Department of Health and Social Care guidance on system working

On 29 July 2022, the Department of Health and Social Care (DHSC) published several pieces of guidance in the context of the Health and Care Act 2022 (the Act) and the establishment of statutory integrated care systems (ICSs) covering:

- the preparation of integrated care strategies;
- the role of health and wellbeing boards (HWBs);
- principles for integrated care partnerships (ICPs) working with adult social care providers; and
- principles for health oversight and scrutiny committees working with ICSs.

This briefing summarises these resources and sets out some initial analysis of the implications for trusts. If you have any comments, feedback or questions about these documents, please contact Georgia Butterworth, senior policy manager (georgia.butterworth@nhsproviders.org).

Key points

- The guidance on integrated care strategies outlines statutory requirements for how ICPs will operate, including involving a range of local stakeholders in the development of the strategy. It also sets out some non-statutory expectations, but empowers ICPs to define the focus and content of their strategies locally.
- The HWB guidance articulates how HWBs will be expected to work with ICPs, as well as confirming that HWBs will maintain their existing roles. There is welcome flexibility for systems to decide how best to manage this interface based on local contexts and footprints.
- The guidance on ICPs working with adult social care providers sets out five high-level principles for their involvement in system working. It makes clear that adult social care providers are key partners in ICPs, and should be involved in system planning discussions.
- The guidance on how HOSCs should work with ICSs sets out that HOSCs largely retain their previous powers with a remit to constructively scrutinise the effectiveness of health and care services, with integrated care boards (ICBs) and ICPs now falling within this scope.
- Overall, the documents provide further clarity around the operating environment for different component parts of ICSs. We welcome DHSC's efforts to broadly maintain a permissive, enabling approach which supports local decision-making and leadership. We engaged with DHSC during

the development of the guidance documents and welcome the changes made following that engagement. However, there are some remaining questions regarding the implications for trusts, including how all the strategies and component parts of the system will fit together without overlap or duplication.

1. Guidance on the preparation of integrated care strategies

This guidance, some of which is statutory, is intended to support ICPs when preparing integrated care strategies. These strategies will set out how the population's broad health and wellbeing needs can be met by the ICB, NHS England (NHSE) and local authorities. They should set the direction of the system, identify priorities among system partners, and support place-based action on issues which are best addressed on smaller footprints. ICBs, local authorities and NHSE have an obligation to have regard to the integrated care strategy as they discharge their planning functions. DHSC positions the strategy as an opportunity to do things differently, including considering the wider determinants of health, reducing geographic disparities in health outcomes, and involving wider partners such as adult social care providers.

In developing their integrated care strategies, ICPs should draw on existing evidence of local needs, including joint strategic needs assessments (JSNAs), partner organisations' insights, and research evidence. ICPs should look to identify and address gaps in their understanding of population health needs. ICPs should also ensure that the strategy facilitates subsidiarity in decision-making and only addresses priorities that are best managed at system level. It is up to ICPs and HWBs to determine how the HWB and integrated care strategies complement each other. ICPs should consider if the ICB, local authorities and NHSE are delivering the strategy.

There will be a transitional period for ICPS between 2022 and 2023. DHSC has asked ICPs to produce their first integrated care strategy by December 2022 with a view to informing the development of ICBs' five-year forward plans, which are due in April 2023. The guidance recognises that this timeframe is challenging and ICPs are at different stages of development, which may limit the breadth and depth of the initial strategy. ICPs can refine their strategy over the coming years. DHSC plans to refresh this guidance in June 2023, and welcomes feedback.

Legal requirements on ICPs

The guidance outlines a number of legal expectations for how ICPs will discharge their functions and develop their integrated care strategies. They must:

- Set out how the 'assessed needs' from JSNAs are to be met by ICBs, NHSE or local authorities. This includes, but is not limited to, shared outcomes and quality improvement
- Consider if population needs could be met more effectively through partnership arrangements under section 75 of the NHS Act 2006 (eg pooled budget arrangements)
- Include in the integrated care strategy a statement on how health and social care services could be better integrated with 'health-related services'
- Have regard to the NHS mandate and any guidance from the secretary of state
- Involve local Healthwatch, and people who live and work in their system footprint
- Publish the integrated care strategy and share it with partner local authorities and ICBs
- Consider revising the strategy whenever they receive a JSNA.

Involving people and organisations in the strategy

When meeting their legal duty to involve local people and organisations in preparing the integrated care strategy (see Annex A of the guidance), ICPs will want to build on existing mechanisms for involvement. In some cases, it may make sense for communities to be engaged at more local levels eg through existing local authority mechanisms. The guidance recognises that ICPs' ability to engage people may vary this year (particularly given the December 2022 target date).

