BRIEFING PAPER FOR THE HEALTH DEVOLUTION COMMISSION

INTEGRATED CARE SYSTEMS BEST PRACTICE ROUNDTABLE 3

Workforce development, partnerships at place and system regulation

CONTENTS

OVERVIEW

This is a Health Devolution Commission briefing paper prepared in advance of the best practice roundtable to be held online from 3.45 - 5.45pm on Thursday 20th October. The focus will be on how to develop an integrated health and social care workforce, deliver the best place-based and neighbourhood partnerships, and getting right the regulation of integrated care systems.

This roundtable follows on from the second roundtable of the Commission in June 2022 which focused on four outcome areas to be achieved by ICSs, namely:

- reducing health inequalities;
- improving the health and wellbeing of children and young people;
- improving mental health services; and
- health support for people with learning disabilities.

The report and recording of this and the previous roundtable can be found on the Commission's website https://healthdevolution.org.uk/resources/

This third roundtable will hear from keynote speakers in three parts: first a focus on workforce development with speakers from HEE, TLAP and S4C; second, on place-based partnerships with speakers from local government and a PCN; and then on regulation with speakers from CQC and Ofsted.

The last meeting of the year, which will see the launch of the Commission's final report and will be in person, will be on Tuesday 6th December from 3 to 5 pm in the Attlee Suite, Portcullis House.

1 DEVELOPING AN INTEGRATED HEALTH AND SOCIAL CARE WORKFORCE

1.1 Context

A number of recent reports have highlighted major concerns about staff shortages, pay, conditions of service, recruitment and training of the workforce within different parts of both the NHS and social care services.

The Parliamentary Health and Social Care Select Committee report (July 2022) concluded that 'The National Health Service and the social care sector are facing the greatest workforce crisis in their history' and spells out in detail the extent of the current crisis in the workforce, for example:

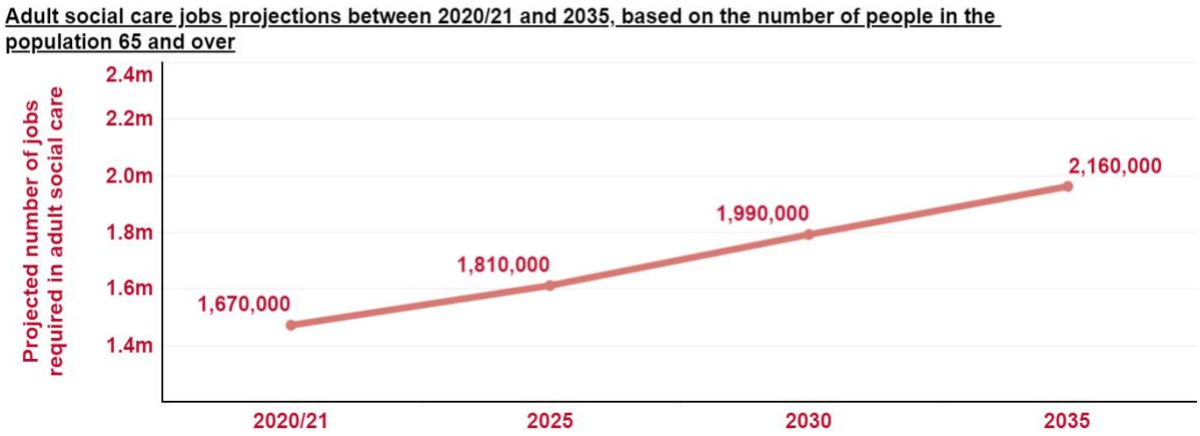
- As of September 2022, the NHS was advertising 99,460 vacant posts: for social care, vacancies are in the order of 165,000
- New research by the Nuffield Trust suggests that the NHS in England could be short right now of 12,000 hospital doctors and over 50,000 nurses and midwives.
- Demand on the health and social care sector continues to grow relentlessly with an extra 475,000 jobs needed in health and 490,000 jobs needed in social care by the early part of the next decade. Almost every healthcare profession is facing shortages,
- The situation is worst in social care. One in three care workers left their job in 2020–21, a serious setback to the continuity of care which is so essential to those who receive social care
- In December 2021, Care England reported that 95% of care providers were struggling to recruit staff, and 75% were struggling to retain their existing staff.

An Expert Panel advising the Committee evaluated the Government's commitments in the area of the health and social care workforce in England and concluded that overall its performance was 'inadequate' – the lowest possible rating.

The Future Social Care Coalition grew out of the Health Devolution Commission in 2021 with the specific purpose of campaigning for better pay and conditions for care workers. It has called on the Government to produce a Social Care People Plan to give national shape and recognition to the sector; increase social carers' pay to at least the Real Living Wage. Lifting all paid carers to the level of the Real Living Wage (£9.90/£11.05 in London); give the Social Care workforce an emergency funding boost to help support the NHS to deliver improved health and care.

An NHS Confederation survey (July 2022) showed that NHS leaders across England are concerned that staffing gaps and a lack of capacity in social care are putting the care and safety of patients in the NHS at risk. Patients are being delayed in hospital much longer than they should, with the knock-on impact resulting in higher demand on A&E departments and longer ambulance response times. They are urging the Government to increase investment in care services, including by boosting wages for care workers. They say failure to act will leave more and more vulnerable people without the care and support they need, as well as piling further pressure on front-line NHS services.

The Skills for Care analysis of workforce data for July 2022 shows there were 165,000 vacancies in the social care workforce and that the workforce will need to grow by 490,000 (29%) between 2020/21 and 2035 to meet growing demographic demand for care.



