPs, including the importance of ensuring the governance is aligned, sharing intelligence and considering how assurance can be provided to the ICP on delivery.
- This publication formally initiates a process of co-production and engagement with the health and care sector to identify examples of good practice for ICPs.

Summary of the ICP engagement document

This engagement document builds on the ICS design framework and explains the role ICPs will play within statutory arrangements for ICSs. The ICP is described as a broad alliance of organisations and representatives concerned with improving the care, health and wellbeing of the population. It will provide a forum for agreeing collective objectives and be responsible for: facilitating joint action to improve health and care outcomes; influencing the wider determinants of health; and supporting place-based partnerships. The engagement document states that as statutory committees, ICPs will:

1. Be required to be established in every system;
2. Have a minimum membership required in law (the ICB and relevant local authorities); and
3. Be tasked with producing an integrated care strategy for their areas (for which all partners will be accountable).

ICPs will also develop strategies for using available resources creatively.

Principles of ICPs

The ICP will be established on the principle of equal partnership between the NHS and local government. Depending on the system and distribution of responsibilities, local government might include district and borough councils, as well as county and unitary councils. DHSC states that local authorities and ICB chairs and boards should use the 10 principles for ICPs outlined in the ICS design framework to guide the establishment of ICPs, their culture and ways of working.

Opportunities for ICPs

DHSC sets out some of the opportunities that ICPs present, including (but not limited to):

- Building on existing and newly forming governance structures at place level to ensure proportionate governance and decision-making across the ICS
- Driving integrated approaches and collaborative behaviours at every level of the system
- Addressing challenges that cannot be addressed by a single sector or organisation alone, including health inequalities and wider determinants of health that drive poor health outcomes

Mandatory requirements for ICPs

The document refers to the mandatory requirements for local authorities and ICBs, and includes the full current Health and Care Bill (subsequently referred to as "the bill") clauses on ICPs in an annex.

With regard to membership of ICPs, the only members specified in the bill are the ICB and local authorities in an area; the membership otherwise should be locally determined. However, DHSC would expect ICPs to be, at the very least, a partnership between the NHS, local authorities and the wider community, and the bill also mentions the involvement of local Healthwatch organisations. Further suggestions on the scope of membership and engagement are detailed in the document, although DHSC acknowledges that local areas will be more familiar with the agencies, providers and individuals who would make an effective contribution to the ICP. DHSC also states that membership should be "kept to a productive level" as not all partners involved in delivering action need to be committee members and can be engaged in other ways, for example through sub-committees or workshops.

The bill states that the ICP's integrated care strategy should have regard to the NHSE/I Mandate and any guidance issued by DHSC. It should also explicitly cover the issue of integration and the use of Section 75 arrangements (e.g. pooled budgets). The strategy should also consider a joint workforce plan, spanning the NHS, local government, social care and voluntary, community and social enterprise (VCSE) sector. The bill also states that areas do not have to prepare a new integrated care strategy if the existing joint health and wellbeing strategies are considered sufficient by NHS, local authority and community partners.

Guiding expectations for ICPs

DHSC, NHSE/I and the LGA have jointly developed a number of expectations for ICPs, which should complement and build on the principles set out in the ICS design framework. The five expectations are set out in bold and explained in the section below.

DHSC sets an expectation that **ICPs will be a core part of the ICS** and that their integrated care strategy will be ambitious and enabling. DHSC explains the relationship between ICBs and ICPs in that:

- ICBs and local authorities will establish the ICP and be statutory members
- 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 local authorities 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, local authorities and other partners should share intelligence with the ICP in a timely manner

The document states that some ICSs may choose to appoint a single chair of the ICP and ICB or draft a joint strategy and plan, while other might choose to have two chairs.

DHSC expects ICPs and their integrated care strategies to be rooted in the needs of people, communities and places (including via health and wellbeing board [HWB] strategies and joint strategic needs assessments). Both ICPs and HWBs can be flexible in their membership and system roles to best suit local circumstances.