DHSC specifies a number of groups that ICPs must (as a statutory duty) or should involve in the development of integrated care strategies:

- Local Healthwatch (the character of that involvement can be agreed locally).
- A breadth of local people and communities, with a focus on people who use a range of services, access mental health services, and who are in groups that experience inequalities.
- A broad spectrum of health and care providers, including adult social care providers, trusts, primary care and voluntary and community sector organisations and social enterprises. ICPs should take into account differing capacities and resources to engage in its activities.
- Local authority leaders – particularly chairs of HWBs and directors of children's services, adult social care services, and public health. In systems with two-tier local authorities, district councils should be closely involved.
- Representatives of wider organisations such as housing and employment support.

Content of the strategy (statutory guidance)

The guidance recognises that integrated care strategies will vary across systems as they need to address local needs and priorities. There is not a specific approach or structure that integrated care

strategies must follow; rather the guidance outlines some topics and mechanisms that ICPs are encouraged to consider.

Integrated care strategies can articulate some priority outcomes for local populations, based on JSNAs. DHSC will provide more detail on shared outcomes in 2023, informed by the implementation of the integration white paper. ICPs should consider how they can secure continuous improvement in care quality and outcomes when preparing the strategy.

Integrated care strategies are required to consider whether population needs could be better met by working through section 75 arrangements – eg pooled budgets between statutory organisations – and should consider the benefits of these arrangements. However, section 75 agreements remain the responsibility of the partners involved. DHSC intends to publish guidance on the scope of pooled and aligned budgets in Spring 2023.

DHSC identifies several areas that integrated care strategies are encouraged to consider, including (but not limited to):

- Opportunities to enhance personalisation, choice and flexibility
- How local services can address unwarranted variations in population health and health disparities between groups, including those experiencing multiple disadvantages
- How to improve the overall health of the local population, including through prevention, and utilise public health expertise and leadership
- The role that local government, NHS bodies and other organisations can play as anchor institutions
- Health protection responsibilities, including action to prevent the spread of preventable diseases
- How to improve care that meets the needs of babies, children and young people
- How joint working in systems can support the health and care workforce
- Opportunities to promote research and spread innovation
- How local partner organisations can share data and information to improve joint working.

NHS Providers view

We have engaged with DHSC on the development of the guidance on integrated care strategies over several months, feeding in trust priorities and key concerns. We are pleased to see many of our comments reflected in several welcome aspects in the final draft, such as: the flexibility for system partners to define the content of their strategy based on local needs and contexts; the focus on building on existing work and strategies within systems and places; the recognition that decision-

making about budget pooling arrangements rests with the organisations involved (not the ICP); and the strategic focus on how ICPs can plan to address health inequalities.

There are some unanswered questions around how the overall priorities for the health and care system will develop given the number of interlinking national and local strategy documents. For example, it is unclear how shared outcomes at place – as envisaged by the integration white paper – will feed into ICP priorities (and vice versa). DHSC is planning to issue guidance on shared outcomes in 2023, and we are concerned to see how this will fit with the integrated care strategy, especially given the sequence of planning expected over the coming nine months. Therein, the *NHS Long Term Plan* refresh and the operational planning guidance for 2023/24 and 2024/25 are expected in September; integrated care strategies are due in December; and ICB five year forward plans are due next Spring. It will be important that these processes are collectively aligned in priorities for systems, places and trusts.

The guidance rightly makes clear that planning bodies will need to be engaged in the development of integrated care strategies, and that their organisational priorities need to be informed by the resulting strategy. We would highlight the important role of providers in shaping the strategic priorities at ICP level and delivering them. Trusts will play a central role in translating aspirations into tangible change for services users. We would encourage ICPs – given they have flexibility over their memberships – to make sure trusts are fully engaged in their strategy development and ongoing work. This would be in keeping with the envisaged direction of travel for ICSs and involve providers in system planning functions.

2. HWBs: draft guidance for engagement

This draft guidance sets out how HWBs will operate in the context of the Act. It is published for engagement over the coming months and includes questions for stakeholder feedback (see page 17), with responses invited by 16 September 2022. DHSC then plans to issue a final draft.

The draft guidance reaffirms existing roles and responsibilities of HWBs. They will continue to be committees of local authorities, tasked with promoting joint working, and have the same legal responsibilities to produce JSNAs and a joint local health and wellbeing strategy (JLHWS, previously known as joint health and wellbeing strategies).

The Act does not change the core membership requirements for HWBs – an elected member, local authority directors relevant to adult and children' services and public health, NHS commissioners, and

a representative of local Healthwatch. All ICBs in the footprint are required to be members of HWBs (replacing the equivalent requirement on CCGs). Beyond this, HWBs will still have flexibility to involve other stakeholders, eg trusts and voluntary sector providers.

