North Northamptonshire Council

Meeting: Health and Wellbeing Board

Date: Thursday 10th March, 2022

Time: 2.00 pm

Venue: North Northamptonshire Council Offices, Cedar Drive, Thrapston, NN14 4LZ

To members of the North Northamptonshire Health & Wellbeing Board

Cllr Jon Paul Carr - Chair	North Northamptonshire Council
Alan Burns	Chair, KGH and NGH Group
Ann Marie Dodds	Assistant Director of Education
Cllr Scott Edwards	Portfolio Holder Childrens, Families, Education and Skills, North Northamptonshire Council
Naomi Eisenstadt	Chair, Northamptonshire Health and Care Partnership
Colin Foster	Chief Executive, Northamptonshire Childrens Trust
Shaun Hallam	Northamptonshire Fire and Rescue
Cllr Helen Harrison	Portfolio Holder Adults, Health and Wellbeing, North Northamptonshire Council
Michael Jones	Divisional Director, EMAS
David Maher	Deputy Chief Executive, NHFT
Cllr Macaulay Nichol	North Northamptonshire Council
Oliver Newbold	NHS England
Dr Steve O'Brien	University of Northampton
Professor Will Pope	Chair, Northamptonshire Healthwatch
Toby Sanders	Chief Executive, NHS Northamptonshire CCG
Chief Superintendent Ashley Tuckley	Northamptonshire Police
David Watts	Director of Adults, Communities and Wellbeing, North Northamptonshire Council
Dr Jo Watt	Chair NHS Northamptonshire
Lucy Wightman	Joint Director of Public Health

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Adele Wylie, Monitoring Officer
North Northamptonshire Council

Proper Officer
2 March 2022

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HEALTH & WELLBEING BOARD

Minutes of the meeting held on 2 December 2021 at 2pm

Venue: The Council Chamber, Thrapston Town Council

Present:

Councillor Jon-Paul Carr (Chair)	North Northamptonshire Council
Councillor Macaulay Nichol (Vice Chair)	North Northamptonshire Council
Councillor Scott Edwards (Portfolio Holder for Children's Families Education & Skills	North Northamptonshire Council
Councillor Helen Harrison (Portfolio Holder for Adults, Health & Wellbeing)	North Northamptonshire Council
Alan Burns	Chair, KGH and NGH Group
Colin Foster	Chief Executive, Northamptonshire Children's Trust
Shaun Hallam	Deputy Chief Fire Officer, Northamptonshire Fire & Rescue Services
Michael Jones	Divisional Director, East Midlands Ambulance Service (EMAS)
David Maher	Deputy Chief Executive Northamptonshire Healthcare Foundation Trust
Professor Steve O'Brien (via Teams)	University of Northampton
Dr Raf Poggi	Primary Care Network
Toby Sanders	Chief Executive, NHS, Northamptonshire CCG
Colin Smith	Chief Executive, Local Medical Committee
Pauline Sturman	Assistant Chief Constable, Northamptonshire Police
Dr Jo Watt	Chair, NHS Northamptonshire
David Watts	Director of Adults, Communities and Wellbeing, North Northants Council
Lucy Wightman	Joint Director of Public Health

Also Present

Cheryl Bird, Health and Wellbeing Board Business Manager
Jenny Daniels, Democracy Officer (Minutes)
Sam Fitzgerald, Assistant Director of Adult Social Services
Olivia Kinsey, PA Consulting

Luke Muir, PA Consulting
Amy Plank, Environmental Protection and Private Sector Housing Manager

And no members of the public

25/21 Apologies

Apologies were received from Cathi Hadley (Director of Children's Services), Naomi Eisenstadt (Chair, Northamptonshire Health & Care Partnership) and Oliver Newbold (NHS England), Professor Will Pope (Chair, Healthwatch Northamptonshire).

26/21 Board membership

The Chair asked the Board to welcome Dr Raf Poggi as the Primary Care Network representative for the Board.

Resolved that: Dr Raf Poggi is co-opted as the Primary Care Network representative for the Board.

27/21 Notification of requests from members of the public to address the meeting

None had been received.

28/21 Declaration of members' interests

The Chair invited those who wished to do so to declare interests in respect of items on the agenda.

No declarations were made.

29/21 Minutes of the Meeting Held On 23 September 2021

RESOLVED that: the Health and Wellbeing Board approved the minutes of the meeting held on 23 September 2021.

30/21 Action Log

The Chairman introduced this item (copies of which had been previously circulated) which gave details of actions that had been and were yet to happen.

- Lucy Wightman to circulate the Population Health Strategy to the Board. **Completed. This was circulated to Board members on 1 November 2021.**
- Details of the BCF Plan would be shared with the Board. **This was an agenda for discussion later in the meeting.**

RESOLVED that: The Health and Wellbeing Board notes the Action Log

31/21 Director of Public Health Annual Report 2020/2021

At the Chairman's invitation the Director of Public Health introduced this report (copies of which had been previously circulated) which detailed the lessons learned from COVID19 highlighting the following:

- It was a statutory duty of Health and Wellbeing Boards to oversee production and publication of the Directors of Public Health Annual Report.
- This report focused on the county's response to the COVID-19 pandemic, including lessons learned, system wide partnership working, challenges and how to improve the response moving forward.
- This was an independent report by the Director of Public Health.

RESOLVED that: the North Northamptonshire Health and Wellbeing Board:

a) notes the Director of Public Health Annual Report; and
b) the draft white copy of the report would be circulated to Board members for feedback; and
c) delegates authority to the Portfolio Holder to approve publication of the final draft of the report.

32/21 Better Care Fund Update

At the Chairman's invitation the Director of Adults, Communities and Wellbeing introduced this report (copies of which had been previously circulated) which gave details of the Better Care Fund Submission for 2021/22 and the Assistant Director of Adult Social Services provided an update on the current performance against those matrices.

- Submission of the BCF Plan 2021/2022 had been made to NHS England, who had fedback that the metrics contained within the plan were not stretched enough. Work continued with both acutes and NHS Northamptonshire CCG on the length of stay and discharge targets. An updated version of the BCF plan had been submitted to NHS England on 2 December.
- The schemes contained within the 2021/2022 plan were largely like the schemes contained within the 2020/2021 plan.

In answer to queries on the update the following was confirmed:

i. the 'pillars' mentioned in the report were made up of a number of bricks. It was a multi-agency approach.
ii. Achieving 95% of people being sent back to their place of residence was a real achievement.
iii. The metric for those who remained at home above 91 days after discharge the 91 days, this counted on the 91st day of discharge regardless of whether there had been re-admission in between.
iv. Within community hubs there are ideal outcome meetings held to ensure everything was provided in the home to assist a person to remain and they give the right amount of support which reduces their care needs.

RESOLVED that:

- The Health and Wellbeing Board notes the spend for 2021/22.
- Once agreed by NHS England the BCF Plan to be circulated to the Board.

- The Assistant Director of Adult Social Service to include performance against re-ablement metrics in the next update.
- To have a specific iCAN update for future meetings to provide a high-level overview of key performance indicators within the bricks and pillars to provide assurance.

33/21 Disabled Facilities Grant Update (DFG)

At the Chairman's invitation the Environmental Protection and Private Sector Housing Manager introduced this report (copies of which had been previously circulated) which highlighted the latest information in relation to the current financial year.

In answer to queries on the report the following was confirmed:

i. There was not a huge increase in demand for DFG's but an ageing population meant there was a steady increase year on year for DFGs. The baseline years had also changed since the aggregation from district councils into North Northamptonshire Council, and this would take approximately 18 months to work through what the baseline would look like and to obtain a clear indication of how many people were coming through the system and the amount of spend with their DFGs.
ii. There was not really anything more partners could do to support this as they were already working with partners on several items such as filling vacant posts. They had also reduced the waiting list for people to get assessments from 6 months to 3. Once resources were available to reduce the waiting list further, they would be able to look at more discretionary measures such as providing minor repairs and handyman schemes, to prevent people from having falls and accidents in the home and reduce admission to hospital.
iii. They looked to employ several professionals across several partners.
iv. They were also looking to provide some work opportunities for occupational therapist students and looking to grow their own staff through provision of apprenticeships. The Service would really like to have a conversation with the University of Northampton concerning the work for occupational therapist students.
v. The surveyors and builders could not be brought in to complete a DFG until the occupational therapists had completed their assessment. Perhaps more could be undertaken such as the Council's maintenance team could assess certain adaptations. The requirements from the 1996 Act required an Occupational Therapist's recommendation before public money could be spent on a DFG. It was also noted that the Northamptonshire Fire & Rescue Team would be happy to be part of the conversation in this.
vi. There was also the need for the Service to improve and work with other services in advertising DFGs to ensure the grant was well advertised and that those who required it could get assistance.

RESOLVED that: The Health and Wellbeing Board notes the DFG spend for 2021/2022.

34/21 COVID19 Update – Oversight and Engagement Board

At the Chairman's invitation the Director of Public Health provided this update highlighting the following:

i. At 3pm that day it would be announced that there were omicron cases in the county. The figures were expected to rise quite significantly in the next few days.
ii. Some targeted testing in some settings would begin the following day.
iii. Currently West Northants was primarily affected.
iv. It was mainly affecting children and adults and one school had already shut.
v. Case loads were going up across the board with the West increasing at a slower rate. There was a higher all age case rate than the England average but Northamptonshire was broadly in line with the East Midlands. The all-age case rate in North Northamptonshire was 568.4 per 100000 population which had risen by 18% in the last few days, primarily driven by primary school children. This was mainly because they hadn't been vaccinated and found it harder to isolate.
vi. Omicron was likely to re-infect a person. There were outbreaks in workplaces, schools, and a small number in care homes although this was waning due to the booster vaccine.
vii. Hospital admissions did not seem to be going up, staying at 6%-7% of the bed base.
viii. There had been more deaths in the last 7 days but the way they were recorded could have something to do with that as someone, could have had a positive COVID result but then be killed in a car crash. Their death would still be recorded as due to COVID.
ix The vaccine provided a level of protection. Even those being hospitalised after having 3 vaccinations could be in ICT if not for those vaccinations.
x. The North of the County was in a good place as it had many vaccination centres and the primary care network and pharmacies were also assisting to provide vaccinations. 191,000 boosters had already been given.
xi There was very little room within the system as the current acute trusts were congested being at level 4 (the highest level) in this respect. This was why the clinical leads had been working on contingency plans and reviewing which services would be stepped back if required.

In answer to queries on the verbal update the following was confirmed:

i. It was noted that the community suffered some nervousness when things like wearing face masks was re-introduced, so due to the expected increased number of calls to Northamptonshire police the Director of Public Health extended an invitation for an officer to attend the next OCT.
ii Current legislation required people who were confirmed or suspected of having Omicron to isolate for 10 days, the challenge was that it was taking 10 days to complete genomic sequencing for someone suspected of being infected with the Omicron variant.
ii. There could therefore be many people self-isolating, and people did not like getting their freedom back only to lose it again.
iii. Schools or town halls were being reviewed as an area where a surge test could be undertaken. Courier related tests were also being considered for those who could not attend a vaccination centre.

iv. It did not take much to wipe out the entire capacity for those covered by small services provided by general practice. NHS Northamptonshire CCG were looking at the BMA green list of services that must be protected within general practice and how people could get access to these services. In particular they were looking at how to promote the message to the public to undertake a PCR test if they had symptoms. General Practice are asked to support staff to wear appropriate PPE to preserve services that were important.

v. A lot work had been undertaken in terms of communications of messaging on which test to take at which time. There was a new Public Elf Christmas campaign to remind people of the COVID-19 safe protocols. People were feeling fatigued so messages need to be balanced so that those medical conditions that could be self-medicated remained so.

vi. The main difference was that the vaccine was more effective in preventing severity of symptoms and needing hospital admission than doing nothing.

vii. They were aware of the need to reinforce best practice measures to ensure communities did not become nervous, and that public trust was maintained in the vaccine.

viii. The Council websites included a lot of information on testing, about benefits, as well as food and medicine deliveries for those self-isolating. The Director of Public Health would ascertain whether a directory of services could also be linked. MiDOS was available and linked through to the social prescribing link workers, enabling people to have non-clinical interventions and support as opposed to default to contacting general practice.

ix. It was also noted that 90% of patient encounters were seen by GP practices and many people had been rude and violent. It was therefore felt that more support was required to GP practices. It was also noted that information regarding the need to respect staff was shortly being produced by NHS England and in social media. It was not just GP practices but any front-line public sector organisation who deserves respect from the local population.

x. A Local Outbreak Management Plan (LOMP) was also presented as it was updated each time the national framework was. It was a statutory requirement to have a political meeting to oversee execution of the LOMP and providing challenge on whether it was effective. The countywide COVID-19 Oversight and Engagement Board was created for this purpose. It was recognised that this was duplication of the work of the Health and Wellbeing Board. The Director of Public Heath proposed to disband the Oversight and Engagement Board and move its governance to the 2 Health and Wellbeing Boards in Northamptonshire.

RESOLVED that: the Health and Wellbeing Board

a) notes the COVID19 Update.

b) Agrees to delegation of governance for oversight of the COVID19 response and LOMP be given to the 2 Health and Wellbeing Boards.

c) endorses the refreshed LOMP.

35/21 Integrated Care System Update

At the Chairman's invitation the Chief Executive of NHS and Northamptonshire CCG presented the report (copies of which had been previously circulated) which provided an update on the Integrated Care System.

RESOLVED that: the Update on the Integrated Care System be noted.

36/21 PA Consulting Paper

At the Chairman's invitation the Director of Adults, Communities and Wellbeing at North Northants Council introduced the report (copies of which had been previously circulated) which outlined what had been undertaken on the integrated care system development. There were 2 papers in the pack, one setting out the recommendations that the health and wellbeing board were being asked to endorse that day. The second one set out the work that had been undertaken and the proposals.

- There have been 2 phases of workshops taking place to design principles and potential geographies used.
- The proposal for North Northamptonshire communities will be based on the geographic footprints of old district and borough local authorities, primarily because of the organisation and distribution of services and identify within the local populations. Within the neighbourhood levels there will be clusters of wards of between £30k-£50k population.
- These proposals will still need to be approved by Executive Full Council in North Northamptonshire and the Executive Boards, within the NGH and KGH Group, NHFT and NHS Northamptonshire Clinical Commissioning Group.

In answer to queries on the report the following was confirmed:

i. It was felt that the workshops had been interesting. They had not just focussed on those who identified as part of a community geographically but also, those of a type.
ii. Within the final proposals around communities and neighbourhoods, there was strength in the original Health and Wellbeing Forums and it was wished that this would continue in the North as a platform for communities to raise issues.
iii. Engagement with communities was important and it was hoped that by creating these groups they would evolve and ensure services really were representative of local need.
iv. The proposal would provide a chance to focus of the drivers of economic wellbeing in communities and the deprivation levels. The pace of change might require different reporting data to show the granularity of changes taking place in communities.
v. Moving forward consideration is needed on the architecture, to establish what problems we were trying to solve for the population and at which levels and how we want teams in different areas working together.
vi. Consideration was also needed about whether services could be commissioned at a Health and Wellbeing Board level, rather than this Board trying to influence the ICS for resources in a particular sector.
vii. It was about recognising what was required in areas and how people's lives

could be improved. It was about ensuring they had the correct clusters and that the clusters were working well.

viii. There was a need for everyone assisting and supporting communities to work together and get in as early as possible to have the best possible result and shape services at the primary care level.

RESOLVED that the Health and Wellbeing Board

a) Formally endorses the development of four communities: Corby, Kettering, Wellingborough, and East Northants as the boundaries for communities in the North.
b) Formally endorses the plans to design neighbourhoods through clusters of wards with approximately 30-50k population size.
c) Endorses governance recommendations to widen the Health and Wellbeing Board remit and membership, establish Community Locality Wellbeing Forums, and utilise existing governance forums for neighbourhoods.

There being no further business the meeting closed at 15.36pm.

North Northamptonshire Health and Wellbeing Board Action Log

Action No	Action point	Progress	Status
091221/04	Director of Public Health to ascertain whether a Directory of Services could be linked to the COVID-19 website.	**Awaiting an update from Caroline Maggs**	

Actions completed since the 2nd December 2021

Action No	Action point	Progress	Status
091221/01	Draft white copy of the Directors of Public Health Annual Report 2020/2021 be circulated to the Board for feedback.	**Completed. Circulated 10th December**	
091221/02	Performance data against re-ablement metrics to be included in the next BCF update.	**Completed. Agenda item for discussion 10th March**	
091221/03	iCAN updates to be standing agenda item for future meetings to provide overview of key performance indicators.	**Completed. Agenda item for discussion 10th March**	

North Northamptonshire Council

Item no:09

North Northamptonshire Health and Wellbeing Board

Report Title	**Local Resilience Forum (LRF) declaration of Major Incident (COVID19) January 2022**
Report Author	**Darren Dovey, Chief Fire Officer and Chair of the Northamptonshire Local Resilience Forum ddovey@northantsfire.gov.uk**

List of Appendices

None

1. Purpose of Report

1.1. To provide information to the board on the lead up and declaration of a Major within Northamptonshire in January 2022 in relation to COVID 19 (Omicron variant), together with some context in relation to the Local Resilience Forum (LRF).

2. Executive Summary

2.1 On 6th January 2022 the Northamptonshire LRF at the Multi Agency Co-ordination Group meeting (MACG) declared a Major Incident due to system wide pressures, predominantly within the Health and Social Care sectors, due to the spread of the Omicron variant of COVID19, particularly over the Christmas and New year period.

2.2 This decision was unanimously supported by all partner agencies in attendance at the meeting following a briefing by Public Health, Health and Social care partners in relation to the increase in positive cases in the County, increase in Hospitalisations together with the increase in staff absence affecting all agencies. There was also good reason to believe that the situation would further deteriorate as we progressed through January which could lead to between 250 – 300 hospitalisations, an approx. 50% increase on the number as at 6th January, together with increasing issues with discharging patients from hospital into social care settings.

2.3 This information was then compared against the accepted Joint Emergency Services Interoperability Principles (JESIP) definition of a Major Incident, which is; "*An event or situation with a range of serious consequences which requires special arrangements to be implemented by one or more emergency responder agency".*

2.4 It was clear that all agencies attending the MACG had special arrangements in place in order to deliver their "critical functions" and that none were working within their own business as usual parameters. Therefore, the Major Incident was declared. It is important to stress that declaring a major incident is a judgement call based the professional assessment of risk based on the information available taking into account whether the situation is likely to improve or deteriorate.

2.5 On 27th January at the Strategic Co-ordination Group (SCG) (which had replaced the MACG once the Major incident had been declared) meetings partners once again assessed the data and situation which indicated that the increase in hospitalisations to the levels feared had not materialised. Also staff absence across all agencies had got markedly better through January relieving the pressure across the system as a whole. The view was at this point that the outlook was also for an improving picture moving forward. Therefore, the assessment was that while the situation remained serious within Health and Social Care, the multi-agency structures were no longer required and that the situation could be managed exclusively within the Health and Social Care structures that had been running side by side with the Multi agency ones.

2.6 Following the stand down from the Major Incident on 27th January and in line with the usual LRF processes a debrief was instigated and initial findings are included in this paper.

2.7 Nationwide learning from the Pandemic as a whole will be disseminated to agencies through their home Government departments or via the LRF in the future once a full national review is complete.

3. Recommendations

3.1 It is recommended that the Board:

a) Note the report
b) Note the purpose of the Local Resilience Forum (LRF) and its role within planning, preparing and responding to a health emergency, nationally or locally.
c) Note category one responder's responsibilities in relation to the LRF

3.2 These recommendations are made in order to inform members of the Health and Wellbeing Board about the role of the LRF within the County of Northamptonshire and how the Major incident in January was managed together with any early learning identified.

3.3 There is no action required of the board at this time.

3.4 Recommendations that fall out of the debrief to this particular event will be dealt with in the first instance by the LRF. Any issues that require notification or action from the HWWB will be subject to a separate report.

3.5 National learning from the UK's response to the Pandemic will be disseminated across Government departments and statutory agencies and partnerships as these become known.

4. Report Background

4.1 In March 2020 the UK Government declared a National Emergency and subsequent "Lockdown" in order to deal with the Coronavirus (COVID19) Pandemic which had originated in Wuhan, China in late 2019.