The **Parliamentary Levelling Up, Housing and Communities Select Committee** (August 2022) report 'Long-term funding of social care' includes an analysis of the workforce challenges in the adult social care sector and concludes that the workforce chapter of the White Paper 'People at the Heart of Care' does not amount to a workforce strategy or what the sector expected to see from one.

It goes on to recommend that: "The Government should publish a 10-year strategy for the adult social care workforce. It should develop the strategy in collaboration with care workers, providers, local Government, the NHS, unpaid carers, and people receiving care. The strategy should not just be a wish-list but needs to be a clear roadmap with core milestones, outcomes, and measures of success."

The Committee agrees that retention should be a key performance indicator but says 'it is important that measures of success also include opportunities for progression, reduced prevalence of zero-hour contracts, and whether care workers feel valued for the highly skilled nature of their work."

Fundamentally, the need for better pay for care workers was emphasised by the Committee which said: 'the Government's proposals for health and care workforce integration in the Joining up Care for People, Places and Populations White Paper are welcome, but they must include a requirement to work towards achieving parity of pay for comparable roles across the NHS and social care. The Government's guidance for fair cost of care exercises should require councils and providers to move towards pay rates for care workers that align with the NHS and that reward more senior staff with meaningfully higher pay than entry level workers.'

1.2 Government and NHSE policy

The **Government White Paper** 'People at the Heart of Care: adult social care reform' recognises that, with over 1.65 million jobs, the adult social care workforce is larger than the NHS, construction, transport, or food and drink service industries. It says the number of jobs in adult social care is forecast to grow by almost one-third by 2035. It understands that as the population grows, and the way care that is delivered evolves and diversifies, the adult social care workforce will need to grow and develop with it.

In that context the White Paper describes the Government's vision as being 'an adult social care workforce where people can experience a rewarding career with opportunities to develop and progress now and in the future. We want staff to be empowered to deliver the highest quality of care.' The Government says that it wants people to be able to say:

- I am supported by a workforce who have the right training, qualifications and values, and are concerned about what matters to me.
- I receive care from a workforce whose careers are valued, and whose professional development and wellbeing are prioritised.
- Social care is a rewarding career with clear opportunities to develop and progress, and where I feel valued in my role.
- I feel recognised for the important role I play in helping people who draw on care and support to receive high-quality personalised support that enriches their lives.
- I feel recognised for the skills I bring, and am able to develop new skills that help me tackle new challenges as I become more experienced.
- There is a culture in my workplace that supports my health and wellbeing.
- I have the confidence to use technology that supports people's needs and to free up time to deliver outstanding-quality care

Health Education England (HEE) is responsible for ensuring that the NHS workforce of today and tomorrow has the right numbers, skills, values and behaviours, at the right time and in the right place. Framework 15 published in 2014 sets out the ambitions of HEE for 15 years (2014-2029) and in 2021 HEE was commissioned to produce a new strategic planning framework to identify the drivers for workforce planning in 2037, including social care.

In addition, HEE and NHSE were asked by DHSC in July 2022 to produce a **Long Term Workforce Plan (LTWP)** that will seek to provide the answers to the questions posed by HEE's forthcoming strategic framework and set out how the NHS workforce will be put on a sustainable footing for the long term. The plan will focus on key areas such as demand, supply, retention, recruitment, and projections of what the NHS needs.

Skills for Care (SfC), established in 2001, is the strategic workforce development and planning body for adult social care in England. It works with employers, Government and partners to ensure social care has the right people, skills and support required to deliver the highest quality care and support now and in the future. Skills for Care and the LGA have agreed to work collaboratively on five shared workforce priorities areas:

1. Strategic workforce planning
2. Growing and developing the workforce to meet future demand
3. Enhancing the use of technology
4. Supporting wellbeing and positive mental health
5. Building and enhancing social justice, equality, diversity and inclusion in the workforce

Joint support for ICSs

HEE and Skills for Care have made a commitment to promoting an integrated approach to the health and social care workforce and supporting Integrated Care Systems to join up their local workforce planning and development for health and social care.

Their joint policy paper 'Integrated Care Systems - Getting the right workforce development support to ICSs' outlines an offer to help support ICSs to look at workforce, building on learning from existing local initiatives at system and place level.

Statutory Guidance

In July 2022 the DHSC published statutory guidance for Integrated Care Partnerships on the preparation of integrated care strategies. It says that the integrated care strategy should set the direction of the system across the area of the Integrated Care Board and Integrated Care Partnership, setting out how commissioners in the NHS and local authorities, working with providers and other partners, can deliver more joined-up, preventative, and person-centred care for their whole population, across the course of their life. The guidance goes on to say that the integrated care strategy presents an opportunity to do things differently to before, such as reaching beyond 'traditional' health and social care services to consider the wider determinants of health or joining-up health, social care and wider services.

On workforce the guidance says that Integrated Care Partnerships should work with providers to build a workforce that can deliver new ways of working that meet population health and wellbeing needs and wrap care and support around the person. This should apply to the workforces that work across health and social care. To support this ambition, integrated care strategies should consider developing shared values and common standard; developing new cross-system ways of working or working with local partners to explore opportunities for system-wide recruitment and deployment informed by joined-up workforce planning; talent management, and skills development.

