Establishing Integrated Care Partnerships - Definitions

Cheshire and Merseyside Health and Care Partnership

Integrated Care Systems (ICS): Bring together NHS organisations, local government and wider partners at a system level to deliver more joined up approaches to improving health & care outcomes. All areas will covered by an ICS by April 2021 and on a statutory footing by 2022. Cheshire & Merseyside is an ICS area.

Place: a defined area within an ICS, typically aligned with local authority boundaries. In C&M there are 9 places aligned with the Local Authorities.

Neighbourhood: a defined area within a Place that is typically co-terminus with a Primary Care Network or other recognised local community footprint.

Integrated Care Partnerships (ICP): term used to describe **place-based** joint working between NHS, local government, community services and other partners. Each Place will determine how it organises itself as an ICP and how these arrangements relate to the Health & Wellbeing Board (HWB). HWB continue to have statutory role for improving health and wellbeing of local population, using JSNA to set local priorities. HWBs are a key component of the ICS and a key role for the ICS is to support place-based working and the development of ICP arrangements.

What is Purpose of an ICP? ICPs will deliver the local priorities set by the HWB and system priorities set by the ICS, by organising how local services and partners can work better together. ICPs will drive improved outcomes and address the inequalities identified by the HWB. They can use enablers such as integrated commissioning, BCF, population health data and improved digital technology to enable this work.

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Core features:

1) **Integrated Care Partnership (ICP) Governance:** clearly defined formal arrangements for place partners to meet and work together to deliver outcomes set by the Health & Wellbeing Board (HWB) and ICS.

2) **ICP nominated 'Place Lead'** with remit for integrated working who will connect with ICS

3) **Shared vision and plan for reducing inequalities and improving outcomes** of local people approved by HWB (underpinned by local population health and socio-economic intelligence)

4) **Agreed ICP development plan**

5) **Defined footprints (e.g. neighbourhoods) for delivery of integrated care**, clinically led by PCNs working with social care, community, mental health, public health and other community groups.

6) **Programme of ongoing public and wider stakeholder engagement** at place

Places will be expected to develop an integrated approach to commissioning between health and local authority (such as shared posts, joint teams and pooled budgets) to underpin and support the work of the ICP

1. ICP Governance

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a. Arrangements for ICPs must outline how link with local HWB who retain statutory role for local population health and are key to the ICS. Some Places may want the Health and Wellbeing Board to be the nominated 'ICP Board' other Places may want to establish an 'ICP Board / Committee' as a sub group of the HWB.

b. ICPs should include a breadth of place partners extending beyond health & social care, e.g. housing, voluntary sector, police

c. ICPs will have a governance framework that sets out:
   - core members represented on the Partnership Groups,
   - the organisations and services that are part of the wider partnership, and
   - how the ICP will work with and alongside existing partnership structures (e.g. safeguarding boards, community safety partnerships, Local Enterprise Partnerships etc) to deliver on the aims of improving the quality of life and reducing inequalities.
   - ICPs should consider developing formal 'place agreements / MOUs' that each partner signs with agreed objectives / outcomes
   - ICPs should bring together statutory and non-statutory organisations & communities
   - ICPs will need to link to ICS (how will be determined as ICS evolves)

d. An ICP should be able to describe and present it's governance arrangements and it should be agreed by all partners

2. ICP nominated ‘Place Lead’

a. The Place lead should be endorsed by members of the ICP and be able to represent Place within the ICS.

b. The Place lead will be a main point of contact for the ICS executive team and will sit on a Place Collaborative Forum and may be asked to represent Place on other ICS forum as system architecture and governance is developed further.

3. Shared vision and plan for reducing inequalities and improving outcomes of local people

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a. The ICP will need a shared vision and plans / strategies aimed at reducing inequalities & improving outcomes, these plans may already exist eg H&WBB and 5 year Place Plans. In addition, the work of the ICP is also likely to contribute to wider Place plans that support broader social and economic development.

b. This will be underpinned by local population health and socio-economic intelligence

c. Using their JSNA, ICPs will have a sound understanding of the characteristics of their population and the local drivers of inequality. There will be a requirement to use 'real time' population health data (supported by case finding and risk stratification) at Place to determine how to best deliver services and address local needs on a personal, neighbourhood & whole Place level.

d. Plans and strategies will be created using robust engagement with local people – including minority groups and those whose voices are seldom heard.

4. Agreed ICP development plan

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a. The ICS will develop an ICP assurance / maturity framework, ICPs will need development plans to support their progress against this framework.

b. An ‘Organisational Development plan’ will be required that sets out how staff from all of the ICPs partners (working at all levels) will be engaged in the vision of the Place and supported to work in an integrated collaborative culture that embeds cross system partnership working.

c. As staff are asked to start working differently there will need to be a structured and significant programme of development in place to support implementation at each stage.

5. Defined footprints for delivery of integrated care, clinically led by PCNs working with social care, community, mental health, public health and other community groups.

a) Each Place should have agreed 'neighbourhood' footprints (ideally based on recognised local communities) where there will be partnerships between voluntary sector and other community groups (eg faith groups), schools and other local agencies who can influence health and wellbeing. There should be strong partnership working between these neighbourhood services / groups and PCNs, in many areas there will be coterminosity with PCNs and established community footprints.

b) PCNs will provide 'clinical' leadership for their registered population and work with social care, community, mental health and voluntary sector on the design and delivery of integrated health and care services at a neighbourhood level linking this to wider place agendas such as economic growth, community safety and education.

6. Programme of ongoing public and wider stakeholder engagement at place

a. Communications teams from each partner in the ICP need to be working closely together to deliver a programme of comms and engagement that is based on common messages and the shared ICP vision. There should be one nominated communications link from each ICP to work with the ICS comms team on how ICP and ICS messages can be coordinated across Cheshire and Merseyside.

b. The local population should be able to influence and co-produce local services to best meet their needs.

c. Each ICP will need an infrastructure to ensure there is ongoing and wide stakeholder and public engagement and a joint ICP engagement plan. This plan will address how to include seldom heard and minority voices.

7. Places will be expected to develop an integrated approach to commissioning between health and local authority (such as shared posts, joint teams and pooled budgets) to underpin and support the work of the ICP

a) As legislative reform is clarified, Places (CCGs & LAs) need to work with ICS on the transition of commissioning functions and development of new operating models. A move towards shared leadership of health & care commissioning, joint posts and pooled budgets at Place would be welcomed.

b) 'Commissioning' at Place should be an **enabler** for the ICP to transform local services, improve outcomes and address inequalities. Integrated commissioning teams should be part of the ICP arrangements and work to support provider collaboration and service re-design

ICP Development - supporting background resources

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Governance and Structures

- Central Lancs ICP-Gov
- Durham ICP-gov
- Tameside Governance
- Rochdale - gov structure

Memorandum of Understanding & Agreements

- Bassetlaw-ICP-MoU
- Thurrock Care Alliance-MoU
- MLCO - ırtnering Agreeme
- Rochdale-Partnering Agreement
- Wigan Alliance Agreement
- St Helens Collaboration Agreement

Stakeholder forum examples

- VCFSE & ICP Checklist - draft
- Inequalities Group-ToR-example
- Primary Care Council - ToR-example