Integrated care partnership (ICP): engagement summary

Introduction

In September 2021, the Department of Health and Social Care (DHSC) published the ICP engagement document which set out the role that ICPs will play within statutory ICSs. Between September and December 2021, DHSC, NHS England and NHS Improvement (NHSE/I), and the Local Government Association (LGA) engaged with a range of stakeholders to understand how systems are developing their ICP arrangements. This briefing summarises the key findings from their latest paper, published yesterday, 23 March 2022, which includes the themes from that engagement process and key actions for systems. Please contact Leo Ewbank, policy advisor (systems) (leo.ewbank@nhsproviders.org), if you have any questions.

Key points

- The document reflects the fact that there are varied approaches to developing ICP arrangements across the country. It endorses the early involvement of system partners and local communities to facilitate progress, and notes that the relationship between the ICP and places/the ICB will be crucial to effective system working.
- Subject to the passage of the health and care bill, DHSC expects ICPs to be formally established by ICBs and relevant local authorities in July 2022 (when integrated care systems [ICSs] are expected to take statutory form).
- The health and care bill places some legal requirements on ICPs, such as a duty to produce an integrated care strategy. In this paper, DHSC encourages – but does not mandate – that ICPs produce this strategy by December 2022, with a view to informing ICBs' five-year forward plans (due April 2023). DHSC plans to issue statutory guidance focused on integrated care strategies in July 2022.
- This document reinforces the important role that ICPs will play in statutory ICSs within a relatively permissive framework. Trust leaders continue to support ICPs as convenors of a wide range of system partners, which aim to align strategies to improve population health and tackle inequalities.

Provisions in the health and care bill

The health and care bill sets out a number of requirements for ICPs and their role within systems, including:

- ICPs must be established as joint committees of ICBs and all upper-tier (or unitary) local authorities in a footprint;
- ICPs must prepare an integrated care strategy – setting out how the health and care needs of the population will be met, informed by local plans such as joint strategic needs assessments; and,
- ICPs must involve local people in the development of this integrated care strategy.

Beyond that, the bill leaves scope for integrated care systems and their constituent organisations to determine how ICPs will form and operate.

Summary of the findings from DHSC's engagement exercise

The engagement discussions were structured around five expectations that DHSC set for ICPs in an earlier policy document (for more detail see here).

Expectation 1: ICPs will drive the direction and policies of the ICS

In most systems, DHSC found that stakeholders are working together effectively to develop their ICP arrangements, although in some areas dialogue between NHS and local authority partners was more nascent given the focus on setting up ICBs.

DHSC heard some concerns among stakeholders about whether ICPs will be able to influence ICBs, given a perceived disparity in their resources and capabilities. DHSC emphasises that the Bill will require that ICBs have regard to integrated care strategies as they develop their five-year forward plans. Additionally, the Care Quality Commission (CQC) will explore the dynamics of interaction between ICPs and ICBs as part of their system reviews.

DHSC suggests two key actions for systems:

- If not already in train, ICB leaders designate and senior leaders in local authorities should initiate discussions about the role and approach of their developing ICP, including engaging with wider partners.
- ICPs should identify and communicate a single point of contact by April 2022 so local partners are aware of how to engage.

Expectation 2: ICPs will be rooted in the needs of people, communities and place

ICPs have a legal responsibility to involve local people and communities in their work, specifically in relation to the development of their integrated care strategies. DHSC found strong support across the sector for involving local people and communities in system working. However, the engagement process highlighted some potential risks around ICPs duplicating engagement work at place level and ensuring Local Healthwatch are sufficiently resourced to fulfil their role in statute to contribute to the development of integrated care strategies. DHSC will produce statutory guidance for ICBs and providers focused on working with local communities.

Some local stakeholders would like to see greater legislative prescription around the memberships of ICPs and decision-making arrangements. But DHSC is clear that systems will have the flexibility to identify and involve the locally appropriate blend of stakeholders in ICPs. Relatedly, some stakeholder groups raised questions about voting rights within ICPs; however, the paper emphasises that ICPs will be expected to operate through building consensus on strategy rather than relying on decision-making via voting.

A number of population groups must not be overlooked in the working of ICPs, including children and young people, social care providers, representatives of the mental health sector, and unpaid carers. Further guidance from DHSC will set out recommendations for ICPs on who to engage with when developing their strategies. The paper notes that involvement can take different forms and is not equivalent to formal membership of ICPs.

Key actions for systems include:

- ICPs should promote an inclusive, listening culture among its participating organisations.
- Healthwatch and voluntary organisations will play an important role in ICPs and systems will need to consider resource demands placed on them as they discharge these functions.

Expectation 3: ICPs create a space to develop and oversee population health strategies to improve health outcomes and experiences

Participants expressed support for ICPs bringing together a broad continuum of system partners to think holistically about the drivers of poor health, and approaches to promote population health and proactive strategies to support people affected by inequalities, social exclusion and deprivation.

Directors of public health, and their teams, have expressed a desire for greater clarity about their role in ICPs, and system working more broadly. DHSC states that directors of public health have an important role to play in ICPs.

Key actions for systems include:

- The ICP's membership and approach should reflect its role in focusing on wider population health outcomes and reducing health inequalities.