4.2 In order to facilitate the response to the Pandemic the Government utilised the LRF structures around the Country (which are based on Police Force areas) to execute the strategy at local level. This was in addition to Public agencies also being engaged via their home Government departments.

4.3 Throughout the period of the Pandemic the LRF structures have been utilised in order to co-ordinate the response within the County. This has necessitated the instigating of a "Major Incident" at times where it was felt that the situation met the definition as outlined in 2.3 above.

4.4 Local Resilience Forums (LRF's) are a construct of the 2004 Civil Contingencies Act. The Act was brought into being following a number of national and international civil emergencies in the early 2000's including Flooding, Fuel shortages, Foot and Mouth disease and Terrorist attacks. The Act set out the structures that were to be utilised to plan and prepare for civil emergencies at local level. These have since been augmented with the Joint Emergency Services Interoperability Principles (JESIP), following the outcomes of other civil emergencies i.e. 7/7 London Bombings, which have become in effect the accepted doctrine in relation to managing a multi-agency incident.

4.5 LRF's prepare a local Community Risk Register, which is derived from the National Risk Register that is updated by Central Government periodically. This sets out the risks within the County and is the basis for setting a business plan and priorities for the LRF in terms of writing, updating, and exercising relevant emergency plans etc. It is worthy of note that the Northamptonshire LRF took part in the National Pandemic Influenza exercise (Cygnus) in 2016.

4.6 It is important to note that the LRF is not a legal entity but a partnership made up of category one and category two responders. Category one responders include the Emergency Services, Local Authorities, NHS England, NHS Foundation Trusts, NHS, Hospital Trusts, Public Health, UKHSA, Environment Agency. Category Two responders include Utility companies, Transport agencies and Voluntary agencies.

4.7 LRF's facilitate a multi-agency response by providing a framework within which agencies can co-ordinate with each other to resolve incidents utilising the JESIP as a guide to ensuring that joint working is effective in managing the immediate situation and consequences that result from it.

4.8 Throughout the Pandemic multi-agency working has been effective within the County which has strengthened relationships and understanding between partner agencies.

4.9 It is worth noting however that while pandemic influenza has been a known risk for many years, it is the first time that LRF's and the multi-agency structures have had to deal with an incident that has lasted over such a protracted period of time. It is also true to say that the Pandemic has been different from the "usual" type of emergency agencies would normally deal with i.e. Large Fire, Flood etc. which tend to be over a relatively short timescale. This in itself will provide learning for the future.

5. Issues and Choices

5.1 Since the beginning of the pandemic the LRF structures have been utilised to manage the response to the Pandemic from a multi-agency perspective, with each agency also having internal arrangements in place to manage their own situation.

5.2 The response element of these structures started to transition to recovery in around July/August 2021. To this effect a Recovery Co-ordinating Group (RCG) and associated sub groups were running to try and co-ordinate recovery activity across the County. However, this was difficult as the Government had not at this point published a National Recovery Strategy.

5.3 As we moved through September and early October it became increasingly clear that some agencies very much felt that we were still in a response as opposed to a recovery situation, albeit it was not felt that we were in Major Incident territory. This was articulated at a recovery workshop held at One Angel Square on 22nd October, in particular by Health Colleagues.

5.4 As a result of this it was decided that the RCG should change to a Multi-Agency Co-ordinating Group (MACG) that included elements of both response and recovery. The MACG was at this time meeting on a fortnightly basis in order that all agencies had a common operating picture in relation to COVID in the County. As were also entering the winter period it was also decided that the MACG should also incorporate the risks from “Winter pressures” in addition to COVID.

5.5 As we went through November awareness of the Omicron variant, which appears to have originated in South Africa, grew. This resulted in the UK Government declaring Omicron a “Variant of Concern” on 26th November 2021.

5.6 On 30th November the Government announced new national restrictions in response to the spread of the Omicron variant. Through early December it was clear that Omicron was spreading quickly within the UK and had become the dominant variant within a relatively short space of time leading to increasing case rates both nationally and within the County.

5.7 At the MACG on 16th December it was agreed to move the frequency of the meeting from fortnightly to weekly in order that all agencies were kept up to speed with what was a fast moving situation with increasing case rates and hospitalisations. In addition, there was a big push both nationally and locally in relation to the booster programme, the Governments preferred response strategy to tackle Omicron, which health colleagues confirmed could be delivered within the County within the current arrangements/resources that were in place.

5.8 A MACG meeting was held on 23rd December where all partners were updated on the increases in case rates and hospitalisations as well as sharing information in relation to staff absence rates.

5.9 It is important to note that in addition to the Multi-Agency structure, a parallel Health and Social Care (H&SC) Incident Management Structure was also

running with a Health and Social Care Strategic Co-ordination Group (SCG) and Tactical Co-ordinating group (TCG) taking place regularly.

5.10 On 29th December a Health and Social care SCG was held, however the Multi Agency MACG due to be held that afternoon was cancelled. It is not clear who took this decision. As the LRF Chair I had been chairing the Multi Agency Meetings but was on leave over the Christmas and New Year period and did not become aware of the cancellation until later on the evening of the 29th Dec.

5.11 The next Planned MACG meeting was held on 6th January. At this meeting all agencies reported their status. From this it was clear that the situation had deteriorated significantly in terms of case rates, hospitalisations and most starkly staff absence across all partner agencies. The most likely reason for this was an increase in social mixing in the lead up and over the Christmas and New Year period. The result of this was twofold, firstly significant pressure across the Health and Social care system, together with other agencies having reduced capability having put business continuity measures in place to deal with increased staff absence. The result of this was a deteriorating situation with less capacity within the system to combat it.

5.12 The discussion on 6th January therefore centred on whether we should collectively declare a major incident. It is important to point out that there was clearly some confusion at the meeting in relation to terminology. Both Health and Local Authorities felt that they were in “Critical” incident status and had requested that the LRF declare a Critical Incident. However, it was pointed out that Critical Incident status does not exist within a Multi-Agency environment and that the term “Major” Incident is used should it be felt collectively that the criteria had been met. Therefore, with agencies in agreement a major Incident was declared but at this point not communicated more widely. At this point the MACG became the Strategic Co-ordinating Group (SCG) in line with accepted doctrine and terminology.

5.13 A supporting structure for the Major Incident was also discussed and it was agreed that as there was already a Health & Social Care TCG running that this TCG would co-ordinate the tactical response inviting other agencies as required. It was also agreed that the COVID programme team within the Local Authorities would provide the secretariat support for the multi-agency structure and it was thanks to them that a “Battle Rhythm” of meetings could be established quickly.

5.14 Also at the meeting on 6th January the representative from the Resilience and Emergencies Division (RED) effectively the Government Liaison Officer offered to arrange a meeting with the Department for Levelling Up Communities and Housing (DLUCH). This duly happened on 11th January, however no Government support was offered, instead Local Authorities asked if the Government would consider “easements” which were subsequently turned down. We were informed that another meeting would be arranged in a weeks’ time to see how things were progressing. This meeting did not take place.

5.15 At 5pm on the evening of the 6th January a H&SC SCG was held to which I as the LRF chair was invited in order to explain/discuss the issue with regard to terminology i.e. Critical/Major Incident. It was also agreed that once agencies

had briefed their respective Governance arrangements and local MP's had been informed a press release would be issued.

5.16 Between 6th January and 27th January weekly multi-agency SCG's were held where updates were given and assistance discussed. At the meeting on the 13th January the Military Liaison Officer informed the SCG that the Military would be sending assistance to the two acute Hospitals and also providing support to East Midlands Ambulance Service (EMAS), this was in addition to the Support the Fire Service was already giving. No-one on the SCG appeared to be aware of the Military support as no Military Assistance to Civil Authority (MACA) request had been made through the LRF. It was later discovered that the MACA had been made by regional health officials direct to Government for support throughout the Midlands region. In addition, the Fire Service were once again asked to assist with mortuary support, moving a number of deceased from NGH to the Temporary Mortuary at the Leys.

5.17 At the SCG on 20th January it was clear that while the situation in terms of case rates and hospitalisations together with the situation within social care remained serious, staff absence rates across all partner agencies was starting to improve as people came out of self-isolation following the holiday period. As such capacity within the system as a whole had started to improve.

5.18 On 27th January a decision was made to stand down the Major Incident from a multi-agency perspective as Health and Social Care partners felt that with an improving picture, they were confident that they could manage the situation within the Health and Social Care structures without the need for outside assistance. It was agreed that the Military support would continue until 11th February and then be reviewed. The mortuary support from the Fire Service had by this time had been stood down.

5.19 A debrief in relation to the Major Incident has been held in recent days and common themes are highlighted below:

- There is general agreement that it was the correct decision to declare a Major Incident.
- Even though the surge in Hospitalisations did not materialise, this could not have been known at the time and preparing for the worst was the key consideration.
- It provided a platform for shared understanding of the situation and risk across all partners in line with JESIP principles.
- Declaration of Major Incident provided the ability to communicate both internally and externally as to the seriousness of the situation.
- Sent a message to Central Government as to the seriousness of the situation in Northamptonshire and facilitated a meeting with the Department of Levelling Up, Communities and Housing (DLUCH)
- It facilitated agencies ability to internally redeploy staff to other duties.
- It provided the framework for agencies to deploy staff to assist in the wider response if and where required.
- The Local Authority COVID programme team were instrumental, working with the LRF business manager, in ensuring that good secretariat support was provided,

- There are differing views about the “value added” by calling a major incident and implementing the multi-agency structure.
- Enhanced understanding that not all agencies need to be in same situation or have the ability to be able to contribute in the same way when a major incident is declared.

5.20 A number of Learning points have also been identified for further consideration:

- Appropriateness of current multi-agency structures for dealing with protracted incidents.
- Awareness of how and who can call a major incident.
- Difficulty of running parallel incident management structures resulting in no Multi-Agency Tactical Co-ordinating Group running.
- Difficulty in integrating the legacy COVID structures into a new major incident structure, leading to a disconnected structure.
- Need to ensure that all partners included in meetings/decisions. In particular, in this case the UK Health Security Agency were not present at the early meetings.
- Awareness of Terminology and meaning i.e. critical/major incident etc.
- Capacity for providing a secretariat function for protracted incidents
- The need for clarity as to what the “ask” is of other agencies/Government in terms of assistance.
- Awareness of process for requesting Military assistance via the Military Assistance to Civil Authority (MACA) process
- Requirement for multi-agency Gold and Silver training across LRF agencies to enhance understanding of JESIP principles.
- Dealing with the expectations and perceptions of the media at this type of incident.

5.21 These issues will be taken forward for discussion and consideration within the LRF and within partner agencies.

6. Implications (including financial implications)

6.1 Resources and Financial

6.1.1 Financial impacts with regard to the LRF can be met from the LRF budget. This is partly via contributions from Countywide partner agencies (approx. £3k per year) or direct from Central Government in the form of LRF Pilot funding, which has recently been agreed for the next 3 financial years. The purpose of the funding is for LRF’s to increase their strategic capacity and capability to deliver in line with the Governments aims and objectives as set out within the HM Government document “Global Britain in a Competitive age: The Integrated Review of Security, Defence and Foreign Policy” known as the “Integrated Review”. The main purpose of which is to increase the resilience of the UK in terms of dealing with a range of threats and risks as outlined in the National Risk Register.

6.1.2 Currently the LRF funding is utilised to fund 1FTE business manager post, however there is a requirement within the LRF to increase this capacity in order to be able to discharge the workload envisaged over the coming years.

6.1.3 Resource and financial impact within each agency would need to be managed within each agencies plans based on their own assessment of risk. However, all category one responders are expected to contribute resources in order to discharge the requirements of the LRF business plan which itself is derived from the assessment of local risk encapsulated within the Northamptonshire Community Risk Register.

6.2 **Legal**

6.2.1 Category one responders as defined within the CCA have a legal obligation to work within the LRF in order to prepare for civil emergencies. However, the LRF cannot direct the resources of individual agencies.

6.3 **Risk**

6.3.1 Planning and preparing for emergencies in terms of organisational resilience, business continuity and response mitigates a variety of corporate risks. As such all agencies as category one responders should play a full part in contributing to the LRF business plan.

6.4 **Consultation**

6.4.1 No consultation has taken place in regard to this paper as it is for information only.

6.5 **Consideration by Scrutiny**

6.5.1 This paper has not been through the Local Authority scrutiny process.

6.6 **Climate Impact**

6.6.1 While there is no direct climate impact from the paper itself, the purpose of the LRF in planning, preparing and responding to emergencies will have a positive climate impact as it mitigates the consequences of environmental events.

6.7 **Community Impact**

6.7.1 While there is no direct community impact from the paper itself, the purpose of the LRF in planning, preparing and responding to emergencies will have a positive Community impact as it mitigates the impact of emergencies on the community.

7. Background Papers

7.1 None

North Northamptonshire Council

Item no: 12

North Northamptonshire Health and Wellbeing Board

Report Title	**Northamptonshire Integrated Care System Update**	
Report Author	**Bhavna Gosai, Head of Programme Delivery, ICS**	
Contributors/Checkers/Approvers		
Other Director/SME	**Naomi Eisenstadt**	**Northamptonshire NHS ICB Chair Designate**
Other Director/SME	**Eileen Doyle**	**ICS Transition Director**
Other Director/SME	**Dionne Mayhew**	**NHCP Communications Lead**

List of Appendices

Appendix A ICS Workstream update
Appendix B Integration White Paper: Joining Up Care for People, Places and Population

1. Purpose of Report

To provide members an update on the Northamptonshire ICS Programme

2. Executive Summary

2.1 This report looks to brief members as to the overall position of the ICS transition programme and provide summary updates for all workstreams.

3. Recommendations

3.1 It is recommended that the Board:

a) Note the changes to the legislative timetable
b) HWBB members are asked to consider how the board is aligned to the ICP arrangements
c) Continue to support the next steps and direction of travel for Northamptonshire ICS delivery to July 2022.

ICS Transition Progress to Date

On 24 December 2021, NHS England, and NHS Improvement (NHSEI) released its operational planning guidance for 2022/23. The guidance confirmed that a new target date of 1 July 2022 has been agreed for ICSs to be legally and operationally established.

This replaces the previously stated target date of 1 April 2022. The reason for this delay was to allow sufficient time for the remaining parliamentary stages. With the delay a refreshed ICB establishment timetable has been released by the national team.

It is important to recognise that the CCG will remain accountable for delivery of our statutory functions until the new ICB is in place and for ensuring that due diligence is undertaken to allow the legal transfer of people, property, and liabilities.

The programme team will continue to support and work with leads and assess the impact of the delay. Appendix A provides an update on each of the workstreams as at the end of January 2022.

The delay to the timetable will mean that all work streams are impacted, in particular Finance, HR and Governance and accountability, as the workload for the leads will increase as many of the activities will need to be completed twice.

There is now significant pressure on the CCG teams with the pressures in the system due to demand and the complexities and additional work the delay will bring.

Integration White Paper: Joining Up Care for People, Places and Population

In September 2021, the Government published Building Back Better: Our Plan for Health and Social Care. This included a commitment to develop a comprehensive national plan for supporting and enabling integration between health and social care, with a renewed focus on outcomes, empowering local leaders and wider system reforms.

The subsequent 'Integration White Paper' (IWP) Joining Up Care for People, Places and Populations was published on 9 February 2022. See Appendix B.

It sets out the Government's proposals for how NHS and local government partnerships can go 'further and faster' across the country, building on the joint-working that has been demonstrated during the pandemic and the legislative changes set out in the Health and Care Bill. It has a particular focus on delivering integration at 'place' through the agreement and pursuit of shared outcomes across health and social care.

Subject to legislation being agreed each ICS will comprise an:

- Integrated care partnership (ICP): the broad alliance of organisations and representatives concerned with improving the care, health and wellbeing of the population, jointly convened by local authorities and the NHS.

- Integrated care board (ICB) bringing the NHS together locally to improve population health and care.

Integrated Care Partnership will be statutory committees formed between (as a minimum) the ICB and the Local Authorities that provide social care services. This will be built on existing partnerships arrangements and collaboration across the system.

The ICP to be formed will be on the principle of equal partnership between the NHS and local government in delivering services. It is expected that each ICP will adopt a model of representation which reflects the diversity of the local provider sector and ensures meaningful engagement with providers of all shapes and sizes.

The formation of our Northamptonshire ICP will need to consider the following;

- How do the two HWBBs link in with the ICP arrangements?
- What are Northamptonshire ICP arrangements?
- Who will chair the Northamptonshire ICP?
- The membership of the Northamptonshire ICP?

Communications and Engagement

The communications and engagement team are scoping the methodology for developing a framework for community engagement at all levels for ICP and ICS key stake holders across will be invited to be part of the framework development. The ambition will be for partners across the ICS we have clear and robust methodology for embedding the community voice at all levels and with consistency. In working together with partners to shape how we work in the coming months we will also aim to have a strategic approach to what we will implement in our first year.

Readiness to Operate Statement (ROS)

Since the October 2021 submission, the team have updated the ROS template based upon the ROS evidence and expectation subsequently received from NHSE/I. The SRO leads have completed the ROS template which include details of the key milestone/evidence completed and where any evidence is held, provides details of upcoming milestones/evidence, any risks/issues/decisions identified and detail any additions that cannot be mitigated by the SRO and/or element lead and therefore need to be escalated.

NHSE/I evidence is based on an assurance level of A – tell us, B Show us and C work with us SRO leads are liaising with the NHSE/I subject matter experts to ensure mutual understanding of progress to date.

Initial feedback from NHSEI colleagues is positive; the system has provided evidence as required and demonstrated progress as of December 2021. The ICB timetable indicates the next iteration of the ROS will be March 2022; the team will work with system SROs to update the ROS progress and evidence.

Next steps

- Programme team to review the checklist and add the evidence required
- Continue to support SRO and workstream leads

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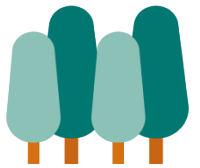
Northamptonshire
Health and Care Partnership

ICS Programme: Transition Steering Group

01 February 2022

Appendix



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Northamptonshire
Health and Care Partnership

Programme Highlight Report

For information and discussion

Programme Highlight Report – 28 Jan 21

Northamptonshire Health and Care Partnership

STRATEGY WORKSTREAM PROGRESS SUMMARY

- Outcomes Framework taken to Jan Partnership Board. Request for the outcomes framework to go to Boards of partner organisations before final ratification.
- Health Inequalities plan is incorporated into the workstream. HI Plan in development with expected sign off in April. Alignment and input to 2022/23 operational planning.
- 'Plan for a plan' requirement by NHSEI being examined locally with options development in progress for wider discussion.

Decisions for fortnight ahead	Dependencies raised	Priority risks / issues	Delivery RAG
Outcomes Framework: • What is the nature of Board engagement? • Are we seeking sign off or are we consulting? • Further advice being sought ahead of Board meetings.	Outcomes Framework: Existing dependencies being mitigated: • **Collaboratives** – re-agreement of revised framework with collabs as part of next steps planning • **Communications** - reliant on the comms team having capacity to support the creation of the final design. There are no indications this is a risk to delivery. Comms have raised risks around resource. **Health Inequalities**: • Collaborative Engagement within 22/23 operational planning programme. **Plan for a Plan** • Potential dependency on other organisations to develop system strategy in line with ICP expectations. This will require further discussion and engagement.	• Development timeline – Framework requires additional development based on ongoing feedback, impacting timeline for development. Will have a knock on effect on PHM programme. Programme to assess knock on impacts for other workstreams • End Product - IF we are not clear on the expected content & scope of the final product THEN we may see delay in final delivery in March 2022. • H&WBB Place - IF we are not clear on the Place based role relating to outcomes framework, THEN there is a risk that ownership relating to delivery is unclear and delayed. Discussions with HWB's are ongoing • Leadership: pending departure of Director of Population Health Strategy: IF we are no clear about interim capacity and ownership, THEN there is a risk of delay to the programme.	