1.3 The Commission's view

The Commission is keen to see the greater integration of the health and social workforce as a key element in the successful development of integrated commissioning of health and social care services. It believes that the Government should act with urgency to develop and publish a 10-year integrated workforce strategy for the health and social care workforce. This should be developed in collaboration with health and social care workers, providers, local Government, the NHS, unpaid carers, and people receiving care. The Integrated Strategy should not just be a wish-list but a clear roadmap with core milestones, outcomes, and measures of success.

The crisis in the social care workforce of shortages and poor retention rates should be tackled forthwith through an immediate uplift to the living wage for care workers.

The Government should publish within 3 months a Social Care People Plan (mirroring the NHS People Plan) to provide a robust career framework for the recruitment, registration, training, education and promotion of care workers to create parity of esteem with their colleagues in the NHS.

This should include appropriate mechanisms to reflect the different nature of the contribution made to support people who draw on care such as personal assistants and unpaid carers. This is a key step to enable achievement of the long-term goal of a more closely aligned and, eventually, fully integrated health and social care service.

Integrated Care Partnerships should each develop an integrated health and social care workforce plan and consider making a partnership commitment to paying care workers the real living wage directly or through contractual arrangements with care providers.

1.4 Key questions

- What are the primary obstacles to developing an integrated workforce strategy and building a truly integrated workforce?
- What more should key national agencies – the Government, NHSE, Health Education England, and Skills for Care - do separately and together to support ICSs to overcome these obstacles?

2 DEVELOPING PLACE-BASED PARTNERSHIPS

2.1 Context

A focus on place

At its first meeting in April 2022, the Commission strongly welcomed the Government's focus on place and identified a number of critical success factors for place-based partnerships including that:

- there may be variation between areas on the level of delegation of budgets and the extent of pooling NHS and council budgets given the maturity of the relationships in each area and how these develop over time.
- they may require 'work arounds' to implement given the complexities of the legislation regarding NHS finances.
- there is clarity between variation that is desirable to reflect local differences and variation which may not be desirable or reflect under-performance
- system leaders agree shared values and to work together to develop high levels of trust, and a learning and performance development culture
- there is use of a broad-based approach to evidenced-based decision making
- there is leadership career development and recruitment opportunities across health and local Government to reflect the new paradigm of collaboration.
- local financial processes reflect key design principles such as removing financial disincentives to allow change in line with system aims and maximising transparency

Genuine collaboration

How different organisations with very different operating procedures, management structures and professional cultures work together is a key challenge across a range of policy areas in the public sector.

Borrowing from an analysis from the education sphere by Deal & Kennedy (1999) and Fullan and Hargreaves (1996), there is a spectrum of partnership working ranging from 'toxic' at one end to 'genuine collaboration' at the other. Applying this analysis to the evolving world of integrated care systems, six different partnership cultures may be present at different times in different ICSs (see below) with the aim of working towards the most effective 'collaborative' approach:

I. **Toxic** – Silo working means that any negative aspects in the delivery of NHS and/or social care services operations ends up being blamed on one another. Survival is prioritised over improvement. Keeping your head down and minding your own business typify this culture. A toxic culture actually expends energy on preventing change.
II. **Fragmented** – Professions pretty much do their own thing with lack of professional interaction. There isn't much tension since most simply don't care what others are doing. Because all are unaware of what their colleagues are up to, they don't feel a stake in the success of the ICS.
III. **Balkanized** – Collaboration occurs but only in cliques of like-minded individuals, if conflict between a clique and the ICS, the former may tend to win. Encourages competition between groups. Those who feel the need to compete for resources, position and territory may end up recruiting others to join them in a clique.
IV. **Contrived collegial** – management determines how staff are to behave with the aim of supporting new approaches and techniques, may discourage true collegiality by forcing relationships. Although some contrivance is necessary for the development of a truly collaborative culture, knowing when to back off and let the seeds germinate can be challenging.
V. **Comfortable collaborative** – Being nice to each other (for example listening and sharing viewpoints) will inhibit the practice of providing critical feedback. It may also make the ICB/ICP wary of risking current achievement in a bid to move towards genuinely collaborative culture. Most ICS will be in this category.
VI. **Collaborative** – Embraces improvement including a culture of constructive criticism for all parts of the ICS. Management is adamant about challenging ineffective practices. This type of culture is the one that enables the most impact. Leaders and others share strong values and all are committed to improving their work.

Evolving to a truly collaborative culture of co-construction will require local leadership and modelling behaviour by the ICB/ICP, and ultimately will need to be reflected in the culture of all parts of the ICS.

Accountability

The DHSC Select Committee is undertaking a short inquiry into the nature of accountability within Integrated care Systems. In its submission to that inquiry, the Commission said that be effective and successful the very welcome system transformation now being implemented requires an entirely new approach to the balance between local and national accountability and autonomy within and between the health and social care system at every level.

The new organising principle of collaboration, the new partnership structure and the new shared outcomes of ICSs require a concomitant shift away from an accountability system based on hierarchy and instruction from above, towards one based on mutual accountability based on local networks, collaboration and partnerships within a national framework.

In particular, the legislation for transformation of the health and care system means that Integrated Care Boards should not, as before, 'look up' for instruction and permission to move. But rather, to 'look out' and fully and formally collaborate with organisations which are locally democratically accountable.

In effect ICBs, like their place-based boards, must now perceive themselves as being primarily accountable to the geography of their system and no longer accountable only or even primarily to the bigger NHS region (and through them nationally to NHSEI and the DHSC) in which they happen to sit.

Specific changes will be required in the nature of national/local accountability in key areas including the purpose and nature of performance targets, financial controls, pooled budgets, accountable officers, public engagement and local democracy.

