Nottinghamshire County Council

Adult Social Care and Public Health Committee

Monday, 08 February 2021 at 10:30

Virtual meeting, **https://www.youtube.com/user/nottscc**

AGENDA

1	Minutes of the last meeting of the Adult Social Care and Public Health Committee held on 11 January 2021	1 - 6
2	Apologies for Absence	
3	Declarations of Interests by Members and Officers:- (see note below) (a) Disclosable Pecuniary Interests (b) Private Interests (pecuniary and non-pecuniary)	
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Notes

(1) Councillors are advised to contact their Research Officer for details of any Group Meetings which are planned for this meeting.

(2) Members of the public wishing to inspect "Background Papers" referred to in the reports on the agenda or Schedule 12A of the Local Government Act should contact:-

Customer Services Centre 0300 500 80 80

(3) Persons making a declaration of interest should have regard to the Code of Conduct and the Council's Procedure Rules. Those declaring must indicate the nature of their interest and the reasons for the declaration.

Councillors or Officers requiring clarification on whether to make a declaration of interest are invited to contact Jo Toomey (Tel. 0115 977 4506) or a colleague in Democratic Services prior to the meeting.

(4) Councillors are reminded that Committee and Sub-Committee papers, with the exception of those which contain Exempt or Confidential Information, may be recycled.

(5) This agenda and its associated reports are available to view online via an online calendar - http://www.nottinghamshire.gov.uk/dms/Meetings.aspx

Nottinghamshire County Council

minutes

Meeting	ADULT SOCIAL CARE AND PUBLIC HEALTH COMMITTEE
Date	11 January 2021 (commencing at 10.30 am)

Membership
Persons absent are marked with an 'A'

COUNCILLORS

Tony Harper (Chairman)
Boyd Elliott (Vice-Chairman)
Francis Purdue-Horan (Vice-Chairman)

Joyce Bosnjak
Dr. John Doddy **A**
Sybil Fielding
David Martin
Andy Sissons **A**
Steve Vickers
Muriel Weisz
Yvonne Woodhead

SUBSTITUTE MEMBERS

Councillor Richard Butler for Councillor Dr John Doddy
Councillor Stephen Garner for Councillor Andy Sissons

OFFICERS IN ATTENDANCE

Melanie Brooks, Corporate Director, Adult Social Care and Public Health (ASC&PH)
Jonathan Gribbin, Director of Public Health, ASC&PH
Ainsley Macdonnell, Service Director, Living Well Community Services, ASC&PH
Sue Batty, Service Director, Ageing Well Community Services, ASC&PH
Grace Natoli, Director of Transformation, ASC&PH
Lucy Jones, Senior Public Health and Commissioning Manager, ASC&PH
Matthew Osborne, Health Improvement Principal, ASC&PH
Jennifer Allen, Strategic Development Manager, ASC&PH
Sharon Hayles, Project Manager, ASC&PH
Cate Bennett, Principal Occupational Therapist, ASC&PH
Jennie Kennington, Senior Executive Officer, ASC&PH
Jo Toomey, Advanced Democratic Services Officer, Chief Executive's

1. MINUTES OF THE LAST MEETING

The minutes of the meeting of the Adult Social Care and Public Health Committee held on 7 December 2020 were confirmed and signed by the Chair.

The Chairman temporarily lost connection to the meeting. Vice-Chairman, Councillor Elliot, assumed the Chair until Councillor Harper re-joined the meeting during agenda item 4.

2. APOLOGIES FOR ABSENCE

- Councillor Dr John Doddy (other reasons) was substituted by Councillor Richard Butler
- Councillor Andy Sissons (other reasons) was substituted by Councillor Stephen Garner

3. DECLARATIONS OF INTEREST BY MEMBERS AND OFFICERS

No interests were disclosed.

4. 'YOUR HEALTH, YOUR WAY' – INTEGRATED WELLBEING SERVICE UPDATE

Jonathan Gribbin introduced the report, which updated the Committee on changes to arrangements for the 'Your Health, Your Way' service and opportunities to engage with members of the public.

During discussions, Members:

- Commented on a chart showing the number of referrals that had been made to 'Your Health, Your Way' across the county categorised by levels of deprivation. Councillors requested that the format of this information be revised in future update reports to show the spread of referrals across the county, including levels of deprivation.

RESOLVED 2021/001

1) That members of the Adult Social Care and Public Health Committee receive future updates on the progress of 'Your Health, Your Way' via routine quarterly performance reports.

2) That members of the Adult Social Care and Public Health Committee do not wish to add any further means of 'Your Health, Your Way' engaging with members of the public.

5. CONTAIN OUTBREAK MANAGEMENT FUND

Jonathan Gribbin introduced his report on the Contain Outbreak Management Fund, which sought approval to use the fund to deliver the proposed funding plan (appended to the report) and the establishment of two fixed-term staffing posts to support the delivery of the COVID-19 communication and engagement strategy.

During discussions, Members:

- Asked questions about the roles of Response and Contain Co-Ordinators and how they would work with the district and borough councils.

- Recognised that the report before Committee concentrated on the financial aspects of the plan and that a future report setting out the detail behind it could be provided.
- Asked for clarification about the advice they should give constituents regarding appointments for the COVID-19 vaccination. The County Council's messaging stated that residents should wait until they were contacted. Conflicting advice from other sources was directing people to a website through which an appointment could be booked (bookings were restricted to the priority groups for whom appointments were being released).

RESOLVED 2021/002

The Adult Social Care and Public Health Committee:

1) Approves the use of the Contain Outbreak Management Fund, as per the proposed funding plan attached to the Committee's papers, for which Nottinghamshire County Council has been allocated £6,625,792.

2) Approves the establishment of two fixed-term staffing posts to support the delivery of the COVID-19 communication and engagement strategy, funded from the Contain Outbreak Management Fund.

3) Requested that the Director of Public Health provide Committee Members with an e-mail update clarifying the message they should be conveying to constituents in respect of booking appointments for COVID-19 vaccination.

6. ADULT SOCIAL CARE & PUBLIC HEALTH SERVICE IMPROVEMENT PROGRAMME FOR 2021/22 TO 2023/24

The report, which was introduced by Melanie Brooks outlined the department's programme of work and the investment required for the delivery of effective, efficient services during 2021/22 to 2023/24.

During discussions, Members:

- Asked about communication mechanisms and a programme which was part of the Digital COVID-19 Response theme in the Adult Social Care and Public Health Digital Strategy, requesting additional information.

RESOLVED 2021/003

The Adult Social Care and Public Health Committee:

1) Having considered the Adult Social Care and Public Health Service Improvement Programme for 2021/22 to 2023/24, recommends that it receives a future report setting out more detail on the Digital COVID-19 Response theme of the Adult Social Care and Public Health Digital Strategy.

2) Agrees the implementation of the Adult Social Care and Public Health Service Improvement Programme for 2021/22 – 2023/24

3) Gives approval for the resources identified at **paragraph 26** of the report, including the establishment of the following posts:

Job title	Grade	Full Time Equivalent	Permanent or temporary
Mosaic Technical Specialist	Hay Band C	2	Temporary posts for one year until 31st March 2022
Project Manager	Hay Band D	2	Temporary posts for one year until 31st March 2022
Business Analyst	Hay Band C	1	Temporary one year until 31st March 2022
Team Manager	Hay Band D	1	Permanent
Senior Practitioner (OT)	Hay Band C	1	Permanent
Occupational Therapist	Hay Band A/B	3	Permanent
Reablement Manager	Hay Band A	3	Permanent
Community Care Officer	Grade 5	6	Permanent
Support Coordinator	Grade 4	3	Permanent
Senior Reablement Worker	Grade 3	32	Permanent

7. UPDATE ON PROGRESS OF THE PROCUREMENT OF A NEW FRAMEWORK AGREEMENT FOR EQUIPMENT-BASED MAJOR ADAPTATIONS IN PEOPLE'S HOMES

Cate Bennett introduced the report, which updated the Committee on progress with the procurement of a Single Provider Framework Agreement for equipment-based major adaptation solutions.

RESOLVED 2021/004

- That there were no further actions arising as a result of this report.

8. TEMPORARY POSTS TO COMPLETE DEFERRED ASSESSMENTS OF CARE PACKAGES FUNDED IN THE SHORT-TERM BY THE NHS DURING THE COVID-19 PANDEMIC

Sue Batty presented the report, which asked the Committee to approve the establishment of temporary posts to complete deferred assessments of care packages.

RESOLVED 2021/005

That Committee approves the establishment of the following posts and equipment budget which will be funded from the £390,000 funding allotted to Nottinghamshire County Council as part of the joint Deferred Assessments Plan agreed with Nottingham and Nottinghamshire Clinical Commissioning Group and Nottingham City Council:

a) Further to the temporary establishment of some posts, the extension of 7.2 FTE (full time equivalent) temporary Community Care Officer (Grade 5) posts until 31 March 2021

b) The extension of 2 FTE temporary Social Care Assistant (Grade 3) posts until 31 March 2021

c) The establishment of 6.2 FTE temporary Community Care Officer (Grade 5) posts until 31 March 2021

d) The establishment of 9 FTE temporary Community Care Officer (Grade 5) posts until 30 April 2021

e) An equipment budget of £43,000.

9. NATIONAL CHILDREN AND ADULT SERVICES CONFERENCE, NOVEMBER 2020

Melanie Brooks presented a report which highlighted the key messages from the National Children and Adult Services Conference in November 2020.

RESOLVED 2021/006

That there were no actions arising as a result of this report.

10. WORK PROGRAMME

RESOLVED 2021/007

That the updated work programme be agreed, subject to the inclusion of the following items:

- Contain Outbreak Management Fund – update on status and detail of projects
- The Digital COVID-19 Response theme in the Adult Social Care and Public Health Digital Strategy

Before closing, the Committee formally acknowledged the recently announced Knighthood awarded to David Pearson, a former officer for the Committee, and agreed that a message should be sent to him to offer Members' congratulations and best wishes.

The meeting closed at 1.05 pm.

CHAIRMAN

Nottinghamshire County Council

Report to Adult Social Care and Public Health Committee

8 February 2021

Agenda Item: 4

REPORT OF THE DIRECTOR FOR TRANSFORMATION AND SERVICE IMPROVEMENT

ADULT SOCIAL CARE AND PUBLIC HEALTH DEPARTMENT'S DIGITAL STRATEGY FOR 2021-2024

Purpose of the Report

1. The purpose of this report is to seek approval for the proposed approach to the development of an Adult Social Care and Public Health Digital Strategy and Plan for 2021-2024.

Information

Review of the department's approach to digital innovation

2. During the Covid 19 pandemic the Adult Social Care and Public Health Department has responded to the need to support people in different ways, including through digital means. Whilst the department already had a good track record of introducing digital innovation, some of which was accelerated as part of the emergency response, the pandemic has emphasised the need to formalise the department's digital approach and offer into a Digital Strategy.

3. Since 2017 the department's approach to digital innovation, which has been largely focused on Adult Social Care, excluding Public Health, has been based on five themes:

   a. **Automation:** to streamline business processes by using technology to replace routine manual activity
   b. **Single view of the person:** for health and social care professionals to have a single view of the person; and for people to be able to access their record from one place
   c. **Data analytics**: to use data to inform and plan, using analysis tools including information sharing with partners such as Health, providers and the voluntary sector
   d. **Digital Notts:** enabling people to access and engage in their services through improved digital channels 24 hours a day
   e. **Internet of things:** the network of devices, vehicles, and home appliances that contain electronics, software and connectivity such as Assistive Technology.

4. Over the period 2017-2020, 70 digital projects were initiated. 21 of these are still at a design stage, 31 are in implementation and 18 have already been delivered. Some of the fully delivered projects include:

a. **Automation** – the development and introduction of an electronic portal to commission home based care directly with providers has reduced the time taken to set up a care package from 1 day to 2 hours. The department also made significant progress during 2019/20 to speed up how referrals are made to the Council's social work teams for hospital patients, and to introduce automatic alerts from health systems informing social care when circumstances change for these patients. For example, if circumstances change, people get discharged via another route or pass away, the Council's staff are made aware of this change immediately, rather than finding out from nursing staff or a person's relatives. Benefits include a reduction in time (4.5 hours on average) spent processing referrals, and the prevention of inappropriate referrals for patients who are not the responsibility of Nottinghamshire County Council. Streamlining processes with health partners in this way has also contributed to a reduction in the average length of hospital stay (e.g. in Mid Nottinghamshire, a reduction from 21 to 18 days).

b. **Single view of the person** – the Health and Care Portal links relevant health information (matched by NHS number) with a person's social care records. The Portal allows social care staff to see which health staff are already involved in a person's care and support, preventing the duplication of work. The department uses NHS tools to ensure that a high proportion of social care records have an accurate NHS number. Additionally, in order to help health colleagues, information about people known to adult social care has been shared into the Portal since April 2020. Sharing information through the Health and Care Portal helps to improve the quality of decision-making and prevents confusion about the status of a person's health and social care support.

   Case study:

   'Vicky was referred for some equipment and re-housing support. Using the Health and Care Portal, the social care worker was able to establish a good understanding of Vicky's wider support needs and was able to include health professionals already known to Vicky (her GP and the local Community Mental Health Team) in arranging her equipment and accommodation needs. This ensured all of Vicky's support needs were taken into account and not just those mentioned in the referral.'

c. **Data analytics** – information sharing with partners is key to anticipating future demand and understanding the need for preventative services. An information governance framework was put in place to enable data sharing between health, social care and district councils. The Council shares information into a Nottinghamshire-wide database, allowing partner agencies to see who is already being supported by the Council, and from this to identify, for example, people who are carers, or people who may be at risk of falls. This information helps front line staff to make better decisions about who is most at risk of losing their health and independence so that staff can intervene proactively to resolve problems at an early stage. During the early stages of the Covid 19 pandemic, the framework enabled health, housing and social care to share data on people who needed to be rehoused as part of the "Everyone In" campaign and supported a joined-up approach to their care and support.

d. **Digital Notts** – the development of an on-line carers assessment and also, based on the information people provide about their income, savings and capital, the care contribution calculator was developed to provide an estimate of the financial contribution a person may be asked to make towards any adult social care and support that is arranged for them by the Council.

e. **The internet of things** – the introduction of technology enabled care solutions to support people to maintain their independence at home for longer, for example systems which use

movement, door and activity sensors to provide an objective overview of how well someone is managing their independence.

5. All 18 of the fully delivered projects have met the intended objectives. These projects have already delivered positive change in the department and continue to deliver proven benefits. For example:

    - reductions in the time spent by staff accessing information and responding to referrals
    - adult social care staff now have access to health information
    - the way the Council has implemented sharing information with health about the people who receive support from the department has fed into standards being adopted at a national level
    - better real time data is also now available for business-critical dashboards
    - automation of processes has supported the virtual ways of working that have been required to support the emergency response to the pandemic.

6. During the period 2017-2020 many lessons about digital development have been learned which the department will take forward into the work to develop a Digital Strategy and Plan for 2021-2024.

7. Information and technology can be used to support people to live at home for longer, enable professionals to work effectively together across multiple organisations, and help commissioners to target services where they will have the greatest impact. The pandemic has presented its own challenges in terms of how people are supported through digital means.

8. Enabling people to interact with care services through digital channels that work for them and enables people to take ownership of their own care, or the care for others, is key. The ability to easily find information and advice, find out eligibility for services, and commission and manage their own care through online channels will give people ownership of their care. Promoting independence and wellbeing through the use of digital services and technologies, at home if needed, helps people to maintain their independence and wellbeing for longer, whilst preventing them from reaching crisis point and reducing social isolation.

9. The key to this work is to improve the way support and services are identified for people by analysis and use of the information available to the department about activity and costs but also about the way in which people want to engage with the support and services that the department provides and commissions.

10. Enabling care professionals to work remotely has been accelerated by the pandemic due to national restrictions. Workers should be able to interact securely with other care professionals, partners and providers using a number of digital tools and methods and be able to deliver care and support to people more efficiently and effectively, working collaboratively across organisations through digital means.

11. Digital innovation, some of which has been driven by the emergency response to the pandemic has continued in the department. For example, as part of the department's Covid 19 response, the department has developed a digital device lending and gifting scheme which is due to launch in March 2021 for a period of 12 months. The scheme was discussed at the Adult Social Care and Public Health Committee on 11th January 2021, as an example of work already underway within the department linked to the Service Improvement Programme for 2021/22-2023/24. Committee asked for additional information about the scheme and this is provided in **paragraphs 12 – 16.**

Digital Device Lending and Gifting Scheme

12. The Covid19 pandemic has meant that some people have been unable to access their usual formal and informal support, such as day services and contact with friends and family. This has exacerbated the isolation and loneliness that some people have experienced. In response to this many support providers have switched to the use of online platforms. For example, the Reach charity has offered online social events and courses for people with learning disabilities, and the Nottinghamshire Carers Hub is providing regular virtual carer support groups using Zoom and one to one video carer support sessions using WhatsApp. Outside of formal support, many families now use video calling to maintain contact with vulnerable family members.

13. Whilst the use of digital platforms has been successful, they require people to have a digital device, internet connection and the skills to be able to use a device. Many people can use a device, but others will need support to use one. To reduce the risk of people, the department supports, being digitally excluded, a lending and gifting scheme will be trialled for a period of 12 months.

14. The scheme will provide digital devices, mobile network-based internet connections and support to vulnerable adults whose access to support has been affected by Covid 19. It is also proposed that carers living in the same property as a person who has been unable to access some long-term social care services will also be able to access the scheme in order to prevent carer breakdown or the cared for person requiring a larger package of support from the Council.

