Greater Manchester
Integrated Care Partnership Board

Date: 28th October 2022

Subject: Establishment of the GM Integrated Care Partnership Board

Report of: Geoff Little, GMCA Chief Executive Portfolio Holder, Health and Social Care

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PURPOSE OF REPORT

To note the establishment of the Greater Manchester Integrated Care Partnership (GM ICP) as a joint committee and to enable the GM ICP to agree its additional members, terms of reference and frequency of meetings.

RECOMMENDATIONS:

The GM ICP is requested:

a) To note that the ten Greater Manchester Local Authorities and the Greater Manchester Integrated Care Board (ICB) have agreed to establish the GM Integrated Care Partnership (ICP) as a joint committee of the ICB and ten local authorities.
b) To note the appointment of the local authority and ICB members and substitute members of the GM ICP.
c) To agree the proposed Terms of Reference of the Greater Manchester ICP.
d) To agree the membership and terms of office of the additional members of the Greater Manchester ICP.
e) To agree that the ICP will meet at least quarterly in public.

CONTACT OFFICERS:

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BACKGROUND

Role of the ICP

1.1 An ICP is one of two statutory components of an Integrated Care System, alongside the Integrated Care Board (ICB). Section 26 Health and Care Act 2022 inserts s.116ZA into the Local Government and Public Involvement in Health Act 2007.

116ZA Integrated care partnerships

(1) An integrated care board and each responsible local authority whose area coincides with or falls wholly or partly within the board's area must establish a joint committee for the board's area (an 'integrated care partnership')

(2) The integrated care partnership for an area is to consist of –

(a) one member appointed by the integrated care board

(b) one member appointed by each of the responsible local authorities

(c) any members appointed by the integrated care partnership

(3) An integrated care partnership may determine its own procedure (including quorum)

1.2 The minimum core membership of the ICP will consist of 10 representatives from the 10 districts and a member of ICB.

2. Purpose and function

2.1 ICPs have a **statutory duty to create an integrated care strategy** to address the assessed needs, such as health and care needs of the population within the ICB's area, including determinants of health and wellbeing such as employment, environment, and housing. In preparing the integrated care strategy each integrated care partnership must have regard to guidance issued by the Secretary of State.

2.2 Statutory guidance has now been issued by Government:

https://www.gov.uk/government/publications/guidance-on-the-preparation-of-integrated-care-strategies/guidance-on-the-preparation-of-integrated-care-strategies

2.3 The legal duties of an ICP are set out in Appendix A, references are to the guidance itself.

3. Further relevant guidance

3.1 Scrutiny

Further guidance issued by Government confirms that the ICP will be subject to local government Health Scrutiny arrangements and that the CQC will review Integrated Care systems including the functioning of the system as a whole which will include the role of the ICP. It is proposed that the GM ICS is scrutinised by the GM Joint Health Scrutiny Committee and at place level, as appropriate.

3.2 Health and Well Being Boards

3.2.1 It is expected that all HWB in an area will be involved in the preparation of the ICP Strategy. ICPs need to ensure that there are mechanisms in place to ensure collective input into their strategic priorities. Guidance also states that ICPs will need to be aware of the work already undertaken at Place and build upon it. They should not override or replace existing place-based plans.

3.3 Principles

3.3.1 This is more clearly delineated in the ICP engagement summary. Government has summarised responses to the ICP engagement document published in September 2021 and set out five expectations:

1. ICPs will drive the direction and policies of the ICS
2. ICPs will be rooted in the needs of people, communities and places
3. ICPs create a space to develop and oversee population health strategies to improve health outcomes and experiences
4. ICPs will support integrated approaches and subsidiarity
5. ICPs should take an open and inclusive approach to strategy development and leadership, involving communities and partners to utilise local data and insights and develop plans

3.3.2 More recent guidance has referred to adopting a set of principles for all partners to develop good relationships including:

Building from the bottom up
Following the principles of subsidiarity
Having clear governance
Ensuring leadership is collaborative
Avoiding duplication of existing governance arrangements

3.3.3 Whilst not specified in the guidance it is anticipated in GM that Locality Boards will input into the GM Strategy.

4. Form of Integrated Care Partnership

4.1 A paper was circulated to local authorities and NHS Bodies on the role and potential makeup of the ICP earlier this year. There were a number of responses which included a concern to ensure that the ICP fully represented all areas of expertise and in particular mental health; that lessons were learnt from the operation of the Health and Care Partnership Board meetings, in that it should not develop into a large and unwieldy meeting; and that it needed to be inclusive and harness the passion and enthusiasm of a wide range of the public, private and voluntary sector on a regular basis without them necessarily being members of the ICP.