One key issue highlighted in the Commission's submission and hopefully to be resolved by the Committee is the need for the public to know "where the buck stops" within an ICS – the Chair of the ICB or ICP or the accountable officer or council leader at the place-based level?

Housing

The Commission identified housing as an important determinant of good health at its second roundtable in June 2022.

This theme has been underlined recently by the DHULC Select Committee Report 'The long-term funding of adult social care' (July 2022) that includes a chapter on housing and planning, and draws attention to evidence it received that:

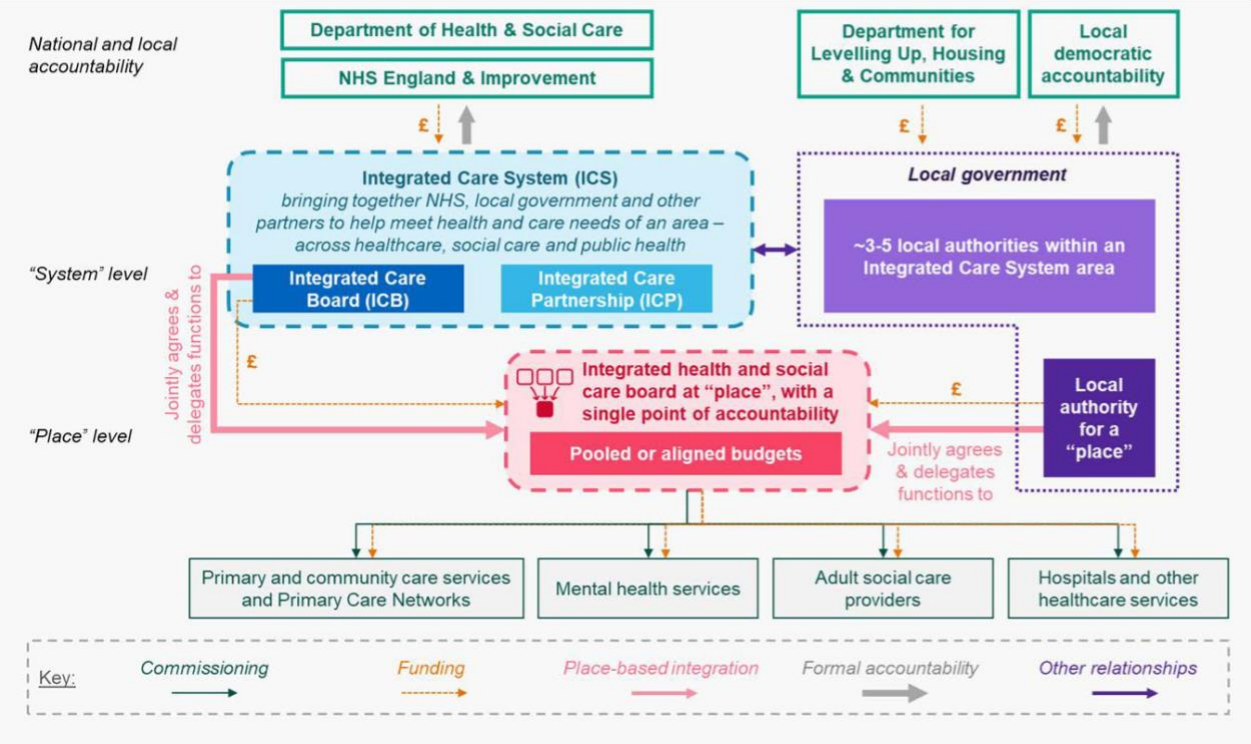
- housing has an important role to play stabilising the adult social care market and introducing more quality and innovation
- ensuring we have the right types of housing to meet the needs of people, including supporting people to stay in their own home, would help to prevent or delay the need for care, residential care, hospital admissions, and needs becoming more complex.
- suitable housing improves wellbeing and quality of life for people, reducing loneliness: a person aged 80 living in a retirement community feels as good as someone aged 10 years younger in the general population
- cost savings from different housing models include:
    - Sheltered housing saves the NHS £486 million a year
    - for every resident in extra care, the local authority saves £6,700
    - Specialist housing for older people saves the taxpayer £3,000 per person per year
    - Specialist housing for people with learning disabilities and mental health needs saves £12,500-£15,500 per person per year

2.2 Government and NHSE policy

Place-based partnerships

Place-based partnerships within each ICS are a central feature of the system as shown in the diagram below taken from the Government White Paper 'Joining Up Care'.

Crucially, it is expected that the Integrated Care Board will jointly agree and delegate functions to an integrated health and social care board at "place" with a single point of accountability. Each place board will have aligned or potentially pooled budgets, and will in turn jointly agree and delegate functions to service providers.



An integrated care strategy

The strategy

Government guidance for Integrated Care Partnerships on the development of integrated care strategies says that the strategy should set the direction of the system across the area of the Integrated Care Board and Integrated Care Partnership, setting out how commissioners in the NHS and local authorities, working with providers and other partners, can deliver more joined-up, preventative, and person-centred care for their whole population, across the course of their life. It emphasises that strategy presents an opportunity to do things differently to before, such as reaching beyond 'traditional' health and social care services to consider the wider determinants of health or joining-up health, social care and wider services.

Health and wellbeing boards

The Health and Wellbeing Board remains responsible for producing both the Joint Strategic Needs Assessment and the Joint Local Health and Wellbeing Strategy. The Integrated Care Strategy should complement the production of these local strategies. It should identify where needs could be better addressed at ICS level and bring learning from across places and the system to drive improvement and innovation, for example challenges that could be met by integrating the workforce or considering population health, care needs and services over this larger area. It should not replace or supersede the joint local health and wellbeing strategies, which will **continue to have a vital role at place**.