15. The scheme has been developed using learning from the Council's deployment of the Department of Education initiative to provide children with devices during Covid19. It is anticipated that there will be a mixed scheme of gifting and lending based on what has been agreed as part of the individual's care and support plan. It is anticipated that up to 300 people will benefit from the scheme. The referral routes for the scheme will be through social care workers as part of a statutory support planning process.

16. The department will work with a third-party provider to issue and support people with technical issues. Safeguards will also be put in place to ensure people and carers can use the devices safely and securely. The cost of providing the service will be met through the existing Adult Social Care budget.

Adult Social Care and Public Health Digital Strategy for 2021-2024

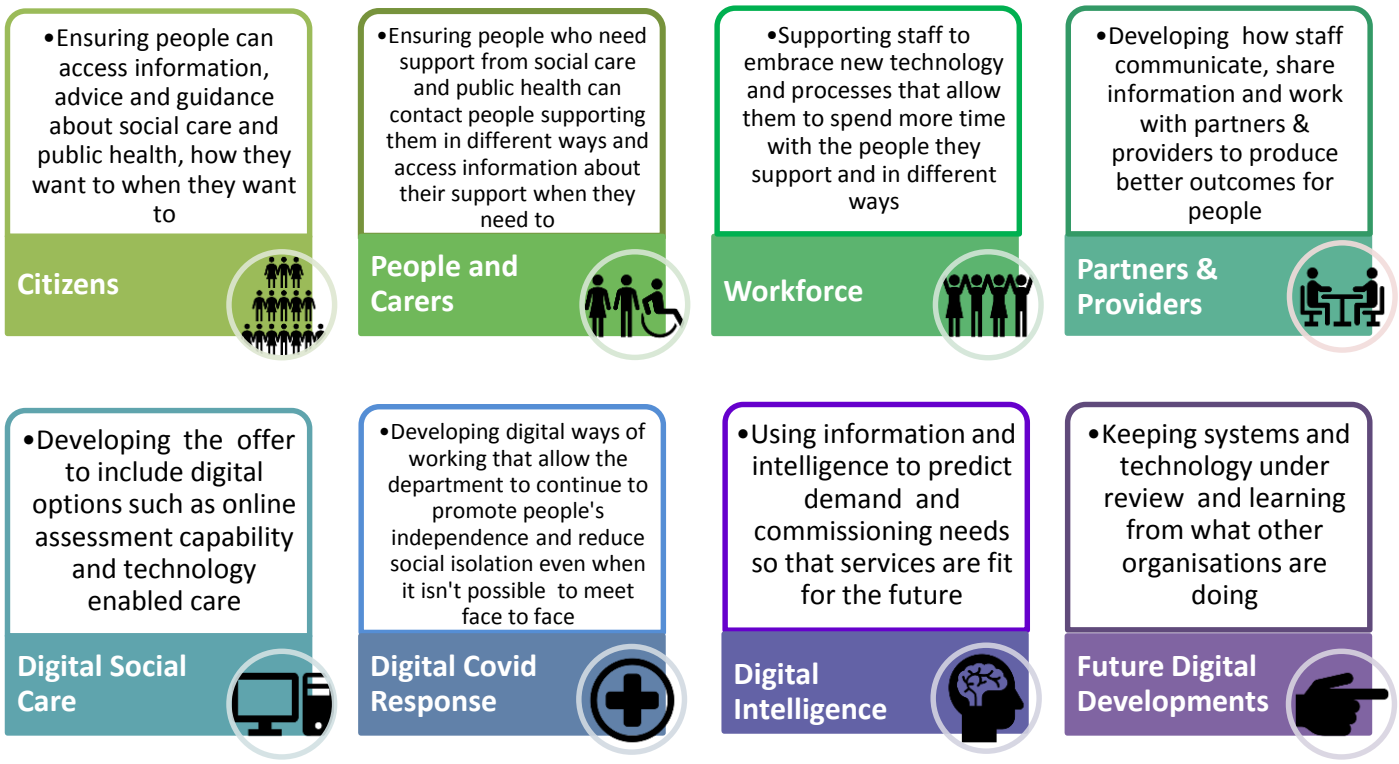
17. The need to develop a Digital Strategy has been identified as a work strand in the Adult Social Care and Public Health Service Improvement Programme for 2021/22 – 2023/24, which was presented to the Adult Social Care and Public Health Committee on 11th January 2021.

18. The following approach to developing the Digital Strategy is proposed:

    a. development of a whole department Digital Strategy, including Public Health
    b. incorporating the learning from the pandemic emergency response
    c. supporting departmental priorities
    d. focused on the need to develop and enhance new ways of working
    e. providing digital capability to support people remotely
    f. building on lessons learned from the implementation of previous digital innovation
    g. closely aligning development with digital transformation across the Council, including for example work already underway corporately to improve residents' access to information, advice, guidance and services from the Council

h. keeping an eye on health partnership developments, for example, the Data, Analytics, Information and Technology Implementation Plan (DAIT) which covers how health and social care partners in Nottingham and Nottinghamshire will develop public facing digital services;
i. co-produced with stakeholders across eight key themes.

19. Building on successes and taking into account lessons learned to date, including those learned during the pandemic, it is proposed that the digital strategy is based on the following eight themes:



20. The following principles that will underpin the department's future digital development are proposed:

a. digital initiatives will be department led but jointly designed, resourced and planned with ICT colleagues
b. the department will co-produce digital initiatives with citizens, the people it supports, the workforce, and its providers and partners
c. the department will avoid technical jargon to make sure that any digital change and its benefits are easily understood
d. accessibility will be at the heart of the department's public facing digital initiatives and work will be actively undertaken to reduce digital exclusion
e. the department will use digital innovation to enhance existing methods of communication and service delivery, not replace them
f. the department will seek to use existing Council digital tools first, providing they are fit for purpose, rather than seek to procure new ones
g. the department will explore the scope to introduce digital innovation in all change and service improvement introduced
h. all initiatives will have an identified Adult Social Care and Public Health sponsor who will be responsible for ensuring that the initiative aligns with departmental, corporate and local Integrated Care System strategies

i. the strategy will build in time to understand what other organisations are doing well so that the department can benefit from their learning and so that the department's learning can be shared with others.

Development of an Adult Social Care and Public Health Digital Plan for 2021-2024

21. Using the approach, themes and principles described in this report, further engagement will be undertaken with a wider cohort of Adult Social Care and Public Health stakeholders, including people who receive social care support, the workforce, and providers and partners, in order to better understand the department's digital requirements and to develop the strategy. Subject to the outcome of engagement with stakeholders, the table at **Appendix 1**, provides a summary of some of what it is proposed will be achieved across the themes described in **paragraph 19.**

22. A Digital Plan will also be developed to accompany the Digital Strategy. Proposed timescales for the development of the strategy and plan are as follows:

Date	Activity	Outcome
9 February 2021 – 9 May 2021	• Engagement and co-production • Develop draft Digital Strategy and Plan	• Co-produced draft Digital Strategy and Plan
14 June 2021	• Adult Social Care and Public Health Committee	• Approval for co-produced Digital Strategy and Plan to be submitted to Policy Committee • Approval of any resources required
14 July 2021	• Policy Committee	• Approval of Adult Social Care and Public Health Digital Strategy
15 July 2021 onwards	• Implementation of Digital Strategy and Plan	• Digital Strategy and Plan implementation

Other Options Considered

23. No other options were considered.

Reason for Recommendations

24. The need to develop the Digital Strategy has been identified as a work strand in the Adult Social Care and Public Health Service Improvement Programme for 2021/22 – 2023/24, which was presented to the Adult Social Care and Public Health Committee on 11th January 2021. The recommendations in this report will support the department to deliver this work strand.

Statutory and Policy Implications

25. This report has been compiled after consideration of implications in respect of crime and disorder, data protection and information governance finance, human resources, human rights, the NHS Constitution (public health services), the public sector equality duty, safeguarding of children and adults at risk, people we support, smarter working, sustainability and the

environment and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Data Protection and Information Governance

26. The General Data Protection Regulations (GDPR) require the Council to put in place appropriate technical and organisational measures to ensure that data protection principles and individual's information rights are built into everything the Council does. The provision of digital devices and data will place some obligations on the Council concerning data protection and information governance. Legal Services and Information Governance colleagues within the Council have provided guidance on how to progress to ensure council obligations are met. The development of the Digital Strategy and Plan, and subsequent implementation of the plan, will also be managed in keeping with this requirement.

Financial Implications

27. Some resource to support the development of the Digital Strategy and Plan has already been identified from within the department's Service Improvement Team. Additionally, a significant number of digital projects are already happening within the department which are already resourced with departmental or ICT staff. This existing work will continue alongside the development of the strategy and plan. It is proposed that any additional resource requirements that are subsequently identified as part of the work, and which cannot be met within existing departmental or ICT resources, will be presented to the Adult Social Care and Public Health Committee in June 2021.

28. The estimated yearly costs for providing the Digital Device Lending and Gifting Scheme, which can be met through the existing Adult Social Care community care budget, are shown in the table below:

Service Element	Cost to support 300 people
Tablet Devices	£62,000
4G Internet Connectivity	£29,500
Device technical set up and device management platform	£18,000
Service User Support (device delivery, training to use the device and remote ongoing support)	£96,000
Total Cost	**£205,500**

Public Sector Equality Duty implications

29. The development of the Digital Strategy and the development and implementation of an accompanying plan will be conducted in keeping with the department's established practices for the safety and inclusion of the vulnerable people the department supports. These practices give due attention to the needs of people with protected characteristics. For this work the main protected characteristics impacted will be age and disability. An Equality Impact Assessment will be produced to accompany this work, taking into account feedback gained as part of the engagement that will be undertaken with Adult Social Care and Public Health stakeholders, including people who receive social care support, the workforce, and providers and partners.

Safeguarding of Children and Adults at Risk Implications

30. During the pandemic operational social care teams have identified that there has been an increase in safeguarding referrals where the primary cause has been additional carer stress

caused by the inability of the carer and cared for person to access their usual formal and informal support services. The proposed lending and gifting scheme will help to reduce carer stress by enabling both carers and the cared for to access support remotely. The development of the Digital Strategy will support the department to continue to maximise the benefits of digital innovation, which include helping people to maintain their independence and wellbeing for longer; enabling professionals to work effectively together across multiple organisations; and helping commissioners to target services where they will have the greatest impact.

Implications for People the Department Supports

31. The Digital Device Lending and Gifting Scheme will provide an alternative route for some people, who have not been able to continue to access support from the department face to face during the pandemic, to access support in different, digital ways.

32. As described in **paragraph 21** of this report, the Digital Strategy and Plan will be co-produced with key stakeholders including representatives of the people who the department supports. In terms of the future development of new digital initiatives, these will seek to enhance existing methods of communication and service delivery and not replace them. Where digital innovation is introduced, accessibility will be a key requirement in order to ensure that everyone who wishes to take advantage of the innovation is able to do so and that digital exclusion is minimised.

RECOMMENDATIONS

That Committee:

1) approves the proposed approach, themes and principles to be adopted for the development of the Adult Social Care and Public Health Digital Strategy for 2021 - 2024 as detailed in **paragraphs 18-20** of this report.

2) gives permission for the engagement and co-production with stakeholders of the eight themes described in **paragraph 19** of this report.

3) agrees to receive a report on the co-produced Digital Strategy and Plan, at the June 2021 Adult Social Care and Public Health Committee meeting, ahead of the strategy being submitted to the County Council's Policy Committee for approval.

Grace Natoli
Director for Transformation and Service Improvement

For any enquiries about this report please contact:

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Strategic Development Manager
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E: jennifer.allen@nottscc.gov.uk

Constitutional Comments (AK 26/01/21)

33. This report falls within the remit of Adult Social Care and Public Health Committee by virtue of its terms of reference.

Financial Comments (KAS 28/01/21)

34. The financial implications are contained within **paragraphs 27 and 28** of the report. Where additional funding is required for individual projects or to develop the strategy and plan this will be brought to committee.

Background Papers and Published Documents

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

Adult Social Care and Public Health Service Improvement Programme for 2021/22 – 2023/24: report to Adult Social Care and Public Health Committee on 11th January 2021

Electoral Division(s) and Member(s) Affected

All.

Appendix 1: Summary of proposed achievements across the 8 themes of the Adult Social Care and Public Health Digital Strategy (2021-2024)

Theme	Proposed Achievements
Citizens	• Public facing information • Access to information 24/7 • Self service • Ability to make online enquiries • Able to access own information through citizen portal if needed • Able to manage own health and well-being • Able to ace and buy services online
People & Carers	• Communicate with professionals • Access digital support and activities • View and share own information securely through a citizen's portal • Address digital exclusion • Access social care and health information • Able to access and buy services online
Workforce	• Digitally interact with the people they support, partners and colleagues • Access, share, process and validate information securely • Share information with partners, people and carers • Digitally collaborate and co-produce solutions • Tech savvy • Access to info hub for proactive advice • Remote working • Digital competency support
Our Partner & Providers	• Able to view, share, process and validate relevant information securely • Providers can bid for work directly through a provider portal
Digital Social Care	• Online assessment capability including financial assessment • View, share, process and validate information securely • Video and chat capability • Social care and health apps • Technology enabled care
Digital Covid Response	• Promote independence and well-being • Reduce social isolation • Virtual info, advice and support • Digital activities • Remote working • Digital social care
Digital Intelligence	• Predictive analytics • Data warehousing of systems data • Review of exiting systems • Demand predictions based on data • Data led commissioning • Data led decision making
Future Digital Developments	• Horizon scan • Identify investment • Future digital development with other departments in the Council • Digital staff development

Nottinghamshire County Council

Report to Adult Social Care and Public Health Committee

8 February 2021

Agenda Item: 5

REPORT OF THE CORPORATE DIRECTOR, ADULT SOCIAL CARE AND HEALTH

DEVELOPING LOCAL AREA COORDINATION (LAC) SUPPORT IN NOTTINGHAMSHIRE

Purpose of the Report

1. This report proposes to introduce Local Area Coordination (LAC) to help and support more people in the community and prevent people from reaching crisis which may result in an escalation of need.

2. The report also seeks approval to establish 3.0 fte Local Area Coordinators (indicative Band A grade) for a period of two years. These posts will report to a Strategic Commissioning Manager (Band E) and sit within the Strategic Commissioning Team.

Introduction

3. LAC is an all-age support model and community-based approach that aims to empower individuals and families to develop their personal strengths and find solutions within their community before considering formal services. It emphasises close collaboration with individuals to develop a shared sense of purpose on what they want to improve, and to seek opportunities and solutions within the communities.

4. Through the development of self-supporting individuals and communities that are more resilient and less reliant on services where appropriate, LAC aims to reduce demand on services and complements community and system working. LAC aligns itself to the Adult Social Care and Health Prevention Strategy based on strength-based approaches, and Themes 7, 8 and 9 of the Council Plan for people to live in vibrant and supporting communities; live independently for as long as possible and enable people to access the right care and support at the right time.

Context for Nottinghamshire

5. There are a number of initiatives and services across Nottinghamshire that aim to support people in different ways. LAC will play a key role in making sense of the offer across the county, particularly for those not deemed eligible for formal social care support. LAC will work in partnership with other parts of the system and act as a glue to ensuring people access the right support at the right time. Key partners will include the voluntary sector, districts, health and other community forms of support such as faith groups as an example.

6. In Adult Social Care and Health, the Maximising Independence Service provides a service for those who need short-term support to retain, regain or increase their independence for people who do and do not already receive support from adult social care. For example, following a stay in hospital or as part of a review of care and support. The team works with people who have been referred by social work teams. Local area coordination works with anyone in the community without the need for 'eligibility'. The focus is on preventing people from reaching crisis point with no time limit.

7. Nottinghamshire health system provides access to people with long term conditions via social prescribing interventions. People already known to the health and social care system are referred for social prescribing support via their GP. The support aims to improve a person's health and wellbeing led by the person with the help of a link worker. Local Area Coordination will work alongside social prescribing initiatives. The fundamental difference being the cohort of people that LAC will support may not yet be known to the health and social care system, but due to issues in their lives, may result in reaching crisis point. Involvement from LAC will focus on early interventions to prevent escalation and empower the person to find solutions for themselves with support within the community.

8. LAC will build upon the system wide emergency Community Hub response, developed and led by the Place department and partners in response to Covid-19. Local Area Coordinators will work alongside community and voluntary partners to implement the recovery plan and maximise on initiatives started as a result of the emergency response. LAC will provide a person-centred approach to those people who are in danger of reaching a crisis point and need more targeted interventions to prevent their needs escalating and reducing future dependency on statutory health and social care services. LAC will provide the glue that connects people and staff from social care district teams to community assets within their neighbourhood.

9. LAC will work alongside colleagues within the Community Friendly Notts team based within the Place department. The team is delivering an established community programme which aims to develop thriving neighbourhoods where people are involved and empowered to make a difference to their local area. This will enable the building of community capacity through social action training. LAC will work in partnership with community teams to ensure alignment, and that the offers complement each other.