Significant issues and delays | Minor issues and delays | On target

Programme Highlight Report – 28 Jan 21

Northamptonshire Health and Care Partnership

ICB GOVERNANCE WORKSTREAM PROGRESS SUMMARY

- Workstream on track with plan.
- Plan has been reviewed in light of national guidance and assurance requirements.
- Draft constitution submitted, feedback received. Further draft to be submitted subject to confirmation of date.
- Delays to passage Secondary legislation, anticipated to be passed through House of Commons May 2022, risk to recruitment to board and ICB legal/ regulatory duties.
- Non-exec recruitment underway.
- Developing plans to establish shadow ICB committee structure from April 2022.
- Draft COI policy, awaiting feedback from NHSEI.

POINTS TO NOTE

- Potential for variations of Constitution dependant upon NHS England feedback.
- Continued iteration of ICB shadow arrangements based upon feedback received

Decisions for fortnight ahead	Dependencies raised	Priority risks / issues	RAG

• Draft TOR for ICB committees prepared 31/01/22
 	
• Submission of Further draft constitution TBC
 	
• Engagement on ongoing CCG governance arrangements and support to establish ICB shadow arrangements –
  • 15/02/2022 (CCG GB)
  • 17/02/2022 (NHCPB)
	Existing dependencies being mitigated:
	
	• **RED Development and agreement of ICS operating model** – Supports system delivery and allows the ICB committees to function as intended – Mitigation - The transition programme to develop and gain agreement on the operating model. (purple boxes)
	
	• **People** - ICB Board design in relation to People workstream. Linkages to HR Resource for recruitment to Non-Exec roles made, work ongoing.
	• **ICP / Place workstreams** – Links with ICP Leads establish to further develop functions and decision map.
	• **Finance - SORD -** Link in to Finance workstream for SORD and decisions map/structure is developed.
		• **ICB governance 1st July 2022 -** Passage of Secondary legislation may not provide sufficient time for the system to undertake the works necessary to establish the ICB. - Continue with Planned works whilst waiting for the guidance.
		
		• The system not able to operate ICB shadow arrangements:
		  • Unable to recruit to essential posts.
		  • Unable to agree ICB shadow committee arrangements.
		  • Vacant posts prevent the establishment of intended shadow arrangements.
		Mitigation: CEO role now recruited to.
		Linkages to the HR resource for Non-Execs established.
		Recruitment underway. Change management process in place.
		Risk that passage of secondary legislation doesn't allow time to recruit partner members. Development of ICB shadow arrangements underway.	

Significant issues and delays | Minor issues and delays | On target

Programme Highlight Report – 28 Jan 22

Northamptonshire Health and Care Partnership

CLINICAL & PROFESSIONAL LEADERSHIP MODEL WORKSTREAM (CPLM WS) PROGRESS SUMMARY

- Next Steps paper agreed by the workstream working group
- NHS Elect sessions developed and three dates scheduled throughout February and March
- O&D ands E&I representatives invited to join working group

Decisions for fortnight ahead	Dependencies	Priority risks / issues	RAG
• Nominations for NHS Elect workshops to develop principle 4 delivery • Leads for all workstrands agreed	**Existing dependencies being mitigated:** • **ICB governance** – Medical director is part of the Core ICB Directors. Senior clinical roles are mandated and clinical membership of sub-committees considered. • **ICP / Place – clinical framework alignment**. Place / Sub Place structures will need clinical participants. To be built into Place hypotheses. • **Collaboratives** – appropriate clinical leadership and engagement in place with those programmes. • **Strategic finance** – system clinical baseline established. Finance workstream engaged. • **People workstream** – O&D and E&I representation engaged. • **Communications workstream** – Clinical framework must sit alongside a clinical engagement model for the system.	• **Covid Level 4 response –** Structures remain in place and absorbing bandwidth of working group participants. WS is not on critical path for safe and legal transition. Sufficient float in plan to mitigate issues until end Feb 22. • **Funding –** alignment of national expectations to current system funding. Workstream have established current funding. A review of current funding vs proposed activity to be integrated into Finance WS. Finance model must include LA data. • **Framework engagement and direction overly medical.** CPLM WG has wide representation with membership reviewed quarterly. LA are now both represented at the group as are O&D and E&I representatives. • **System buy-in** for clinical model. Test and refine stage will engage with clinical forums across the system.	

Significant issues and delays | Minor issues and delays | On target

Programme Highlight Report – 28 Jan 21

Northamptonshire Health and Care Partnership

INTEGRATED CARE PARTNESHIP DESIGN WORKSTREAM – No update from last report

Recommendations to Jan 2022 Partnership Board

- Agree that a co-chair arrangement be put in place to consist of the incumbent Chair of the Northamptonshire Integrated Care System Board and an Elected Member from one of the two Unitary Local authorities
- Agree to twice yearly formal partnership meetings, with the option to add in additional development days (suggestion: two development days in year one, and one development day for future years)
- Discuss, propose and agree membership at the NHCP
- Agree that the current administrative function that supports the current NHCP continues to provide administrative support, with all partners continuing to commit to drafting papers and presentations relevant to their contributions at the partnership
- Recognise that significant work was previously undertaken to develop the Northamptonshire Health and Care Partnership name and brand and agree that this is retained, subject to small changes to align consistently to the overall ICS branding

Decisions for fortnight ahead	Dependencies raised	Priority risks / issues	RAG
• Agreement of proposed approach / plan • Agreement of working principles for the Integrated Care Partnership and Board, including approach for appointment of the ICP Chair and high-level membership proposals	**Existing dependencies being mitigated:** • **Place/sub-place** - high degree of dependency with Place workstream discussed – agreed merging of 2 workstreams as mitigation • **ICB** – ICP needs to be aligned to ICB proposed governance, in addition to Place governance	• Capacity and timing – risk that high level approach will not be developed in time for wider engagement or for the completion of the ROS schedule of submissions.	

PLACE AND SUB PLACE MODEL WORKSTREAM PROGRESS SUMMARY – No update from last report

Next steps being considered by the delivery team.

Decisions for fortnight ahead	Dependencies raised	Priority risks / issues	RAG
Place Paper revised timeline • Partnership Board – 20th Jan • System Transformation Delivery Board – Discussion around next steps	**Existing dependencies being mitigated:** • **Collaboratives** – Place proposal to be incorporated into case for changes. • **ICP Design -** ICP Design governance to incorporate place proposal . Agreed to go though the System Exec, Steering Board.	• **Alignment with IC Board and Partnership mapping –** Task and Finish Group developing decision map. • Resource with PA roll out of programme to be confirmed	

Significant issues and delays | Minor issues and delays | On target

Programme Highlight Report – 28 Jan 21

Northamptonshire Health and Care Partnership

DIGITAL WORKSTREAM PROGRESS SUMMARY

NHSX have agreed to provide £250k to support development of the Northants Digital Strategy & Costed Plan. Currently chasing when the funds are expected to land and whether work can commence “at risk” before the funds are in hand.
Natasha Chare has begun familiarisation with the work already undertaken to gather potential themes and principles for the strategy
KW has begun drafting the resourcing plan required to support the digital elements of What Good Looks like for the ICB

POINTS TO NOTE
Current strategic IG contract has come to an end and there is a gap in provision

Decisions for fortnight ahead	Dependencies raised	Priority risks / issues	RAG
• Agreement of the Consultancy organisation to support the Strategy and Plan development • SRO meeting with ICB CEO 7 Feb to consider the digital roadmap for the ICB	• Multiple workstreams	• Lack of clarity when the allocated funding will be available for the consultancy to develop the Digital Strategy. Mitigation Requested to start working ‘at risk’ • Funds are allocated for 2021/22 for work spanning into 2022/23 – Mitigation Plan how best to hold/manage funds in order to delivery work beyond 21/22 • Lack of capacity to drive the strategy development – Mitigation NC allocated to drive strategy activity with support of consultancy services • Lack of clarity on the organisation to be used to provide consultancy services – Mitigation Confirmation from NHSX of the options and buying mechanism	

Significant issues and delays | Minor issues and delays | On target

Programme Highlight Report – 28 Jan 21

Northamptonshire Health and Care Partnership

CCG TRANSITION WORKSTREAM PROGRESS SUMMARY

- Project team have a robust methodology in place to oversee the CCG closedown work continues with each of the workstreams however the impact the delayed ICB timetable needs further investigation. The next CCG transition board will focus on the impact and risk areas of an in year closedown
- Following the board meeting the workstreams leads will be required to assess new and changed review/checklist issues agree them with the project team.
- The team have drafted a paper on the CCG Transition for CMT, this is being reviewed by the SRO.
- Continue to review and identify the evidence required to ensure progress
- Resourcing, alongside BAU, new variant of COVID 19, winter and continued incident response remains the key risk

- POINTS TO NOTE
- CCG Transition timetable to be reviewed in light of delay in timetable.
- Oundle project and timetable impact risk escalated with Regional Lead

Decisions for fortnight ahead	Dependencies raised	Priority risks / issues	RAG
• Meet and support the requirements of the CCG Due diligence checklist audit the RSM team. • Administration support for future meetings will become a gap due to staff changes.	• None raised	• **Resourcing** - Conflicting demands of CCG staff and their capacity to deliver the transition programme may lead to risks with delivery. Mitigation - Weekly meetings in place to monitor progress, support from comms with fortnightly newsletter, CEO staff briefing. • **Resourcing** - Potential CSU transfers and relocation of services. Close working with the CSU/NHSE/I to mitigate. • **Third party and national agencies** will need to engage with transition (SBS, GBS etc.) and capacity in these agencies is a risk. Consistent engagement and seeking of assurance on detailed transition plans as mitigation. • **Oundle workstream -** Timetable from NHSEI for boundary change remains under discussion. C&P constitution requires 2/3 majority agreement, if required to be in place 1 April 22 decision must be made WC 7 Feb to get through governance process. • **Natural funding transfer between the 2 CCGs** - Raised with NHSE/I Team • **PCN alignment** with Northamptonshire - Confirmation of joining Rockingham Forest PCN- part of Lakeside group • Continue with use of **Out of area Acute service** - Planned/contracting /urgent care workstream to ensure contracts are in place for out of area services are continued	

Significant issues and delays | Minor issues and delays | On target

Programme Highlight Report – 28 Jan 21

Northamptonshire Health and Care Partnership

COLLABORATIVES DEVELOPMENT WORKSTREAM PROGRESS SUMMARY

- MH collaborative case for change (Gateway 1-5) was approved at NHCP Board and will now progress tranche one of the Outcome-Based Collaborative Contract for Adult & Older People's Mental Health Pathways, as from 1 April 2022, between the CCG and the Collaborative
- The Elective Care collaborative case for change (Gateway 1&2) was approved at NHCP Board and will now move onto technical and contractual development
- Both CYP and iCAN have held 2nd stakeholder workshops in January to inform discussions and progress update for NHCP Board in February
- Contracting guidance being developed which will include contracting design principles and definitions of what a contract could look like versus full delegation for 1st April 2022

POINTS TO NOTE

Lessons learnt from MH and Elective Care cases for change governance and engagement process to be discussed at Central Collaborative Steering Group 26th January 2022

Decisions for fortnight ahead	Dependencies raised	Priority risks / issues	RAG
• Following CYP Board (24th January 2022) CYP task and finish group will prepare progress update for February NHCP Board to be signed off virtually by CYP Board	• ICS strategy / outcomes framework - Development of an outcomes framework that resonates with collaboratives (and vice versa – collaboratives that can meet the needs of Northamptonshire's population) • ICB, ICS Partnership design - Development of governance structures that can "dock into" ICS structures at different levels of maturity • Place/sub-place - Linking in with local / neighbourhood structures to ensure place-based input into service models and integration plans • All cross-cutting workstreams (people, finance, infrastructure) - These are all critical enablers for the system and collaboratives within that so ensure to link in • CCG transition - Provide a pathway for transition of some functions at right stage of maturity - must be mindful of collaboratives development	• Capacity of Collaborative teams impacted by Level 4 Covid 19 response. Impact on delivery of Case for Change, delays manageable at this time - Mitigation: Continued monitoring of the programmes against timelines. Collaboratives not on critical path for 1 April. ICS Go-Live confirmed nationally for July 2022. • Contracting team capacity to support Collaboratives through technical requirements - Mitigation: Not all collaboratives require transactional support immediately or at the same time. • Lack of project support to task and finish groups may causing delays to content creation and delivery support to T&F Chairs - Mitigation: Sourced from provider resources where possible. Central funding allocated to support the delivery teams. Additional project support has been secured for CYP and elective care. • Engagement with professional and communities to update on current workstreams required - Mitigation: Engagement with Communications and engagement strategy. Imbed Comms representatives into Collaborative sub workstreams	

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Significant issues and delays | Minor issues and delays | On target

Programme Highlight Report – 28 Jan 21

Northamptonshire Health and Care Partnership

STRATEGIC FINANCE WORKSTREAM PROGRESS SUMMARY – No update from last report

Draft documents supplied as evidence to support ROS sign off sent to NHSEI including the following documents:

- Draft ICB SORD Template
- Function mapping for SORD
- Draft Financial Framework
  - Inc: Description of system financial arrangements to support and enable agreed place-based, provider collaborative arrangements and any commissioning delegation

Work progressed on :

- Financial Strategy Engagement
- SBS full project plan

Decisions for fortnight ahead	Dependencies raised	Priority risks / issues	RAG
• Expecting feedback from NHSEI on draft documents submitted • Revised SBS Project Plan being drafted following the delay to the ICB start date • 22/23 financial planning assumptions agreed in line with national guidance	• **CB / ICP Governance** – Draft Financial Model (FM), Scheme of Reservation and Delegation (SORD) and Standing Financial Instructions (SFIs) are being discussed across the system. • **ICB governance and Collaboratives** – need to identify opportunities to define system wide sustainable finance and transformation plans post ICS transition. • **Collaboratives** – Understanding timeline and financial requirements for integration into SORD and FM. • **Place/sub-place** - developing ICS place based budgets and underpinning mechanisms • **Strategy development / outcomes framework** - financial plans need to link and correspond with system strategy • **Guidance from NHS England** - NHS England sharing further guidance in a timely manner for prompt development of requirements for transition	• **Transformation plans not developed** – Fully developed or delayed transformation plans not in place for April 2022. - Additional extraordinary meetings in place as required. • **Reliance on Third Party Organisations** - delay in response from third party organisations such as SBS, GBS, RBS, HMRC, ESR etc. - Close liaison with Regional Finance to agree approach. • **Finance Team Capacity** - capacity within existing Finance teams to deliver all tasks required for transition. Mitigated by ongoing resource discussions across CFO/DOFs are discussing options	

Significant issues and delays | Minor issues and delays | On target

Programme Highlight Report – 28 Jan 21

Northamptonshire Health and Care Partnership

PEOPLE WORKSTREAM PROGRESS SUMMARY

Continue to progress approved ICS Workforce Plan (agreed Dec 2020) and SWIM objectives.
ICB Chair and CEO appointment process concluded.
NED appointments made following conclusion of recent selection process.

Decisions for fortnight ahead	Dependencies raised	Priority risks / issues	RAG

• People Committee in wider ICS structure to be determined, key meetings scheduled to progress. CO and MS - chairs of the People Board are recommending that the core functions of a people committee including monitoring functions as envisaged by the ICS People and Culture regional programme, governance discussions need to be progressed to agree the format and structure of this approach.
• The proposed approach will allow the ICS people functions to be managed within an appropriate committee and will build on the positive work already undertaken, which has been acknowledged regionally and nationally
	• **Clinical Leadership** –
	  • Dedicated leadership development plan.
	  • Identifying, recruiting and creating a pipeline for clinical and professional leaders.
	  • Creating a culture of shared learning – Mobilisation of Task and Finish Group with OD leads to develop.
	• Place and Sub Place - people plan integration to ICS establishment.
		• **People Committee/People Board** - Need to determine the combination of these two functions. Further discussions planned during Jan to determine way forward.
		• **Workstream resource** - Query over future use of system WDF (HEE funded) funding or future people function use. Mitigation: Discussion with Finance needed to determine recurrent funding gap to ensure stability in the system.
		• **Unable to fully recruit to key posts prior to 1 Apr 21** – CEO / Chair now in role, NEDs appointments in progress with selection processes in Jan 21. Ongoing organisational change process in place.	

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Significant issues and delays | Minor issues and delays | On target

Programme Highlight Report – 28 Jan 21

Northamptonshire Health and Care Partnership

COMMUNICATIONS AND ENGAGMENT WORKSTREAM PROGRESS SUMMARY

- Focus area 1: System stakeholder engagement strategy – focus on planning stakeholder sessions to engage staff cohorts (in planning).
- Focus area 2: System (ICB) community engagement framework (strategy) – meeting with potential interim resource to support with mobilisation. Interviews scheduled for roles 2 February 2022.
- Focus area 3: Development of communications ways of working post ICS establishment (April 2022) System working / supporting collaboratives - comms plan in development for staff, public and stakeholder 'day one' comms (in planning).
- Focus area 4: Development of updated digital suite (ICS, ICB, CCG websites and related intranets) – scoping resource activity and structure planning.
- Focus area 5: Development of styling and 'brand' approach - co-design session planning to be scoped to align collaborative styling
- Focus area 6: Creation of 'day one' comms plans – narrative signed off and design in progress

Decisions for fortnight ahead	Dependencies raised	Priority risks / issues	RAG
• Interim recruitment support for development of engagement strategy / framework (DM – Comms). Workshops to happen from late February • Resourcing additional capacity for digital support (DM / AF – Comms) • ICB day one comms planning – share with CMT • Stakeholder session timings and bookings with organisations / focus areas. Tying in with OD team to coordinate delivery.	No new dependencies noted	• **Stakeholder engagement** – limited stakeholder engagement with critical groups (clinicians, localised staff groups and pubic). • Focussed stakeholder planning has begun for relevant workstreams • Comms team to drive engagement plan, materials and delivery mechanism on behalf of workstream leads.	

PMO WORKSTREAM PROGRESS SUMMARY

- Revised STG format and timetable – moving to a once per month highlight report with alternative weeks focus on enabling workshops.
- Team have begun a review plans with workstreams to make a provisional assessment of the impact of revised timetable released by NHSE.
- Digital and People workstrand check in rhythm established

Decisions for fortnight ahead	Dependencies raised	Priority risks / issues	RAG
Work with SROs to assess the impact of revised timetable for implementation	Place and ICP delivery team contract end Dec 2021	• Requirement to assess critical path for go live given potential national implementation • Place and ICP workstream support gap – discussions ongoing with SROs • Collaborative workstream support due to leave post next fortnight – replacement to be identified	

Significant issues and delays | Minor issues and delays | On target

Programme Risk Summary	RAG
There are currently 19 live risks on the central programme risk register. There are two risks to note. The highest risk recorded is Amber Red and is concerned with the level 4 national Covid response and the impact on plans from a revised NHSE timetable. PMO is conducting check-in meetings with workstreams to revise associated risks throughout February. The second Risk to note is the Boundary Change Project for Oundel, the decision point on implementation of boundary changes from NHSE is WC 7 Feb or the change will not take affect by 1 April 2022.	15 – 28 Jan 2022

Details					Mitigation	Residual score				
Risk ID	Date Logged	Description	• Impacts	Owner	Actions and Individual Owners (Contingency / Mitigating)	Impact	Likelihood	Total	Owner	Status
NEW	12/12/22	Oundle workstream – Decision to implement changes of boundaries wef 1 April 2022 and not 1 July 2022 is outstanding from NHSE	• Failure to implement boundary change 1 April 2022		Escalated to Regional Representative	3	4	12	Sarah Stansfield	Open
11	15/07/21	The current Covid scenario means that **Covid incident response** structures need to be stood up again, absorbing bandwidth and attention, causing delays to this project	• Delays to deliverables • Critical path prioritised for delivery (ICS Transition) best effort for none critical deliverables in 2022.	SRO's, Prog Dir	**Update:** Contingency had been added to work plans where possible, this float in the plan has been used over quarter three and four. A revised timetable issued by NHSE WC 24 January, has adjusted the delivery of the safe and legal transfer to 1 July 2022. Some areas have benefited from the revised timetable but the complexity and volume of work added some areas is considerable. Clarification points have been requested from regional links and SROs have been asked to assess the impact on current plans, maintaining links to workstream Regional Leads.	3	5	15	SRO, ESG	Open

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Department of Health & Social Care

Joining up care for people, places and populations

Published 9 February 2022

The government's proposals for health and care integration

CP 573

Joining up care for people, places and populations

Presented to Parliament
by the Minister of State for Health
by Command of Her Majesty

February 2022

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Contents

Foreword: Rt Hon Sajid Javid, Health Secretary and Rt Hon Michael Gove, Secretary of State for Levelling Up, Housing and Communities

The storms we have weathered over the past two years have been a great test, but also a great teacher.