ICPs will be expected to:

- Have input from directors of public health and other clinical and professional experts
- Have input from representatives of adult and children's social services
- Have relevant representation from other local experts, through HWB chairs, primary and community care representatives and other professional leads
- Have appropriate representation from any providers of health, care and related services
- Have appropriate representation from the VCSE sector and independent providers, including social care
- Have representation from people with lived experience, including children and young people
- Have representation from Healthwatch

The document makes clear that it is not a requirement for all of these stakeholders to be 'members' of the ICP's statutory committee. Instead, the key is that the ICP creates opportunities for co-production and expert input into its strategies, through sub-committees or dedicated public meetings for example. ICPs should also consider how existing governance arrangements, such as HWBs, could provide the opportunity for better alignment between different partners and the community to ensure joined-up and effective decision-making.

DHSC also sets the expectation that **ICPs will create a space to develop and oversee strategies and priorities for improving system-wide health and care outcomes**, while promoting the principle of subsidiarity and local decision-making. The ICP and place-based partnerships will need a mechanism for determining which issues are dealt with where; most issues can be best dealt with at place and these should not be decided at ICP meetings.

ICP priorities should be informed by local population wants and needs, and specific communities identified through population health management data. ICPs should consider how they can best work together in and across place-based partnerships to deliver these priorities. The document also states that ICPs will create a forum in which partners should hold each other mutually to account for delivering the priorities set in its integrated care strategy. DHSC will provide practical examples of how this accountability could be exercised by ICPs in future documents.

The document outlines how ICPs will promote the mobilisation of resources and assets in the community, system, and place-based partnerships and share these solutions with the ICB and local authorities.

DHSC also expects **ICPs to support integrated approaches and the principle of subsidiarity**. DHSC states that ICPs will set the strategic direction and workplan for organisational, financial, clinical and informational integration. For example, through integrated provision, commissioning, patient records, strategic plans, budgets and data sets. In addition to championing these different integrated approaches across the ICP footprint, ICPs will need to be aware of and engaged with the work already being undertaken at place and the strategies that have been drawn up by HWBs and other relevant system structures. The ICP should not try to overrule or replace existing place-based plans. The guidance also states that it will be up to ICPs to work with HWBs and other place-based partnerships to determine the integrated approach that will best deliver joined-up care.

Finally, DHSC expects that the **ICP will have a key leadership role to play in setting the tone and culture for each system, which should be open and inclusive**. The culture within an ICP should promote co-production, diversity, equality and inclusiveness. ICPs should develop a structured approach to co-production with communities and people with lived experience. It also states that ICPs should be open and agree arrangements for transparency and local accountability, including meeting in public with meaningful minutes and papers that are easily accessible.

Timings and establishment of ICPs

This section of the engagement document sets out DHSC's expectation around timings and responsibilities for establishing ICPs, including:

- All systems will have at least interim ICPs up and running for April 2022, comprising a chair and a committee of at least statutory members, as well as an agreement over how the committee will be resourced. Linkages with other governance structures could also be agreed. As it will not be possible to formally convene the ICP before the ICB has been established in April 2022, DHSC expects local authorities and existing ICS leaders to discuss with partners how they want the ICP to work. DHSC therefore understands that in some areas there may only be an interim ICP in April 2022.
- While some ICPs may have draft integrated care strategies by April 2022, others may rely on existing health and wellbeing strategies. DHSC expects that the work of developing and formally agreeing complete integrated care strategies will continue after April.
- Some ICPs may have established their membership by April 2022, whilst others might still be building their membership in an interim form. DHSC hopes that all ICPs will be able to build their membership to a steady state by September 2022, as this will enable ICPs to fully develop their integrated care strategies.
- DHSC does not propose to set national expectations for the appointment, remuneration or person specification of the ICP chair beyond stating that it should be a fair and transparent process and agreed by the ICB and local authorities.

Next steps

DHSC intends to use this document as the start of a conversation with systems, communities and key partners including trust leaders, on the development and evolution of ICPs. It may be followed by statutory guidance on integrated care strategies, case studies showcasing how ICPs are being established, and FAQs.