A real-life story of difference gained from a Local Authority practising LAC

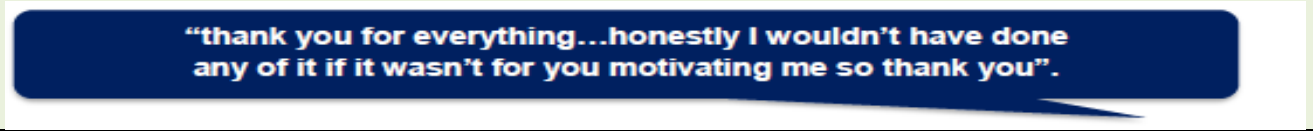
The Local Area Coordinator was introduced to Alan by a local elected councillor. Alan had been evicted from a flat, was sofa surfing and sleeping on the streets. He had also been diagnosed with mental health conditions and had a drug and alcohol addiction. Alan had previously not engaged with professionals. Over several months, the Local Area Coordinator worked with him to build up a trusting relationship and find out what was important to him. Alan shared that he would like to get a secure home, focus on his mental health and move forward in his life.

The Local Area Coordinator worked with Alan to:

- Challenge the eviction as he was a vulnerable adult. He was then provided with a place in a hostel.
- Engage with therapy led services to understand about the impact of drugs and alcohol on his life.
- Engage with the Prince's Trust programme
- Bid on a flat. The man engaged with the housing department who provided some basic furniture for the property as the man had no furniture.

Outcomes:

- **Addressing addictions** – Before the Local Area Coordinator was involved Alan was not engaged with any services. The Local Area Coordinator worked with him to help him attend therapy for his addictions.
- **Finding a home** – The Local Area Coordinator helped the man get a property and supported him to make it into a home with help from the housing department.



The Role of Local Area Coordinators

10. Local Area Coordinators will work alongside people, their local community and partners to strengthen relationships and maximise community assets by joining them up. They will support people who:

    - are not yet known by or accessing services within the health and social care system but who may be at risk of needing them if things do not change
    - are seeking support to live good lives but who are ineligible for funded care and support
    - are currently accessing funded support.

11. A large proportion of the Coordinators' time (80%) is spent working in local communities with individuals and families of all ages and backgrounds. The people they will be supporting tend to be facing isolation from their community and barriers to services as a result of their circumstances. This could be due to number of factors including age, mental and physical health challenges and inequalities, disability, family breakdown, unemployment, homelessness, domestic violence and drug and alcohol addiction.

12. Coordinators support people in identifying their strengths and vision of a good life by building capacity and preventing future crisis and problems. They work *with* people and don't do *to* or *for.* They are entirely person-centred, with no eligibility, assessment process or time limits on their input. They are focused on practical interventions that help people connect with their local community and find natural solutions.

13. The other part of the Coordinators' time (20%) is spent bridging connections, supporting and building on local community assets which could take the form of groups, buildings and activities, particularly if there are gaps and opportunities that local people have identified. This type of intervention and support can add huge value to local neighbourhoods and a sense of purpose for people themselves. LAC can actively encourage and support opportunities for inclusive participation from people who are often excluded.

Adult Social Care and Health Context

14. LAC supports people to engage and connect with others in order to lead fulfilling lives and promote good health and wellbeing. They link people with community assets, strengths and resources available within the community. They help uncover potential resources that can be enhanced to identify and address support needs of people to help them become more resilient. This reduces the long-term pressures and increasing costs on health and social care and enables people to participate in and benefit from local community resources and activities.

15. Strength-based social work practice identifies 'what's strong not wrong'. It focusses on the individual's strengths – personal, community and social networks – and maximises those strengths to enable them to achieve their desired outcomes, thereby meeting their needs and improving or maintaining their wellbeing. Local Area Coordinators will enable people to connect with their community whilst making the most of the resources available to them.

16. Nottinghamshire already has many community assets, a number of 'hidden gems' of activities at the heart of their local neighbourhoods. To gain more value, the department needs to connect community initiatives and assets together to complement place-based working. LAC will provide the platform to connect assets together, building upon and developing interventions and solutions that uncover and maximise community capacity and capabilities. It will play a fundamental role in identifying the strengths and resources within a community. Local Area Coordinators will support people to become more resilient, connecting them with their community and increasing their contribution.

17. LAC supports and strengthens the cultural shift that Adult Social Care and Health is seeking to make through improved practice and commissioning:

Shift from	**To**
Deficit approach	Asset based approach
Deficiencies and needs	Starts with assets available to the person and in the community
Sees people as clients/people who 'use' services	Sees people as citizens and co-producers with something to offer
Treats people as passive and 'done to'	Helps people to take control of their lives
Responds to problems	Identifies opportunities and strengths
Provides services to users	Invests in people as citizens
Emphasises the role of agencies	Emphasises the role of civil society
Focuses on individuals	Focuses on communities and neighbourhoods
'Fixes people'	Supports people to develop their potential

Impact and success measures

18. Impact and effectiveness can be found at three levels:

- **People and families** achieve good lives by finding natural solutions from within their own community first, with services and funded support as a backup. This means achieving multiple and diverse health and wellbeing outcomes, increased and sustained independence, increased connectivity meaning reduced isolation and increased opportunity for people to make contributions, feel empowered to make a difference in their own communities
- **Communities** have a locally based, named person to connect with around concerns and ideas. Local Area Coordination offers a bridge between communities and the wider service system, helping groups access funding, more opportunity for co-production and developing new activities
- **The system/services** have a local person who is present in the community for colleagues to make introductions to. It brings the service system together and provides insights for better commissioning, promotes system culture change.

19. Positive outcomes and impacts as a result of Local Area Coordination support include:

- improved opportunities in employment and volunteering
- reduction in visits to GP surgery and A&E
- preventing and reducing dependency on formal health and social services
- preventing escalation of mental health challenges
- reduction in housing evictions and costs
- supporting people to become active participants in their own health and wellbeing
- liaison with wider health and social care system including Local Resilience Forum support for vulnerable people.

A real-life story of difference gained from a Local Authority practising LAC

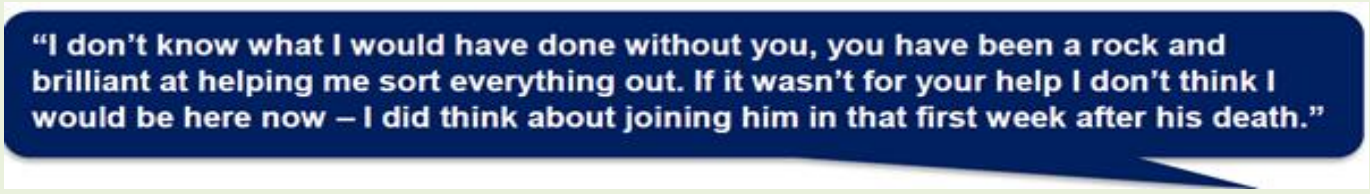
Anne contacted a Local Area Coordinator to ask for help after her partner passed away suddenly. Anne's partner had been her main carer and was the named tenant of the Council property they lived in together. As well as a great sense of loss, she felt anxious and overwhelmed wondering how she was going to cope. Anne also had several serious long-term health conditions which impacted on her daily activity and mobility, needing to be on an oxygen machine for 15 hours a day. Anne had spoken to someone at the Housing Department who told her she would 'need to present as homeless'. She felt anxious and upset and feared she would lose her home.

The Local Area Coordinator:

- Spent time listening and empathising with what a difficult situation Anne was in and together they made an immediate plan of action
- Supported Anne to contact the Housing Management Officer to find out whether she would be able to stay in her home. They said they had no immediate intentions of asking Anne to leave the property, but she would need to provide evidence she had lived there for over a year to succeed the tenancy.
- Helped Anne to gather the proofs she needed to give her claim to the tenancy and her partner's belongings.
- Helped Anne to initiate a social care assessment and a referral for a warden call system.
- Whilst waiting for support to be put in place the Local Area Coordinator offered support alongside another local citizen who provided regular visits, emotional and practical support, and information.

Outcomes

- **Avoiding crisis** – Anne was able to stay in her home and be independent with support to get through the initial difficult time after the loss of her partner and help to make arrangements for longer term support from adult social care.
- **Building resilience** – Anne is now feeling more in control of life and confident about managing her future. She is now able to focus on managing her grief.
- **Building connections** – Anne is building her support network in the community after making links through the Local Area Coordinator.



Set up and Design

20. This is developed through a supportive partnership with Community Catalysts who are the

lead agency and home of Local Area Coordination in England and Wales. Community Catalysts offer bespoke support with the full design, development, implementation, recruitment, training and evaluation framework. This usually takes around 12 months depending on where each area is starting from. This programme is bolstered through the expert input, support and membership of the Local Area Coordination Network (the areas already doing it).

An indicative budget for Nottinghamshire

21. Local Area Coordination is part of the Adult Social Care and Health department's work to improve the availability and robustness of ordinary community assets that are available to help more people be supported in the community. To this end £466,000 was allocated to support this work from the Better Care Fund reserves. £62,000 has already been committed to support a Good Neighbours pilot scheme with Age UK and £44,000 to support community services for people with dementia. This leaves £360,000. As seen below the cost of developing Local Area Coordination is £350,820. These posts will be established within the Department and form part of the Strategic Commissioning Team.

22. The overall costs for developing Local Area Coordination are displayed in the table below. The staffing costs are calculated at a Band B level and the indicative grade for these posts is currently a Band A. The job role description will be co-produced by key stakeholders across the system and will describe the responsibility of a Local Area Coordinator, which is to lead as a practitioner of the evidence based model of Local Area Coordination. The job role will then be subject to full job evaluation.

Activity	**2020/21**	**2021/22**	**2022/23**	**Total**
Set up and design	£8,000	£34,000		£42,000
3.0 fte Local Area Coordinators (Indicative Band A)		£135,262	£147,558	£282,820
Equipment		£3,000	£3,000	£6,000
Evaluation			£20,000	£20,000
Total	£8,000	£172,262	£170,558	**350,820**

The value of Local Area Coordination through Covid 19 recovery and reset

23. Local Area Coordinators will be able to support people, their communities and the wider system by:

- being present to support people and families tackle their challenges and rebuild their lives in recovery from the pandemic
- prevent further escalation of people who are isolated and lonely, which has been made worse as a result of Covid-19
- support community groups to re-purpose their efforts to meet future challenges e.g. austerity, unemployment and mental health
- create new pathways of support in community instead of services
- enhance existing community facing roles whilst over time replacing funded work that is not having the greatest impact
- save the system money as people are introduced to Local Area Coordinators earlier on for connections and practical support, rather than being referred in crisis to health and social

care services for assessment and funded support.

Challenges

24. As the County Council emerges from the pandemic crisis, it will face many changes in the way in which it works with communities. Introducing LAC mitigates against a number of these challenges. It embraces and builds upon the abundance of neighbourliness that has become so apparent throughout the pandemic and supports people first whilst services remain in the background, accessed only if necessary.

Other Options Considered

25. The impact of not introducing LAC would mean an increase in people directly contacting Nottinghamshire County Council for support from statutory services. LAC will engage with people within their community to empower them to prevent this happening and ultimately lead a good life.

Reason/s for Recommendation/s

26. Local Area Coordinators will work with current community providers to enhance existing assets already being delivered in local communities across Nottinghamshire. They will add value to the existing community offer by connecting people to a range of resources, bridging identified gaps and wiring community assets together.

Statutory and Policy Implications

27. This report has been compiled after consideration of implications in respect of crime and disorder, data protection and information governance, finance, human resources, human rights, the NHS Constitution (public health services), the public sector equality duty, safeguarding of children and adults at risk, service users, smarter working, sustainability and the environment and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Data Protection and Information Governance

28. A Data Protection Impact Assessment will be undertaken for this work and updated/refreshed at different stages of the project.

Financial Implications

29. The total cost of developing Local Area Coordination is £350,820. The posts will be established within the Department and form part of the Strategic Commissioning Team.

Human Resources Implications

30. To recruit the following fixed term posts (indicative Band A) from May 2021 to March 2023 that would be integrated into the current Adult Social Care and Health workforce.

Posts	Cost
3.0 fte Local Area Coordinators (Indicative Band A)	£282,820

Public Sector Equality Duty Implications

31. An Equality Impact Assessment will be undertaken for this work and updated and refreshed at different stages of the project.

Implications for people we support

32. The project will seek people's views using a place based local coproduction approach. This will also form part of the strength-based innovation sites evaluation taking place within the department and any implications for people will be assessed as options are being developed and recommendations are being made.

RECOMMENDATION/S

That Committee:

1) approves the development of Local Area Coordination within Adult Social Care and Health.

2) approves establishment of 3.0 fte Local Area Coordinator (indicative Band A grade).

3) receives a progress evaluation report in April 2022.

Melanie Brooks
Corporate Director for Adult Social Care and Health

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Constitutional Comments (initials (CEH 28/01/21)

33. The recommendations are within the remit of the Adult Social Care and Public Health Committee under its terms of reference.

Financial Comments (KAS 28/01/21)

34. The post costings in the table in paragraph 22 have been calculated at Band B to allow for any increase as the roles are co-produced. With the posts costed at Band B, the total cost is £350,820 which can be funded from the remaining £360,000 within the £466,000 allocation agreed from the BCF Reserve.

HR Comments (WI 28/01/21)

35. The newly established posts will be subject to full job evaluation and recruited to on a fixed term basis, for the duration as outlined in the report, in line with the Authority's grading policy and recruitment procedures.

Background Papers and Published Documents

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

None.

Electoral Division(s) and Member(s) Affected

All.

Nottinghamshire County Council

Report to Adult Social Care and Public Health Committee

8 February 2021

Agenda Item: 6

REPORT OF THE CORPORATE DIRECTOR, ADULT SOCIAL CARE AND HEALTH

DEVELOPMENT OF INTEGRATED CARE SYSTEMS IN NOTTINGHAMSHIRE AND NATIONAL CONSULTATION RESPONSE

Purpose of the Report

1. The report summarises the Council's role in system leadership of health and care and the success of system working over the last year and makes a recommendation on the level of partner contribution to the Nottingham and Nottinghamshire Integrated Care System.

2. The report also summarises the proposals of relevance to local government in the NHS consultation document 'Integrating Care – next steps to building strong and integrated care systems across England'. It highlights the key messages, questions and concerns and provides the County Council's response to the consultation.

Information

Council's Role in System Leadership in Health and Care

3. The Council has a number of statutory duties to lead partnership and system working for the benefit of residents, through both individual statutory officers and the Health and Wellbeing Board.

4. The Council, as Strategic Commissioner, is responsible for identifying the needs of the population and planning for how those needs are met. The Health and Wellbeing Boards are a formal committee of the local authority charged with promoting greater integration and partnership between bodies from the NHS, Public Health and local government. They have a statutory duty, with Clinical Commissioning Groups (CCGs), to produce a joint strategic needs assessment and a joint health and wellbeing strategy for their local population.

5. Through the duties of the Director of Public Health (DPH), local authorities must take the action that they decide is appropriate to improve the health of the people in their areas. The DPH has responsibilities to work with the NHS and be able to promote action across

the life course and contribute to and influence the work of NHS commissioners, helping to lead a whole system approach across the public sector.

6. The Director of Children and Young People's Services (DCS) holds similar responsibilities individually and as a statutory member of local health and wellbeing boards, including a clear role in driving the development of the local Joint Strategic Needs Assessment (JSNA) and joint health and wellbeing strategy. The DCS will also help join up local commissioning plans for clinical and public health services with children's social care and education, where appropriate, to address the identified local needs. The DCS is responsible for any agreements made under section 75 of the National Health Service (NHS) Act 2006 between the local authority and NHS relating to children and young people – for example, pooled budgets for commissioning and/or delivering integrated services covering children's health, social care and education.

7. The Director of Adult Social Care Services has a key leadership role to deliver the local authority's part in promoting local access and ownership and driving partnership working, delivering an integrated whole systems approach to supporting communities and promoting social inclusion and wellbeing.

8. Therefore, the Council has a role in supporting the development of the Integrated Care System (ICS) and in particular through the statutory officer and Committee duties, working to ensure the ICS delivers improved outcomes for residents of all ages.

Integrated Care System Development in Nottinghamshire

9. The Integrated Care System is an NHS led mechanism outlined in the NHS Long Term Plan. Nottinghamshire is part of two Integrated Care Systems; Nottingham and Nottinghamshire (NN ICS), and South Yorkshire and Bassetlaw (SYB ICS).

10. The NN ICS Board is attended by the Chair of the Health and Wellbeing Board, Chair of the Adult Social Care and Public Health Committee, and the Director of Adult Social Care and Health on behalf of the Chief Executive Officer of the Council. In SYB ICS, the Council engages in partnership events, not board meetings, for the Bassetlaw Integrated Care Partnership (ICP). District and Borough Councils and voluntary, community and social enterprises attend ICPs and the Primary Care Networks (PCN) are operational delivery units. Adult services are organised to link with PCNs.

11. Prior to the Covid-19 pandemic, the two ICS delivered these outputs which have previously been considered by Committee:

- Strategic Plan
- Governance structure
- Integrated Care Partnerships
- Primary Care Networks development plan
- Outcomes framework
- Clinical Services Strategy
- System Financial plan for NHS Organisations
- Bassetlaw Local Plan.

12. Public Health produced PCN population profiles. Officers attend relevant workstreams, such as mental health and universal personalised care. The Local Authority is a partner and makes inputs such as providing budget and performance information to help planning. There are no formally agreed section 75 or joint commissioning arrangements that sit at ICS level, and no formal outputs or influence into the Adult Social Care and Public Health or Children & Young People's Committees. There is a section 75 agreement with both CCGs that supports historic joint finance arrangements and the Better Care Fund management overseen by the Health and Wellbeing Board, and a section 75 with both CCGs to enable Child Health joint commissioning as below.