We have learned, most notably from our world-leading vaccination programme, that we are stronger when we work together and are united in our purpose and resolve.

We have also seen the moral outrage of persistent health disparities, mirroring other disparities in our society, illuminated as never before in our lifetimes. We have been reminded, once more, of the inextricable link between health services and social care.

So, as we recover and level up, it is right that we draw on our experience of the pandemic to bridge the gaps – between health and social care, between health outcomes in different places and within society – that are holding us back.

This is what our white paper aims to achieve by bringing together the NHS and local government to jointly deliver for local communities.

It sets out a new approach with citizens and outcomes at its heart instead of endless form-filling, unnavigable processes and a bureaucracy which sees too many people get lost in the system, not receiving the care they need. It is the start, not the end, of a new wave of reform which will both put power and opportunity in the hands of citizens and communities and build a state that is sustainable and just.

Through introducing a single person accountable for delivery of a shared plan at a local level, our proposals will ensure a more joined-up approach between health and social care. It will give health and social care professionals access to the right data and

technology to make more informed decisions, and it will also help to create a more agile workforce with care workers and nurses easily moving between roles in the NHS and the care sector.

Moreover, the white paper also delivers on our ambition to level up health outcomes over the long term.

It champions health and well-being as a real priority and places a much greater emphasis on prevention.

To that end, it promotes community-centred care to help people with disabilities, who are suffering from dementia and other mental health issues to live independent and healthy lives.

Crucially, we are proposing measures to help bridge the gap in Healthy Life Expectancy (HLE) between local areas by making sure there's universal access to high-quality treatments and support in all parts of the country.

At every step, this white paper has been shaped by the real-world experience of people as well as nurses, care workers and doctors on the front line, drawing on some of the great examples of collaborative working we have seen at a local level in recent years, not least over the pandemic.

It presents the next component of a bold vision for the future of health and social care in this country with people and patients at its very heart.

Executive Summary

The NHS and local government have delivered remarkable things for the public, in the most challenging circumstances, over the last 18 months. From the extraordinary success of the vaccine programme, to meeting the needs of people previously identified as Clinically Extremely Vulnerable and many other examples of reshaping services to continue to deliver care safely. There is a lot for local government and the NHS to be proud of and to learn from as we move into recovery from COVID-19. Through multi-agency community hubs, integrated neighbourhood teams, and other locally developed arrangements, local partners developed a shared understanding of local needs and made flexible use of resources across services to ensure that people got the support they needed. A vast range of other activity has been jointly delivered by various organisations thanks to a combined commitment to go beyond normal organisational boundaries and do whatever has been required to support their local residents. The resilience, commitment to finding a way through for citizens, and the willingness to innovate will all be just as important as we tackle the challenges ahead.

Among the lessons of the pandemic is the need to do more to bring the resources and skills of both the NHS and local government together to better serve the public. So, as well as record investment, NHS and local government reform will be needed to recover from the pandemic and deliver on the government's priorities, including on its central mission to level up every part of the UK. Our health and care system needs to take this agenda forward with real urgency if the challenges the sectors face - both in the short and long term - are to be met; and this will need to be done with the full involvement of local leaders and the public.

Successful integration is the planning, commissioning and delivery of co-ordinated, joined up and seamless services to support people to live healthy, independent and dignified lives and which improves outcomes for the population as a whole. Everyone should receive the right care, in the right place, at the right time.

We want to go further and faster in building integrated health and care services. People should experience joined up care which makes the best use of public resources and services. While a more integrated approach clearly will not address all of the challenges facing staff, joining up services around users can also improve job satisfaction for the staff delivering them - removing some of the barriers that stop staff delivering care as they would like. This requires change that builds on improvements made across the health and care sectors in recent years.

While progress has been made, our system remains fragmented and too often fails to deliver joined up services that meet people’s needs. The goals of different parts of the system are not always sufficiently aligned to prioritise prevention, early intervention and

population health improvement to the extent that is required. That needs to be our focus if we are to continue building better health, tackling unjustifiable disparities in outcomes, and ensuring the sustainability of the NHS and other public services. People too often feel like they have to force services to work together, rather than experiencing joined-up health, public health, social care and other public services.

This paper is part of a wider set of mutually reinforcing reforms: our Adult Social Care Reform white paper, People at the Heart of Care; the Health and Care Bill and reforms to the public health system. It sets out our plans to make integrated health and social care a reality for everyone across England and to level up access, experience and outcomes across the country. Specifically, this paper:

- sets out our approach to designing shared outcomes which will place person-centred care, improving population health and reducing health disparities at the centre of our plans for reform, and ensuring that accompanying oversight arrangements and regulatory structures have a clear focus on the planning and delivery of these outcomes

- sets out proposals to strengthen the health and care services in places that feel familiar to the people living in them. While strategic, at-scale planning is carried out at the Integrated Care System[1] (ICS) level, places will be the engine for delivery and reform

- introduces an expectation for a single person, of accountable at place level, across health and social care, accountable for delivering shared outcomes and strong, effective leadership

- sets out how we will make progress on the key enablers of integration (workforce, digital and data and financial pooling and alignment) required to further join up services around people and populations

- reinforces the role of robust regulatory mechanisms to support the delivery of integrated care at place level

Joined up care: better for people and better for staff

As people who use health and care services require ever-more joined up care to meet their needs, achieving this will make all the difference both to the quality of care and to the sense of satisfaction for staff. Without a decisive shift to consistently joined up care, we will

[1]In this document we refer to 'Integrated Care Systems' or ICSs - an ICS is made up of both the Integrated Care Board (ICB) and the Integrated Care Partnership (ICP) that are set out in the Health and Care Bill. The term 'ICS' is also used to refer to the geographical area covered by the system.

continue to see fragmentation for people and frustration for staff. For example, closer working between primary and secondary care will improve access to specialist support and advice and enable care to be delivered closer to home, managing risk more effectively and keeping people healthy and independent. And closer working between mental health and social care services can reduce crisis admissions and improve the quality of life for those living with mental illness.

Unlocking the power of data across local authorities and the NHS will provide place-based leaders with the information to put in place new and innovative services to tackle the problems facing their communities. A more joined up approach will bring public health and NHS services much closer together to maximise the chances for health gain at every opportunity.

Shared outcomes which prioritise people and populations

Shared outcomes are a powerful means of bringing organisations together to deliver on a common purpose for the people they serve. We have set out the case for a new approach for designing and measuring progress against these. We will work with stakeholders to develop and introduce a framework with a focused set of national priorities, and an approach for prioritising shared outcomes at a local level, focused on individual and population health and wellbeing. We will set out a framework which makes space for local leaders to agree shared outcomes that meet the particular needs of their communities, whilst also supporting national priorities. Places will be able to choose health and care priorities that matter most to their citizens, alongside national commitments. Implementation of shared outcomes will begin from April 2023. There will be robust arrangements in place to assure both the planning and delivery of both national and local outcomes.

Ensuring strong leadership and accountability

Effective leadership, accountability and oversight are key to delivering integration. Local leaders - including in local government and the NHS, in partnership with their citizens - have a unique understanding of, and relationships with, their populations. We will make changes that bring together these leaders to deliver on shared outcomes in an accountable and transparent manner, through formal place-based arrangements which provide clarity over the responsibility for health and care services in each area. Several places such as Tameside have already successfully adopted arrangements of this kind.

We will set out criteria for place-level governance and accountability for the delivery of shared outcomes. We have suggested a model which meets those criteria and expect places to adopt either this specific governance model, or an equivalent, by Spring 2023.

The key characteristics needed in any model will be for it to develop a clear, shared plan and, crucially, to be able to demonstrate a track record of delivery against agreed shared outcomes over time, underpinned by pooled and aligned resources.

Local NHS and local authority leaders will be empowered to deliver against the agreed outcomes and will be accountable for delivery and performance against them. Any governance model should also provide clarity of decision-making, covering contentious issues, practical arrangements for managing risk and resolving disagreements between partners, and agreeing shared outcomes. There should be a single person, accountable for shared outcomes in each place or local area, working with local partners (e.g. an individual with a dual role across health and care or an individual who leads a place-based governance arrangement). This person will be agreed by the relevant local authority or authorities and Integrated Care Board (ICB). We would expect place-based arrangements to align with existing ICS boundaries as far as possible. We recognise that in some geographies this can be challenging, and we expect NHS and local authority partners to work together (drawing, where needed, on the flexibilities that the legislation will provide, subject to Parliament) to ensure that all citizens are able to benefit from effective arrangements wherever they live .These proposals will not change the current local democratic accountability or formal Accountable Officer duties within local authorities or those of the ICB and its Chief Executive.

Places will be supported by central government, NHS England, ICBs and others to develop arrangements which deliver the best outcomes for their populations.

Finance and integration

Financial frameworks and incentives can play a key role in enabling the integration of services and supporting service innovation.

Local leaders should have the flexibility to deploy resources to meet the health and care needs of their population, as necessary. NHS and local government organisations will be supported and encouraged to do more to align and pool budgets, both to ensure better use of resources to address immediate needs, but also to support long-term investment in population health and wellbeing.

Working within the principles set out in this paper, we will work with partners to develop guidance for local authorities and the NHS to support going further and faster on financial alignment and pooling. We will also review existing pooling arrangements (e.g. section 75, NHS Act 2006), with a view to simplifying the regulations for commissioners and providers across the NHS and local government to pool their budgets to achieve shared outcomes. This will continue to be subject to both NHS and local authority partners agreeing what constitutes a fair and appropriate contribution.

Digital and data: maximising transparency and personal choice

A core level of digital capability everywhere will be critical to delivering integrated health and care and enabling transformed models of care. When several organisations are involved in meeting the needs of one person, the data and information required to support them should be available in one place, enabling safe and proactive decision-making and a seamless experience for people.

Digital tools will empower people to look after their health and take greater control of their own care, offering flexibility and support - through the NHS App and NHS.uk, remote monitoring and digital health apps. We will aim to have shared care records for all citizens by 2024 that provide a single, functional health and care record which citizens, caregivers and care teams can all safely access.

We will support digital transformation by formally recognising the Digital Data and Technology profession within the NHS Agenda for Change and including basic digital, data and technology skills in the training of all health and care staff. We will support all health and care staff to be confident when recommending digital interventions to patients and individuals using services, based on what we know works and what people want to access.

To support place-based organisations, Integrated Care Systems (ICSs) will develop digital investment plans for bringing all organisations to the same level of digital maturity. These plans will outline how ICSs will ensure data flows seamlessly across all care settings and use tech to transform care so that it is person-centred and proactive at place level.

The digital and data transformations outlined in this document provide an opportunity for greater transparency. We will look to introduce mandatory reporting of outcomes for local places, putting citizens at the heart of what we do.

Delivering integration through our workforce and carers

The health and care workforce are our biggest asset, and they are at the heart of wrapping care and support around individuals. We want to ensure that staff feel confident, motivated and valued in their roles and that they can work together in a person’s interests regardless of who they are employed by. Staff numbers and skills across teams should be planned to meet the needs of their local populations and places. They should also be able to progress their careers across the health and social care family, supporting the skills agenda in their local economy. Our proposals in this paper build on our proposals to support the social care workforce, as outlined in our Adult Social Care Reform white paper, People at the Heart of Care.

To achieve this, ICS will support joint health and care workforce planning at place level, working with both national and local organisations. We will improve initial training and ongoing learning and development opportunities for staff, create opportunities for joint continuous development and joint roles across health and social care and increase the number of clinical practice placements in adult social care for health undergraduates.

What this means for people and communities

Taken together, these reforms will support a better joined up health and care system, with people's wishes and wellbeing at its heart. Citizens with access to more information will be more empowered to make decisions about their care and have more choices about where and how they access care. Working with local places and ICSs, we will remove unnecessary barriers so places will be empowered to do what is best for their citizens. They will be supported to be transparent and accountable for the delivery on the outcomes which matter to communities, and variations in performance between areas will be addressed. The financial frameworks and incentives which support this will be reformed over time so that the way funding is allocated and accounted for does not prevent places and ICSs doing the right thing for the people they serve.

These reforms will help us develop a world-leading health and care system which works for every person, and where people work together to deliver continuous improvement in the delivery of health and care services. This is possible and necessary, and we will start making it a reality now.

1. Introduction: Delivering More Integrated Services for the 21st Century

The case for going further and faster on integration

1.1 When health and care organisations have a shared mission, work with their local citizens, and pool their ideas, energy and resources to serve the public, the result is often the delivery of outstanding quality and tailored, joined up care, which improves the experience and outcomes for individuals and populations. In recent years, and in particular during the pandemic, we have seen many examples of the power of collaborative working.

1.2 This is, however, far from the norm everywhere, and as the challenges of demography, the possibilities of technology and the expectations of citizens all grow, we will need to move beyond a health and care system where organisations and services operate in a compartmentalised way. People have a range of needs which cannot always be addressed neatly by one organisation or another. There is a greater need for holistic care that fits around these needs; our services, processes, institutions, and policies need to catch up. We know that, currently the public often experiences:

- a lack of coordination between the range of services looking after them. Information or actions can be lost between primary and secondary care; where primary care and hospital teams might have to form treatment plans without the crucial insights from a person's carer; or different specialists might focus only on one or two conditions, without considering the needs of a person holistically

- organisations that are forced or incentivised - by regulation or the financial framework - to focus on their narrow set of organisational outcomes, rather than a health and care service that considers the health needs of the whole community

- duplication in use of resources or patients' time. People being asked for the same information multiple times, by different organisations, which can lead to delays in diagnosis or treatment; or the use of NHS personal health budgets without considering whether an individual also has a personal budget for social care (and vice versa) and the impact on them of managing both budgets simultaneously

- delays in being discharged as a result of competing budgets and care processes

1.3 Ensuring there is holistic care that fits around people needs includes ensuring that people receive the right care and support, and can maintain healthy independent living, beginning with where they live, and the people they live with. Getting these housing arrangements right for individuals and communities is one example that requires the joining up of not just health and care partners, but a wider set of local government functions and housing providers. Today, too many people with care and support needs live in homes that do not provide a safe or stable environment. People's homes should allow effective care and support to be delivered regardless of their age, condition or health status. We want people to have choice over their housing arrangements, and we also want to ensure places 'think housing and community' when they develop local partnerships and plan and deliver health and care services.

1.4 Over the last few years, there has been a great deal of valuable work to bring about greater integration:

- GP practices are already working together with community health services, mental health, social care, pharmacy, hospital and voluntary services in their local areas in groups of practices known as Primary Care Networks (PCNs). Building on existing primary care services, they are enabling greater provision of proactive, personalised, coordinated and more integrated health and social care for people closer to home NHS Chief Executive, Amanda Pritchard, has asked Dr Claire Fuller (CEO Surrey Heartlands ICS) to lead a stocktake of how systems can enable more integrated primary care at neighbourhood and place, making an even more significant impact on improving the health of their local communities. This will report later in the spring

- the Better Care Fund was introduced to support places to integrate better by pooling budgets and ensuring there is joint planning between NHS commissioners and local authorities to deliver care. Better Care Fund plans have aided integrated work to support people to remain independent for longer, integration of reablement and improved performance on hospital discharge[2]

- new models of care and Sustainability and Transformation Partnerships (STPs) considered local health priorities, encouraged better joint planning of services and tested innovative models of integrated care. For example, provider collaboratives in mental health have been empowered to reconfigure

[2] The health and social care interface (nao.org.uk)

local services to reduce out of area placements and bring people closer to home to aid their recovery. STPs aimed to develop sustainable services to improve person-centred care in key areas and to improve hospital performance

- devolution, such as that seen in Greater Manchester, allows local places to have more flexibility to integrate care around the needs of their local populations

- local government and the NHS have jointly planned and commissioned some health services, to join up people's experience of care and address both prevention and treatment

1.5 We know there is more we can do to better integrate health and care services, joining up planning, commissioning and delivery. We must go further, faster. The experience of COVID-19 has shone a spotlight on the health disparities which persist across the country. We need to prioritise prevention decisively and collectively, so that we build health resilience and are well placed to meet the multiple health and care challenges of our changing demographic. Done right, integration will enable concerted, collaborative effort across the whole of the health and care system to reduce the disparity gap and improve population health. In February 2021 we set out our ambitions for the future of health and social care, and for legislative reform to support this, in Integration and innovation: working together to improve health and social care for all. These proposals, including (subject to Parliament) establishing statutory Integrated Care Boards (ICBs) and statutory Integrated Care Partnerships (ICPs), ensure the health and care system will be much better equipped to collaborate across boundaries, make joint decisions and form alliances to tackle shared problems[3].

1.6 These proposals were based on the learning from those at the forefront of delivering more integrated care and support locally; in particular how important their partnerships had been when responding to the COVID-19 pandemic. We remain committed to this direction of travel and just as proud of the achievements of our health and care services as they continue to rise to the ongoing operational challenges they face.

1.7 The creation of ICSs as a formal part of our health and care system is a critical opportunity to remove remaining barriers to integrated care and create the conditions for local partnerships to thrive. This paper builds on those ambitions

[3] In this document we refer to 'Integrated Care Systems' or ICSs - an ICS is made up of both the Integrated Care Board (ICB) and the Integrated Care Partnership (ICP) that are set out in the Health and Care Bill. The term 'ICS' is also used to refer to the geographical area covered by the system.

and provides further detail on our plans to empower leaders and strengthen collective working between the NHS and local government at place to work in partnership to achieve the best for those they serve.

Case study: Teesside

Sexual health services across Teesside's four local authorities, two CCGs and NHS England are collaboratively commissioned by one prime provider. With a strong focus on prevention, the new service has both improved access and achieved savings, and is highly rated by users, consistently getting a high score on the 'Friends and Family' test. It has enabled a greater focus on improving the sexual health of young people, including chlamydia screening, provision of young-people friendly services, access to contraception and outreach, and the prioritisation of HIV prevention. Using equity measures they monitor progress, not just at borough level but using universally shared outcomes.

Our vision for integrated health and care services

1.8 Integration is not an end in itself, but a way of improving health and care outcomes. Successful integration is the planning, commissioning and delivery of co-ordinated, joined up and seamless services to support people to live healthy, independent and dignified lives and which improves outcomes for the population as a whole. Everyone should receive the right care, in the right place, at the right time. Our vision is that integration makes a significant positive impact on population health through services that shift to prevention and address people's needs promptly and effectively; but it is also about the details and the experience of care - the things that often matter most to people, carers and families. This is captured in the 'Think Local Act Personal' statement below:

Everyone should be able to say: "I can plan my care with people who work together, to understand me and my carer(s), who allow me control, and bring together services to achieve the outcomes important to me." (National Voices, TLAP 2013)

1.9 This paper seeks to deliver this vision, through the introduction of shared outcomes, agreed by all local health and care organisations, and the delivery of which all local leaders will be held to account for. To facilitate this, we outline the place level accountability arrangements to underpin delivery and the arrangements for aligning and pooling of resources, digital transformation and changes to regulation that will enable change.

1.10 Integration needs to be delivered at every level:

- individuals: for people wanting to live lives which are as healthy and independent as possible, their communities, for carers and families
- neighbourhood and communities: areas covered by, for example, primary care and their community partners)
- place: a geographic area that is defined locally, but often covers around 250-500,000 people, for example at borough or county level
- system: usually larger geographies of about one million people which often (but not always) cover multiple places
- national: in this case, the whole of England

1.11 Our focus in this document is at place level. It is where local government and the NHS face a shared set of challenges at a scale that often works well for joint action. Strong places are also important for effective working at both system level (with many Integrated Care Systems investing a great deal of effort into developing places within their geography) and at neighbourhood and community level (where the support of places in making improvements happen is critical to success). Our responsibility in central government to facilitate and support improvements at place level, ensuring the right structures, accountability and leadership are in place to enable effective integration locally.