The relationship between HWBs and ICSs

The guidance emphasises that local partners will develop ways of working across ICBs, ICPs and HWBs that make sense based on local configurations and relationships. These should be guided by some common principles, including promoting subsidiarity and avoiding duplication.

In many respects the relationships that HWBs maintain with other organisations/entities in their local systems will remain unchanged: they will continue to be consulted by NHSE as part of the annual assessment process for ICBs; they will have flexibility to work jointly with other HWBs over wider footprints if there are issues which require a larger population lens; and they will continue to have an oversight responsibility for the Better Care Fund (BCF).

In some other respects, there are some tweaks to how HWBs' will relate to other system entities. All HWBs in a system footprint are expected to be involved in developing the ICP's integrated care strategy, informed by the population health intelligence codified in JSNAs. When ICPs publish a finalised integrated care strategy, HWBs will be required to 'consider' revising their JLHWS (although there is no requirement to refresh it, if considered sufficient).

ICBs must involve HWBs in developing their five-year forward plan, which must set out what steps the ICB plans to take to progress HWBs' JLHWSs, and share a draft with HWBs. ICBs' forward plans must include a statement from local HWBs outlining whether the forward plan takes proper account of the JLHWSs. In preparing their annual reports, ICBs are required to consult HWBs about progress made in implementing the priorities of the JLHWSs.

There are comparatively fewer mandated requirements for how ICPs and HWBs will work together. In many systems, HWBs will focus on sub-system footprints and ICPs will lead the system-level integrated care strategy. In these cases, ICPs and HWBs will work together to clarify how their strategies and priorities will complement each other without duplicating. For instance, the integrated care strategy may focus on cross-cutting issues which should be addressed at system level eg data. In other systems, ICPs and HWBs will cover the same geographic footprints. In these cases, there is flexibility for ICPs and HWBs to decide how to streamline, such as bringing the two forums together and conducting business in one meeting.

NHS Providers view

We welcome how the updated guidance for HWBs largely maintains a flexible framework for systems to decide what arrangements will work best locally. We worked closely with DHSC on the guidance, feeding in views from trust leaders and ensuring that it reflected the reality of HWB relationships and effectiveness on the ground. For instance, we supported DHSC to frame how HWBs might operate at system or place level, and how various leadership and decision-making arrangements are developing at place. We are pleased to see both these points and others are now reflected in the guidance.

However, there remain questions about how HWB plans and integrated care strategies should build on and complement each other without overlap or duplication. It will take some time to see how local areas implement this in practice, with many trust leaders concerned about the proliferation of plans in development at system and place level. While it is right that local systems determine how these plans interrelate, it will be important for national developments (such as the implementation of the integration white paper and shared outcomes framework) to consider how further plans and priorities align with existing arrangements.

3. Expected ways of working between integrated care providers and adult social care providers

This document sets out principles for how ICSs – particularly ICPs – are expected to support providers of adult social care services to be fully engaged in the work of the partnership in order to shape, influence and support the strategic direction of the ICS. Jointly developed by DHSC, the Local Government Association (LGA) and NHSE (in partnership with the Care Provider Alliance), the document outlines a number of principles which emphasise the importance of adult social care providers as key partners within ICPs, regardless of whether they are independent or voluntary, community and social enterprise sector. These principles include:

1. **All system partnerships should work together collaboratively to achieve better population health and wellbeing outcomes.** For systems to achieve this, they will need to bring together a variety of partners including local authorities, NHS bodies, adult social care providers and wider partners, and build a shared purpose and open culture.

2. **Adult social care providers are critical partners in improving health and wellbeing outcomes.** They should be fully engaged in the work of the ICP, their views should be fully represented, and their expertise used to support ICPs to: tackle health inequalities; improve population health and

wellbeing; and drive personalisation. ICPs will need to be aware of the capacity and capability of adult social care providers to be involved at system level and should consider supporting their involvement e.g. by providing resources and training.

3 **ICPs and adult social care providers should collectively support the whole adult social care voice to be heard.** ICPs should aim to reflect the variety of adult social care provider voices when producing integrated care strategies and communicate how the strategy affects them. As part of this, adult social care providers should be encouraged, supported and resourced (where appropriate) to build sustainable networks and relationships, e.g. through care associations, local authority provider forums or an ICP adult social care provider forum.

4 **ICPs should promote place-based integration.** ICPs should encourage adult social care providers, NHS organisations, local authorities and other partners to build on existing place-based arrangements and foster greater partnership working. Care associations and other provider organisations should be supported to work closely with their local HWB and any place-based ICB sub-committees. The guidance notes that the involvement of local authority directors of adult social services in HWBs and ICPs is not an adequate proxy for the adult social care provider voice.