13. The Integrated Children's Commissioning Hub is independent of ICS and was developed prior to its inception. The Hub integrates commissioning across child health and brings together strategic commissioning activity from the two CCGs, the city and the county.

14. Nottingham and Nottinghamshire ICS is currently looking at its governance and leadership for the third time. Recruitment for the ICS Chair is underway with an appointment expected for the New Year. The leadership and management arrangements are due to be reviewed as the emergency planning period ends.

15. The NN ICS has sought contributions to the costs of supporting the ICS. It is recommended that the County Council does not contribute to the costs at this stage as the current outputs do not deliver to County Council work. Support is offered in kind through the participation in numerous workstreams and areas within the work programme. The System Plan is an NHS planning requirement and the ICS outputs for performance management are directly linked to the Long Term Plan and NHS assurance to which the County Council is not subject.

16. SYB ICS has not requested contributions from Local Authority Partners.

Emergency Planning and Impact of Covid-19

17. Through the response to Covid-19, partnership and strategic structures were paused and emergency planning structures in the Local Resilience Forum (LRF) stood up.

18. In SYB ICS, partnership activity has been about networking, rather than planning. NN ICS reconvened the ICS Board in the early Autumn, but with a reduced agenda. ICS Chief Officers have continued to meet regularly as a group.

19. The emergency planning structures set up through the LRF have delivered excellent integrated and system approaches to the pandemic response. Of particular benefit to the County Council the LRF is system wide and includes Bassetlaw in one planning mechanism.

20. Key areas of activity have been:

- Data Cell and system reporting, routine and ad-hoc reports - analysts from across the system, but particularly from Public Health (city and county) and the CCG work to provide 'one version of the truth' with data and intelligence about the pandemic. There is regular reporting as well as impact reporting on key areas of risk such as excess deaths or mental health.

- Discharge to Assess - work to develop virtual integrated discharge hubs across the county and linking to the three hospitals was led through the Discharge Cell. This has driven consistency in approach and delivery across the county and led to a community focussed model of support.
- The two-key leadership fora have been the Public Health led Tactical Commissioning Group and the Health and Social Care Tactical Commissioning Group with an NN ICS Lead. This has enabled system leadership, engagement with partners and sharing of resources when needed.
- The Care Home and Home Care Cell is jointly chaired between Nottinghamshire CCG and the County Council and has provided a place for rapid decision-making, oversight and shared governance for social care market infection control and support. This has been a crucial part of the system leadership from a County Council perspective and has been essential in delivering a joined-up approach to delivering statutory duties of Health and Social Care.

21. The Local Resilience Forum exists apart from the ICS and has delivered huge gains in integrated working across housing, health and care. It is recognised that an important driver for this is the shared focus on responding to the emergency giving clarity and shared vision. The working style of bringing key people together to work differently is also thought to be a key factor in the success.

22. From a County Council perspective, an important factor is the countywide planning footprint and having all partners in the room to agree a way forward in a way the two ICS do not afford us.

23. This way of working must be maintained as the county recovers from Covid-19 and as the partnerships with Health develop through the Health and Wellbeing Board and the Integrated Care Systems, the learning from what makes that work successful must be taken forward in the design of those partnership structures.

Integrating care: next steps to building strong and effective integrated care systems – NHS England and NHS Improvement consultation

24. The above-mentioned paper, which is attached as **Appendix 1**, builds on the commitments and ambitions set out in the NHS Long Term Plan for health and care to be joined up locally around people's needs. It refers to a renewed ambition to support greater collaboration between partners in health and care systems and to help accelerate progress in meeting critical health and care challenges.

25. It is also intended to open up discussion with the NHS and its partners about how ICSs could be embedded in legislation or guidance and presents options for how to do this.

26. The consultation document sets out the future of Integrated Care Systems and outlines two options for ICSs to become legal entities by April 2022, subject to legal reform. National Health Service England and National Health Service Improvement (NHSEI) are inviting views on the proposed legislative options by Friday 8th January 2021.

27. The document builds on the NHS Long Term Plan and outlines proposals to promote greater collaboration between NHS bodies and between NHS and other partners to:

- improve population health and healthcare
- address inequalities in health and outcomes
- enhance productivity and value for money, and
- help NHS to support broader social and economic development.

28. Integrated care systems will lead stronger partnerships in local places between NHS, local government and others with a greater role for primary care, provider collaboration, strategic outcome-based commissioning, and connecting data across providers and commissioning.

29. The document gives a commitment to devolution of functions and resources including planning, commissioning and organisation of some specialised services, and to devolve greater share of primary care funding and improvement resource. There is also a focus on place; for most ICSs place will mean local authority boundaries. There is recognition that economies of scale may need more strategic commissioning and delivery at ICS, regional or even national level.

30. The document outlines two options for placing ICSs on a statutory footing: creating them as a statutory joint committee, bringing together current statutory organisations, or a statutory corporate NHS body which includes current CCG functions.

31. The consultation document gives a clear preference for option two. There would be local government representation in each option but the nature of the relationship between the NHS and local government will be affected by the legal form the Board takes. **Option 1 is a statutory committee model** with an Accountable Officer that binds together current statutory organisations. **Option 2 is a statutory corporate NHS body model** that additionally brings CCG statutory functions into the ICS.

32. The paper ends with next steps for ICS Boards and gave a commitment for the Department of Health and Social Care and NHSEI to lead conversations with different types of health and care organisations, local councils, people who use and work in services, and those who represent them to understand their priorities for further policy and legislative change. It is noted that the timeframe for the conversation was short and coincided with the response to the pandemic and the Christmas period.

Summary of key messages, concerns and questions in response to the consultation

33. Placing the ICS on a statutory footing has an impact on the County Council and will initiate a review of engagement in both ICS Boards, the relationship between Health and Wellbeing Board, Children and Young People's Committee and Adult Social Care and Public Health Committee.

34. The County Council remains committed to building strong partnerships and collaborations with NHS partners (and other partners in the system) and the principle of integrated health and care that gives a benefit to the resident or improves population health and wellbeing.

35. The County Council supports the principle of collaboration and system working in the commissioning and delivery of health services as well as the principle of subsidiarity where delegation of budget and decision making is linked to place and population.

36. The County Council remains concerned that decision-making at a strategic level in the NHS is divided between two NHS regions and two ICS Boards. This threatens the ability of the County Council to 'do policy once', tackle health inequalities, and integrate key strategic functions given the duplication of effort.

37. The Local Government Association (LGA), the NHS Confederation, NHS Clinical Commissioners, NHS Providers, the Association of Directors of Adult Social Services (ADASS) and the Association of Directors of Public Health (ADPH) published joint principles that must underpin effective integrated care. They are:

- collaborative leadership
- subsidiarity - decision-making as close to communities as possible
- building on existing, successful local arrangements
- a person-centred and co-productive approach
- a preventative, assets-based and population-health management approach
- achieving best value.

38. The County Council is very supportive of the proposal to place ICSs on a statutory footing and shares the view put forward by ADASS. This is support for the general direction of travel, including the intention to shift resources and decision-making closer to people and communities; and welcome recognition of an important role for councils, as well as the ambition to create an offer that puts people at the heart of their own care. With agreement in principle to the proposals, judgement is reserved on the proposed amendments to legislation until further detail is available. This includes more about how the principle of subsidiarity will be achieved in practice and how the role of health overview and scrutiny will be assured.

39. The consultation document is not clear on delivery and how the objectives will be realised through the two options proposed. The Local Authority has a role in both options, but without the detail of what this looks like it is difficult to assess the implications for it.

40. The document is high level and is not explicit about co-production and patient involvement in the statutory ICS Board or how wider stakeholders would participate in a large statutory Board. The paper implies this would be for local determination.

41. The Local Government Association has made a response to the consultation (https://www.local.gov.uk/parliament/briefings-and-responses/lga-response-nhs-england-and-nhs-improvement-consultation) and in support of greater integration, place based working and local accountability, it is calling on the government to introduce:

- **a new statutory reciprocal duty of collaboration to improve population health and address health inequalities** on all NHS organisations and local authorities
- **a legal requirement on ICSs to involve health and wellbeing boards** (HWBs) in the development of plans and to devolve the development of place or locality plans to HWBs
- **a new power for HWBs to 'sign off'** on all ICS plans
- **commissioning to continue to have a strong place-based focus**, with a strong and proactive role in HWBs in approving commissioning plans

- **a statutory duty on ICSs to be accountable to their local communities** through existing democratic processes.

42. The County Council supports this and has made this part of its response to the consultation (**Appendix 2**).

43. The consultation response was drafted with involvement of the Leader, Chair of Adult Social Care and Public Health Committee, senior officers of the Council, and senior leaders within the health and care system. Views from the sector including the LGA and ADASS were considered. The Council has also had the opportunity to contribute to the consultation response submitted by the Nottingham and Nottinghamshire Integrated Care System.

Other Options Considered

44. There are no other options considered. The Council is required to make a decision regarding the level of partner contribution to the Nottingham and Nottinghamshire Integrated Care System.

45. The Council could choose not to contribute to the consultation on the future arrangements of Integrated Care Systems, but the proposals have a significant impact on the Council.

Reason/s for Recommendation/s

46. The report acknowledges the progress that has been made in relation to the development of the Integrated Care Systems and the Council's contribution to these. However, given that the current outputs of the NN ICS do not contribute to County Council priorities the report recommends that no financial contribution to the ICS is made at this time. The Council will continue to offer support through participation in numerous workstreams and areas within the work programme.

47. The Council's consultation response supports the direction of travel of the proposals relating to the future of ICSs, with a focus on engaging the local authority as an essential and equal partner in the local health, wellbeing and care system. The Council would like to see proposals build on the strong and effective partnerships that already exist between the NHS, local government and other key partners at place level.

Statutory and Policy Implications

48. This report has been compiled after consideration of implications in respect of crime and disorder, data protection and information governance finance, human resources, human rights, the NHS Constitution (public health services), the public sector equality duty, safeguarding of children and adults at risk, service users, smarter working, sustainability and the environment and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Financial Implications

49. There are no financial implications arising from the report if the Committee approves the recommendation not to contribute to the Nottingham and Nottinghamshire Integrated Care System in 2020/21.

Implications for Service Users

50. The proposals relating to Integrated Care Systems and the NHS Long Term Plan are based on the goal of joining up health and care support around people to provide a better experience, with collaboration between health, housing and social care organisations at a local level.

RECOMMENDATION/S

That the Adult Social Care and Public Health Committee

1) reviews the progress made in the health and care system working across Nottinghamshire over the last year.

2) agrees that no financial contribution to the Nottingham and Nottinghamshire Integrated Care System is made in 2020/21.

3) endorses the County Council's response to the consultation.

Melanie Brooks,
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Constitutional Comments (CEH 21/01/21)

51. The recommendations fall within the remit of the Adult Social Care and Public Health Committee under its terms of reference.

Financial Comments (KAS 27/01/21)

52. As per paragraph 49 of the report, there are no financial implications arising from the report if committee approve the recommendation not to contribute to the Integrated Care System in 2020/21.

Background Papers and Published Documents

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

The NHS Long Term Plan – report to Adult Social Care and Public Health Committee on 4th March 2019

Adult Social Care and Public Health alignment to the two Integrated Care Systems architecture for Bassetlaw, Mid Nottinghamshire and South Nottinghamshire – report to Adult Social Care and Public Health Committee on 9th September 2019

Electoral Division(s) and Member(s) Affected

All.

ASCPH746 PDMv3

Integrating care

Next steps to building strong and effective integrated care systems across England

Contents

Introduction

This document builds on previous publications that set out proposals for legislative reform and is primarily focused on the operational direction of travel. It opens up a discussion with the NHS and its partners about how ICSs could be embedded in legislation or guidance. Decisions on legislation will of course then be for Government and Parliament to make.

This builds on the route map set out in the *NHS Long Term Plan*, for health and care joined up locally around people's needs. It signals a renewed ambition for how we can support **greater collaboration** between partners in health and care systems to help accelerate progress in meeting our most critical health and care challenges.

It details how systems and their constituent organisations will accelerate **collaborative ways of working** in future, considering the key components of an effective integrated care system (ICS) and reflecting what a range of local leaders have told us about their experiences during the past two years, including the immediate and long-term challenges presented by the COVID-19 pandemic.

These are significant new steps towards the ambition set out in the *NHS Long Term Plan*, building on the experience of the earliest ICSs and other areas. Our challenge now is to spread their experience to every part of England. From April 2021 this will require all parts of our health and care system to work together as Integrated Care Systems, involving:

- Stronger **partnerships in local places** between the NHS, local government and others with a more central role for primary care in providing joined-up care;
- **Provider organisations** being asked to step forward in formal collaborative arrangements that allow them to operate at scale; and
- Developing strategic **commissioning** through systems with a focus on population health outcomes;
- The use of **digital and data** to drive system working, connect health and care providers, improve outcomes and put the citizen at the heart of their own care.

This document also describes options for giving ICSs a firmer footing in **legislation** likely to take affect from April 2022 (subject to Parliamentary decision). These proposals sit alongside other recommendations aimed at removing legislative barriers to integration across health bodies and with social care, to help deliver better care and outcomes for patients through collaboration, and to join up national leadership more formally. NHS England and NHS Improvement are inviting views

on these proposed options from all interested individuals and organisations by Friday 8 January.

It builds on, and should be read alongside, the commitments and ambitions set out in the *NHS Long Term Plan* (2019), *Breaking Down Barriers to Better Health and Care (2019)* and *Designing ICSs in England* (2019), and our *recommendations to Government and Parliament for legislative change (2019)*.

1. Purpose

1.1. The NHS belongs to us all[1] and any changes to it must bring clear improvements for our health and care. Since 2018, integrated care systems (ICSs) have begun doing just this, enabling NHS organisations, local councils, frontline professionals and others to join forces to plan and provide around residents' needs as locally as possible.

1.2. By doing this, they have driven a 'bottom-up' response to the big health and care challenges that we and other countries across the world face and have made a real difference to people's lives. They have improved health, developed better and more seamless services and ensured public resources are used where they can have the greatest impact.

1.3. These achievements have happened despite persistent complexity and fragmentation. This document describes how we will simplify support to local leaders in systems, making it easier for them to achieve their ambitions. Our proposals are designed to serve four fundamental purposes:

- improving population health and healthcare;
- tackling unequal outcomes and access;
- enhancing productivity and value for money; and
- helping the NHS to support broader social and economic development.

1.4. The *NHS Long Term Plan* set out a widely supported route map to tackle our greatest health challenges, from improving cancer care to transforming mental health, from giving young people a healthy start in life to closing the gaps in health inequalities in communities, and enabling people to look after their own health and wellbeing.

1.5. The COVID-19 pandemic has given the NHS and its partners their biggest challenge of the past 70 years, shining a light on the most successful approaches to protecting health and treating disease. Vulnerable people need support that is joined up across councils, NHS, care and voluntary organisations; all based on a common understanding of the risks different people face. Similarly, no hospital could rise to the challenge alone, and new pathways have rapidly developed across multiple providers that enable and protect capacity for urgent non-COVID care.

1.6. This has all been backed up by mutual aid agreements, including with local councils, and shared learning to better understand effective response. It has

[1] https://www.gov.uk/government/publications/the-nhs-constitution-for-england

required openness in data sharing, commitment to collaboration in the interests of patients and communities, and agile collective decision-making.

1.7. The significant challenges that face health and care as we recover from the pandemic make it even more important to have strong and thriving systems for the medium term. Important changes were driven by emergency response but must be hard-wired into our future working so that the gains of 2020 can endure. DHSC's 'Busting Bureaucracy: Empowering frontline staff by reducing excess bureaucracy in the health and care system in England' report, published on the 24th November 2020, describes in detail some of these important areas of change. The report found that there are many sources of excess bureaucracy and that these are often exacerbated by duplicative or disproportionate assurance systems and poorly integrated systems at a national, regional and local level. The report also acknowledges that the more levels of hierarchy in a system, the more likely it is that bureaucracy will exist and grow. ICS' therefore have the potential to reduce bureaucracy through increased collaboration, leaner oversight through streamlined assurance structures and smarter data-sharing agreements.

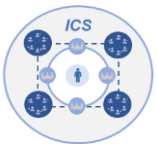
1.8. To deliver the core aims and purposes set out above, we will need to devolve more functions and resources from national and regional levels to local systems, to develop effective models for joined-up working at "place", ensure we are taking advantage of the transformative potential of digital and data, and to embed a central role for providers collaborating across bigger footprints for better and more efficient outcomes. The aim is a progressively deepening relationship between the NHS and local authorities, including on health improvement and wellbeing.

1.9. This reflects three important observations, building on the *NHS Long Term Plan*'s vision of health and care joined up locally around people's needs:

- **decisions taken closer to the communities** they affect are likely to lead to better outcomes;
- **collaboration between partners in a place** across health, care services, public health, and voluntary sector can overcome competing objectives and separate funding flows to help address health inequalities, improve outcomes, and deliver joined-up, efficient services for people; and
- **collaboration between providers** (ambulance, hospital and mental health) across larger geographic footprints is likely to be more effective than competition in sustaining high quality care, tackling unequal access to services, and enhancing productivity.

1.10. This takes forward what leaders from a range of systems have told us about their experiences during the past two years.

Devolution of functions and resources



1.11. Joining up delivery is not enough on its own. In many areas, we can shift national or regional resources and decision-making so that these are closer to the people they serve. For example, it will make sense to plan, commission and organise certain specialised services at ICS level, and to devolve a greater share of primary care funding and improvement resource to this more local level.