1.12 Whilst children's social care is not directly within scope of this paper, places are encouraged to consider the integration between and within children and adult health and care services wherever possible. The transition to ICSs represents a huge opportunity to improve the planning and provision of services to make sure they are more joined up and better meet the needs of babies, children, young people and families. The Independent Review of Children's Social Care is taking a fundamental look at the needs, experiences and outcomes of the children supported by children's social care. We will consider and respond to the recommendations and final report of the care review once it is published. Government is championing the continued join up of services, expanding family hubs to more areas across the country, and funding key programmes such as Supporting Families and supporting the implementation of the Early Years Healthy Development Review. At the recent Budget, we announced a £500m package for these services, to provide more support for families so that they can access the help and care that they need. Ensuring that every area has joined up, efficient local services, that are able to identify families in need and provide the right

support at the right time, will enable children and young people who rely on multiple public services to thrive.

1.13 This paper sets out our ambition for better integration across primary care, community health, adult social care, acute, mental health, public health and housing services which relate to health and social care.

1.14 Our plans will support the development of a health and care system which:

- is levelled-up in terms of outcomes and reduced disparities
- ensures people have access to health and care services which meet their needs, and experience outstanding quality care
- transforms where care is delivered, according to people's preferences (including at home and in the community). This includes ensuring that people are discharged in a timely, safe and efficient way from hospital
- enables people to access personalised information about their health and care - to give them more control over their own health and care journey - informed by excellent, timely data and integrated care records
- enables data and information sharing to support joined up and informed decisions around an individual’s care, and better understanding of the needs and priorities of local populations
- is delivered by a capable, confident, multidisciplinary workforce which wraps services around individuals and their families and carers
- allows and encourages innovation and digitisation to ensure that we have the right tools which enable people to have their needs met in the right place
- has joined up, workforce planning at the system level to ensure the right people, with the right skills and training to deliver collaborative, person-centred care
- incentivises organisations to prioritise the same shared outcomes and goals, so rather than a narrow focus on their own organisational targets, they can think about health and care journeys and outcomes, to ensure people don't fall through gaps between services or settings, or bounce around the system
- incentivises organisations to collectively prioritise upstream interventions for individuals and communities, and increasingly allocate resource to improve population health and address disparities

- is driven forward by decisive leadership, who listen to and understand the needs of their local people and have clear accountability for delivering those outcomes

1.15 There is a widespread commitment to this agenda - we know health and care professionals and leaders want to do more to join up services. People want the services they use to be better joined up around their needs. Better integration can facilitate better care for people now, as well as in the long-term, as the importance of prevention grows.

1.16 Change is needed, and the potential reward - in better outcomes and value for citizens - is significant. Integration does not, of itself, guarantee improved outcomes - doing it well is what is required.

Our policies, interventions and the support we provide will therefore continue to promote the benefits of flexibility, local learning and the evolution of ways of working at place and system. The truly radical possibilities in this agenda are much more likely to be identified and realised by local organisations than through central prescription.

Case studies

Tom and Maureen:

Tom is 85 years old and has mild undiagnosed dementia, he is currently living at home with his wife of 60 years, Maureen, who has been his constant support. The couple have lived in their home for 55 years. Maureen, who is of similar age to her husband, suffers with pain in her heart from angina and has high blood pressure. It is of increasing concern to their children, Dan and Sarah - who do not live locally, that the couple do not receive support from local services. Tom and Maureen are unaware of where to seek help as both unfamiliar with and lack confidence when using digital technology and feel like they are able to support themselves. Tom suffered from a fall down the stairs and fractured his hip.

Bunmi

Bunmi is a woman with chronic obstructive pulmonary disease (COPD), osteoarthritis and early dementia. She lives in sheltered accommodation and is moving around less than she usually would. Bunmi still tries to attend church every Sunday, however over the past few weeks she has been struggling to get out because of her worsening health and it is affecting her mood

Kwame:

Kwame is from the North East of England and has just celebrated his 18th birthday. Kwame loves to be outdoors and is a big fan of Star Wars. He also has a learning disability, autism and when anxious, he can display behaviour that can be particularly challenging to services.

Kwame has spent several years in an out of area residential, educational placement arranged by the local authority. This caused considerable increase in his anxiety and behaviours, placing himself, staff and other children at risk. This led to him spending more time in self-imposed seclusion. He was admitted for treatment at a specialist children's hospital where he seriously assaulted a member of staff. To make the situation safer for people around him, Kwame's interaction with family and staff was done through a glass pane and intercom system.

Madeleine:

Madeleine is 65 years old and lives alone with her guide dog. She has been visually impaired since birth. She has two grown up children and one grandchild all of whom live abroad. Good technology means that she is in contact with them on a daily basis but gets practical support from being involved in her local community. In common with most visually impaired people, Madeleine does not have any statutory support but relies on the services provided by Guide Dogs for the Blind Association.

Mandeep

Mandeep is a 24-year-old who struggles to maintain a job due to issues with his mental health. He had learning difficulties which were undiagnosed, resulting in his inability to gain a formal qualification. This affected Mandeep's relationship with his family who did not understand why he was not achieving. Mandeep left home at 16 and stayed with friends or in supported accommodation when he could. He has type 2 diabetes and is often tired which has caused issues for him in the workplace. Mandeep is at risk of homelessness as he does not have a steady income and is unsure of where to go for help.

Richard

Richard has long term schizophrenia. He has spent many years constantly bouncing in and out of long stay psychiatric inpatient admissions, but he wanted to live at home independently. After a recent relapse and hospital admission, the ward team identified that part of the reason for his psychotic relapse was that he was falling behind rent payments and his house had damp/heating problems that he couldn't fix. While the clinical team on the ward worked to stabilise Richard, including taking his medication, they also sought

early input from local authority housing workers who work into the ward and could start on the paperwork to maintain Richard's tenancy and arrange work to get the damp sorted.

2. Shared outcomes

Summary

Collaboration is essential to delivering joined up care. Our frameworks should support organisations and systems to work together in pursuit of the same goals, which focus on individuals and population health and wellbeing.

It is right that the national government sets some delivery standards for organisations, to ensure that the public receive a consistent standard of care. But if we are to allow local leaders to work together to make the most of their shared resources on behalf of local people, we need to better support organisations to pull in the same direction.

Some outcomes and goals are appropriately set nationally, but we also need to make space for local leaders to agree shared outcomes that meet the particular needs of their communities. We need a new approach to setting shared priorities which is integrated and focuses on key outcomes which matter for people's health and wellbeing and improve population health. Some local organisations will be focused on the delivery of outcomes relatively independently of other organisations; but to respond to increasing complexity and multi-morbidity, services should be free to support partner organisations, even when they are not the main delivery agent. For example, hospitals should be incentivised to support public health outcomes, and primary care should be incentivised to support social care outcomes.

Following further work with stakeholders, we will set out a framework with a focused set of national priorities and an approach from which places can develop additional local priorities.

Implementation of shared outcomes will begin from April 2023. In parallel, we will ensure that accompanying oversight arrangements and regulatory structures have a clear focus on the planning and delivery of these outcomes.

As part of the shared outcome setting process, we will review alignment with other priority setting exercises and outcomes frameworks across the health and social care system and those related to local government delivery.

Why shared outcomes matter

2.1 Shared outcomes bring organisations and the people they serve together, and shared outcomes with clear plans for delivery make impactful change happen. We have seen this in both the Integrated Care Systems that have made the most progress in recent years and in the collaborative working during the pandemic. Priorities tend to be most effective when they are outcome-focused (rather than focusing on output or inputs), when they are specific, and when they reflect clearly the most important issues for local people. The right outcomes will encourage local innovation and positive change.

2.2 Currently, we have many and varied priorities and outcomes for the health and care system, used by different organisations for different purposes, albeit with some areas of overlap and alignment. There are Outcomes Frameworks for each of public health, the NHS and adult social care, as well as outcomes for local government more broadly. In parallel, priorities have been set in the NHS Long Term Plan and in the Government's Mandate to NHS England. Organisational priorities are also shaped by the broader regulatory framework and by statutory duties.

2.3 In recent years we have seen systems and local partnerships working together to deliver shared outcomes and we need our national frameworks to reflect the increasing importance of collaboration in pursuit of joined-up care for local people. Whilst acknowledging the varying roles the current outcomes do serve across the system, it is important that they do not pull local leaders away from collaboration, but rather enable partner organisations to work together to deliver against outcomes that truly matter to the people they serve.

2.4 As we increase our expectations of integrated working at system and place, it is right that we revisit how outcomes are articulated and prioritised- nationally and locally - to ensure that we are doing all we can to support the achievement of greater integration. This will be vital if we are to achieve a decisive shift to a model focused on population health and delivered through a shared understanding of population need and what can be done to improve services. Outcome frameworks, prioritisation exercises and associated processes designed for one or more organisation- or sector-specific purposes will need greater alignment if we want to go further and faster on integration.

2.5 What counts as a good outcome will, in many cases, require much closer working with people who use health and care services. This should result in people having more control in decision-making about what matters in their individual lives. This is perhaps more developed in social care than in health care, and it is becoming an increasingly important element of effective support for people with multiple

conditions. In defining shared outcomes, success will therefore be reflective of what individuals want for their own care and what will maximise their wellbeing, focused not only on an individual organisation's services but also the connections between organisations and services they provide.

2.6 A new approach to shared outcomes will ensure that organisations can work together, focusing on shared goals which improve outcomes for people and populations, and underpinned by measures which support this aim. Following publication, we will work with stakeholders to set out national priorities and a broader framework for local outcome prioritisation for implementation from April 2023.

Design Principles for a Shared Outcomes Framework

2.7 Generally, places are best placed to prioritise the outcomes for local people that matter the most.

2.8 Shared outcomes will need to be designed by partners across the system and with citizens, grounded in shared insight and understanding of the needs of the population.

2.9 Integration of services and ambition in improving outcomes go hand in hand. Where there is strong alignment, trust and common purpose between partner organisations, accompanied by a strong local role in identifying priorities, we expect to see high levels of ambition in the outcomes which places identify.

2.10 An approach for agreeing local outcomes will be an essential part of the shared outcomes framework. Some national priorities will, of course, always be needed to secure the improvements in care and outcomes that the public expect - such as those to support elective recovery and hospital discharge to ensure people receive the right care in the right place at the right time. To this end, the government will continue to set a Mandate for NHS England. We intend to set out a small and focused set of national priorities, which all places will be expected to deliver alongside their own local priorities. Local and national prioritisation and goal-setting processes should therefore be complementary and realistic. Central government will need to ensure that the priorities set at national level allow sufficient space for local prioritisation in pursuit of the needs of their local populations.

2.11 Outcomes will sit alongside - and complement - systems' and organisations' statutory responsibilities and wider regulatory frameworks, and our intention is to

address the problem of organisations being pulled in different directions by competing outcomes and targets.

2.12 There is also an important national role in ensuring that national and local outcomes work and sit together coherently such that there is clarity and consistency, and so that local organisations and partnerships are able to consider their own progress in comparison with others.

2.13 We do not intend that shared outcomes should add to the overall burden of national requirements. In defining national outcomes, we will consider what can be aligned or replaced from our current priority and outcome setting exercises and frameworks.

2.14 We want to focus on outcomes rather than outputs. Although outcomes are harder to measure and can take longer to deliver, they offer the best prospect of decisions and services which are both person-centred and improve population health over time. When outcomes are long term, we will need to identify interim or proxy metrics which demonstrate that organisations are collectively making progress towards them.

2.15 Our outcomes-centred approach must therefore be focused on the end goals of better person-centred health and care, improving population health and addressing disparities rather than on the process of integration per se. So, for example, outcomes should focus on areas such as people's experience of care, wellbeing, and independence, not on organisational processes or decision-making. Further illustrative examples of outcomes are provided below.

2.16 National bodies with a regulatory or oversight role will consider the setting and delivery of outcomes in discharging their regulatory duties.

Illustrative Examples of Shared Outcomes

Mental health

A shared outcome for mental health could mean people with mental illness living well in the community. A shared set of patient reported outcome measures (PROMs), could help align NHS clinical support with local authority support through social care, housing, and other services to improve recovery rates and quality of life for people living with mental illness.

Maternal smoking

Greater Manchester (GM) have taken a whole system approach to addressing smoking in pregnancy. Working collaboratively with Foundation Trusts, Clinical Commissioning Groups, maternity services and across 10 local authorities. GM have implemented a financial incentives scheme, which enables women to access shopping vouchers at certain timepoints during pregnancy and beyond, conditional on them remaining smoke free. Outcomes from this integrated approach include an increase in the number of women successfully stopping smoking, higher average birth weight of babies and reductions in the number of babies requiring neonatal care.

Enhanced Heath in Care Homes

Enhanced Health in Care Homes (EHCH) provides proactive care for care home residents and is delivered through a whole-system collaborative approach across health and care providers. Primary Care Networks must ensure that every care home has a named clinical lead, receives a weekly home round, and is supported by a multi-disciplinary team, and that every care home resident has a personalised care and support plan within 7 working days of admittance or readmittance. It involves a range of partners, including those from health (both primary and community care services), social care, voluntary, community, and social enterprise (VCSE) sector, as well as care homes, who are expected to work collaboratively with care homes to improve their local models over time.

As part of the care model, there are various shared outcomes which these providers are trying to achieve including:

a. high-quality personalised care within care homes

b. access to the right care and the right health services in the place of their choosing

c. reducing unnecessary conveyances to hospitals, hospital admissions, and bed days whilst ensuring the best care for people living in care home

Hospital discharge

Discharging people from hospital is an activity that needs acute, community, primary care and adult social care to work together. A shared outcome around discharge could bring together a group of outcomes in various existing frameworks to look beyond discharge to ‘right care, right place’.

What we will do

2.17 The government will undertake further engagement with partners and stakeholders and use these discussions to set a focused set of national outcomes alongside a

broader framework for local outcome priorities. Initially, outcomes will focus on health services, the public's health and adult social care. National and regional partners will play a key role in setting coordinated and consistent strategies to enable all organisations within the wider health and care landscape to align their activity to these national and local outcomes.

2.18 Places, working with local people and communities, will then identify and agree their local outcome priorities with reference to the broad framework. Places will agree action required to meet national and locally identified priorities.

2.19 Integrated Care Systems will provide support and challenge to each local area as to the assessment of need and local outcome selection and plans to meet both national and local outcomes. Plans should be in place for implementation from April 2023.

2.20 We expect local arrangements, and the ICSs they are within, to take the lead on identifying issues and barriers to delivery and bring about real change for citizens. The Care Quality Commission (CQC) will consider outcomes agreed at place level as part of its assessment of ICSs. The CQC will also continue to develop its assessment of individual providers, to ensure their contribution to plans that improve outcomes at place and ICS level are assessed as part of the overall oversight framework.

2.21 These will build on existing oversight arrangements, some of which we are aiming to strengthen through the Health and Care Bill. The CQC will play a critical role. In addition to its current role in regulating and inspecting health and care providers, the CQC will review integrated care systems including NHS care, public health, and adult social care and assess local authorities' delivery of their adult social care duties.

2.22 Working with partners, the CQC will consider both the starting position for each ICB and local authority, and the local and national priorities each area needs to manage, to help understand how all those responsible for health and care services are working together to deliver safe, high quality and integrated care for the public. Further work is underway to develop the detail and methodology of the CQC reviews, in line with existing oversight and support processes.

We will engage with partners and stakeholders to effectively design and implement shared outcomes. We will invite views on the following questions:

1. Are there examples where shared outcomes have successfully created or strengthened common purpose between partners within a place or system?

2. How can we get the balance right between local and national in setting outcomes and priorities?

3. How can we most effectively balance the need for information about progress (often addressed through process indicators) with a focus on achieving outcomes (which are usually measured and demonstrated over a longer timeframe)?

4. How should outcomes be best articulated to encourage closer working between the NHS and local government?

5. How can partners most effectively balance shared goals / outcomes with those that are specific to one or the other partner – are there examples, and how can those who are setting national and local goals be most helpful?

3. Leadership, accountability and finance

Summary

Leaders are essential for bringing partners together to deliver outcomes that really matter to people and populations.

We will empower effective leaders at place level to deliver the shared outcomes that matter for their populations by setting an expectation that by Spring 2023, all places within an Integrated Care System should adopt a model of accountability, with a clearly identified person responsible for delivering outcomes, working to ensure agreement between partners and providing clarity over decision making.

We will also work with the CQC and others to ensure there is effective regulation and oversight and that these new models achieve their purposes. CQC reviews will consider both how services deliver safe, high quality and integrated care to the public and the strength of integration within an ICS.

We will develop a national leadership programme, addressing the skills required to deliver effective system transformation and local partnerships, subject to the outcomes of the upcoming leadership review.

We want to build on progress in recent years to go further and faster in pooling and aligning funding to enable delivery at place level. Our expectation is that aligned financial arrangements and pooled budgets will become more widespread and grow to support more integrated models of service delivery, eventually covering much of funding for health and social care services at place level. These should be supported by robust frameworks to manage risk and deliver value for money.

To support this, we are reviewing section 75 of the NHS Act 2006 (which allows partners such as NHS bodies and councils to pool and align budgets) to simplify and update the underlying regulations.

Finally, we are reaffirming our commitment to personal health budgets, personal budgets, and integrated personal budgets as a means for supporting integration around individual patients and people who draw on care services.

3.1 Leaders are essential for bringing partners together to deliver outcomes that really matter to people and populations.

3.2 There are many great leaders in health and care across places in England who have made incredible progress to integrate health and care services and to join up care to improve outcomes for their populations.

3.3 At place level, this is especially important. Local leaders - including clinical and professional leaders - are well placed to understand the health and care needs of their local populations and to deliver the right change to level up health and care outcomes.

3.4 Effective local leaders are responsible - and seen to be responsible - for delivering the right outcomes and value for money, tackling health disparities, and for how well they have brought together the relevant partners to do so. We need to create the conditions to make this the norm in all places.

3.5 Many leaders, however, find that significant effort, persistence and resources are required to achieve the levels of collaboration and integration that match their ambitions and commitment. In particular:

- financial flows, priorities set nationally, and regulations can pull organisations away from shared goals
- managing complexity and a multitude of relevant actors can make partnership working difficult to do
- a reliance on relationships and 'soft' levers can work well in areas where there are strong relationships built over time, but lacks resilience as it is vulnerable to change in leadership, and is not universal
- support and incentives for leaders often focus on developing effective leaders for individual organisations within their siloes, rather than effective leadership of partnerships

Developing effective leadership for integration

3.6 The Health and Social Care Leadership Review will look to improve processes and strengthen the leadership of health and social care in England. It will consider how to foster and replicate the best examples of leadership and will aim to reduce regional disparities in efficiency and health outcomes. The review will report to the Secretary of State for Health and Social Care in early 2022 and will be followed by a delivery plan with clear timelines on implementing agreed recommendations.

3.7 Without pre-empting that review, we believe effective local leaders for health and care should:

- bring their partners together around a common agenda with decisive action in the interest of local people, even when it runs counter to organisational interests

- be able to judge when it is right to remove or challenge organisational boundaries and when it is better to make connections between distinct organisations

- be responsible for delivering outcomes, ensuring data is used and shared safely and effectively, to provide shared insight and a holistic understanding of the health and care needs of their local population

- focus decisions both on what happens at the point of care, and on what is of most benefit from a population perspective – taking a strong interest in what delivers value for money over time

- listen to the voices of people who draw - or may need to draw - on services when designing and improving those services and in defining which outcomes matter to individuals and populations

- support and enable clinical and adult social care leadership in the development and delivery of services

3.8 Again, subject to the recommendations of the leadership review, we will also look to develop a national leadership programme, addressing the skills required to deliver effective system transformation and local partnerships. This programme will also help to build locally the relationships and shared mission that we know is so important to successful integration.

Clear accountability

3.9 Effective integration and local prioritisation require both a strong, shared sense of purpose and clarity of accountability at place level, so everyone is clear who is responsible for delivering what, with which levers and what budgets. This has been demonstrated time and again in local places and wider health and care systems with a strong track record on integration.

3.10 All areas should ensure there is excellent value, good outcomes and improved experience for people. However, the specific areas for action will differ from place to place, as will the accountability arrangements that work best; as is already the case in the most successful places and systems. We therefore have not prescribed either. We do, however, want to ensure the benefits of integrated care are experienced in all places and as soon as possible, and to that end will set out

criteria for local governance and accountability for the delivery of shared outcomes. We have suggested a model which meets those criteria.