Subsidiarity

For many Integrated Care Partnerships there will be multiple health and wellbeing boards in their area, and there could be multiple joint strategic needs assessments and joint local health and wellbeing strategies (and in some cases a health and wellbeing board will be part of multiple Integrated Care Partnerships).

Integrated Care Partnerships should ensure that the integrated care strategy facilitates subsidiarity in decision making, ensuring that it only addresses priorities that are best managed at system-level, and not replace or supersede the priorities that are best done locally through the joint local health and wellbeing strategies. The Integrated Care Partnership should ensure that it builds the principle of subsidiarity in the system, encouraging partners to reflect on whether decisions and delivery are happening at the right level when they produce the strategy.

Community engagement

Integrated Care Partnerships should explore which other local partners and stakeholders they will need to engage in the development of the integrated care strategy either directly or indirectly through other organisations. These will vary between areas.

It will be, at times, more appropriate for the individuals or organisations to be involved directly at a local level in their neighbourhoods and communities rather than at the level of the Integrated Care Partnership. The Integrated Care Partnership should complement and champion this place-based and neighbourhood engagement and ensure that there are mechanisms for relevant local insights to inform the integrated care strategy.

The guidance gives an illustrative list of organisations that could be involved including Healthwatch, people and communities, providers of health and social care services, the VCSE sector, local authority and Integrated Care Board leaders, wider organisations e.g., housing, district councils in 2-tier areas, other relevant fora.

Content

Areas that should be covered by the strategy include:

- Shared outcomes
- Quality improvement
- Joint working and section 75 of the National Health Service Act 2006

- Personalised care
- Disparities in health and social care
- Population health and prevention
- Health protection
- Babies, children, young people, their families and healthy ageing
- Workforce
- Research and innovation
- 'Health-related' services
- Data and information sharing

Housing

The Government has made a commitment to "make every decision about care a decision about housing" and the White Paper 'Joining Up Care' that called on people to 'think housing and community' when they develop their local partnerships and strategies includes:

- £300 million over the next 3 years to embed the strategic commitment in all local places to connect housing with health and care and drive the stock of new supported housing the purpose of which is to:
    - Enable all local areas to agree a plan embedding housing in broader health and care strategies, including investing in jointly commissioned services;
    - Boost the supply of supported housing, coupled with driving innovation in how services are delivered alongside housing where possible; and
    - Increase local expenditure on services for those in supported housing;
- An additional £210 million over three years for the Care and Support Specialised Housing Fund, to incentivise the supply of specialised housing for older people and people with a physical disability, learning disability, autism, or mental ill- health

2.3 The Commission's view

The Commission believes that place-based partnerships are the engine room of integrated care systems and is keen to identify, highlight and promote examples of best practice around the country as every ICS develops their local structures and systems. The Commission has already heard in previous sessions how areas such as Greater Manchester, West Yorkshire, Surrey and London are developing their approach.

The Commission strongly supports an approach based on true collaboration which embraces improvement through a culture of constructive criticism for all parts of the ICS and where management is adamant about challenging ineffective practices. This type of culture is the one that enables the most impact and is where leaders and others share strong values and all are committed to improving their work.

The Commission believes that there must now be a shift away from an accountability system based on hierarchy and instruction from above, towards one based on mutual accountability based on local networks, collaboration and partnerships within a national framework. If left in place unchanged, the current system will fatally undermine the new legal purpose and structure of a system rooted in place and based on collaboration and partnership.

The Commission supports the view of the DHLUC that housing is a critical element in determining good health and would like place-based partnerships to clearly show how housing is an integral part of their plans and services. This is an area of practice that the Commission would like to see further analysis and examples of best practice including national as well as local housing policy and partnership working across the public and private sectors.

ICSs and their relationship to place-based partnerships will vary between areas and evidence of best practice would also be helpful in relation to the relationship between the ICS-wide integrated care strategy and the place-based plans developed for each local authority area; and the footprint of place-based boundaries in two-tier county areas.

There is a continuing concern at the apparent lack of joined-up working both between DHSC and DLUHC - and within DLUHC - on housing, planning, and social care; and between DHSC, DHLUC and DfE in relation to the health and wellbeing of children and young people.

2.4 Key questions

- How can ICSs and place-based partnerships develop a truly collaborative culture in their shared leadership, governance and accountability?
- How can local and national housing policy support place-based health improvement?
- How could Government departmental collaboration support place-based partnerships as the 'engine-room' of ICSs?

3 DEVELOPING INTEGRATED NEIGHBOURHOOD PARTNERSHIPS

3.1 Context

The development of Integrated Care Partnerships with clinically-based Primary Care Networks at their centre has been underway in many local areas for some time. The Fuller Stocktake Report - 'Next Steps for Integrating Primary Care' commissioned by the Government - describes a wide range of examples of this kind and describes a new vision for integrating primary care, improving the access, experience and outcomes for our communities, which centres around three essential offers:

- **streamlining access to care and advice** for people who get ill but only use health services infrequently: providing them with much more choice about how they access care and ensuring care is always available in their community **when they need it**
- **providing more proactive, personalised care with support from a multidisciplinary team of professionals** to people with more complex needs, including, but not limited to**,** those with multiple long-term conditions
- **helping people to stay well for longer** as part of a more ambitious and joined-up approach to prevention.