1.12. ICSs also need to be able to ensure collectively that they are addressing the right priorities for their residents and using their collective resources wisely. They will need to work together across partners to determine:

- **distribution of financial resources** to places and sectors that is targeted at areas of greatest need and tackling inequalities;
- **improvement and transformation resource** that can be used flexibly to address system priorities;
- **operational delivery** arrangements that are based on collective accountability between partners;
- **workforce planning, commissioning and development** to ensure that our people and teams are supported and able to lead fulfilling and balanced lives;
- **emergency planning and response** to join up action at times of greatest need; and
- the use of **digital and data** to drive system working and improved outcomes.

"Place": an important building block for health and care integration

1.13. For most people their day-to-day care and support needs will be expressed and met locally in the place where they live. An important building block for the future health and care system is therefore at '**place**.'

1.14. For most areas, this will mean long-established local authority boundaries (at which joint strategic needs assessments and health and wellbeing strategies are made). But the right size may vary for different areas, for example reflecting where meaningful local communities exist and what makes sense to all partners. Within each place, services are joined up through primary care networks (PCNs) integrating care in neighbourhoods.

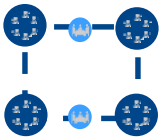
1.15. Our ambition is to create an **offer to the local population of each place**, to ensure that in that place everyone is able to:

- access clear advice on **staying well**;
- access a range of **preventative services**;
- access **simple, joined-up care and treatment** when they need it;
- access digital services (with non-digital alternatives) that put the citizen at the heart of their own care;
- access proactive support to keep as well as possible, where they are **vulnerable or at high risk**; and to
- expect the NHS, through its employment, training, procurement and volunteering activities, and as a major estate owner to play a full part in **social and economic development** and **environmental sustainability**.

1.16. This offer will be met through providers of primary care, community health and mental health services, social care and support, community diagnostics and urgent and emergency care working together with meaningful delegated budgets to join up services. It will also allow important links to be made to other public or voluntary services that have a big impact on residents' day-to-day health, such as by improving local skills and employment or by ensuring high-quality housing.

1.17. Delivery will be through NHS providers, local government, primary care and the voluntary sector working together in each place in ICSs, built around primary care networks (PCNs) in neighbourhoods.

Developing provider collaboration at scale



1.18. At some times, many people will have more complex or acute needs, requiring specialist expertise which can only be planned and organised effectively over a larger area than 'place'. This may be because concentrating skills and resources in bigger sites improves quality or reduces waiting times; because it is harder to predict what smaller populations will need; or because scale working can make better use of public resources.

1.19. Because of this, some services such as hospital, specialist mental health and ambulance needs to be organised through **provider collaboration** that operates at a whole-ICS footprint – or more widely where required.

1.20. We want to create an **offer that all people served by an ICS** are able to:

- access a full range of high-quality acute hospital, mental health and ambulance services; and
- experience fair access to these services, based on need and not factors such as geography, race or socio-economic background.

1.21. We also need to harness the involvement, ownership and innovation of clinicians, working together to design more integrated patient pathways horizontally across providers and vertically within local place-based partnerships.

2. Putting this into practice

2.1. There are many good examples of recent system working that have improved outcomes and productivity, and helped to address inequalities. But COVID has made the case for a step up in scope and ambition. NHS and local government are increasingly pressing for a more driven and comprehensive roll out of system working.

2.2. So, in this section we set out a series of practical changes which will need to be in place by April 2022 at the latest, to make a consistent transition to system working focused on further devolution to systems, greater partnership working at place and closer collaboration between providers on a larger footprint. The main themes are:

1. Provider collaboratives
2. Place-based partnerships
3. Clinical and professional leadership
4. Governance and accountability
5. Financial framework
6. Data and digital
7. Regulation and oversight
8. How commissioning will change

2.3. We will support preparatory work during 2021/22 with further guidance for systems and in the NHS Operational Planning Guidance for 2021/22.

Provider collaboratives

2.4. Provider organisations will play an **active and strong leadership role** in systems. Through their mandated representation in ICS leadership and decision-making, they will help to set system priorities and allocate resources.

2.5. **Providers will join up services across systems.** Many of the challenges that systems face cannot be solved by any one organisation, or by any one provider. Joining up the provision of services will happen in two main ways:

- **within places** (for example, between primary, community, local acute, and social care, or within and between primary care networks) through place-based partnerships as described above ('vertical integration'); and

- **between places** at scale where similar types of provider organisation share common goals such as reducing unwarranted variation, transforming services, providing mutual aid through a formal provider collaborative arrangement ('horizontal integration' – for example, through an alliance or a mental health provider collaborative).

2.6. **All NHS provider trusts will be expected to be part of a provider collaborative**. These will vary in scale and scope, but all providers must be able to take on responsibility for acting in the interests of the population served by their respective system(s) by entering into one or more formal collaboratives to work with their partners on specific functions.

2.7. This greater co-ordination between providers at scale can support:

- higher quality and more sustainable services;
- reduction of unwarranted variation in clinical practice and outcomes;
- reduction of health inequalities, with fair and equal access across sites;
- better workforce planning; and
- more effective use of resources, including clinical support and corporate services.

2.8. For provider organisations operating across a large footprint or for those working with smaller systems, they are likely to create **provider collaboratives that span multiple systems** to provide an effective scale to carry out their role.

2.9. For ambulance trusts specifically we would expect collaboration and integration at the right scale to take place. This should operate at scale to plan resources and join up with specialist providers, and at a more local level in places where focused on the delivery and redesign with other partners of urgent and emergency care pathways.

2.10. We want to spread and build on good work of this type already under way. The partnerships that support this collaboration (such as provider alliances) often take place on a different footprint to ICS boundaries. This should continue where clinically appropriate, with NHS England and NHS Improvement helping to ensure consistent and coherent approaches across systems, especially for smaller partnerships.

2.11. Local flexibility will be important but providers in every system, through partnership or any new collaborative arrangements, must be able to:

- deliver relevant programmes on behalf of all partners in the system;
- agree proposals developed by clinical and operational networks, and implement resulting changes (such as implementing standard

operating procedures to support agreed practice; designating services to ensure their sustainability; or wider service reconfiguration);

- challenge and hold each other to account through agreed systems, processes and ways of working, e.g. an open-book approach to finances/planning;
- enact mutual aid arrangements to enhance resilience, for example by collectively managing waiting lists across the system.

2.12. In some systems, larger providers may also choose to use their scale to host functions on behalf of other system partners.

2.13. NHS England and NHS Improvement will set out further guidance in early 2021, describing a number of potential models for provider collaboratives, based on those that have been established in some parts of the country, including looser federations and more consolidated forms.

2.14. We know that providers are already making progress towards effective, collaborative working arrangements despite the constraints of relevant legislation and frameworks. Indeed, many crucial features of strong system working – such as trust between partners, good leadership and effective ways of working – cannot be legislated for.

But we recognise that these could be supported by changes to legislation, including the introduction of a 'triple aim' duty for all NHS providers to help align priorities, and the establishment of ICSs as statutory bodies with the capacity to support population-based decision-making and to direct resources to improve service provision. Our recommendations for this are set out in part 3.

2.15. Systems will continue to play an increasingly important role in developing multidisciplinary leadership and talent, coordinating approaches to recruiting, retaining and looking after staff, developing an agile workforce and making best use of individual staff skills, experience and contribution.

2.16. From April 2022, this will include:

- developing and supporting a 'one workforce' strategy in line with the NHS People Plan and the People Promise, to improve the experience of working in the NHS for everyone;
- contributing to a vibrant local labour market, with support from partner organisations and other major local employers, including the care home sector and education and skills providers.
- enabling employees to have rewarding career pathways that span the entire system, by creating employment models, workforce sharing arrangements and passporting or accreditation systems that enable

their workforce to be deployed at different sites and organisations across (and beyond) the system, and sharing practical tools to support agile and flexible working;

- valuing diversity and developing a workforce and leadership which is representative of the population it serves; and
- supporting organisational and leadership development at all levels, including talent management. This should encompass investment in, and the development of improvement expertise.

Place-based partnerships

2.17. In many places, there are already **strong and effective place-based partnerships** between sectors. Every area is different, but common characteristics of the most successful are the full involvement of all partners who contribute to the place's health and care; an important role for local councils (often through joint appointments or shared budgets); a leading role for clinical primary care leaders through primary care networks; and a clear, strategic relationship with health and wellbeing boards.

2.18. The place leader on behalf of the NHS, as set out above, will work with partners such as the local authority and voluntary sector in an inclusive, transparent and collaborative way. They will have four main roles:

- to support and develop primary care networks (PCNs) which join up primary and community services across local neighbourhoods;
- to simplify, modernise and join up health and care (including through technology and by joining up primary and secondary care where appropriate);
- to understand and identify – using population health management techniques and other intelligence – people and families at risk of being left behind and to organise proactive support for them; and
- to coordinate the local contribution to health, social and economic development to prevent future risks to ill-health within different population groups.

2.19. Systems should ensure that each place has **appropriate resources, autonomy and decision-making capabilities** to discharge these roles effectively, within a clear but flexible accountability framework that enables collaboration around funding and financial accountability, commissioning and risk management. This could include places taking on delegated budgets.

2.20. Partnerships within local places are important. Primary care networks in neighbourhoods and thriving community networks are also provider collaboratives, and for integration to be successful we will need primary care

working with community, mental health, the voluntary sector and social care as close to where people live as possible.

2.21. The exact division of responsibilities between system and place should be based on the principle of subsidiarity – with the system taking responsibility only for things where there is a clear need to work on a larger footprint, as agreed with local places.

The NHS's offer to local government

2.22. We will work much more closely with local government and the voluntary sector at place, to ensure local priorities for improved health and care outcomes are met by the NHS becoming a more effective partner in the planning, design and delivery of care. This will ensure residents feel well supported, with their needs clearly understood; and with services designed and delivered in the most effective and efficient way for each place.

2.23. As ICSs are established and evolve, this will create opportunities to further strengthen partnership working between local government, the NHS, public health and social care. Where partnership working is truly embedded and matured, the ability to accelerate place-based arrangements for local decision-making and use of available resources, such as delegated functions and funding, maximises the collective impact that can be achieved for the benefit of residents and communities.

Clinical and professional leadership

2.24. Clinical and other frontline staff have led the way in working across professional and institutional boundaries, and they need to be supported to continue to play a significant leadership role through systems. ICSs should embed **system-wide clinical and professional leadership** through their partnership board and other governance arrangements, including **primary care network** representation.

2.25. **Primary care clinical leadership** takes place through critical leadership roles including:

- Clinical directors, general practitioners and other clinicians and professionals in primary care networks (PCNs), who build partnerships in **neighbourhoods** spanning general practice, community and mental health care, social care, pharmacy, dentistry, optometry and the voluntary sector.
- Clinical leaders representing primary care in **place-based partnerships** that bring together the primary care provider leadership role in federations and group models

- A primary care perspective at system level.

2.26. **Specialist clinical leadership** across secondary and tertiary services must also be embedded in systems. Existing **clinical networks** at system, regional and national level have important roles advising on the most appropriate models and standards of care, in particular making decisions about clinical pathways and clinically-led service change. System-wide clinical leadership at an ICS and provider collaborative footprint through clinical networks should:

- be able to carry out clinical service strategy reviews on behalf of the ICS;
- develop proposals and recommendations that can be discussed and agreed at wider decision-making forums; and
- include colleagues from different professional backgrounds and from different settings across primary care, acute, community and mental health care.

2.27. **Wider clinical and professional leadership** should also ensure a strong voice for the wide range of skills and experience across systems. From nursing to social care, from allied health professionals to high street dentists, optometrists and pharmacists, and the full range of specialisms and care settings, people should receive services designed and organised to reflect the expertise of those who provide their care.

Governance and public accountability

2.28. Systems have told us from recent experience that good partnership working must be underpinned by mutually-agreed governance arrangements, clear collective decision-making processes and transparent information-sharing.

2.29. In the *NHS Long Term Plan* and *NHS planning and contracting guidance for 2020/21*, we described a set of consistent operating arrangements that all systems should put in place by 2021/22. These included:

- system-wide governance arrangements (including a system partnership board with NHS, local councils and other partners represented) to enable a collective model of responsibility and decision-making;
- quality governance arrangements, notably a quality lead and quality group in systems, focused on assurance, planning and improvement;
- a leadership model for the system, including an ICS leader with sufficient capacity and a chair appointed in line with NHSEI guidance; and
- agreed ways of working with respect to financial governance and collaboration.

2.30. ICSs now need to put in place firmer governance and decision-making arrangements for 2021/22, to reflect their growing roles and responsibilities. With the below consistent framework, these should be flexible to match local needs.

2.31. As part of this, each system should define:

- **'place' leadership** arrangements. These should consistently involve:
    i. every locally determined 'place' in the system operating a partnership with joined-up decision-making arrangements for defined functions;
    ii. the partnership involving, at a minimum, primary care provider leadership, local authorities, including Director of Public Health and providers of community and mental health services and Healthwatch;
    iii. agreed joint decision-making arrangements with local government; and
    iv. representation on the ICS board.

  They may flexibly define:

    i. the configuration, size and boundaries of places which should reflect meaningful communities and scale for the responsibilities of the place partnership;
    ii. additional membership of each place partnership that is likely to include acute providers, ambulance trusts, the voluntary sector and other partners;
    iii. the precise governance and decision-making arrangements that exist within each place; and
    iv. their voting arrangements on the ICS board.

- **provider collaborative leadership** arrangements for providers of more specialist services in acute and mental health care. These should consistently involve:
    i. every such provider in a system operating as part of one or more agreed provider collaboratives with joined up decision-making arrangements for defined functions;
    ii. provider collaboratives represented on the appropriate ICS board(s).

  They may flexibly define:

    i. the scale and scope of provider collaboratives. For smaller systems, provider collaboratives are likely to span multiple systems and to be represented on the board of each. These arrangements should reflect a meaningful scale for their responsibilities;

ii. the precise membership of each collaborative (acute providers, specialist providers, ambulance trusts at an appropriate footprint, mental health providers);

iii. the precise governance and decision-making arrangements that exist within each collaborative; and

iv. their voting arrangements on the ICS board.

- **individual organisation** accountability within the system governance framework. This will consistently involve:

  i. the responsibility and accountability of the individual provider organisations for their current range of formal and statutory responsibilities (which are unchanged); and

  ii. the accountability relationship between the provider organisation and all place-based partnerships and provider collaboratives of which it is a member.

  It may flexibly define:

  iii. Any lead provider responsibility that the organisation holds on behalf of a place partnership or a provider collaborative.

2.32. Integrated care systems draw their strength from the effectiveness of their constituent parts. Their governance should seek to minimise levels of decision-making and should set out defined responsibilities of organisations, partnerships at place, provider collaboratives and the core ICS role. Each ICS should seek to ensure that all the relevant bodies feel ownership and involvement in the ICS.

2.33. The local test for these governance arrangements is whether they enable joined-up work around a shared purpose. Provider collaboratives and place-based partnerships should enable peer support and constructive challenge between partners delivering services and accelerate partners' collective ability to improve services in line with agreed priorities.

2.34. The greater development of working at place will in many areas provide an opportunity to align decision-making with local government, including integrated commissioning arrangements for health and social care, and local responsiveness through health and wellbeing boards. There is no one way to do this, but all systems should consider how the devolution of functions and capabilities to systems and places can be supported by robust governance arrangements.

2.35. ICS governance is currently based on voluntary arrangements and is therefore dependent on goodwill and mutual co-operation. There are also legal constraints on the ability of organisations in an ICS to make decisions jointly. We have previously made a number of recommendations for legislative change to Government and Parliament to increase flexibility in decision making by enabling decision making joint committees of both

commissioners and providers and also committees of Providers. Section 3 of this document captures these options and also describes our thinking on clarifying arrangements for an ICS.

2.36. Many systems have shown great ways to involve and take account of the views and priorities of local residents and those who use services, as a 'golden thread' running through everything they do. During 21/22, every ICS should work to develop systematic arrangements to involve lay and resident voices and the voluntary sector in its governance structures, building on the collective expertise of partners and making use of pre-existing assets and forums such as Healthwatch and citizen's panels.

2.37. In particular, governance in ICSs should involve all system partners in the development of service change proposals, and in consulting and engaging with local people and relevant parts of local government (such as with overview and scrutiny committees and wider elected members) on these. It should appropriately involve elected councillors, and other local politicians such as metro mayors where relevant, and reflect transparency in wider decision-making.

2.38. Each system should also be able to show how it uses public involvement and insight to inform decision-making, using tools such as citizens' panels, local health champions, and co-production with people with lived experience. Systems should make particular efforts to understand and talk to people who have historically been excluded.

Financial framework

2.39. In order that the collective leadership of each ICS has the best possible opportunity to invest in and deliver joined-up, more preventative care, tailored to local people's needs, we will increasingly **organise the finances of the NHS at ICS level** and put **allocative decisions in the hands of local leaders**. We are clear that we want ICSs to be key bodies for financial accountability and financial governance arrangements will need to reflect that. NHSEI will update guidance to reflect these changes.

2.40. That means that we will **create a 'single pot**,' which brings together current CCG commissioning budgets, primary care budgets, the majority of specialised commissioning spend, the budgets for certain other directly commissioned services, central support or sustainability funding and nationally-held transformation funding that is allocated to systems.