3.11 Success will depend on making rapid progress towards clarity of governance and clarity of scope in place-based arrangements. We are therefore setting the expectation that, by Spring 2023, all places within an ICS should adopt either a governance model as outlined below, or an equivalent model which achieves the same aims. The characteristics we would expect a governance model to have are:

- a clear, shared, resourced plan across the partner organisations for delivery of services within scope and for improving shared local outcomes
- over time, a track record of delivery against agreed / shared outcomes
- a significant and, in many cases, growing proportion of health and care activity and spend within that place, overseen by and funded through, resources held by the place-based arrangement

3.12 We would also expect a governance model to provide clarity of decision-making covering:

- contentious issues such as reshaping services within the place (and contributions to wider decisions such as reconfigurations across a wider geography)
- clear, practical arrangements for managing risk, resolving disagreements between local partners, and for agreeing the outcomes to be pursued locally in addition to any set nationally, with strong involvement for the health and care provider organisations for that place
- a single person, accountable for the delivery of the shared plan and outcomes for the place, working with local partners (e.g. an individual with a dual role across health and care or an individual lead for a ‘place board’ as outlined from paragraph 3.18). The single person will be agreed by the relevant local authority or authorities and ICB. This proposal will not change the current local democratic accountability or formal Accountable Officer duties within local authorities, those of the ICB Chief Executive or relevant national bodies, such as the ability of NHS England to exercise its functions and duties

3.13 These arrangements should, as a starting point, make use of existing structures and processes including Health and Wellbeing Boards and the Better Care Fund. They should also provide clarity about what is done at place and at system levels.

An accountability model and local innovation

3.14 We expect all local areas to put in place-based arrangements to bring together NHS and local authority leadership. This will include responsibility for effective commissioning and delivery of health and care services. Local health and care leaders set and agree the shared outcomes and will be held accountable for delivery of these outcomes.

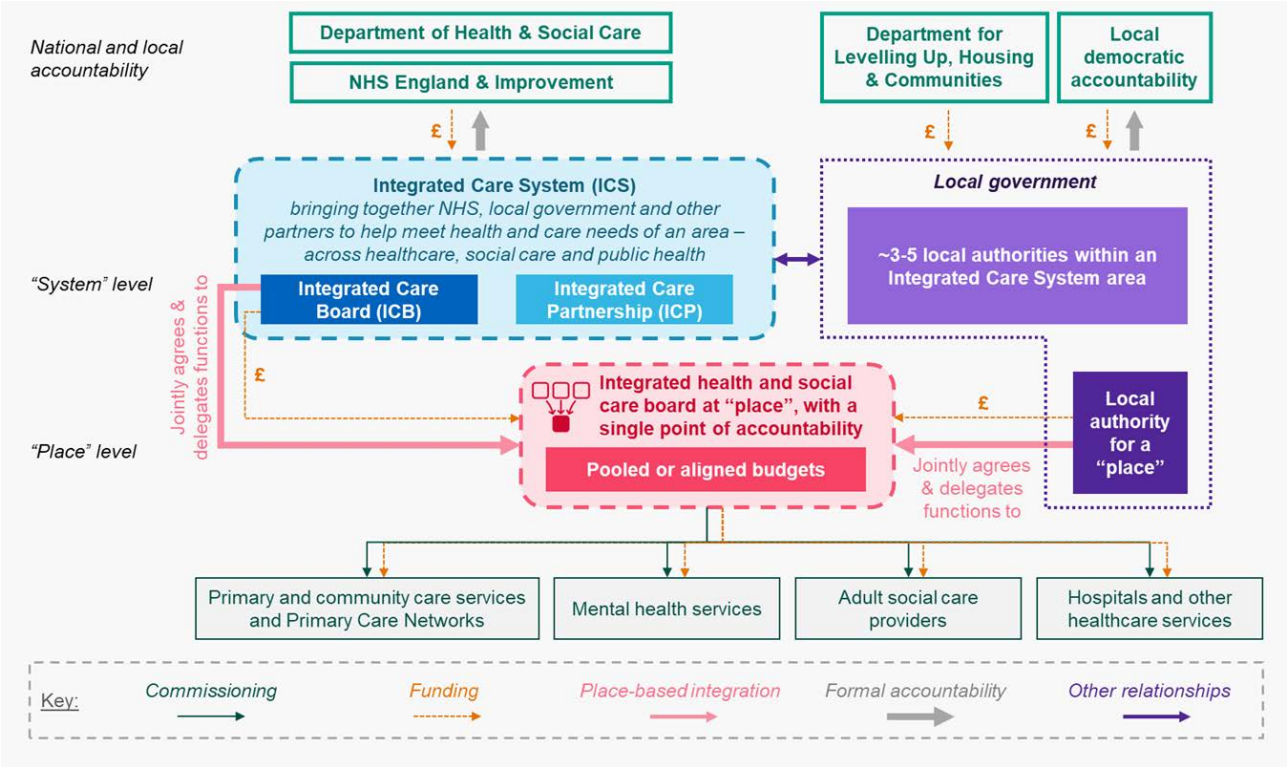
3.15 Places will be able to decide which model they adopt, and we have outlined one illustrative model (the place board model) that is a good basis for delivering the characteristics described above.

3.16 This will build on ‘Thriving Places’, the joint LGA – NHSE guidance published in September 2021.

3.17 Places will be supported in this work by their ICSs and by an NHS England/ local government support offer.

The place board model

3.18 In this arrangement, a 'place board' brings together partner organisations to pool resources, make decisions and plan jointly – with a single person accountable for the delivery of shared outcomes and plans, working with local partners. In this system the council and ICB would delegate their functions and budgets to the board. Integration of decision-making would be achieved through formal governance arrangements (likely to include definition of membership; responsibility for outcome-setting; responsibility for delivery of functions or programmes delegated; financial arrangements including pooling; and dispute resolution and decision-making). The place board lead would be agreed by the ICB and the local authority (or authorities) for the place.



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3.19 As the development of ICSs has shown, there is enormous potential within the health and care system to find innovative ways of managing and improving care, and we want to bring that same spirit to the development of places. We are likely to secure more value through setting challenges than through setting limits on that innovative potential. We would therefore stress that the model described here is simply a model, and not the only one. We believe it meets the criteria we have set out above, and so serves as a helpful illustration of what is needed; but the criteria are what really matter. Both places and ICSs vary in size, with some ICSs covering nearly three million people and others scaled to the same size as places within other systems. Strong systems and strong places complement and support each other; and this means that it will be important for all relevant partners to work together to agree suitable, proportionate, complementary governance arrangements at place and at system level. In the small number of cases where systems and places are effectively the same geography, we would not expect both place-based and ICS arrangements to be set up as that would be bureaucratic and unhelpful. There are no national plans for further changes to ICS boundaries.

[4] Note: This diagram this is a simplified example of potential governance arrangements and not a full representation of the richness, complexity and range of partnership working across the organisations within systems

3.20 In addition to clarity of governance, all places will need to develop ambitious plans for the scope of services and spend to be overseen by 'place-based' arrangements. From April 2023, arrangements for national and local shared outcomes will go live.

3.21 Those able to go further should do so by putting in place extensive inclusion of services and spend at a local level.

3.22 All local areas should work towards inclusion of services and spend by 2026. Of course, local partners would need to agree fairness in pooling arrangements set out at para 3.24 in working towards this goal.

Financial frameworks and incentives

3.23 Financial frameworks, like other critical enablers of integration such as leadership, workforce and digital are essential to realising our vision of integrated care. However, financial frameworks cannot and do not operate in isolation. They must align with and reinforce our wider strategic objectives and delivery approach, including regulatory, accountability, behavioural and organisational frameworks.

3.24 However, in practice, over the last decade, financial frameworks have often been cited as a barrier to the development and delivery of integrated approaches. There is no one-size-fits-all approach, given how different local systems are in terms of the populations they serve and the existing organisations they contain. However, this complexity is challenging to navigate, often requiring complex workarounds which make it hard to plan and share risk - this being critical to delivering integrated approaches. There are mechanisms that places can use to overcome this (e.g. pooled budgets underpinned by legislation through section 75 of NHS Act 2006), but there is scope to simplify and update these mechanisms. In this document, we refer to both 'pooling' and 'aligning' of resources. Pooling requires a more formal agreement while aligning resources - which can include significant resource and collaboration - is less formal. We want to ensure there is flexibility to enable as much collaboration and integration as possible. In some cases, particularly as arrangements at place mature, it may well make sense to put in place more formal pooling arrangements, and we would expect the overall level of pooling to increase in the years ahead. Pooling agreements will remain subject to both NHS and local authority leadership and NHS system and place leaders agreeing what constitutes a fair and appropriate contribution. A clear sense of fairness for all partners is an important basis for integration and, as we have seen in the most effective systems and partnerships in recent years, a strong culture of trust and mutual accountability allows partners to then focus on the pursuit of shared outcomes.

3.25 We have recognised these challenges. Within the NHS, through the Health and Care Bill (subject to bill passage) we are seeking to enable different parts of the health and care system to work together as part of a move towards a whole population-based approach. This will be underpinned by a collective approach to managing resources, with ICSs as the primary unit for NHS financial planning and accountability, operating with a single system funding envelope across acute, ambulance, community, mental health and primary care (starting with general practice).

3.26 Subject to bill passage, these changes will be complemented by other measures such as Joint Committees, as well as a holistic set of statutory duties and oversight. For example, there is the Triple Aim duty which covers the health and wellbeing of people in England, the quality of services provided or arranged by both themselves and other relevant bodies (NHS England, Trusts and Foundation Trusts, and ICBs), and the sustainable and efficient use of resources by both themselves and other relevant bodies. There are strengthened duties to cooperate, as well as clauses on system collaboration and financial management agreement in NHS standard contracts. We are also joining up services for individuals through expanding the use of personal health budgets (PHBs). The NHS Long Term Plan sets out the commitment to grant individuals more control over their own health, and more personalised care when they need it, through initiatives such as the national roll-out of the NHS's comprehensive model for personalised care across the country and accelerating the roll out of personal health budgets to give people greater choice and control over how care is planned and delivered (with up to 200,000 people benefiting from a PHB by 2023/24).

3.27 Pooling of funding to support joint delivery of services is not new and we have established mechanisms for doing this (such as the Better Care Fund (BCF) and section 75 of the 2006 Act). Many areas already use these mechanisms to ensure that the right funding is in the right place to support the delivery of shared objectives with pragmatic mechanisms to manage financial risk. There are examples of systems using these to enable ambitious models of integration which involve pooling a significant proportion of their funding. However, there are also examples of bureaucracy and conflict which prevent pragmatic attempts to improve services. This is not in the interests of those receiving or providing care – local organisations have a shared responsibility to maximise the outcomes of patients, service users and value for the taxpayer.

3.28 Our proposals in the Health and Social Care Bill seek to simplify the governance mechanisms around these arrangements, making it easier for local organisations to collaborate. However, as set out above, we want to go further to drive progress. Our vision for integration, centred around individuals and local populations requires shared objectives, dynamic and collaborative leadership; alongside

mechanisms to enable joint working (such as- pooled or aligned budgets). When set up effectively, framed around people and service delivery, these are an important way of putting the public pound towards a shared purpose.

3.29 The current system allows a lot of ambition using pooled budgets, but it largely relies on local leadership to drive this. Since 2015, through the Better Care Fund, local NHS commissioners (CCGs) have pooled a proportion of their allocations, alongside funding from local government to enable the delivery of joint plans to support person-centred integrated care. The 2019 review of the BCF concluded that it had been effective in incentivising areas to work more effectively, with over 90% of areas saying that the BCF had improved joint working in their locality consistently since 2017[5], and that any attempt to remove or dismantle a pooled budget scheme would be a clear backward step on integration. Moreover, places have voluntarily pooled increasing amounts of money into the BCF year-on-year. In 2020-21, voluntary contributions totalled £3bn above the nationally mandated minimum, double the figure in 2015-16. This represents significant progress and demonstrates what can be achieved through a framework with an element of national requirements and scope for local partners to go further. Later this year we will set out the policy framework for the BCF from 2023, including how the programme will support implementation of the new approach to integration at place level.

3.30 Despite this, we know that local systems say the arrangements to pool budgets can be complex and there are limitations which prevent the most ambitious models of integration. To address this, we will review the legislation covering pooled budgets (section 75a of the 2006 Act) and publish revised guidance. As indicated above, this will continue to be subject to both NHS and local authority partners agreeing locally what constitutes fair.

3.31 Local organisations must, of course, demonstrate careful consideration of value for money and use available funding in line with their respective accountabilities and delegations. Our vision is that this can, and should, also serve shared objectives and secure wider value. Wherever possible, pooled or aligned budgets should be routine and grow to support more integrated models of service delivery, eventually covering much of funding for health and social care services at place level.

3.32 Some systems are already doing this, and it needs to become the norm along with shared objectives and shared delivery plans to improve outcomes for patients and those who use care services. In line with our wider approach, we will not at this

[5] Better Care Fund Policy Framework 20-21. 2021 to 2022 Better Care Fund policy framework - GOV.UK (www.gov.uk)

point mandate how this is achieved, but our expectation is that funding should be pooled and aligned around pathways where the case for joined up care is most pressing. As progress accelerates, we will need to carefully consider the implications for existing mechanisms, including the BCF.

3.33 We will also build on the roll out of personal budgets and personal health budgets across health and social care. The overarching aim is an outcomes-based approach to provide patients and people who draw on social care and support with greater flexibility, choice and control over their care that enables services to be tailored to their particular health and care needs.

3.34 Integrated budgets support integration at an individual level by ensuring support is holistic and can improve a range of health, social care, work and education outcomes for people. Alongside reaffirming our commitment to personal health budgets and personal budgets we will continue to identify opportunities to promote the rollout by supporting places with guidance and sharing best practice.

Oversight and support

3.35 The Health and Care Bill, if passed into law, places a new duty on the CQC to review ICSs as a whole. This will help inform the public about the quality of health and care in their area and review progress against our aspirations for delivering better, more joined up care across ICSs. These reviews are required to look at how system partners are working together to deliver care. The use of resources will be a running theme in the different reviews and assessments, along with delivery against shared outcomes. The CQC will consider outcomes agreed at place level as part of its assessment of ICSs. CQC will also continue to develop its assessment of individual providers, to ensure their contribution to plans that improve outcomes at Place and ICS level are assessed as part of the overall oversight framework.

3.36 Working with partners, the CQC will consider both the starting position for each ICS and local authority, and the local and national priorities each area needs to manage to help understand how all those responsible for health and care services are working together to deliver safe, high quality and integrated care to the public. Further work is underway to develop the detail and methodology of the CQC reviews. This work will be complementary to existing oversight and support processes (including those used by NHS England to support integrated care systems, and sector led improvement in local government).

3.37 We will also work with others to ensure that local authorities also receive appropriate support to play their part in place-based arrangements.

To ensure these proposals on accountability, financial frameworks and oversight will be implemented effectively, we will engage with stakeholders and partners, inviting views on the following questions:

1. How can the approach to accountability set out in this paper be most effectively implemented? Are there current models in use that meet the criteria set out that could be helpfully shared?

2. What will be the key challenges in implementing the approach to accountability set out in the paper? How can they be most effectively met?

3. How can we improve sharing of best practice regarding pooled or aligned budgets?

4. What guidance would be helpful in enabling local partners to develop simplified and proportionate pooled or aligned budgets?

5. What examples are there of effective pooling or alignment of resources to integrate care / work to improve outcomes? What were the critical success factors?

6. What features of the current pooling regime (section 75) could be improved and how? Are there any barriers, regulatory or bureaucratic that would need to be addressed?

4. Digital and data

Summary

Joining up data and information is central to integrating services. All citizens should expect to have access to their own shared care record and for it to cover their health and care journey, with full access, where appropriate, for all the staff they come into contact with.

Health and adult social care providers within an Integrated Care System must reach a minimum level of digital maturity, and these providers should be connected to a shared care record. This will ensure each ICS has a functional and single health and adult social care record for each citizen by 2024, with work underway to enable full access for the person, their approved caregivers and care team to view and contribute to. A suite of standards for adult social care, co-designed with the sector, will enable providers across the NHS and adult social care sector to share information. This will begin with the consolidation of existing terminology standards by December 2022 Data to support an understanding of population health, including unmet need and disparities, should be fully shared across NHS and local authority organisations, to allow 'place boards' or equivalents, and ICSs to plan, commission and deliver shared outcomes, including public health and prevention services.

Each ICS will implement a population health platform with care coordination functionality that uses joined up data to support planning, proactive population health management and precision public health by 2025.

Digital integration will open up new ways for individuals to access health and adult social care services. There has been rapid expansion of digital channels in primary and secondary care services, but there is more we can do to ensure individuals can choose how they interact with services. By 2022, one million people will be supported by digitally enabled care pathways at home.

4.1 The effective use of data and technology to record and share information, is key to the integration of health and care. It will support citizens to take more control of their health and care. The joined up, real-time data that comes from an integrated health and care system will enable continuous improvement, as well as research into new treatments and support developers and innovators to build solutions that improve health and care.

4.2 Better integrated data and technology systems enable people to take greater control of their own health and care needs and preferences using digital tools to

manage their appointments, accessing additional support when they need it and contributing to their record at a time that is convenient to them.

4.3 People will move seamlessly between health and care settings because people and those supporting their health and care, including both professionals and unpaid carers, will be able to see and contribute to their care record and care plans.

4.4 They can be assured that they will not become lost in the gaps between services, either experiencing long delays or with risk factors that should be proactively managed, because data is joined up and everyone who needs it can access it.

4.5 Individuals will use technology to access information and services in more flexible ways, to keep themselves well, and support independence when living with a physical or learning disability, helping to reduce health disparities. They will be confident that health and care staff have their up-to-date information and preferences, regardless of the care setting and won't have to repeat details unnecessarily and understand, with increased transparency, how the health and care system protects and uses their data.,

Using Digital and Data to integrate care

Digitising: records of health and care delivery to be digital, not paper, everywhere

4.6 While more than 60% of NHS Trusts have made good progress into digitisation with 21% now digitally mature (as set out in the What Good Looks Like Framework), and only 10% continuing to rely heavily on paper, the picture is often much more challenging in social care. Only 40% of social care providers have electronic care records, with the rest largely paper based - and this is only improving slowly, at around 3% per year.

4.7 In our Adult Social Care Reform white paper, People at the Heart of Care, we committed to at least £150 million of new funding to deliver a programme of digital transformation over the next 3 years. Digitalisation will not only drive up the safety and quality of care, but also has the potential to increase productivity benefits for social care providers, with digital social care records expected to reduce the administrative burden placed on staff.

4.8 While we are making good progress, there is still work to be done to bring all organisations up to the minimum level of maturity as outlined in the What Good

Looks Like Framework. This framework will be extended to cover community health services and social care, and a tailored framework will be developed for nurses. We will provide support to enable every health and adult social care provider within Integrated Care Systems to reach a minimum level of digital maturity.

Connecting: different systems to exchange information

4.9 "Data Saves Lives", the draft data strategy for health and care, sets out a vision for data that moves seamlessly across health and care and has transparency at its core, giving people access to high quality, timely data to help them make choices about their care and improve outcomes. The data strategy sets out when and how information can be accessed and used by individuals, those caring for them and those planning services. A final version of the strategy will be published in early 2022.

4.10 Basic shared care records are now in place in all but one ICS. However, we must ensure that shared care records cover the entirety of a person's life and include both health and care, which they currently do not. For adult social care, we will ensure that within six months of providers having an operational digital social care record in place, they are able to connect to their local Shared Care Record, enabling staff to appropriately access and contribute to the record. We will also reinforce the use of the NHS number universally across social care to support this. Work is also underway to enable citizens to be able to access and contribute to their shared care records, building on successes to date.

4.11 Standards will be key to delivering integrated care. We will establish a suite of standards for adult social care, co-designed with the sector, to enable providers across the NHS and adult social care sector to share information. This will begin by developing a process to consolidate existing social care terminology standards by December 2022. We will develop a roadmap for standards development (April 2022), which will be underpinned by a new end to end process for development).