The engagement document then sets out five steps for ICPs to carry out, with the expectation that ICB chairs designate will oversee these steps for their system, in partnership with local government:

1. Recognise that it is for the NHS and local authorities – as the statutory partners in each ICS – to start the process jointly of creating an ICP in preparation for legislation (September 2021).
2. Reach agreement between NHS and local authority leaders by October 2021 as to how the ICP will be established and a secretariat resourced, at least during 2021/22 transition year.
3. Ensure that the statutory ICP partners come together as required to oversee ICP set up, including engagement with stakeholders (November 2021).

4. Appoint an ICP chair designate, taking account of national guidance on functions and ensuring there is a transparent decision-making process (February 2022).
5. Determine key questions to be resolved for that particular system (April 2022). DHSC provides some example questions that ICSs may refer to.

NHS Providers view

This engagement document on the role of ICPs begins to build on the requirements set out in the ICS design framework (June 2021) and the Health and Care Bill (as introduced in July 2021). It provides some further clarity on the role and responsibilities of the ICP, and how they fit with those of the ICB and place-based partnerships. We support DHSC's intention to maintain a permissive framework for systems and will continue engaging with trust leaders to assess whether the cumulative impact of national guidance and legislation enables sufficient local flexibility to continue designing what works best for their local populations, services and circumstances.

We welcome DHSC's efforts to build on existing local relationships and system-working arrangements, and the emphasis on designing the ICP's purpose in line with the priorities of local communities, which are two key elements to successful collaboration. ICPs will play an important role in bringing together a wide range of partners to align purpose and respond to local population needs, so flexibility is key. Ensuring the ICP engages with (and has full buy-in from) all relevant partners, as well as keeping the ICP to a "productive" size, will be a key challenge for the ICP. Trust leaders will want to see the ICP driving real improvements in population health outcomes and reductions in health inequalities, and supporting the focus on place. It would be helpful if DHSC set out how ICPs will demonstrate success as part of their next phase of engagement.

While we support the principle of equal partnership between the NHS and local government in establishing the ICP, the current proposal for how the ICP is established does not seem to follow through on this intention. The bill states that the ICB and all relevant local authorities will set up the ICP. In our view, this creates an asymmetry as local authorities are already represented on the ICB in the same way trusts are, but trusts are not explicitly included in the establishment of the ICP. It also risks creating a two-tier hierarchy within the ICP, with the ICB and local authorities framed as core, specified members, while other key members such as the VCSE sector, or housing providers are a secondary priority. It will be essential for ICSs to maintain the spirit of willing partnership which has characterised system working so far, if they are to make progress on population health outcomes. In addition, only "NHS Trusts" are included in Annex C, which sets out an illustrative list for ICP

membership and engagement, so we will seek assurance that this is a drafting error and also includes "NHS Foundation Trusts".

We welcome the additional clarity around what the ICP's integrated care strategy should cover, including the use of Section 75 agreements and a joint workforce plan. However, it will be crucial for systems to avoid any duplication or confusion around how the integrated care strategy relates to other plans at place and system level, such as the ICB's responsibilities around workforce planning. Ensuring there is a clear delineation between the role and responsibilities of the ICP, ICB, place-based partnerships and HWBs, and how they all fit together, will avoid increased bureaucracy and overlapping priorities in the system. We will therefore continue to engage with DHSC and NHSE/I to gain further clarification on the different strategies, roles and accountabilities in the system. Although the guidance does start to clarify how HWBs and ICPs, and ICBs and ICPs, will inter-relate, it would be helpful to see examples of what this relationship might look like in different systems. We will also seek clarity around what DHSC means by the ICP promoting the "mobilisation of assets", developing strategies for using available resources creatively, and setting the strategic direction and workplans for different forms of integration.

We welcomed the opportunity to feed into the draft engagement document and we are pleased to see that some of our feedback has been incorporated into this final draft. We were keen to avoid the guidance positioning the ICP as holding the ICB to account, given that this could lead to confused governance/accountabilities, but note the reference to ICBs providing assurance to ICPs on delivery. As ICPs will not hold ICBs to account, we welcome further clarity on how this assurance will add value rather than duplication. We look forward to supporting the next steps of the engagement process on ICPs, and would welcome the opportunity to facilitate engagement with trust leaders.