2.41. ICS leaders, working with provider collaboratives, must have the freedom – and indeed the duty – to distribute those resources in line with national rules such as the mental health, and the primary and community services investment guarantees and locally-agreed strategies for health and care, for example targeting investment in line with locally-agreed health inequalities

priorities, or responding flexibly as new, more preventative services are developed and patient journeys change.

2.42. ICS leaders will also have a duty to ensure that they deploy the resources available to them in order to protect the future sustainability of local services, and to ensure that their health and care system consumes their fair share of resources allocated to it.

2.43. It also means that ICS leaders will be expected to use new freedoms to delegate significant budgets to 'place' level, which might include resources for general practice, other primary care, community services, and continuing healthcare. Similarly, through active involvement at place level, providers will have a greater say in how transformation funding is deployed. Decisions about the use of all of these budgets will usually be made at the lowest possible level, closest to those communities they serve and in partnership with their local authority. New powers will make it easier to form joint budgets with the local authority, including for public health functions.

2.44. Providers will through their role in ICS leadership have the opportunity to shape the strategic health and care priorities for the populations they serve, and new opportunities – whether through lead provider models at place level or through fully-fledged integrated care provider contractual models – to determine how services are funded and delivered, and how different bodies involved in providing joined-up care work together.

2.45. We will deliver on the commitment set out in the Long Term Plan to mostly move away from episodic or activity-based payment, rolling out the blended payment model for secondary care services. This will ensure that provider collaboratives have greater certainty about the resources available to them to run certain groups of services and meet the needs of particular patient groups. Any variable payments will be funded within the ICS financial envelope, targeted to support the delivery of locally-identified priorities and increasingly linked to quality and outcomes metrics. Each ICS will be expected to agree and codify how financial risk will be managed across places and between provider collaboratives.

2.46. These changes will reduce the administrative, transactional costs of the current approach to commissioning and paying for care, and release resources for the front line - including preventative measures - that can be invested in services that are planned, designed and delivered in a more strategic way at ICS level. This is just one way in which we will ensure that each ICS has to capacity and capability to take advantage of the opportunities that these new approaches offer.

2.47. Finally, we will further embed reforms to the capital regime introduced in 2019/20 and 2020/21, bringing together at ICS level responsibility for allocating capital envelopes with responsibility for allocating the revenue

budgets which fund day-to-day services. This will ensure that capital investment strategies:

- are not only coordinated between different NHS providers, but also aligned with local authorities' management of their estates and wider assets;
- reflect local judgments about the balance between competing priorities for capital expenditure; and
- give priority to those investments which support the future sustainability of local services for future generations.

2.48. We will set out in the 2021/22 planning guidance how we will support ICSs to begin operating more collective financial governance in 2021/22 and to prepare for the powers and duties set out above.

Data and Digital

2.49. Data and digital technology have played a vital role helping the NHS and care respond to the pandemic. They will be at the heart of creating effective local systems, helping local partners in health and social care work together. They can help improve productivity and patient outcomes, reduce bureaucracy, drive service transformation and stimulate improvement and research.

2.50. But digital maturity and data quality is variable across the health and care. Data has too often been held in siloes, meaning that clinicians and care professionals do not have easy access to all of the information that could be useful in caring for their patients and service users.

2.51. To fulfil the potential of digital and data to improve patient outcomes and drive collaborative working, systems will need to:

(1) build smart digital and data foundations
(2) connect health and care services
(3) use digital and data to transform care
(4) put the citizen at the centre of their care

Build smart digital and data foundations

- Have clear **board accountability** for data and digital, including a member of the ICS Partnership Board being a named SRO.
- Have a system-wide **digital transformation plan.** This should outline the three year journey to digitally-driven, citizen-centred care, and the benefits that digital and data will realise for the system and its citizens.

- Build the **digital and data literacy** of the whole workforce as well as specific digital skills such as user research and service design.

- Invest in the **infrastructure** needed to deliver on the transformation plan. This will include **shared contracts and platforms** to increase resiliency, digitise operational services and create efficiencies, from shared data centres to common EPRs.

Connect health and care services

- Develop or join a **shared care record** joining data safely across all health and social care settings, both to improve direct care for individual patients and service users, and to underpin population health and effective system management.
- Build the tools to allow **collaborative working** and frictionless movement of staff across organisational boundaries, including shared booking and referral management, task sharing, radiology reporting and pathology networks.
- Follow **nationally defined standards** for digital and data to enable integration and interoperability, including in the data architecture and design.

Use digital and data to transform care

- Use digital technology to **reimagine care pathways**, joining up care across boundaries and improving outcomes.

- Develop shared **cross-system intelligence and analytical functions** that use information to improve decision-making at every level, including:

    - actionable insight for frontline teams;
    - near-real time actionable intelligence and robust data (financial, performance, quality, outcomes);
    - system-wide workforce, finance, quality and performance planning;
    - the capacity and skills needed for population health management.
- Ensure **transparency of information** about interventions and the outcomes they produce, to drive more responsive coordination of services, better decision-making and improved research.

Put the citizen at the centre of their care

- Develop a road map for **citizen-centred digital channels** and services, including access to personalised advice on staying well, access to their own data, and triage to appropriate health and care services.

- Roll out **remote monitoring** to allow citizens to stay safe at home for longer, using digital tools to help them manage long-term conditions.

- We want to build on the experience of data sharing during COVID so that data is shared, wherever it can and should be. This will inform the upcoming Department of Health and Social Care Data Strategy. While this will be mainly about embedding a culture of sharing data with appropriate safeguards, we would support legislative change that clarifies that sharing data for the benefit of the whole health and care system is a key duty and responsibility of all health and adult social care organisations. This will require a more flexible legislative framework than currently exists to support further evolution and empower local systems to lead and drive that agenda.

Regulation and oversight

2.52. We have consistently heard that regulation needs to adapt, with more support from national regulators for systems as well as the individual organisations within them, and a shift in emphasis to reflect the importance of partnership working to improve population health.

2.53. Regulation best supports our ambitions where it enables systems and the organisations within them to make change happen. This means a focus on how effective local arrangements are at implementing better pathways, maximising use of collective capacity and resources, and acting in partnership to achieve joint financial and performance standards.

2.54. We have already taken steps to bring together NHS England and NHS Improvement to provide a single, clear voice to the system and our legislative proposals haven't changed – this merger should be formalised in future legislation.

2.55. As a formally merged body, NHS England will of course remain answerable to Parliament and to the Secretary of State for Health and Social Care for NHS performance, finance and healthcare transformation. There will need to be appropriate mechanisms in law to ensure that the newly merged body is responsive and accountable. We envisage Parliament using the legislation to specify the Secretary of State's legal powers of direction in respect of NHS England in a transparent way that nevertheless protects clinical and operational independence.

2.56. There are a further practical steps that we can take to support systems:

- working with the CQC to seek to embed a requirement for strong participation in ICS and provider collaborative arrangements in the "Well Led" assessment;
- issuing guidance under the NHS provider licence that good governance for NHS providers includes a duty to collaborate; and
- ensuring foundation trust directors' and governors' duties to the public support system working.

2.57. We expect to see greater adoption of system- and place- level measurements, which might include reporting some performance data such as patient treatment lists at system level. Next year, we will introduce new measures and metrics to support this, including an 'integration index' for use by all systems.

2.58. The future **System Oversight Framework** will set consistent expectations of systems and their constituent organisations and match accountability for results with improvement support, as appropriate.

2.59. This approach will recognise the enhanced role of systems. It will identify where ICSs and organisations may benefit from, or require, support to help them meet standards in a sustainable way and will provide an objective basis for decisions about when and how NHSEI will intervene in cases where there are serious problems or risks.

The proposed future Intensive Recovery Support Programme will give support to the most challenged systems (in terms of quality and/or finance) to tackle their key challenges. This will enable intervention in response to CQC findings or where other regulatory action is required. This approach enables improvement action and targeted support either at organisation/provider level (with system support) or across a whole system where required and may extend across health and social care, accessing shared learning and good practice between systems to drive improvement.

2.60. Greater collaboration will help us to be more effective at designing and distributing services across a local system, in line with agreed health and care priorities and within the resources available. However there remains an important role for patient choice, including choice between qualified providers, providers outside the geographic bounds of the system and choice of the way in which services need to be joined up around the individual person as a resident or patient including through personal health budgets.

2.61. Our previous recommendations to government for legislation include rebalancing the focus on competition between NHS organisations by reducing the Competition and Market Authority's role in the NHS and

abolishing Monitor's role and functions in relation to enforcing competition. We also recommended regulations made under section 75 of the *Health and Social Care Act 2012* should be revoked and that the powers in primary legislation under which they are made should be repealed, and that NHS services be removed from the scope of the *Public Contracts Regulations 2015*. We have committed to engage openly on how the future procurement regime will operate subject to legislation being brought before Parliament.

How commissioning will change

2.62. Local leaders have repeatedly told us that the commissioning functions currently carried out by CCGs need to become more strategic, with a clearer focus on **population-level health outcomes** and a marked reduction in transactional and contractual exchanges within a system. This significant change of emphasis for commissioning functions means that the organisational form of CCGs will need to evolve.

2.63. The activities, capacity and resources for commissioning will change in three significant ways in the future, building on the experience of the most mature systems:

- Ensuring a single, system-wide approach to undertake **strategic commissioning**. This will discharge core ICS functions, which include:
    - assessing population health needs and planning and modelling demographic, service use and workforce changes over time;
    - planning and prioritising how to address those needs, improving all residents' health and tackling inequalities; and
    - ensuring that these priorities are funded to provide good value and health outcomes.
- Service transformation and pathway redesign need to be done differently. Provider organisations and others, through partnerships at place and in provider collaboratives, become a principal engine of transformation and should agree the future service model and structure of provision jointly through ICS governance (involving transparency and public accountability). Clinical leadership will remain a crucial part of this at all footprints.
- The greater focus on population health and outcomes in contracts and the collective system ownership of the financial envelope is a chance to apply capacity and skills in transactional commissioning and contracting with a new focus. Analytical skills within systems should be applied to better understanding how best to use resources to

improving outcomes, rather than managing contract performance between organisations.

2.64. Many commissioning functions are now **coterminous with ICS boundaries**, and this will need to be consistent across the country before April 2022. Under the legislative provisions recommended in section 3 current CCG functions would subsequently be absorbed to become core ICS business.

2.65. However, with the spread of place-based partnerships backed by devolved funding, simplified accountability, and an approach to governance appropriate to local circumstances along with further devolution of specialised commissioning activity, there will be flexibility for local areas to make full use of the local relationships and expertise currently residing in CCGs.

2.66. Systems should also agree whether individual functions are best delivered at system or at place, balancing subsidiarity with the benefits of scale working. Commissioners may, for example, work at place to complete service and outcomes reviews, allocate resources and undertake needs assessments alongside local authorities. But larger ICSs may prefer to carry out a wider range of functions in their larger places, and smaller ones to do more across the whole system.

2.67. Commissioning support units (CSUs) operate within the NHS family across England, providing services that have been independently evaluated for quality and value for money. We expect that CSUs will continue to develop as trusted delivery partners to ICSs, providing economies of scale which may include joining up with provider back office functions where appropriate and helping to shape services through a customer board arrangement.

Specialised commissioning

2.68. Specialised services are particularly important for the public and patients, with the NHS often working at the limits of science to bring the highest levels of human knowledge and skill to save lives and improve health.

2.69. The national commissioning arrangements that have been in place for these services since 2013 have played a vital role in supporting **consistent, equitable, and fast access for patients** to an ever-expanding catalogue of cutting edge technologies - genomic testing, CAR-T therapy, mechanical thrombectomy, Proton Beam Therapy and CFTR modulator therapies for patients with cystic fibrosis to name just a few.

2.70. But these national commissioning arrangements can sometime mean fragmented care pathways, misaligned incentives and missed opportunities for **upstream investment and preventative intervention**. For example, the split in commissioning responsibilities for mental health services has

potentially slowed the ambition to reduce the number of children admitted for inpatient treatment and, where they are admitted, making sure they are as close to home as possible. Bringing together the commissioning of mental health services has aligned incentives and enabled resources to be moved into upstream services, reducing over-reliance on geographically distant inpatient care.

2.71. Integrated care systems provide an opportunity to further **align the design, development and provision of specialised services with linked care** pathways, where it supports patient care, while maintaining consistent national standards and access policies across the board.

2.72. The following principles will underpin the detailed development of the proposed arrangements:

- ***Principle One: All specialised services, as prescribed in regulations, will continue to be subject to consistent national service specifications and evidence-based policies determining treatment eligibility.*** NHS England will continue to have responsibility for developing and setting these standards nationally and whoever is designated as the strategic commissioner will be expected to follow them. Over time, service specifications will need to become more outcomes focused to ensure that innovative and flexible solutions to unique system circumstances and/or opportunities can be easily adopted. But policies determining eligibility criteria for specific treatments across all specialised services will remain precise and consistently applied across the country.

- ***Principle Two: Strategic commissioning, decision making and accountability for specialised services will be led and integrated at the appropriate population level: ICS, multi-ICS or national.*** For certain specialised services, it will make sense to plan, organise and commission these at ICS level. For others, ICSs will need to come together across a larger geographic footprint to jointly plan and take joint commissioning decisions. And many services, such as those in the highly specialised services portfolio, will continue to be planned and commissioned on a national footprint. Importantly, whichever level strategic commissioning occurs the national standards will apply.

- ***Principle Three: Clinical networks and provider collaborations will drive quality improvement, service change and transformation across specialised services and non-specialised services.*** Clinical networks have long been a feature of the NHS. But, during the COVID pandemic they have become critical in supporting innovation and system wide collaboration. Looking ahead they will be supported to drive clinically-led change and service improvement with even greater

accountability for tackling inequalities and for improving population health.

- ***Principle Four: Funding of specialised services will shift from provider-based allocations to population-based budgets, supporting the connection of services back to 'place'.*** We are considering from April 2021 allocating budgets on a population basis at regional level and are considering the best basis for allocating funding and will provide further information in due course. In this first year, adjustments will then be made to neutralise any changes in financial flows and ensure stability. We intend to publish a needs-based allocation formula, before using it to inform allocations against an agreed pace of change in future years. A needs-based allocations formula will further strengthen the focus on tackling inequalities and unwarranted variation.

3. Legislative proposals

3.1. The detailed policy work described above will be necessary to deliver our vision but will not by itself be sufficient. While legislation is only part of the answer, the existing legislation (*the National Health Service Act 2006 and the Health and Social Care Act 2012* does not present a sufficiently firm foundation for system working.

3.2. In September 2019, NHSEI made a number of recommendations for an NHS Bill[2]. These aimed to remove current legislative barriers to integration across health and social care bodies, foster collaboration, and more formally join up national leadership in support of the ambitions outlined above.

3.3. Recommendations included:

- rebalancing the focus on **competition** between NHS organisations by reducing the Competition and Markets Authority's role in the NHS and abolishing Monitor's role and functions in relation to enforcing competition;
- simplifying **procurement** rules by scrapping section 75 of the 2012 Act and remove the commissioning of NHS healthcare services from the jurisdiction of the Public Contracts Regulations 2015;
- providing increased flexibilities on **tariff**;
- reintroducing the ability to establish **new NHS trusts** to support the creation of integrated care providers;
- ensuring a more coordinated approach to planning **capital investment**, through the possibility of introducing FT capital spend limits;
- the ability to establish decision-making **joint committees** of commissioners and NHS providers and between NHS providers;
- enabling **collaborative commissioning** between NHS bodies – it is currently easier in legislative terms for NHS bodies and local authorities to work together than NHS bodies;
- a new "**triple aim**" duty for all NHS organisations of 'better health for the whole population, better quality care for all patients and financially sustainable services for the taxpayer; and

2 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/875711/The_government_s_2020-2021_mandate_to_NHS_England_and_NHS_Improvement.pdf

- **merging NHS England and NHS Improvement** – formalising the work already done to bring the organisations together.

3.4. These recommendations were strongly supported and backed across the health and social care sector[3]. We believe these proposals still stand.

3.5. One of the key considerations in our recommendations was how, and to what extent, ICSs should be put on a statutory footing. Responses to our engagement were ultimately mixed – balancing the relatively early stage of development of some ICSs against a desire to enable further progress and to put ICSs on a firmer footing.

3.6. At the time, we proposed a new statutory underpinning to establish ICS boards through voluntary joint committees, an entity through which members could delegate their organisational functions to its members to take a collective decision. This approach ensured support to those systems working collectively already and a future approach to those systems at an earlier stage of development.

3.7. Many respondents to our engagement and specifically Parliament's Health and Social Care Select Committee raised a number of questions as to whether a voluntary approach would be effective in driving system working. There was particular focus on those areas at an earlier stage of their development and whether a voluntary model offered sufficient clarity of accountability for health outcomes and financial balance both to parliament and more directly to the public.

3.8. The response of the NHS and its partners to COVID-19 and a further year of ICS development has increased the appetite for statutory "clarity" for ICSs and the organisations within them. With an NHS Bill included in the last Queen's Speech, we believe the opportunity is now to achieve clarity and establish a "future-proofed" legislative basis for ICSs that accelerates their ability to deliver our vision for integrated care.

3.9. We believe there are two possible options for enshrining ICSs in legislation, without triggering a distracting top-down re-organisation:

Option 1: a statutory committee model with an Accountable Officer that binds together current statutory organisations.

Option 2: a statutory corporate NHS body model that additionally brings CCG statutory functions into the ICS.