4.12 We will put in place systems to link and combine data to enable improved direct care and better analytics for population health management. This includes connecting data from every health and adult social care provider to provide a near real-time picture of NHS care, sharing consistent data at ICS, region and national levels to enable transformation of care pathways, and providing insight to all users through user led product design and supporting deployment functions.

4.13 The digital and data transformations outlined in this document provide an opportunity for greater transparency. We will look to introduce mandatory reporting of outcomes, for local places, for citizens at the heart of what we do.

Information governance

4.14 The Health and Social Care Information Governance (IG) Portal provides simplified advice and guidance on information sharing to health and social care providers. This includes an IG Framework for Shared Care Records to support the workforce to have the confidence to share information where appropriate and enable joined up care. This guidance recognises certain roles within the adult social care sector such as registered managers to be 'health and care professionals', which ensures that information can be more easily shared across health and social care settings.

4.15 Forthcoming proposals in the Health and Care Bill, if passed into law, will support integration introducing a power to mandate standards for how information is collected and stored, so that information flows through the system in a usable way. This will make sure that when it is accessed or provided (for whatever purpose), it is in a standard form, both readable by and consistently meaningful to the user or recipient). The Bill also proposes to create a statutory duty for organisations within the health and care system to share anonymous data.

Transforming: Digitally enabled transformation and the funding, skills and time needed to do it well

4.16 In social care we are driving rapid adoption of proven technologies, such as risk stratification tools, and will scale technology such as acoustic monitoring to prevent falls. By March 2024, over 20% of care homes will have acoustic monitoring solutions or equivalent care tech in place.

4.17 Tech has been demonstrated to have a positive impact on the quality and safety of care, including medications management and hydration monitoring to prevent urinary tract infections (UTIs) and benefits to people's wellbeing such as improved quality of sleep, through enabling more proactive and responsive models of care.

4.18 We continue to improve citizen access to information and services directly through NHS.uk and the NHS App. These products provide access to advice and guidance, individuals with access to their records, the ability to book appointments with their GP, order prescriptions, set preferences for data usage and organ donation, and access their COVID Pass.

Skills and workforce

4.19 NHSX has supported Health Education England to build the next cadre of digital leaders through the NHS Digital Academy. We are addressing the specialist tech skills gap through professionalising the digital profession, bringing in talented tech graduates, increasing the number of apprenticeships offered and harnessing talented entrepreneurial and analytical clinicians through the Clinical Entrepreneur scheme and new fellowships.

4.20 NHS England and NHSX, with partners, have created a 16,000 strong online community of practice (AnalystX) for data professionals and analysts to share knowledge, learning and development, supporting the development of analytical skills for transformation.

4.21 Ipsos MORI, the Institute of Public Care and Skills for Care have supported us with a review of the social care workforce's current digital skills and future skills needs, as well as the barriers and enablers to the use and effectiveness of digital technology in social care. We will use these insights to develop a comprehensive digital learning offer, as well as targeted leadership support, to build the capability and confidence of social care staff to drive change in their organisations. This offer will complement the wider workforce investment package outlined in our Adult Social Care Reform white paper, People at the Heart of Care.

4.22 Well-evidenced digital health technologies can empower patients to manage their own health and help frontline staff to provide high quality care and make best use of their time. The Digital Technology Assessment Criteria for health and social care (DTAC) gives staff, patients and citizens confidence that the digital health tools they use meet our clinical safety, data protection, technical security, interoperability and usability and accessibility standards.

Integrated Care Systems

4.23 An integrated health and care system requires data to flow seamlessly between staff, citizens and their carers. The insights generated will be used to make decisions more quickly, responsively and safely, proactively tailor services to the needs of populations, enable more personalised care and reduce unnecessary interventions. People will have the tools to stay healthy and independent and drive their own care when they need it and will be able to navigate the system and make the decisions that are best for them.

Population health management

4.24 ICBs are expected to agree a plan for embedding population health management capabilities and ensuring these are supported by the necessary data and digital infrastructure, such as linked data and digital interventions.

4.25 ICSs will use Population Health Management to help deliver personalised and predictive care based on an individual's risk. The inclusion of wider determinants of health, will be key to identifying and recognising the impact that factors outside of health and social care can have on the outcomes that people achieve. This must include information about people's living circumstances - for example homelessness or social isolation. The inclusion and transparency of workforce, operational capacity, and financial data across an ICS can also support better use of scarce resources, and improve productivity.

4.26 Real-time insights from joined-up, aggregated data can support multi-disciplinary working, clinical decision support, waiting list management and make the best use of new diagnostic centres in the community.

4.27 The digital transformation of screening will enable the identification of at-risk groups more accurately and target interventions towards them appropriately.

ICS first

4.28 We will take an 'ICS first' approach. This means encouraging organisations within an ICS to use the same digital systems, making it easier for them to interact and share information and providing care teams working across the same individual's pathway with accurate and timely data. Where necessary, we will intervene with ICSs and vendors - including by setting conditions of funding, producing guidance, providing support, encouraging disruption and leveraging other allies. This will allow ICSs to provide the best possible support to the places they contain, and the leaders of place-based arrangements.

4.29 Every ICS will need to ensure that all constituent organisations have a base level of digital capabilities and are connected to a shared care record by 2024 enabling individuals, their approved caregivers and their care team to view and contribute to the record.

4.30 ICSs have been asked to identify digital priorities to support the delivery of out-of-hospital models of care through the development of system digital investment plans, ensuring community health services providers are supported to develop robust digital strategies to support improvements in care delivery. Where appropriate, digital investment should be purchased and deployed at ICS level.

4.31 To achieve 80% adoption of digital social care records among CQC-registered social care providers by March 2024, ICSs must work with partners to drive adoption.

Rapid adoption

4.32 We will maintain the pace of adoption seen through the pandemic, when - at extraordinary speed - consultations moved online, clinicians and other staff worked from home, people were monitored remotely, including in care homes, and information flowed more effectively between care settings. This has changed the mindset of many staff and citizens about digitally enabled health and care - they do not want to go back to old ways of doing things.

4.33 We have a real opportunity to build on this progress and to truly integrate health and care services. To do this, we need to bring everyone on this journey, one which will ultimately transform how care is delivered, improving both safety and experience. We will do this by building transparency and trust through ongoing dialogue with citizens and developing our approach to Information Governance, giving confidence to the workforce and leveraging the maximum benefit from information. We will ensure we are inclusive, recognising that the use of digital services can create opportunities for people who struggle to access traditional services, as well as barriers for others, but should always be part of a multi-channel offering that reflect the preferences and needs of individuals. Digital investment plans should be finalised by June 2022 which include the steps being taken locally to support digital inclusion.

4.34 For adoption to be rapid, the frontline needs to be confident when recommending digital interventions, and people who use services need to be aware of and be able to access new products. There’s a lot more we can do to increase confidence.

4.35 The NHS App will offer a personalised experience for users and encourage them to engage in tailored preventative activity (screening, immunisations and vaccinations, health checks etc). We will help people, their families, unpaid carers and care providers to understand what technologies are effective for helping

maintain independence and quality of life, such as smart home technologies that give medication reminders, or sensor-based tech that provides alerts if someone has had a fall.

4.36 Led by clinicians, and in partnership with NHS England and Improvement, we will develop new pathways for musculoskeletal, dermatology, ophthalmology, perioperative and cardiovascular pathways used by approximately 20m people

4.37 Clinical decision support tools, within an electronic health record, will improve clinical outcomes and reduce unwarranted variation. Finally, approaches to regulation of health and care technologies must be proportionate and support the needs and priorities of the health and care system - such as virtual wards and reducing health disparities

5. The health and care workforce and carers

Summary

This chapter sets out proposals to ensure that staff working in health and care settings are supported to provide integrated services focused on the needs of people by:

●strengthening the role of workforce planning at ICS and local levels

● reviewing the regulatory and statutory requirements that prevent the flexible deployment of health and social care staff across sectors

● increasing the number of appropriate clinical interventions that social care workers can safely carry out by developing a national delegation framework of healthcare interventions

● exploring the introduction of an Integrated Skills Passport to enable health and care staff to transfer their skills and knowledge between the NHS, public health and social care

● increasing the number of learning experiences in social care, including health undergraduate degree programmes and for those undertaking apprenticeships

● exploring opportunities for cross-sector training and learning, joint roles for ASC and health staff in both regulated and unregulated roles

● promoting the importance of the roles of link workers, care navigators and care coordinators to ensure consistent access to these roles across the country

Our proposals will strengthen those laid out in the workforce chapter of our Adult Social Care Reform white paper, People at the Heart of Care, which are:

● a knowledge and skills framework, careers pathways and linked investment in learning and development to support progression for care workers and registered managers

● funding for Care Certificates, alongside significant work to create a delivery standard recognised across the sector. This will improve portability, so that care workers do not need to repeat the Care Certificate when moving roles

● continuous professional development budgets for registered nurses, nursing associates, occupational therapists and other allied health professionals

● investment in social worker training routes

● Initiatives to provide wellbeing and mental health support, and to improve access to occupational health

● a new digital hub for the workforce to access support, information and advice, and a portable record of learning and development

● new policies to identify and support best recruitment practices locally

● exploration of new national and local policies to ensure consistent implementation of the above, as well as higher standards of employment and care provided

The importance of workforce integration

5.1 It is through the staff delivering health and care that the ambitions of this paper will be delivered. People's interactions with health and social care services are through the workforce and, often, no single individual or team can provide all the care and support that a person needs. Joined-up services are delivered effectively when staff work together within and across organisations.

5.2 A workforce with a shared ambition for health, wellbeing and independence can improve the delivery of shared outcomes. Integrated services can only be delivered by a capable, confident, collaborative health and care workforce, which works together to wrap care and support around individuals, and which feels valued for the work they do.

An integrated workforce is where:

● staff work as part of a team to plan and deliver services based on the needs and wishes of the individual, and that takes into consideration the individual's wider family context

● staff numbers and skills across teams and organisations are planned to meet the needs of their local population

● staff feel confident in their roles and work together in the person's interests wherever they are employed

● staff understand what all organisations contribute, including the value of unpaid carers and wider community, and have clear processes, lines of communication and the technology and data needed for working with others

● if multiple staff are involved in delivery of services to support a person's care, they collectively have the skills and capacity to deliver the best person-centred care

● staff are empowered to use their skills to progress their careers across the health and care family

5.3 The response to the COVID-19 pandemic has shown what can be achieved when the workforce comes together to safeguard and promote health and wellbeing by breaking down boundaries in the system. We want to celebrate this approach by making it routine rather than something that only happens in a crisis, with barriers to collaboration removed and the workforce equipped to work across sectors.

5.4 Staff across health and social care already strive to provide person-centred care. Too often, however, structural and/or financial barriers get in the way of effective joint working. This is true within the health and social care sectors, as well as between them. The landscape is even more complex when we factor in public health, community health services, education, housing and homelessness provision, the voluntary, and community health services, and unpaid carers, all of which play a key role in providing joined-up care, support and treatment.

5.5 The new structures being put in place at a national and local level provide an opportunity to overcome these barriers. Through the Health and Care Bill, we are creating a legislative framework for partnership working which will bring the NHS, local government and social care closer together to help ensure everyone receives outstanding, person-centred, outcome-focused services they need. The workforce will be a key part of strategies and plans developed by ICBs and ICPs.

5.6 This government is committed to supporting the NHS, public health and social care workforces, with a focus on workforce capacity and capability. For example, we are delivering 50,000 more nurses in the NHS. Our Adult Social Care Reform white paper, People at the Heart of Care, sets out an ambitious vision to transform the workforce, with an unprecedented investment of at least £500 million. This will directly address some of the barriers to integration by improving learning and development and providing more opportunities for progression within adult social care.

Tackling the barriers to workforce integration

5.7 At a national level we can further facilitate workforce integration by removing barriers to collaborative planning and working. We will review regulatory and

statutory requirements that prevent the flexible deployment of health and social care staff across sectors. To make integration a reality, places must consider integration in a way that meets their local needs. The role of central government is to facilitate and support that, ensuring the right structures, accountability and leadership is in place to enable workforce integration locally.

Workforce planning

5.8 There are currently limited fora to develop shared approaches to workforce planning, and a lack of clarity about which national and local bodies are responsible for what. Planning is often carried out in isolation, meaning that social care providers and local authorities frequently compete with the NHS, or each other, to attract and retain staff. This siloed approach can also result in a lack of alignment with broader health services commissioned by local authorities, those delivering support to children and young people, unpaid carers, housing, and the voluntary sector.

5.9 To improve workforce planning, in July 2021, the Department commissioned Health Education England (HEE) to work with partners to review long-term strategic trends for the workforce. For the first time, regulated adult social care professions will be included in this framework, which will take a 15-year forward view to guide planning, education and training for the workforce. The framework will provide the information needed for ICBs to fulfil their role on shared workforce planning across health and social care services and will support localities to plan and improve services to meet the needs of people now and in the future.

5.10 Workforce planning is kept under close review by DHSC and other bodies. The Health and Care Bill will propose a that report that will set out the role and responsibility of each of the bodies (at national, regional and local level) in the system responsible for workforce planning in the NHS in England for the first time, to increase accountability and transparency and provide assurance that the system is making this issue a priority. This workforce accountability report will cover the whole of the NHS including primary, secondary, and community health services including where sections of the workforce are shared between health, public health and social care – for example, registered nurses.

5.11 Adult Social Care is a largely private sector market and core responsibilities of workforce planning and market shaping are devolved to local authorities who are accountable to their local populations for management and delivery under the Care Act. As set out in the Adult Social Care Reform white paper, People at the Heart of Care, we recognise the ongoing hard work by providers and local

authorities – working with system partners including the NHS – to address difficult workforce capacity issues. We will continue to work closely with local authorities and care providers to monitor workforce pressures, including identifying whether further action may be required.

5.12 We will further improve integrated workforce planning at place level by:

- working with local government and NHS England to strengthen guidance for systems and increase co-production with social care stakeholders, for example, by gathering intelligence about the experience and aspirations of people who use care and support services and have clear approaches to using these insights to inform decision-making and quality governance. Government will incorporate this into the development of guidance for ICPs, so that all components of an ICS are clear on the role they can play in integrated workforce planning across the whole health and care system

- encouraging the expansion of local feedback fora, building on good practice in a number of regions that have led to closer collaboration between NHS regional teams, local government, and other stakeholders such as Skills for Care representatives

- working closely with NHSE and system leaders across the comprehensive health and care system to support the development of ICSs' "people operating model" and to support places develop a 'one workforce' approach

- considering what further national action needs to be taken following the publication of the long-term strategic framework later this year, including what more is needed to support workforce planning for the unregulated adult social care workforce

Working within the devolved Greater Manchester Health and Social Care Partnership, Bury have created a strategic commissioning board which has equal representation from members of Bury Council and the borough's clinical commissioning group (CCG). The board brings together the governance of health and social care, allocation of shared resources including pooled budgets, and strategic commissioning across adult social care and health.

Crucially, the board brings together the whole of Bury's Cabinet with the CCG, including housing, public health, drug and alcohol services, and children's social care, allowing for joint workforce planning and commissioning of services to meet needs in a holistic way. This is reflected at a neighbourhood level, with integrated teams reporting to a single line manager, improving people's direct experience of health and social care.

Learning and development

5.13 Initial training and ongoing learning and development opportunities are an excellent opportunity to prepare people for partnership-working with other teams. Although some health and social care dual qualifications are available, there is disparity in access to, and quality of, learning and development opportunities for staff in adult social care compared to the NHS, which can act as a disincentive to enter or stay in the sector and can create barriers to partnership working.

5.14 Training and learning together can play a key role in enabling an integrated workforce, with staff from different sectors, and teams within a sector, learning together and gaining an understanding of the roles of others they work with. We will:

- work with national and local partners to identify ways to improve initial training and learning for staff in roles at the interface between health and social care, to ensure they have the skills and knowledge needed to work collaboratively across sectors

- identify opportunities for joint continuous professional development across sectors. This could involve joint training on topics such as mental capacity, frailty, and strengths-based and assets-based practice to help staff develop the understanding needed for team working

- move towards a more collective approach to promoting careers in health and social care: the view of health and social care as an integrated system with equal value should be reinforced as people make decisions around whether to pursue a career in health and social care, including career changers

North Tyneside Clinical Commissioning Group is working in partnership with four large care home providers to appoint seven Advanced Care Practitioners (ACP) nurse trainees as part of the Health Education England ACP apprentice scheme. This is introducing a new way of working with care home providers to enhance the health of residents. It is also supporting apprenticeships with a model that promotes career progression and staff development for care home staff.

Progression and movement within and between sectors

5.15 There are diverse, rewarding opportunities available in all parts of health and social care, but there are barriers to people moving across organisational boundaries. Even where roles have similar skills and responsibilities, there is often not a ‘healthy’ flow of workers between health and social care roles. This is, in

part, driven by a lack of cross-sector experience built into training; disparities in career progression, with adult social care in particular viewed as lacking opportunities compared to the NHS, and regulatory barriers.

5.16 We want to make it easier for the workforce to move between health and social care. Within primary care, roles are increasingly being recruited through rotational and joint employment models. We want to build on this approach, to encourage movement of staff within and between sectors, to help build knowledge, relationships, and experience of different settings.

5.17 The Adult Social Care Reform white paper, People at the Heart of Care, sets out how we will improve career pathways and progression within adult social care and support local areas to recruit people with the right skills and values to meet care needs now and in the future. We will provide funding to support local authorities to prepare their local markets for reform, including by moving towards paying providers a fair rate for care that reflects local costs, including workforce, where appropriate. In addition to this, we will:

- work with stakeholders to develop and test joint roles in health and social care, for example roles which support integrated care planning, which coordinate across sectors, or which allow people to work flexibly across settings

- consider the introduction of an Integrated Skills Passport to enable staff to transfer skills and knowledge between the NHS, public health and social care. NHSE/I and DHSC are developing skills passports to allow health and care workers to demonstrate their knowledge and skills so that employers can easily access this information when a worker moves between organisations

- increase the number of learning experiences in social care to understand perspectives across sectors, enhance future team working and create a sense of a joint health and social care career structure. This will include health undergraduate degree programmes and those undertaking apprenticeships. Our long-term ambition is for all health undergraduates to experience adult social care, to understand perspectives across sectors, enhance future team working, and create a sense of a joint health and social care career structure. To begin with, we will work with the Council of Deans to increase the number of trainee nurses who undertake a placement in adult social care

5.18 We will also remove barriers that prevent particular professions working across settings and make the best use of each person's skills. We will:

- promote the importance of the roles of link workers, named key worker and care navigator roles[6] as crucial enablers of integrated care provision. Current care navigator roles exist in multidisciplinary teams, or voluntary services, and are responsible for delivering assessments, advice, signposting, and coordination. Care managing in this way offers ways of sensibly sharing work and responsibility, helping to relieve front-line clinician pressures and improves overall quality of care for patients[7]. Building on good practice from across the UK and internationally[8], the roles support people at the interfaces between health and care and we will ensure that access to these types of roles are consistent across the country

- explore appropriate interventions that can be safely delegated or transferred between the sectors

- consider developing a national delegation framework of appropriate clinical interventions to increase the range of appropriate clinical interventions undertaken in care settings while ensuring safe, appropriate and confident practice and exploring what additional support care workers need. Our Adult Social Care Reform white paper, People at the Heart of Care, sets out plans for establishing a foundation for the future registration of social care staff in a way that benefits staff and care providers alike, which we intend to explore further. We want to build confidence in registered professionals delegating these interventions to social care workers

- commission research into how occupational therapists working in community health services and social care can work more effectively to complement one another

- create opportunities for social housing support and homelessness workers, often supporting people with care and support needs, to progress into adult social care, public health and health roles. This will include taking forward recommendations from HEE's scoping study with the Voluntary, Community and Social Enterprise Health and Wellbeing Alliance

- make the best use of the skills of pharmacy professionals by consulting on regulatory barriers, improving placement opportunities, and delivering the Pharmacy Integration Programme

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[6] Care Navigation Competency Framework_Final.pdf (hee.nhs.uk)
[7] General Practice Forward View (england.nhs.uk)
[8] 1525785625_learning-from-japan-final.pdf (nuffieldtrust.org.uk)

Volunteering programmes significantly improve the experience of users of care and enable a greater level of support for staff. The pandemic saw excellent examples of the support they can offer, for example, the NHS Volunteer Responders Programme successfully supported thousands of people who were shielding in their communities. Building on the success of this programme, DHSC and NHSEI have been working together on how to build volunteering capacity for local health and social care systems. This type of joint action can strengthen community ties and improve life outcomes for health and social care users. The creation of 'blended' enhanced home care roles that take on elements of some interventions previously carried out by district nurses has been piloted in Tameside (Greater Manchester) with plans to scale up in other Greater Manchester localities.