ICS leaders believe they can only achieve their four primary aims (improving outcomes in population health and healthcare; tackling inequalities in outcomes, experience and access; enhancing productivity and value for money; and helping the NHS support broader social and economic development) if there is support and development of a thriving integrated primary care system.

The report makes clear this will need to be built as locally as possible, drawing on the insights, resourcefulness and innovations of patients and their carers, local communities, Local Government and NHS teams, other care providers and wider system partners, as well as, of course, primary care leaders.

Cross-sector realignment

Delivering integrated neighbourhood teams will require a step-change in progress, with a systematic cross-sector realignment to form multi-organisational and sector teams working in neighbourhoods. For example:

- full alignment of clinical and operational workforce from community health providers to neighbourhood 'footprints', working alongside dedicated, named specialist teams from acute and mental health trusts, particularly their community mental health teams
- making available 'back-office' and transformation functions for PCNs, including HR, quality improvement, organisational development, data and analytics and finance – for example, by leveraging this support from larger providers (eg GP federations, supra-PCNs, NHS trusts)
- a shared, system-wide approach to estates, including NHS trust participation in system estates reviews, with organisations co-locating teams in neighbourhoods and places.

Partnerships with people and communities

PCNs that are most effective in improving population health and tackling health inequalities, are those that work in partnership with their people and communities and local authority colleagues. This partnership focuses on genuine co-production and personalisation of care, bringing local people into the workforce so that it reflects the diversity of local communities, and proactively reaching out to marginalised groups breaking down barriers to accessing healthcare.

Urgent care pathways in the community

Implementing the vision for integrating primary care will enable local systems to plan and organise a coherent urgent and emergency care service by developing an integrated urgent care pathway *in the community*. Critically, we need to create the conditions by which they can connect up the wider urgent care system, supporting them to take currently separate and siloed services – for example, general practice in-hours and extended hours, urgent treatment centres, out-of-hours, urgent community response services, home visiting, community pharmacy, 111 call handling, 111 clinical assessment – and organise them as a single integrated urgent care pathway in the community that is reliable, streamlined and easier for patients to navigate.

Support for people with complex and long-term conditions

By managing urgent care differently and supporting the growth and development of integrated neighbourhood teams, the capacity for team-based continuity can be created, focusing specifically on those people most likely to benefit. Determining which patients benefit most from more personalised continuity of care can depend on a range of medical, psychological or social reasons and should be determined through conversations with patients and using clinical judgement, as well as supported by risk stratification using the wealth of data increasingly available to primary care teams.

A personalised care approach means *'what matters to me, not what's the matter with me' that* starts with people's abilities and works with them to support self-care and self-management of complex and long-term conditions. This also means shared decision-making with patients and carers and improving availability and usability of patient-held records – for example, ensuring that reasonable adjustments for people with a disability are seen and accessed by all people involved in their care. It also means the further planned expansion of personal budgets and building on the progress made to date in expanding the role of social prescribing in primary care teams.

Neighbourhood networks within a place

At place level (which will often mean local authority footprints covering populations of around 250-300,000), neighbourhood teams working together and with wider system partners, will provide more intensive support to patients. This should consolidate the multitude of existing models and teams focused on discharge to assess, virtual wards, mental health crisis response, enhanced health in care homes and urgent community response to support people who are unwell to be cared for safely at home, and for those requiring hospital treatment, to ensure safe and effective transfers into and back from hospital. Carers – and the role they play as well as the additional capacity they provide – will be essential partners to these teams.

Reducing health inequalities

The June 2022 Commission roundtable spelt out how as a nation, life expectancy since 2010 has been stalling, while the amount of time people spend in poor health has been increasing. This trend, we know, is driven in large part by wider socio-economic determinants and a failure to address the health inequalities that result, and it masks significant variability in outcomes, especially between more affluent and more deprived areas where healthy and overall life expectancy are lower. Primary care has an essential role to play in preventing ill health and tackling health inequalities, working in partnership with other system players to prevent ill health and manage long-term conditions.