4.2 The paper was refined and the following issues on the form of the ICP have been further considered by the wider local authority and NHS system through a paper circulated to Place-Based Leads, NHS Provider Forum, NHS Primary Care Board and the ICB through their governance officers.

4.3 Responses to the paper were considered by a meeting of the Shadow ICP who have agreed the membership as set out below -

- ICB Chair
- ICB CEO
- 10x LA representatives (political)
- GMCA Mayor
- At least one Healthwatch rep
- One Director of Public Health (LA) as nominated by DPHs
- One DASS (LA) as nominated by DASSs
- One Director of Children's Services (LA) as nominated by DCSs
- One LA Chief Executive – Chief Executives health lead
- GMCA Chief Executive
- Two Provider Federation representatives: one mental health, one physical as nominated by PFB
- Four Primary Care representatives, one from each discipline
- Health Innovation Manchester representative
- One Trade Union representative
- One VCS representative
- One housing representative as nominated by GM Social Housing providers
- One Work and Skills representative.

This would result in an ICP of 30 members if it is possible to have one representative from the housing sector and work and skills, with others invited as required e.g. GMP

5. Membership

Core membership
All local authorities and the ICB either have confirmed membership or will have done so at the time of the meeting. A list of appointments will be circulated at the meeting.

Additional members
Organisations representing the proposed additional membership as set out in 4.3 above have confirmed the following nominations –

GM Healthwatch	Heather Fairfield
DPH	Katrina Stevens
DASS	Stephanie Butterworth
DCS	*To be confirmed*
Provider Federation	Kathy Cowell
	Evelyn Asantemensah
Primary Care	Darmish Patel
	Tracey Vell
	Don McGrath
	Luvjit Kandula
Health Innovation Manchester	*To be confirmed*

Trade Union	James Bull
VCSE	Lynne Stafford
Housing	Noel Sharpe
Work and Skills	*To be confirmed*

It is proposed that the nominating organisations may change their nominee at their discretion and in any event no nominee serves more than a three year term. Additional members will need to be formally appointed by the GM ICP itself.

6. Sub-committees and working groups

6.1 The engagement summary envisages that the ICP will convene and coordinate the activities of sub-committees, working groups or other forums as its role develops.

7. Frequency of meetings

7.1 This is not specified in the guidance but is has been suggested that it meets three or more times a year. It is suggested that it meets at least quarterly on the same day as the GMCA meeting.

8. Secretariat

8.1 The guidance says that no additional money will be available to local authorities. It is proposed that the ICP secretariat is provided by the GMCA governance team.

9. Recommendations

10. Members are requested:

a) To note that the ten Greater Manchester Local Authorities and the Greater Manchester Integrated Care Board (ICB) have agreed to establish the GM Integrated Care Partnership (ICP) as a joint committee of the ICB and ten local authorities.

b) To note the appointment of the local authority and ICB members and substitute members of the GM ICP.

c) To agree the proposed Terms of Reference of the Greater Manchester ICP.

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e) To agree that the ICP will meet at least quarterly in public.

Appendix A

Legal duties and powers - where to find more information in this guidance

Statutory requirements	Further detail in this guidance
The integrated care strategy must set out how the 'assessed needs' from the joint strategic needs assessments in relation to its area are to be met by the functions of integrated care boards for its area, NHSE, or partner local authorities.	See 'Evidence of need and the integrated care strategy' for detail on evidence of need. See 'Content of the integrated care strategy' for a non-exhaustive selection of topics for the integrated care partnership to consider, including: shared outcomes; quality improvement, joint working and section 75 of the NHS Act 2006; personalised care; disparities in health and social care; population health and prevention; health protection; babies, children, young people, and their families, and health ageing; workforce; research an innovation; 'health-related services'; data and information sharing.
In preparing the integrated care strategy, the integrated care partnership must, in particular, consider whether the needs could be more effectively met with an arrangement under section 75 of the NHS Act 2006.	See 'Joint working and Section 75 of the NHS Act 2006' in this document for further detail on this requirement.
The integrated care partnership may include a statement on better integration of health or social care services with 'health-related' services in the integrated care strategy.	See 'Health-related services' in this document for further detail on this power.