Expectation 4: ICPs will support integrated approaches and subsidiarity

DHSC specifies that ICPs should avoid cutting across or duplicating joint working at place level, and instead work in ways which support place-based collaboration and follow the principle of subsidiarity. For example, the ICP may develop system-level integration strategies or advocate new place-based approaches.

Statutory guidance on integrated care strategies will aim to "reinforce the role of the ICP" in addressing the challenges and opportunities ICPs are best placed to oversee. DHSC will also be publishing refreshed guidance for health and wellbeing boards.

Key actions for systems include:

- The ICP should consider the existing and potential role of place and neighbourhood to ensure there are clear mechanisms that enable subsidiarity of decision making.

Expectation 5: ICPs should take an open and inclusive approach to strategy development and leadership, involving communities and partners, and utilise local data and insights

Following stakeholder feedback, DHSC does not intend to produce detailed guidance on what should be in every integrated care strategy, but will include recommendations on groups the ICP should consider engaging with. There was interest in who should be engaged in the development of the strategies, including children, young people and social care providers.

Stakeholders are also interested in who would be appointed to chair ICPs. The paper makes clear that chair appointments will be made by ICBs and relevant local authorities, who will need to work together to build consensus in the selection of the ICP chair. DHSC wants to hear from specific areas where the appointment of ICP chair has been a cause for concern, and to understand why.

Key actions for systems include:

- Local authorities and ICB leaders will need to build consensus in the selection of the ICP chair.
- ICPs should seek to promote an open and inclusive culture, as the success of system working will depend on fostering the right behaviours and trusting relationships.

Emerging models of ICPs

DHSC's engagement with the sector illustrated that there is significant variation between ICSs across the country and therefore material differences in approaches to developing ICPs, including in relation to chair arrangements and memberships. Some areas are approaching ICPs as broad forums with over 40 members while others are made up of a much smaller group.

Areas are making different choices around chairs. Some systems expect that their ICB will share a chair with the ICP; other ICPs will be chaired by a local authority representative (typically an elected member on a permanent basis); and some are exploring co-chairs or rotating convenors.

ICP membership typically includes the ICB chief executive, local authority representatives, NHS providers, voluntary sector representatives, Healthwatch and public representatives. Many ICPs are also planning to have specific place representatives, and include representation from other public services such as educational institutions, housing organisations, blue light services and others. The document includes some brief case studies of developing ICP arrangements in an annex.

NHS Providers view

We welcome the steps colleagues in the national bodies have taken to engage the sector in developing national policy around the role and responsibilities of ICPs. We fed in the views of trust leaders during this engagement process, both in writing and in senior stakeholder meetings, and look forward to continuing to engage with officials on upcoming statutory guidance. We are also continuing to work with NHS Confederation and the Local Government Association on our peer support offer, which aims to support trusts and their partners to develop partnerships (including ICPs), and we were pleased to see this referenced in the paper.

Trust leaders continue to support the key role of ICPs as convenors, bringing a wide set of partners together to align strategies to improve population health and tackle health inequalities. This paper provides a useful summary of views across the health and care system at this early stage of setting up ICPs, without being prescriptive about the future direction of travel. DHSC implies further national guidance will set out the challenges and opportunities that ICPs are best placed to oversee. While we

understand the calls for greater clarity around the role of the ICP, we would strongly encourage the national bodies to maintain an enabling framework with local discretion.

There are some tensions inherent in the design of ICSs which the paper acknowledges. For instance, there remain some risks around the proliferation of strategic documents within systems and places which may lead to a range of competing priorities. The document rightly emphasises ICPs should strive to avoid duplication with places or health and wellbeing boards. They will also want to work with partners to consider the role of provider collaboratives and how they will interact with ICPs and place based arrangements as well. It is important that the suggestion that ICPs could undertake strategic workforce planning is fully worked through, as ICBs, places and some provider collaboratives will also have roles and potentially responsibilities in this space. We will continue to engage with DHSC and NHSE/I to gain further clarification on the different strategies and accountabilities in the system.

In addition, there is a potential tension between ICPs needing to operate as an inclusive forum for a diverse continuum of stakeholders – spanning a range of organisations, professional groups and communities of interest – while also ensuring they remain a workable size and are able to function and develop coherent strategies. In this context, the paper is right to note that ICPs may wish to make arrangements which facilitate sub-groups to take on leadership or coordination functions, eg via steering groups, while using a range of forums and mechanisms to involve local partners.

There remain some questions about what support will be available in those systems – hopefully a small minority – where the ICB / ICP interface is challenged. DHSC points to CQC system reviews playing a role and that may be useful as external challenge. However, managing the risk for disharmony between these two key system planning entities – albeit an extreme scenario – should be acknowledged explicitly and potential mitigations considered.

Finally, trusts support local systems modelling a culture of equal partnership between the NHS and local government, and ICPs will be one important embodiment of this principle. We are therefore slightly concerned that the current framing of ICPs appears to emphasise the role and agency of ICBs and local authorities in establishing and running ICPs, and to an extent overlooks the contribution that trusts will need to make to shaping the broader health and wellbeing agenda led by ICPs. Trusts are central to any strategy to address the wider determinants of health, integrate care, and develop a strategic approach for those people experiencing social exclusion and deprivation. We look forward to exploring the contribution of trusts to this agenda in more detail with DHSC and wider partners.