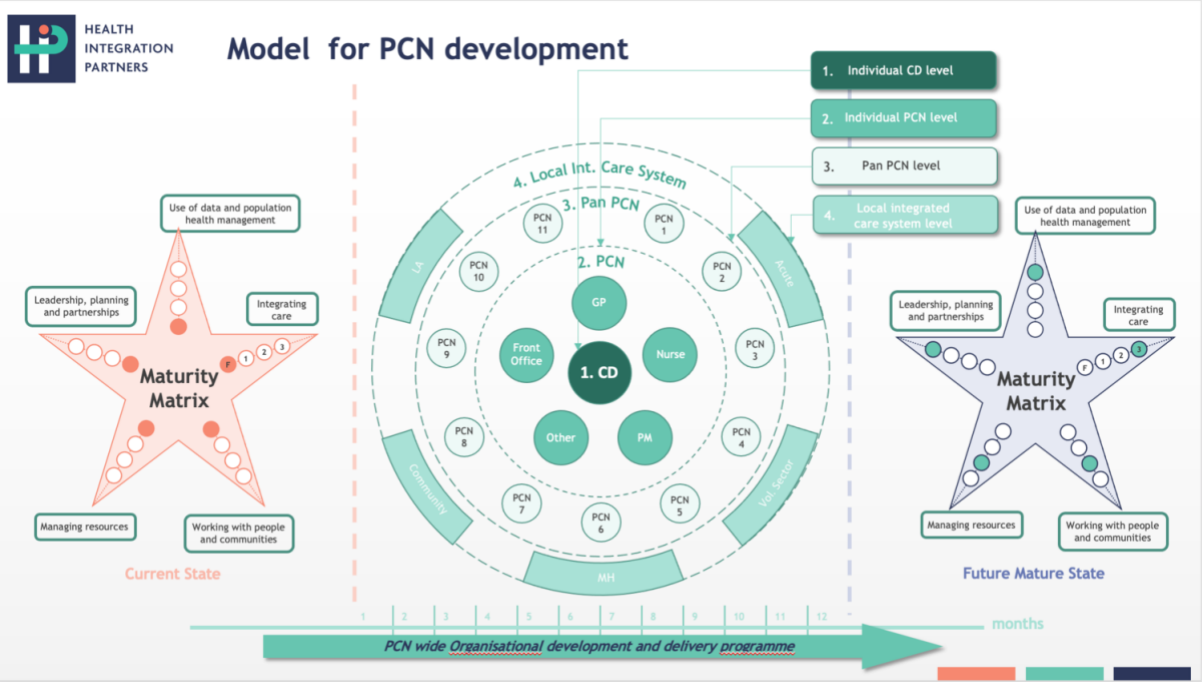
The Core20PLUS5 approach provides a focus for reducing healthcare inequalities across systems, identifying a target population comprising the most deprived 20% of the population of England (the Core20) and other groups identified by data (plus groups), alongside five clinical priorities for action to reduce inequalities. Areas in which primary care can take a more active role in creating healthy communities and reducing the incidence of ill health are by:

- working with communities - building trust, connecting up services and galvanising the wealth of expertise in the VCSE sector
- more effective use of data to empower neighbourhood teams to increase uptake of preventative interventions, and identify and tackle health inequalities
- closer working relationships with local authorities
- building on successful national programmes providing lifestyle advice e.g., stop smoking, 'Couch to 5k' and alcohol awareness campaigns
- using health coaches and social prescribing link workers
- increasing the role of community pharmacy, dentistry, optometry and audiology in prevention,
- 'making every contact count' in more services

System changes

Workforce, estates and data are the three policy areas crucial to the delivery of the new neighbourhood model because they can enable the flexibilities on workforce that will be central to creating integrated neighbourhood teams, provide the opportunity to co-locate those teams in hubs to ensure greater accessibility for patients and a positive working environment for staff, and equip them with the information to target services where they are most needed.

One example of best practice in PCN development is the matrix maturity model created by Health Integration Partners with stakeholders in south London.



3.2 Government and NHSE policy

Each of the 1,250 Primary Care Networks across England are based on GP registered patient lists, typically serving communities of between 30,000 to 50,000 people (with some flexibility). PCNs are led by clinical directors who may be a GP, general practice nurse, clinical pharmacist or other clinical profession working in general practice.

The NHSE describe Primary Care Networks as small enough to provide the personal care valued by both people and GPs, but large enough to have impact and economies of scale through better collaboration between GP practices and others in the local health and social care system. The Fuller Stocktake report was commissioned by NHSE to review existing practice and recommend ways forward.

3.3 The Commission's view

The journey that Primary Care Networks are on to become integrated neighbourhood partnerships described in the Fuller Stocktake report clearly reflects the Commission's core values and principles. These new models are devolved partnerships that go well beyond clinical care to achieve better health and care outcomes, provide a better experience of health and care services and address the wider determinants of health at a very local level.

However, the development of integrated neighbourhood partnerships could be characterised as a national-to-neighbourhood process that has not yet been connected development to the parallel national-to-place process of developing ICSs and place-based partnerships. This may be because the neighbourhood partnership model has been based on and built out from Primary Care Networks led by GP practices who have a separate national contract with NHSE.

It is perhaps significant that place-based partnerships are not referred to in the Fuller Stocktake although it is recommended that ICSs should ensure primary care is represented on all place-based boards.

So, there appears to be a key task to connect and align the network of smaller neighbourhood partnerships within larger place-based partnerships if this 'triple devolution' from the national to the ICS, from the ICS to place, and from place to neighbourhood is to be effective. In effect neighbourhood partnerships could be seen the building blocks for the architecture (or part of it) of place-based partnerships.

It would be helpful to identify examples of best practice by ICSs in their role in supporting:

- an appropriate relationship between neighbourhood partnerships and place-based partnerships given the parallel nature of their respective development
- the inclusion of primary care in ICS and place governance arrangements
- meaningful partnerships between all sectors, including the role of health and care organisations as anchor institutions, in place-based and neighbourhood partnerships
- population health improvement activities as the 'norm' in place and neighbourhood partnerships
- attention and resources directed toward providing effective support for children and young people, and to people with a learning disability and autistic people at place and neighbourhood
- ways to develop and enhance the local workforce; develop modern, fit-for-purpose primary care estates; and put in place the data and digital infrastructure to transform primary care

3.4 Key Questions

- What should be the relationship between neighbourhood partnerships, place-based partnerships and the Integrated Care System?
- How can ICSs and place-based partnerships ensure the neighbourhood partnership model is developed appropriately for their area?

4 REGULATING INTEGRATED CARE SYSTEMS

4.1 Government policy

CQC

The Care Quality Commission (CQC) has the statutory responsibility for the inspection and regulation of the NHS, the adult social care system and Integrated Care Systems.

The Care Quality Commission will, for example, assess how the Integrated Care Strategy is used to inform the commissioning and provision of quality and safe services across all partners, within the integrated care system, and that this is a credible strategy for its population. This could include, for example, the quality of the equal partnership between the Integrated Care Board and the Integrated Care Partnership.