Place-Based Workforce Integration

5.19 To deliver shared outcomes, local leaders will need to consider how the health and care workforce in the area can be deployed in the most effective way. This should prevent duplication across health and care, consider the impacts of one sector on the other, and ensure that citizens contact with members of both workforces is coherent and coordinated.

5.20 While national action can foster the conditions for workforce integration, to make this a reality, places must implement integration in a way that meets their needs. Changes in the Health and Care Bill will embed and speed up integration locally, with flexibility for areas to determine which models of integration will work best at place. For example, ICBs will have the flexibility to determine governance arrangements in their area – including the ability to create committees and delegate functions to them. This would allow systems to create local 'place'-based committees to plan care where appropriate. Every area should strive to achieve the greatest level of integration possible with appropriate governance arrangements for this at place level.

5.21 For the health, social care and public health workforce, ICSs will be a lynchpin between national organisations and places, providing a key forum for planning and direction setting. But it is at a more local level that the workforce makes integration a reality – and at an individual level where people experience the benefits of an integrated workforce. Local leaders will need to think about what workforce integration looks like in their area, the conditions that are needed, the practical steps required, and who needs to be involved in shaping this.

In The Principles of Workforce Integration, Skills for Care has identified six principles to aid areas in their development of workforce plans and workforce development in an integrated way:

● successful workforce integration focuses on better outcomes for people with care and support needs

● workforce integration involves the whole system

● to achieve genuine workforce integration, people need to acknowledge and overcome resistance to change and transition. There needs to be an acknowledgement of how integration will affect people's roles and professional identities

● a confident, engaged, motivated, knowledgeable and properly skilled workforce supporting active and engaged communities is at the heart of workforce integration

● process matters—it gives messages, creates opportunities, and demonstrates the way in which the workforce is valued

● successful workforce integration creates new relationships, networks and ways of working. Integrated workforce commissioning strategies give each of these attention, creating the circumstances in which all can thrive

5.22 Our proposals in the leadership, shared outcomes and accountability chapters will empower local leaders to embed these principles. Places must build a culture that supports integrated service delivery, sets a shared vision, develops a common language that truly covers the whole workforce, and engenders a culture of partnership. Involving and empowering the workforce directly will be crucial, for example through shared decision councils, as recommended in The Principles of Workforce Integration, adopting local "Integration Champions" or supporting local communities to build the partnerships and plans to embed housing as part of the local health and care system, as set out in our Adult Social Care Reform white paper, People at the Heart of Care.

5.23 There are a variety of models being implemented at place level. The NHS Long Term Plan, for example, includes a commitment to expand community multidisciplinary teams as a means to integrate primary and community health services, and many places have started to use multidisciplinary teams across other parts of the workforce. Other areas have found that physical co-location of staff has had an impact, or that a nominated key worker model is useful to provide a single point of contact for a person receiving care. The family hub model, which

emphasises building strong connections between services and families, and on building relationships, is an important way of bringing together[9].

Health and care leaders in Portsmouth – including Portsmouth City Council, NHS Portsmouth Clinical Commissioning Group, Solent NHS Trust, Portsmouth Hospitals NHS Trust, Portsmouth GP Alliance and local voluntary sector organisations – developed a blueprint setting out their ambition for integrated services. This Portsmouth Blueprint had at its heart the principle that first comes the person and family being cared for, then comes the team, and only after that comes the organisation. Partners have made extensive use of co-location to bring teams together, with the chief operating officer of Solent NHS Trust (which provides community and mental health services across Portsmouth, Southampton, Isle of Wight and Hampshire) being first to work from within the city council's headquarters. The civic offices now accommodate community nursing and social care, the learning disability service, health visiting, 0-19 young people's services, and school nursing for the centre and south of the city. As part of this, they will explore the role that family hubs can play in bringing together services in the community to support families.

Greater Manchester – Inclusive Workforce

Greater Manchester Combined Authority and Greater Manchester Health and Social Care Partnership co-invested in the Working Well Early Help programme, a health-led employment support programme for residents in all ten local authority areas in Greater Manchester. It supports individuals with a health condition or disability who have recently become unemployed or taken medical leave, to return to sustained employment. The programme is built upon early intervention through personalised and holistic support focused on addressing the barriers to employment and is integrated with local services, including health and skills services. The partnership and governance are set up through key partners including Local Leads from local authorities and GP Leads in each delivery area. Local Leads are designated members of staff from each of the local authorities who have a responsibility to oversee the performance of Working Well contracts at a borough level and are often from the Work and Skills team. Recent qualitative impact assessment indicates that the support has led to 53% positive health and wellbeing outcomes and 39% positive employment outcomes. Working Well Early Help is part of the wider family of Working Well programmes in Greater Manchester. Since its inception in 2014, Working Well has achieved employment outcomes for over 15,200 Greater Manchester residents.

[9] Family Hub model framework (publishing.service.gov.uk)

Due to its successes, Greater Manchester has also successfully negotiated for the opportunity to co-design, procure and deliver a localised version of the new Work and Health Programme which will support nearly 23,000 individuals across Greater Manchester until 2024.

Cornwall - Healthy Cornwall

Commercial fishing is known to be a physically and mentally straining occupation. The workforce is predominantly male and often less engaging with healthcare services for various reasons such as previous bad experience or working during normal assessment hours. Therefore, Healthy Cornwall (Cornwall Council), together with the GetSeaFit programme, co-ordinated and commissioned healthcare services and brought them to the quayside. The overall aim was to influence the NHS and local authority public health teams at a local level by highlighting the health needs of this vulnerable section of society, with traditionally a history of poor access to health and preventative services, whose work and lifestyle put them at risk of developing chronic and serious health issues later in life. Furthermore, it was envisaged that the wider long-term impact would be social change among fishing communities, with better physical and mental health which would lead to sustained hours at sea, less financial hardship, reduced deprivation and an improved home life through greater financial stability. Activities included conducting quayside health checks, holding health and wellbeing events and having regular informal conversations about health and wellbeing to raise awareness amongst this workforce. The GetSeaFit programme was a joint two-year initiative, with a time extension of seven months, run by the Fishermen’s Mission and the Seafarers Hospital Society but also partners such as local GPs, opticians, dentists, health professionals and other charitable organisations. The programme has been successful and representatives from Healthy Cornwall are now trusted members of this community and fishermen and family members who received support are benefitting from better health and are encouraging their peers and fellow crew members to seek advice or treatment. Healthy Cornwall also modernised last September to an operating model that is much more focused on vulnerable groups with increased local initiatives.

Health and Social Care Volunteering

National and local volunteering programmes present great opportunities to build capacity in local systems, with volunteers providing support in a range of settings to assist staff and users of care. The pandemic saw excellent examples of the support they can offer, for

example, the NHS Volunteer Responders Programme successfully supported thousands of people who were shielding in their communities. Building on the success of this programme, DHSC and NHSEI have been working together on a scheme to build volunteering capacity for local health and social care systems. This type of joint action can strengthen community ties and improve life outcomes for health and social care users."

Workforce: Conclusion

5.24 Integration will be delivered by a workforce equipped with the skills and opportunities to move across the health, public health and social care family, supported by holistic workforce planning to ensure there are the right people to deliver the best outcomes for people and populations. Over the coming years we will work with national and local partners to achieve this vision. Alongside concerted action at a place level, this package of initiatives will improve integration between the health, public health and social care workforce, leading to improved outcomes, and better person-centred care and population health outcomes.

As we begin the implementation of these policies, we are seeking views from stakeholders and partners on the following questions:

1. What are the key opportunities and challenges for ensuring that we maximise the role of the health and care workforce in providing integrated care?

2. How can we ensure the health and social care workforces are able to work together in different settings and as effectively as possible?

3. Are there particular roles in the health or adult social care workforce that you feel would most benefit from increased knowledge of multi-agency working and the roles of other professionals?

4. What models of joint continuous professional development across health and social care have you seen work well? What are the barriers you have faced to increasing opportunities for joint training?

5. What types of role do you feel would most benefit from being more interchangeable across health/social care? What models do you feel already work well?

6. Conclusion: Impact on People and Next Steps

At the beginning of this document, you met Tom and Maureen, Bunmi, Kwame, Madeleine Mandeep and Richard. The policies proposed in this paper will have a material impact on their lives

Case studies

Tom and Maureen

Tom and Maureen have some digital skills as they use an iPad to keep in touch with their children, grandchildren and great grandchildren. With some support from their children they sign up to the NHS App where they can access their health and care records, book appointments and order repeat medication to be delivered to their door. Tom has given Dan and Sarah access so they can see test results, the outcome of conversations with his care team and can converse with the GP electronically.

To help Tom manage his diabetes more effectively alongside his dementia, he is given a glucose monitoring device so that his blood sugar levels are automatically recorded using a mobile app. This information can help Maureen see if they are high or low and where he might need adjustments to his insulin or diet. This automatically uploads data to his record so that Tom's clinical team can see how well he is managing his diabetes and offer the right kind of interventions.

These changes mean that Tom's diabetes is stable again and he and Maureen, as well as their children, have the information they need to empower them to manage his health at home and keep him independent at home for longer.

Tom was admitted to hospital where he received great care, however due to COVID-19 restrictions in the area, Dan and Sarah were not able to visit Tom. They supported their mother and discussed with medical professionals what would be best for their elderly parents going forward. Despite Maureen feeling extremely overwhelmed when a care assessment was carried out, there was much discussion of what could be done locally from their own home.

An assessment for dementia was completed in the hospital and his records were shared with his GP and local care services to ensure that they did not have to be repeated. Tom and his family were offered help with his diagnosis and his community mental health team were involved from the start.

After several weeks in hospital, Tom was discharged, and the detailed package of care was delivered. Dan and Sarah frequently visited and were kept informed by the local care team as to how their parents' conditions were and how they were being cared for personally.

Tom, Maureen and family are able to hold a meeting with his care worker to discuss the recent trips to A&E and the impact that is having on his dementia and wellbeing.

Care workers and nurses who care for Tom locally have recently taken part in shared learning days so that teams who support Tom at home have good working relationships and open communication. They were able to jointly work on a collaborative care plan with Tom and family to agree how his support needs have changed and develop and implement action plans.

The diabetes team encouraged Tom's care workers to build their competency in insulin management, and as a result they were able to delegate this intervention using the national framework so the care workers could provide insulin management for Tom. This helped reduce unnecessary interactions with multiple staff so Tom is not distressed due to his dementia.

These improvements in working across specialties mean that Tom is better able to manage his diabetes at home, and the family have a clearer picture of how his overall care is being managed.

Bunmi

A monitoring system is installed in Bunmi's home, which checks for changes in patterns of use of several connected home devices, including a kettle, a fridge, a bed mat and light switches in her bedroom and bathroom. Bunmi has allowed for this information to be recorded in her longitudinal health and care record.

As Bunmi's mobility deteriorates the system noticed that she was moving around her home a lot less than usual and sent an alert to the warden to check on Bunmi. On arrival to Bunmi's home, the warden used his smartphone to record some basic observations. These suggested a worsening of her conditions and were sent to Bunmi's multidisciplinary primary care team. The duty member of the multidisciplinary team reviewed Bunmi's longitudinal health and care record and care plan which is stored securely in the cloud. A clinician then visited Bunmi at home to prescribe medication which was delivered to her within 2 hours. The clinician also admitted Bunmi to the 'hospital at home' service, which monitors and supports her over the next few days without needing to admit her to hospital. To help Bunmi with her day-to-day life, the social care representative of the multidisciplinary team will use the system to book carer visits to help with shopping and laundry while Bunmi is unwell and recovering.

These changes mean that Bunmi has support for the management of her long-term conditions, allowing her to live well at home for longer. Bunmi and her multidisciplinary team have the means to identify when she needs additional support, and she is now feeling more confident to resume her day-to-day activities that make her happy.

Kwame

The lack of join up between the various services Kwame was using meant that there was no co-ordination from one provider to the other and Kwame was then caught up in a system where he could not receive the appropriate help he required.

A Multi-Disciplinary Team (MDT) identified a new placement for Kwame, with options including segregated living arrangements being replicated in the community. Meeting Kwame's requirements was challenging for several established providers but as Kwame was transitioning to adult services (16+), the option of adapting a property to become his long-term home was explored. Kwame was referred to a micro provider which runs small supports programmes using innovative individualised care. Placing Kwame at the centre of every decision they made, they invested time to get to know him, gaining his trust before he re-joined his local community.

After three months, many physical barriers preventing closer contact began to be removed. Kwame could now take excursions, started contacting his extended family, and his education was reinstated through digital platforms. Kwame applied for funds to buy and adapt a property and moved into his new home in the Summer of 2020.

Madeleine

For Madeleine the COVID-19 pandemic has highlighted how important good collaboration between the statutory sector and voluntary sector is as she was unable to get to any vaccination centre or carry out any tests. Once the situation had been explained to her GP surgery, they responded with at home visits. During one of the visits, the staff who had visited Madeleine picked up on how she has been affected by loneliness and how this had taken a toll on her wellbeing. She was recommended to the well-being team who signed her onto an ongoing well-being programme to tackle her loneliness. She was also put in touch with local volunteers who were able to help her with her shopping and other basic services in the community.

This local collaboration meant that Madeleine was able to access various basic services in her community that made her life more comfortable.

Mandeep

After contacting a charity that Mandeep had seen on the side of a bus, Mandeep went to see a GP who referred him to a crisis centre and provided him with self-care techniques to help manage his mental health problems. He was also referred to specialist help that would help Mandeep manage his diabetes.

At the crisis centre, Mandeep was able to work with social workers, care coordinators, community mental health and employment support. It was the first time he felt cared for and listened too. Through this engagement, Mandeep had continuity of support with people he trusted and this opportunity to gain his independence and gain practical life skills that will help Mandeep get and maintain a job. He secured a more suitable housing arrangement

Mandeep is more engaged than ever before in improving his health. He now has prescriptions to support his nutrition and his mental health has been far more stable. He is actively taking part in conversations about his future and has better understanding of his support needs. As a result, his personal care has improved greatly.

Richard

Richard was able to be discharged earlier than usual because he moved to a ‘step down’ bed where clinical teams and social workers helped him get back on his feet and get used to living life in the local community again. The community psychiatric nurse helped him manage his medicines, and social care and support workers helped him learn how to cook some recipes. The lead social worker supported Richard in applying for PIP payments and getting a new tenancy agreement sorted with the housing officers so he could move back home. While he was in the step down placement the team learned that Richard was a massive Tina Turner fan!

Richard was able to move home eventually, with home adaptations completed and a joint NHS and social care discharge package of support to keep helping him manage daily activities such as shopping and taking his medicines. The package also included a small ‘personalisation fund’ with which Richard chose to buy a few essential items for his kitchen, as well as a cheap last minute ticket deal to the Tina Turner musical, which was one of his long-standing personal life goals. Richard said that it was an experience he would never forget and going out to the theatre helped him feel valued as a person living in society again – it was something he had never imagined he would be able to do when he spent years living in psychiatric units. While his community health and social care package now costs slightly more than it did before, he has thrived and lived well at home and the costs are negligible compared to the NHS costs of repeat cycle of admissions.

Next Steps

6.1 To provide everyone with the person-centred care they need, we will:

- On shared outcomes, consult stakeholders and set out a framework with a concise number of national priorities and approach for developing additional local shared outcomes, by Spring 2023
- We will review alignment with other priority setting exercises and outcomes frameworks across health and social care system and those related to local government delivery
- Ensure implementation of shared outcomes will begin from April 2023
- On leadership, accountability and oversight, set an expectation that by Spring 2023, all places should adopt a model of accountability and provide clear responsibilities for decision making including over how services should be shaped to best meet the needs of people in their local area
- Review section 75 of the 2006 Act which underpins pooled budgets, to simplify and update the regulations
- We will work with partners to develop guidance for local authorities and the NHS to support going further and faster on financial alignment and pooling.
- Publish guidance on the scope of pooled budgets Spring 2023
- Work with the CQC and others to ensure the inspection and regulation regime supports and promotes the new shared outcomes and accountability arrangements at Place
- Develop a national leadership programme, addressing the skills required to deliver effective system transformation and place-based partnerships, subject to the outcomes of the upcoming leadership review
- Publish a final version of the Data Strategy for Health and Care will be published (Winter 2021/22)
- Ensure every health and adult social care provider within an ICS to reaches a minimum level of digital maturity
- Ensure all professionals have access to a functionally single health and adult social care record for each citizen (by 2024) with work underway to put these in the hands of citizens to view and contribute to

- Ensure each ICS will implement a population health platform with care coordination functionality, that uses joined up data to support planning, proactive population health management and precision public health (by 2025)

- Develop a standards roadmap (2022) and co-designed suite of standards for adult social care (Autumn 2023)

- Ensure 1 million people to be supported by digitally enabled care at home (by 2022)

- On workforce, strengthen the role of workforce planning at ICS and place levels

- Review barriers (including regulatory and statutory) to flexible movement and deployment of health and care staff at place level

- Develop a national delegation framework of appropriate clinical interventions to be used in care settings

- Increase the number of clinical practice placements in social care during training for other health professionals

- improve opportunities for cross-sector training and joint roles for ASC and NHS staff in both regulated and unregulated roles

- Appoint a set of front-runner areas in Spring 2023. These will trial the outcomes, accountability, regulatory and financial reforms discussed in this document

Questions for implementation

6.2 The policies outlined in this document build on the proposals in the Health and Care Bill and provides further indications of how we expect local organisations to make progress in integrating health and care, while also setting out some of the support we will provide. We are keen to learn and improve our understanding of what works as we begin the effective implementation of these proposals. To that end, we would like to invite views on a number of key issues to support progress towards implementation. As part of the engagement with stakeholders which we intend to start shortly (referred to above). We will therefore engage stakeholders across the sector with a view to answering the following questions:

Outcomes

(i) What role can outcomes play in forging common purpose between partners within a place or system – and can you point to examples of this?

(ii) How can we get the balance right between local and national in setting outcomes and priorities?

(iii) How can we most effectively balance the need for information about progress (often addressed through process indicators) with a resolute focus on achieving outcomes (where data can lag)?

(iv) How should outcomes be best articulated to encourage closer working between the NHS and local government?

(v) How can partners most effectively balance shared goals / outcomes with those that are specific to one or the other partner – are there examples, and how can those who are setting national and local goals be most helpful?

Financial

(vi) How can we improve sharing of best practice regarding pooled or aligned budgets?

(vii) What guidance would be helpful in enabling local partners to develop simplified and proportionate pooled or aligned budgets?

(viii) What examples are there of effective pooling or alignment of resources to integrate care / work to improve outcomes? What were the critical success factors?

(ix) What features of the current pooling regime (section 75) could be improved and how? Are there any barriers, regulatory or bureaucratic that would need to be addressed?

Accountability

(x) How can the approach to accountability set out in this paper be most effectively implemented? Are there current models in use that meet the criteria set out that could be helpfully shared?

(xi) What will be the key challenges in implementing the approach to accountability set out in the paper? How can they be most effectively met?

Workforce

(xii) What are the key opportunities and challenges for ensuring that we maximise the role of the health and care workforce in providing integrated care?

(xiii) How can we ensure the health and social care workforces are able to work together in different settings and as effectively as possible?

(xiv) Are there particular roles in the health or adult social care workforce that you feel would most benefit from increased knowledge of multi-agency working and the roles of other professionals?

(xv) What models of joint continuous professional development across health and social care have you seen work well? What are the barriers you have faced to increasing opportunities for joint training?

(xvi) What types of role do you feel would most benefit from being more interchangeable across health/social care? What models do you feel already work well?

Digital and data

(xvii) What are the key challenges and opportunities in taking forward the policies set out in this paper, and what examples of advanced / good practice are there that could help?

(xviii) How do we best ensure that all individuals and groups can take advantage of improvements in technology and how do we support this?

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