Statutory requirements	Further detail in this guidance
The integrated care partnership must have regard to the NHS mandate in preparing the integrated care strategy.	See the section in this document on the ‘NHS mandate’ for further detail on this requirement.
The integrated care partnership must involve in the preparation of the integrated care strategy: local Healthwatch organisations whose areas coincide with or fall wholly or partly within the integrated care partnership’s area; and people who live and work in the area.	See the section on ‘Involving people and organisations in the strategy’ for further detail on involving people and groups for the integrated care partnership to consider, including: local Healthwatch; people and communities; providers of health and social care services; the VCSE sector; local authority and integrated care board leaders; wider organisations; other partnerships and fora.
The integrated care partnership must publish the integrated care strategy and give a copy to each partner local authority and each integrated care board that is a partner to one of those local authorities.	See the section on ‘Publication and review’ for further detail on this requirement.
Integrated care partnerships must consider revising the integrated care strategy whenever they receive a joint strategic needs assessment.	See the section on ‘Publication and review’ for further detail on this requirement.

NHS mandate

The government sets objectives for NHSE through a statutory mandate. The integrated care partnership must have regard to the mandate, alongside the guidance from the Secretary of State, when preparing their integrated care strategy.

For integrated care partnerships, having regard to the mandate means following the mandate unless there are compelling or exceptional reasons not to do so. In practical terms, integrated care partnerships should ensure they act in accordance with the mandate, where its content is applicable to their context. The mandate will also be reflected in NHSE's own strategic documents and planning guidance

ICBs and LAs will be required by law to have regard to the integrated care strategy when exercising any of their functions. NHS England (NHSE) must have regard to the integrated care strategy when 'exercising any functions in arranging for the provision of health services in relation to the area of a responsible LA'.

The guidance goes on to set out the requirements of the Integrated Care Strategy and how it may be developed with partners and states that Healthwatch must be involved in its production.

Terms of Reference for GM ICP

The Greater Manchester Integrated Care Partnership is a joint committee created by the ten Greater Manchester local authorities ("the Constituent Authorities") and the Greater Manchester Integrated Care Board under s.116ZA into the Local Government and Public Involvement in Health Act 2007.

Membership of the Committee

The membership of the committee shall be

one member appointed by the integrated care board

one member appointed by each of the responsible local authorities

any members appointed by the integrated care partnership

The Constituent Authorities and the GMCA shall also each nominate a substitute executive member/assistant portfolio holder to attend and vote in their stead.

Role of the Committee

To enable the discharge of the ICP's functions under the Local Government and Public Involvement in Health Act 2007 and any related guidance concerning the role of integrated care partnerships.

Powers to be discharged by the Committee

The Committee shall have the power to discharge jointly the functions of the ICP.
The discharge of such functions includes the doing of anything which is calculated to facilitate, or is conducive or incidental to, the discharge of any of those functions

Operation of the ICP

- The ICP shall appoint a chair at its first meeting;
- The Quorum of the ICP shall be met where there are at least a third of the members appointed by the responsible local authorities present and the ICB appointee.
- Each member shall have one vote;
- The Chair shall not have a casting vote;
- Unless required by law, decisions shall be made by a simple majority.
- In relation to rights of access to information, including the publication/availability of agendas, reports, background documents and minutes, and public attendance at meetings, the ICP shall apply rules equivalent to those applying to local authority committees under Part VA of the Local Government Act 1972 ("the 1972 Act"). Such rights of access to information may be limited where the ICP considers "confidential information" or "exempt information", in a manner equivalent to that provided for by the 1972 Act.