In addition, the Health and Care Act 2022, creates a new duty for the Care Quality Commission to independently review and assess the performance of councils' adult social care duties and gave Ministers the legal power to intervene where 'serious failings or risk of failure' have been identified.

Office for Local Government

A new Office for Local Government is to be set up to assess local Government performance across England. The Secretary of State for Levelling Up Housing and Communities said the new body would analyse existing data covering areas such as education, recycling, adult social care, and climate change to ensure it was "useful for local leaders, rather than an administrative burden".

The body will produce an annual report on local Government which the Secretary of State said will "improve our understanding in central Government of the picture across Local Government." Plans for an independent body collating data on Local Government performance were first announced in the Levelling Up White Paper earlier this year but were not included in the Levelling up and Regeneration Bill that followed it in May.

Ofsted

Ofsted has the statutory responsibility for the inspection and regulation of children's social care services, education and skills. Children and young people are now included within the within the scope of ICSs and there is therefore a need for clarity on:

- the relationship between Ofsted and ICSs with regard to inspection and regulation of both services and system performance relating to children and young people
- the relationship between Ofsted and CQC on the exercise of their respective regulatory powers towards commissioners, service providers and ICS systems

4.2 The Commission's view

Regulation of children and young people's services

The Commission welcomes the inclusion of children and young people within the scope of ICSs and at the roundtable in June 2022 made a number of detailed observations and recommendations including:

- ***Mental health First***: The key health challenge now for children's health is the major decline in their mental health.
- ***National Leadership***: The landscape for children and young people is more complex for ICSs to manage as it includes education – schools and academies – as well as the NHS, local Government and the voluntary sector.
- ***ICS Policy Framework***: ICSs should develop a children and young people's policy framework based on a common set of design principles and containing clear indicators of success. Schools and academies must be fully engaged in the strategy and recognise their role as anchor institutions in local communities.
- ***Avoid over-medicalisation*:** Care services for children and young people should not become medicalised but address the wider social, family, financial, educational and cultural factors influencing their growth and development.
- **Children's voice**: The voice of children and young people is essential if change is to be successful.

This discussion raised the issue of the role of Ofsted as the regulator of children's services in an integrated care system that is regulated by a separate body – the CQC. This carries obvious risks of overlap, duplication, confusion, and potential conflicting assessments.

Inspection of Local Government

The Commission shares the concerns of Sarah McClinton, the president of the Association of Directors of Adult Social Care that, at a time of major upheaval for adult services, this is the wrong moment for the Government to bring in a new local Government inspection regime. The risk of local councils failing the new inspections is made greater because they are juggling so many pressures consecutively including acute workforce pressures, a Government consultation on new Liberty protection safeguards reforms, and charging reforms with care accounts and new IT systems that need to be set up to track what people are paying for care.

4.3 Key questions

- What are the roles and relationships of the CQC and Ofsted respectively regarding inspection and regulation of ICSs as a system and its services to improve the health and wellbeing of children and young people?
- To what extent will school and academy inspections by Ofsted reflect an integrated approach to improving children's health and wellbeing?
- To what extent will a new inspection regime of local Government performance in delivering their social care statutory duties social care reflect the varying maturity of ICS development?

5. Key questions for the Government (Integration Minister).

The health and social care system is experiencing an unprecedented combination of financial pressures and service demands resulting from the effect of the Covid-19 pandemic, chronic workforce shortages, high levels of inflation, the increased costs of living, and the unforeseen energy crisis.

This is having a dramatic impact on the health and wellbeing of those who need care and support, and the viability and performance of services to meet those needs at a time of significant system transformation to implement integrated care systems are. Given this context:

- **Unprecedented challenges:** What can the Government do to support ICSs (both the NHS and Local Government) as they seek to support their local services, communities and their populations during this extraordinary period of challenge and change including the impact of the cost of living crisis and steeply rising energy costs on population health?

- **National action on heath inequality**: Does the Government acknowledge that for ICSs to be successful in their primary task of reducing health inequalities national Government must take complementary activity? For example, and put simply, if child poverty is allowed to increase then better health outcomes for children will be almost impossible for ICSs to deliver.

- **National/local balance:** Is the Government confident it has struck the right balance between **national** direction, priorities and assurance, and **local** decision making, priorities and accountability, for ICSs, place-based partnerships - and neighbourhood partnerships - to be successful?

- **Partnership of equals:** To what extent does the Government support a 'partnership of equals' between the NHS and Local Government, embedding the voluntary sector in governance arrangements and ensuring a strong voice for people with a lived experience of care within integrated care systems?

- **Place-based partnerships**: To what extent are place-based partnerships seen as the 'engine room' of integrated care systems, where budget and accountability are pooled; and where do neighbourhood partnerships fit in? And are there implications for the machinery of Government to support this e.g., greater DLUHC and DHSC joined up working?

- **Inspection/Regulation**: Is this the right time to introduce a new national system of assurance for local Government on social care given the structural changes now underway; and how should ICSs work with the Ofsted and CQC on regulating children's services and systems? To what extent can the Government leave accountability of ICSs to regulators and local systems?

- **Funding for social care**: To what extent does the Government recognise that adequate funding of social care is 'not yet done', and that low pay for social care workers leading to high staff turnover and chronic workforce shortages has major impacts on the NHS as well as impeding the development – ideally within 5 years - of an integrated workforce?

Please note the Secretariat will circulate an update to this briefing paper on 17th October