[3] https://www.aomrc.org.uk/wp-content/uploads/2019/09/190926_Support_letter_NHS_legislation_-proposals.pdf

3.10. Both models share a number of features – broad membership and joint decision-making (including, as a minimum, representatives from commissioners; acute, community and primary care providers; and local authorities); responsibility for owning and driving forward the system plan; operating within and in accordance with the triple aim duty; and a lead role in relating to the centre.

Option 1 – a statutory ICS Board/ Joint Committee with an Accountable Officer

3.11. This option is closer to our original proposal. It would establish a mandatory, rather than voluntary, statutory ICS Board through the mechanism of a joint committee and enable NHS commissioners, providers and local authorities to take decisions collectively.

3.12. Unlike previously proposed versions of this model it would have a system Accountable Officer, chosen from the CEOs/AOs of the Board's mandatory members. This Accountable Officer would not replace individual organisation AOs/CEOs but would be recognised in legislation and would have duties in relation to delivery of the Board's functions. There would be a duty for the Board to agree and deliver a system plan and all members would have an explicit duty to comply with it.

3.13. In accordance with our stated ambition, there would be one aligned CCG only per ICS footprint under this model, and new powers would allow that CCGs are able to delegate many of its population health functions to providers.

3.14. This option retains individual organisational duties and autonomy and relies upon collective responsibility. Intervention against individual NHS organisations (not working in the best interests of the system) would continue to be enhanced through the new triple aim duty and a new duty to comply with the ICS plan.

3.15. The new Accountable Officer role would have duties to seek to agree the system plan and seek to ensure it is delivered and to some extent offer clarity of leadership. However, current accountability structures for CCG and providers would remain.

3.16. There remain potential downsides to this model. In effect, many of the questions raised through our engagement in 2019 about accountability and clarity of leadership would remain. While the addition of an Accountable Officer strengthens this model, there remains less obvious responsibility for patient outcomes or financial matters. Having an ICS Accountable Officer alongside a CCG Accountable Officer may in some cases confuse rather than clarify accountability. The CCG governing body and GP membership is

also retained, and it is questionable whether these are sufficiently diverse arrangements to fulfil the different role required of CCGs in ICSs.

3.17. Furthermore, many may not consider this model to be the "end state" for ICSs and opportunities for primary legislative change are relatively rare. There are therefore strong arguments to go further when considering how the health and care system might evolve over the next ten years and more.

Option 2 – a statutory ICS body

3.18. In this option, ICSs would be established as NHS bodies partly by "re-purposing" CCGs and would – among other duties – take on the commissioning functions of CCGs. Additional functions would be conferred and existing functions modified to produce a new framework of duties and powers.

3.19. The CCG governing body and GP membership model would be replaced by a board consisting of representatives from the system partners. As a minimum it would include representatives of NHS providers, primary care and local government alongside a Chair, a Chief Executive and a Chief Financial Officer. The ICS body should be able to appoint such other members as it deems appropriate allowing for maximum flexibility for systems to shape their membership to suit the needs of their populations. The power of individual organisational veto would be removed. The ICS Chief Executive would be a full-time Accounting Officer role, which would help strengthen lines of accountability and be a key leadership role in ensuring the system delivers.

3.20. The ICS's primary duty would be to secure the effective provision of health services to meet the needs of the system population, working in collaboration with partner organisations. It would have the flexibility to make arrangements with providers through contracts or by delegating responsibility for arranging specified services to one or more providers.

3.21. This model would deliver a clearer structure for an ICS and avoids the risk of complicated workarounds to deliver our vision for ICSs. Although there would be a representative for primary care on the Board, there would no longer be a conflict of interests with the current GP-led CCG model (created by the 2012 Act) and it could be possible to allocate combined population-level primary care, community health services and specialised services population budgets to ICS.

3.22. Many commissioning functions for which NHSE is currently responsible could, for the most part, be transferred or delegated to the ICS body, but with the ability to form joint committees as proposed through our original recommendations, with NHSE, if and where appropriate.

3.23. Through greater provider involvement, it could also reduce some of the transactional burdens of the current contracting processes. There would be powers for the ICS to delegate responsibility for arranging some services to providers, to create much greater scope for provider collaboration to use whole-population budgets to drive care pathway transformation.

Our approach

3.24. Either model would be sufficiently permissive in legislation to allow different systems to shape how they operate and how best and most appropriately deliver patient care and outcomes support at place.

3.25. Under either model we would want local government to be an integral, key player in the ICS. Both models offer a basis for planning and shaping services across healthcare, social care, prevention and the wider determinants of health. Both would allow for the delegation of functions and money to place-based statutory committees involving NHS bodies and local government. Both would enable NHS and local government to exploit existing flexibilities to pool functions and funds.

3.26. While both models would drive increased system collaboration and achieve our vision and our aims for ICSs in the immediate term, we believe Option 2 is a model that offers greater long term clarity in terms of system leadership and accountability. It also provides a clearer statutory vehicle for deepening integration across health and local government over time. It also provides enhanced flexibility for systems to decide who and how best to deliver services by both taking on additional commissioning functions from NHS England but also deciding with system colleagues (providers and local councils) where and how best service provision should take place.

3.27. Should these proposals be developed further and proposed by Government as future legislation, we would expect a full assessment of the impact of these proposals on equalities and public and parliamentary engagement and scrutiny as is appropriate.

Questions

Q. Do you agree that giving ICSs a statutory footing from 2022, alongside other legislative proposals, provides the right foundation for the NHS over the next decade?

Q. Do you agree that option 2 offers a model that provides greater incentive for collaboration alongside clarity of accountability across systems, to Parliament and most importantly, to patients?

Q. Do you agree that, other than mandatory participation of NHS bodies and Local Authorities, membership should be sufficiently permissive to allow systems to shape their own governance arrangements to best suit their populations needs?

Q. Do you agree, subject to appropriate safeguards and where appropriate, that services currently commissioned by NHSE should be either transferred or delegated to ICS bodies?

4. Implications and next steps

4.1. The ambitious changes set out here are founded on the conviction that collaboration will be a more effective mechanism for transformation against long term population health priorities and also for driving sustainable operational performance against the immediate challenges on quality, access, finance and delivery of outcomes that make difference to people's experience of services today.

4.2. International evidence points to this being the case as across the world health systems change to pursue integration as the means of meeting health needs and improving health outcomes. We have seen this reinforced through our experiences in tackling COVID-19.

4.3. The rapid changes in digital technology adoption, mutual cooperation and capacity management, provision of joined up support to the most vulnerable that have been essential in the immediate response to the pandemic have only been possible through partners working together to implement rapid change as they focus on a shared purpose.

4.4. As we embed the ways of working set out above, partners in every system will be able to take more effective, immediate operational action on:

- managing acute healthcare performance challenges and marshalling collective resource around clear priorities, through provider collaboratives;
- tackling unwarranted variation in service quality, access and performance through transparent data with peer review and support arrangements organised by provider collaboratives;
- using data to understand capacity utilisation across provider collaboratives, equalising access (tackling inequality across the system footprint) and equalising pressures on individual organisations.

The NHS England and NHS Improvement's operating model

4.5. NHSEI will support systems to adopt improvement and learning methodologies and approaches which will enable them to improve services for patients, tackle unwarranted variation and develop cultures of continuous improvement.

4.6. This will be underpinned by a comprehensive support offer which includes:

- access to our national transformation programmes for outpatients and diagnostics;
- support to tackle unwarranted variation and increase productivity (in partnership with the Getting it Right First Time programme);
- the data they need to drive improvement, accessed through the 'model health system';
- the resources and guidance that they need to build improvement capability; and
- assistance from our emergency and electivity intensive support teams (dependent on need).

4.7. Much of this support offer will be made available to systems through regional improvement hubs, which will ensure that improvement resource supports local capacity- and capability-building. Systems will then able to flexibly and rapidly deploy the support into place partnerships and provider collaboratives.

4.8. NHSEI developed a joint operating model during 2019, with input from senior NHS leaders including those in systems and regions, as well as frontline staff and other stakeholders. This resulted in a description of the different ways NHSEI will operate in future, underpinned by a set of principles including subsidiarity, and a set of 'levers of value' that NHSEI can use at national and regional level to support systems.

4.9. NHSEI will continue to develop this operating model to support the vision set out above, and any legislative changes. This will include further evolving how we interact with systems nationally and regionally; and ensuring that its functions are arranged in a way that support and embed system working to deliver our priorities.

4.10. The new operating environment will mean:

- increased freedoms and responsibilities for ICSs, including greater responsibility for system development and performance, as well as greater autonomy regarding assurance.
- the primary interaction between NHSEI and systems will be between regions and the collective ICS leadership, with limited cause for national functions to directly intervene with individual providers within systems.
- as systems take on whole population budgets they will increasingly determine how resource is to be used to 'move the dial' on outcomes, inequalities, productivity and wider social and economic development

against their specific health challenges and population health priorities.

- NHSEI regional teams will become ‘thinner’ as we move direct commissioning responsibility out to systems (individually and collectively). They will increasingly continue to enable systems to take on greater autonomy, working with them to identify their individual development priorities and support needs.

Transition

4.11. The experience of the earliest ICSs shows that great leadership is critical to success and can come from any part of the health and care system. But, to be effective, it must be felt right across, and draw on the talents of leaders from every part of, a system.

4.12. These systems have developed a new style of behaviour, which makes the most of the leadership teams of all constituent organisations and empowers frontline leaders. System leaders have impact through a collaborative and distributive leadership style that operates across boundaries, leading for communities.

4.13. This shared approach to leadership is based on qualities such as openness and transparency, honesty and integrity, a genuine belief in common goals and an ability to build consensus.

4.14. ICSs need to be of sufficient size to carry out their ‘at scale’ activities effectively, while having sufficiently strong links into local communities at a much more local level in places and neighbourhoods.

4.15. Pragmatically we are supporting ICSs through to April 2022 at their current size and scale, but we recognise that smaller systems will need to join up functions, particularly for provider collaboration. We will support the ability for ICSs to more formally combine as they take on new roles where this is supported locally.

4.16. We will work with systems to ensure that they have arrangements in place to take on enhanced roles from April 2022. We will set out a roadmap for this transition that gives assurance over system readiness for new functions as these become statutory.

4.17. We know that under either legislative proposal we need to ensure that we support our staff during organisational change by minimising uncertainty and limiting employment changes. We are therefore seeking to provide stability of employment while enabling a rapid development of role functions and purpose for all our teams, particularly in CCGs directly impacted by legislative Option 2.

4.18. We want to take a different approach to this transition; one that is characterised by care for our people and no distraction from the 'day job': the critical challenges of recovery and tackling population health.

4.19. **Stable employment:** As CCG functions move into new bodies we will make a 'continued employment promise' for staff carrying out commissioning functions. We will preserve terms and conditions to the new organisations (even if not required by law) to help provide stability and to remove uncertainty.

4.20. **New roles and functions:** For many commissioning functions the work will move to a new organisation and will then evolve over time to focus on system priorities and ways of working. The priority will be the continuation of the good work being carried out by the current group of staff and we will promote best practice in engaging, consulting and supporting the workforce during a carefully planned transition, minimising disruption to staff.

4.21. Other functions will be more directly impacted, principally the most senior leaders in CCGs (chief officers and other governing body / board members). ICSs need to have the right talent in roles leading in systems.

4.22. Our commitment is:

- not to make significant changes to roles below the most senior leadership roles;
- to minimise impact of organisational change on current staff during both phases (in paragraphs 4.19 and 4.20 above) by focusing on continuation of existing good work through the transition and not amending terms and conditions; and
- offer opportunities for continued employment up to March 2022 for all those who wish to play a part in the future.

Next steps

4.23. We expect that every system will be ready to operate as an ICS from April 2021, in line with the timetable set out in the *NHS Long Term Plan*. To prepare for this, we expect that each system will, by this time, agree with its region the functions or activities it must prioritise (such as in service transformation or population health management) to effectively discharge its core roles in 2021/22 as set out in this paper.

4.24. All ICSs should also agree a sustainable model for resourcing these collective functions or activities in the long term across their constituent organisations.

4.25. To support all of the above, all systems should agree development plans with their NHSEI regional director that clearly set out:

- **By April 2021:** how they continue to meet the current consistent operating arrangements for ICSs and further planning requirements for the next phase of the COVID-19 response
- **By September 2021:** implementation plans for their future roles as outlined above, that will need to adapt to take into account legislative developments.

4.26. Throughout the rest of 2020, the Department of Health and Social Care and NHSEI will continue to lead conversations with different types of health and care organisations, local councils, people who use and work in services, and those who represent them, to understand their priorities for further policy and legislative change.

4.27. The legislative proposals set out in this document takes us beyond our original legislative recommendations to the government. We are therefore **keen to seek views on these proposed options from all interested individuals and organisations**. These views will help inform our future system design work and that of government should they take forward our recommendations in a future Bill.

4.28. Please contact england.legislation@nhs.net or write with any feedback to NHS England, PO Box 16738, Redditch, B97 9PT by Friday 8 January.

4.29. For more information about how health and care is changing, please visit: www.england.nhs.uk/integratedcare and sign up to our regular e-bulletin at: www.england.nhs.uk/email-bulletins/integrated-care-bulletin

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

Appendix 2 - Nottinghamshire County Council response to NHSE/I consultation paper

Comments on Purpose (Section 1)

- The Council supports the objectives and supports the ICS Board moving to a statutory body. However, it does not support the creation of two statutory bodies in the County of Nottinghamshire and would therefore expect to see one Statutory ICS Board for the County and its residents.
- The Council fully agrees with the principles of a place-based approach and strongly supports the principle of a greater focus on population health needs and health inequalities in NHS commissioning and planning. It is not clear what this means in practice and how the statutory powers of the new body will be exercised to enable place worked partnership working.
- The Council would want to see further detail about how NHSE/I nationally and regionally will devolve decision-making to the ICS and powers, or budget of the CCG and newly formed ICS would be devolved. This detail would enable the Local Authority to have a view as to how Integration of Health and Care would be developed within the new Statutory Body.
- The paper refers to 'system' when what it actually means is the NHS providers and commissioners in a particular area. This is a different set of relationships in what the Local Authority would consider the Nottinghamshire system. It would be helpful to describe this as the health system.

Comments on Putting this into Practice (Section 2)

In paragraph 2.18, the paper described the NHS identifying a place leader who would:

- *work with partners such as the local authority and voluntary sector in an inclusive, transparent and collaborative way. They will have four main roles:*
  - *to support and develop primary care networks (PCNs) which join up primary and community services across local neighbourhoods;*
  - *to simplify, modernise and join up health and care (including through technology and by joining up primary and secondary care where appropriate);*
  - *to understand and identify – using population health management techniques and other intelligence – people and families at risk of being left behind and to organise proactive support for them; and*
  - *to coordinate the local contribution to health, social and economic development to prevent future risks to ill-health within different population groups.*

- This function would sit well as a practical vehicle for the NHS to take forward the Nottinghamshire Health and Wellbeing Strategy and to translate the Joint Strategic Need Assessment (JSNA) into practical action in local areas. This is welcomed.
- The population health profiles are a key tool and the work undertaken with interoperability and the successful DAIT strategy in the ICS are key enablers here.
- A focus on commissioning for improved health outcomes and addressing health inequalities is fully supportive and a positive step. Clearly, this is a huge shift in patterns of planning and commissioning, and further detail is required to understand how this would happen in practice and how the ICS Board would shape that approach.

In paragraph 2.22, the Paper sets out the NHS's offer to local government:

We will work much more closely with local government and the voluntary sector at place, to ensure local priorities for improved health and care outcomes are met by the NHS becoming a more effective partner in the planning, design and delivery of care. This will ensure residents feel well supported, with their needs clearly understood; and with services designed and delivered in the most effective and efficient way for each place.

2.23. As ICSs are established and evolve, this will create opportunities to further strengthen partnership working between local government, the NHS, public health and social care. Where partnership working is truly embedded and matured, the ability to accelerate place-based arrangements for local decision-making and use of available resources, such as delegated functions and funding, maximises the collective impact that can be achieved for the benefit of residents and communities.

- The role of the Health and Wellbeing Board needs to be strengthened in this thinking and the governance formalised to ensure the ICS delivers to local health priorities.
- Services, whether commissioned or provided, are best placed to link at neighbourhood level to deliver personalised care and support based around families and communities. It is not clear how system working at a strategic level will enable integration at place to support more effective personalised care.
- The role of the person in planning their own care and coproduction in strategic planning is evidenced as effective. Greater emphasis on how this will be supported and developed would be welcome.
- Partnership with wider partners that have a role in health, housing or care for adults, children and families are central to system thinking and approach. This

is a large and complicated set of relationships and partners to manage. This takes time, a culture of partnership and agile ways of working. There is huge variation in the success of this work. The intention is welcome but will take clear commitment and objectives to deliver this ambition.

The paper sets out:

As part of this, each system should define: 'place' leadership arrangements. These should consistently involve:

i. every locally determined 'place' in the system operating a partnership with joined-up decision-making arrangements for defined functions;
ii. ii. the partnership involving, at a minimum, primary care provider leadership, local authorities, including Director of Public Health and providers of community and mental health services and Healthwatch; i
iii. agreed joint decision-making arrangements with local government; and
iv. representation on the ICS board.

They may flexibly define:

i. the configuration, size and boundaries of places which should reflect meaningful communities and scale for the responsibilities of the place partnership;
ii. additional membership of each place partnership that is likely to include acute providers, ambulance trusts, the voluntary sector and other partners;
iii. the precise governance and decision-making arrangements that exist within each place; and
iv. their voting arrangements on the ICS board.