5 **ICPs should facilitate sharing good practice across places and systems.** ICPs should communicate to adult social care providers how they are using and acting on local insights and data, including when developing their integrated care strategy. ICPs may wish to think about setting up communities of practice or taking practical steps such as collaborative data sharing agreements. DHSC has already committed £150m to drive digitisation in the social care sector and set a target of at least 80% of social care providers having adopted digital social care records by March 2024. ICPs will also be expected to use data and insight to support system-wide workforce planning.

DHSC, NHSE and the LGA will support ICPs and adult social care providers through:

- Helping providers understand and participate in ICP development and functioning
- Making national connections between ICPs and adult social care provider organisations
- Developing a wider support offer to help build capability in ICPs and providers
- Sharing case studies and examples of how engagement is working
- Providing support for care providers to drive uptake of digital technologies.

NHS Providers view

We welcome DHSC emphasising the important role adult social care providers play as strategic partners in improving health and wellbeing outcomes for local populations. These providers have the knowledge and expertise to help systems shape services and pathways around population needs, as well as contributing to health and care workforce planning and action to tackle the wider determinants. It is therefore right that they are fully supported to be represented at ICP level through existing or new provider networks, although we question how ICPs will be resourced to support these arrangements.

Trusts already work collaboratively with adult social care providers at a local level and will welcome the focus in this document on ICPs supporting these collaborative arrangements. However, there are still structural barriers to integration between health and social care, such as different accountability structures, inadequate funding and challenges in sharing data. For example, while the government's investment in the digitisation of the social care sector is welcome, implementation will be challenging for many care providers who currently do not have the necessary infrastructure. There is a risk that pushing this process forward without adequate support in place will result in poor implementation and electronic records that providers do not actually use. This would miss an important opportunity to deliver better, more joined up, and more efficient care.

Overall, trust leaders remain very concerned about the social care sector, which still needs a sustainable funding solution and national action to tackle staff shortages. These issues are significantly affecting the sector's ability to meet the needs of those who require care, and will likely make it challenging for adult social care providers to fully engage in system working.

4. HOSC principles

This document sets out national expectations for how ICSs and local authority HOSCs will work together. This is intended to ensure scrutiny and oversight are a core part of how ICBs and ICPs operate and to ensure local accountability to communities in systems.

HOSCs retain all their existing legal duties around reviewing and scrutinising the planning and provision of health services in the local area. HOSCs must ensure their requests for evidence are reasonable and proportionate and NHS providers and commissioners are expected to respond positively and constructively. HOSCs will also continue to consider HWB strategies.

In the new system architecture, ICBs and ICPs are in scope of HOSCs. They are both expected to report on their activities and develop a trusting relationship with HOSCs to enable effective scrutiny.

For issues that cut across local authority boundaries, councils will need to take a collaborative approach and set up joint HOSCs (including when scrutinising the delivery and outcomes of the ICP's integrated care strategy).

DHSC positions HOSCs as having a key role in scrutinising the impact and effectiveness of integration on health services and outcomes, both at system and place level. However, DHSC also recommends maintaining an appropriate balance between scrutiny at both levels. This scrutiny should enable local people to comment on priorities for health improvement and therefore provide insight into the health needs and concerns of local communities. DHSC sets out five principles for ways of working between HOSCs, ICSs and other local system partners: outcome-focused, balanced, inclusive, collaborative and evidence-informed.

The Act introduces a power for the Secretary of State to call in and take decisions on or connected to reconfiguration proposals at any stage in the process. This does not change local authorities' scrutiny responsibilities for service change. DHSC will issue statutory guidance on the Secretary of State's new powers relating to reconfigurations (timelines to be determined).

NHS Providers view

We welcome the five principles for how HOSCs and ICSs should work together, as well as the emphasis on HOSCs maintaining an appropriate balance between local and system level scrutiny and proportionate information requests. Trust leaders report varying experiences in terms of the effectiveness of their local HOSCs, given that they have no formal accountabilities and the relationship between HOSCs and the decision-making arm of local authorities varies across the country. We therefore urge DHSC to support HOSCs to move into this system working space and adapt in a way that supports the delivery of better outcomes.

ICSs have accountability upwards to parliament and outwards to their local populations and partner organisations. Their responsibility to work with communities to deliver better outcomes and joined up care extends beyond the role of HOSCs. System partners will need to coordinate how this engagement with local communities aligns with other system and place plans.

Finally, the guidance identifies a role for HOSCs in scrutinising integration, which could risk duplicating or cutting across other oversight mechanisms, such as NHSE's oversight framework and CQC's assessments, as well as the role of ICPs in supporting integration. In addition, for this scrutiny to be effective it would need an agreed definition of integration and a means by which outcomes can be

measured objectively. We urge the national bodies and ICSs to align these different oversight, regulatory and scrutiny approaches as much as possible.