- There is clearly an opportunity here to shape places as it makes sense to residents and be clear as to what activity takes place in what partnership or ICS level. For the County, the work must tackle planning at population level that incorporates Bassetlaw, and a focus on neighbourhood and PCNs that reflect local people and their lives, rather than boundaries of services
- It is not clear how this will enable a focus on population and place-shaping, and Health and Wellbeing Board will be an important component of ensuring that happens.
- The County Council would be looking for the ICS to add value in terms of supporting the shift in commissioning away from service consumption and transaction to relational commissioning for health outcomes.

Comments on Legislative Proposals (Section 3)

Q. Do you agree that giving ICSs a statutory footing from 2022, alongside other legislative proposals, provides the right foundation for the NHS over the next decade?

Yes. This is important if the NHS wants to move to a systems approach.

It is not clear how the Local Authority would relate its democratic decision-making to the body in practice. Clarity about the level of delegation with the NHS and expected accountability would be needed for the LA to determine the possibility of the relationship in driving integration and/or place based approaches.

The Local Government Association has made a response to the consultation (https://www.local.gov.uk/parliament/briefings-and-responses/lga-response-nhs-england-and-nhs-improvement-consultation) and has called on the government to introduce a number of duties and powers in support of greater integration, place based working and local accountability, and to deliver the principles identified by the LGA, the NHS Confederation, NHS Clinical Commissioners, NHS Providers, the Association of Directors of Adult Social Services (ADASS) and the Association of Directors of Public Health (ADPH) that must underpin effective integrated care. They are:

- collaborative leadership
- subsidiarity - decision-making as close to communities as possible
- building on existing, successful local arrangements
- a person-centred and co-productive approach
- a preventative, assets-based and population-health management approach
- achieving best value.

The Council supports the LGA response.

Q. Do you agree that option 2 offers a model that provides greater incentive for collaboration alongside clarity of accountability across systems, to Parliament and most importantly, to patients?

- No, not necessarily. There is still a great deal of work to address the different working styles, culture and practice that enables integration to happen in places.
- Option 2 does give greater accountability for strategic commissioning and NHS budgets/governance and is more consistent with a top down approach of the NHS, but not of collaboration.
- The consultation document is not clear on delivery and how the objectives will be realised through the two options proposed. The Local Authority has a role in both options, but without the detail of what this looks like it is difficult to assess the implications for it.
- The role and boundaries of the CCGs (there are two in Nottinghamshire) are not explicit in the paper. It is not clear if Bassetlaw CCG would become an ICS in Option 2 for example, or what the role of the CCGs are in option 1.

Q. Do you agree that, other than mandatory participation of NHS bodies and Local Authorities, membership should be sufficiently permissive to allow systems to shape their own governance arrangements to best suit their populations needs?

- Yes. The right people need to be in the room to make decisions and there is local variation due to different commissioning approaches on who the key providers and partners are. Patient groups, user led organisations, local politicians, councils and VCSE need to engage in the right parts of the ICS to make a meaningful contribution.
- Due to ICS boundaries not matching council boundaries, this needs to be locally determined rather than centrally defined.
- For example, in Nottingham and Nottinghamshire the ICP for Nottingham is a relevant planning footprint for the City Council and City partners. The ICPs in Nottinghamshire are less relevant, as are the two ICSs, as they do not match. However, the PCNs make sense on an operational planning footprint for integration around the person's life.

Q. Do you agree, subject to appropriate safeguards and where appropriate, that services currently commissioned by NHSE should be either transferred or delegated to ICS bodies?

- Yes. The underlying principles cannot be achieved without this. We welcome the lead Accountable Officer role with similar duties for system leadership with local authority statutory roles.
- The ICS has the potential to offer a place for wider partnership, especially in public health, health, housing and care.
- The Health and Wellbeing Board remains the key statutory body for integration and county-wide population health planning through the JSNA and associated work programme. The BCF is a key element of the work.
- The JSNA and Health and Wellbeing strategy should drive ICS priorities and strategic commissioning
- PCNs are a place to build neighbourhood approaches with partners to meet need and new ways of working. There is a huge opportunity in mental health. Bassetlaw ICP is a useful planning footprint as it makes sense to people and partners. Further work is needed to understand activity at place level and what value an ICP can add.

Nottinghamshire County Council

Report to the Adult Social Care and Public Health Committee
8 February 2021

Agenda Item: 7

PUBLIC HEALTH PERFORMANCE AND QUALITY REPORT FOR CONTRACTS FUNDED WITH RING-FENCED PUBLIC HEALTH GRANT, 1 JULY 2020 TO 30 SEPTEMBER 2020

Purpose of the Report

1. To enable Members to scrutinise the performance and quality of services commissioned by Public Health (PH)

Information

2. This report provides the Committee with an overview of performance for Public Health directly commissioned services funded either in whole or in part by PH grant, in July to September 2020 against key performance indicators related to Public Health priorities, outcomes and actions within:

    a). the Public Health Service Plan 2020-2021;

    b). the Health and Wellbeing Strategy for Nottinghamshire 2017-21; and

    c). the Authority's 12 Commitments as set out in the Council Plan 2017-21.

3. A summary of the key performance measures is set out on the first page of **Appendix A**.

4. Appendix A also provides a description of each of the services and examples of the return on investment achievable from commissioning public health services. Furthermore, it provides a breakdown of some commissioned services at District level.

5. Quarter two began just as the Prime Minister announced some easing of the strictest form of lock-down restrictions due to COVID-19. This quarter provided different challenges for our providers with the relaxation of restrictions and the restoration of service delivery to the 'new normal'.

6. Providers of public health commissioned services were contacted again as the County moved out of the emergency response phase and entered Phase two of the UK Government's COVID-19 recovery strategy. Providers were advised that public health was keen to ensure that commissioned services resumed normal provision as soon as possible for as many service users as possible. This should be done as fast and fairly as possible whilst remaining alert and abiding by the latest Government advice.

7. Providers continued to work innovatively to overcome the new challenges of the five steps to working safely (Working safely during coronavirus (COVID-19) Department for Business,

Energy & Industrial Strategy, published 11 May 2020) which included social distancing and good hygiene practices.

8. Providers were asked to submit updated action plans, COVID-19 risk assessments and operational plans for work places and were assured that subject to their continued cooperation in delivering services, as the country moved into recovery, that they would continue to be reimbursed on the basis of the charges contained in the agreements with the Authority.

9. The Public Health team continues to monitor performance. Where any issues are identified, officers work in partnership with providers and as required with wider stakeholders to find solutions to mitigate against the issues. Public health continues to review the challenges on a regular basis across the County identifying the pressure points and working collaboratively to support providers to provide the commissioned services to residents.

10. Public health officers maintained a close dialogue with providers during this quarter to ensure that the Authority continued to be assured of good performance and safe practices and that services were reinstated as soon as practicable in line with emerging guidance.

11. The good working practices born out of the need to work differently in quarter one have been maintained in this quarter and will form part of service provision moving forward so that the Authority and residents do not lose these positive changes.

NHS Health Checks (GPs)

12. Quarter two continued to be a pressured time for GP practices as they responded to the additional challenges in responding to the COVID-19 pandemic. As the NHS Health Checks programme focuses on prevention and early detection of cardiovascular disease, activity on this preventative programme remained at a reduced level in quarter two as part of the response to the pandemic.

13. However, the payments made to most practices in quarter one, was stopped in quarter two. The payment in quarter one was intended to help support GP practice income during that period when they were advised to stop health checks.

14. Further to ongoing reviews, payment returned to actual activity delivered in quarter two as there was an expectation that GP practices would gradually restart the NHS Health Checks programme alongside other recovery activity based on emerging guidance.

15. The aim of this programme is to help prevent heart disease, diabetes, stroke, kidney disease and certain types of preventable dementia by offering a check once every five years to everyone between the ages of 40 and 74 who has not already been diagnosed with one of these conditions.

Integrated Sexual Health Services (ISHS) (Nottingham University Hospitals (NUH), Sherwood Forest Hospital Foundation Trust (SFHFT) and Doncaster and Bassetlaw Hospitals (DBH)

16. The ISHS is provided by the three NHS Trusts in Nottinghamshire. In quarter one, as part of the response to the COVID-19 outbreak, sexual health staff were redeployed to other duties

in the hospitals. However, in quarter two all three providers had staff returned to their services as pressure on the COVID and A&E wards reduced.

17. During quarter two further building modification work continued to ensure social distancing as the providers moved into full recovery.

18. Emergency and essential sexual health and contraception services including sexually transmitted infection responses (genital warts/molluscum contagiosum) and insertion and removal of long acting reversible contraception (IUD/S and Implants) continued. Pre-procedure consultations were undertaken remotely by telephone to ensure the service user (or anyone living in their household) was free of COVID-19 symptoms and that the service user was suitable for the relevant procedure. The remote consultations helped to reduce the length of time that service users were in the hospitals. Home treatments were given where possible.

19. PrEP medication taken by HIV-negative people to prevent infection continued to be supplied to service users (predominantly men who have sex with men) already on the PrEP trial. Service users were asked to take an on-line HIV test prior to attending a face to face appointment with evidence of their HIV negative result. If a service user had an HIV positive result, they were seen for HIV care and treatment.

20. Social distancing for examinations and the procedures themselves could not be maintained but requisite infection prevention control measures and PPE guidance was followed. All sexual health staff used disposable plastic aprons, disposable latex gloves, fluid resistant masks and face visors and service users were asked to wear fluid resistant masks too. Social distancing in waiting rooms and staggered appointment times helped to reduce the risk of exposure to COVID-19.

21. A video was produced by SFHFT for the 'Virtual' Pride event in July. By September alternative means to health promotion had been established and risk assessments and plans for opening some spoke clinic settings were underway.

Young People's Sexual Health Service- C Card (In-house)

22. The C-card scheme is a free and confidential advice and condom service for young people living in Nottinghamshire.

23. The service is popular with young people but with the closure of schools and youth clubs, the service was unable to provide the service as usual during quarter two.

24. However, the Authority officer continued to work with pharmacies in Nottinghamshire, providing advice about managing possible increases in demand, possible delays in receiving supplies and minimising contact by preparing bags of condoms in advance. The officer produced weekly on-line guidance and resources for youth workers to enable them to distribute condoms safely in their areas. The website was updated to inform young people how they could access condoms during the pandemic. Furthermore, training was moved on-line and both registration and refresher training sessions have been provided.

25. The officer has begun working with our sexual health providers to streamline the provision of condoms by post.

All Age Alcohol and Drug Misuse Services (Change Grow Live)

26. CGL continued to provide this critical service in line with emerging guidance. The service stayed largely remote so the vulnerable service users who had been bought mobile telephones in quarter one in order to maintain contact, continued to access video calling and recovery zoom sessions. However, outreach workers continued to work during the first lockdown to support those who were homeless and rough sleeping. A remote service continues in order to protect vulnerable adults but some socially distanced face to face work has begun including medical reviews.

27. Over capacity remains an issue with an extra 185 adult opiate service users and an extra 265 adult alcohol service users above the original need forecast in the contract value. During quarter two there was a significant number of people presenting to CGL with alcohol problems which has caused a large number of the overcapacity in the service. To add to this pressure, CGL is at 235% capacity with adult non opiate service users: 218 in structured treatment compared to a forecast capacity of 65.

28. Even under this pressure, CGL has organised regular socially distanced gatherings in its car park in Bassetlaw offering hot drinks, snacks and fellowship which have been very popular.

29. Offering postal blood-borne virus screening is an innovation born out of need due to the inability to offer face to face services. Whilst take up has been low, service users have been utilising the service and are being tested rather than not having this opportunity. CGL are returning to face to face screening but will continue to offer the postal service as an alternative treatment option.

Integrated Wellbeing Service (ABL Health)

30. Since June, ABL has continued to provide a full remote online service including smoking cessation, weight management, physical activity and alcohol reduction support.

31. Despite the challenges of mobilising a new service during the pandemic, ABL has made good progress in generating referrals from across the system and the rate of referrals has increased in quarter 2. ABL continues to work with system partners to drive quality referrals and promote the service widely to support self-referrals, but this is challenging and dependent on the priorities and capacity of services.

32. In recognition of the variation in health risk behaviours across the county, ABL is incentivised to deliver 60% of service outcomes in the 40% most disadvantaged communities and they are working well towards this aim.

33. The recovery plan in quarter two aimed to support a return to face to face service delivery safely. This has involved refining risk assessments and working with venues across Nottinghamshire to ensure that safety measures are in place. These efforts have been hampered because a large number of community buildings have not reopened following the easing of restrictions.

34. ABL is liaising with service users as to whether there is an appetite for outside fitness classes. ABL has produced a range of materials including falls prevention and other exercise videos to support people to exercise safely at home.

35. All aspects of the smoking cessation service are being provided remotely.

36. Remote working has its own challenges, but service users have reported that simply being in contact with advisors from the service has been a lifeline to some in regard to their mental wellbeing.

Illicit Tobacco Services (In-house)

37. In quarter two, officers resumed visits to make test purchases at premises about which intelligence had been received on the sale of illicit tobacco products.

38. A couple of the shops visited claimed to have sold out, but officers noted that foreign nationals were seen soon after exiting the shops with purchased illicit tobacco products. A request has been made to fund a Polish speaking police officer in order to thwart such attempts to evade justice.

39. The number of home sellers rose sharply during lockdown and there are now complaints about 30 people selling from their homes. Whilst these can be difficult to prove, the officer is continuing to pursue the leads and will swear out warrants and search the properties with the police as necessary.

40. This quarter also saw a foreign national who was involved in two cases brought by our illicit tobacco service, who had previously fled the country, arrested on his return and remanded until his trial in March next year.

Domestic Abuse Services (Notts Women's Aid, JUNO Women's Aid and Equation)

41. The Domestic Abuse service continues to be stretched in quarter two. Staff have started to return to workplaces and visiting of service users resumed where it was safe to do so.

42. Together with the higher volume of calls, the calls themselves are getting longer as the complexity of need increases. There has also been an increase in service users with English as a second language. Providers are holding survivors in their services for longer, which means that waiting lists are growing and staff are overwhelmed. The situation has not been helped by delays in the court system. Currently cases are not being heard until May 2021 at the earliest, creating additional stress for survivors.

43. A new prevention promotion and training service was started online by Equation during this second quarter to improve the domestic abuse information available for professionals and young people across the County.

44. The services are ready for face to face contact, with children and young people finding remote delivery challenging.

Healthy Families (Nottinghamshire Healthcare NHS Foundation Trust)

45. The teams have continued to work innovatively to overcome challenges in the 'new normal'. The provider has continued to deliver all elements of the service using a blended approach of face to face contacts, telephone and digital platforms to support the most vulnerable children, young people and their families as well as deliver all the universal and targeted elements of the core offer.

46. The provider management team has actively engaged their staff through Listening Events, learning from their feedback to ensure they have shared the successes of what has worked well for them and the service users and understand their challenges so they can wherever possible adapt the way they work.

47. In quarter two the provider has focused on increasing time spent in face to face contacts and where there is availability of venues, increased the number of sessions to undertake the mandated reviews.

48. During this second quarter the provider has demonstrated that using a blended approach to service delivery has seen significant improvements in areas where they have struggled to meet performance targets previously. Any dips in performance have been largely due to parents declining reviews with the service due to anxieties in relation to the pandemic and in part due to an administrative oversight which the service has now rectified.

Oral Health Promotion Services (Nottinghamshire Healthcare Trust)

49. Nottinghamshire's specialist Oral Health Promotion Team works to improve oral health within local communities and among vulnerable groups by delivering training for the health, social care and education workforce, a supervised tooth-brushing programme in targeted primary schools (with linked nurseries) and health promotion activities such as the provision of tooth-brushing packs to one-year olds.

50. The supervised tooth brushing scheme was suspended in line with Public Health England advice early in the pandemic. During quarter two, when schools were open only for the children of key workers, regular remote communication was maintained by the service, with schools being supported as required through e-bulletins with suggestions for learning activities around good oral health. The distribution of toothbrush packs to families with one-year olds remained problematic due to limited face to face contacts in the quarter.

Homelessness (Framework)

51. The service provides intensive support in short term hostel accommodation (up to 18 weeks) and less intensive support in Move On accommodation (typically for six months, and up to a maximum of 12 months) aimed at enabling the service user to achieve a range of outcomes including self-care, living skills, managing money, motivation and taking responsibility, social networks and relationships, managing tenancy and accommodation, reducing offending and meaningful use of time.

52. Framework had to revise the service provision substantially during this period with less emphasis on moving people on from hostel and move on accommodation. However, the

provider exceeded the target of 80% for those service users that were moved on in a planned way. The services commissioned by public health continued and the outcomes remain good.

Other Options Considered

53. None

Reason/s for Recommendation/s

54. To ensure performance of Public Health services is scrutinised by the Authority.

Statutory and Policy Implications

55. This report has been compiled after consideration of implications in respect of crime and disorder, data protection and information governance finance, human resources, human rights, the NHS Constitution (public health services), the public sector equality duty, safeguarding of children and adults at risk, service users, smarter working, sustainability and the environment and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Financial Implications

56. Robust performance and quality reporting ensures that financial implications are monitored and reviewed effectively to minimise financial risk to the council.

Public Sector Equality Duty implications

57. Monitoring of the contracts ensures providers of services comply with their equality duty. Equality performance is a standing agenda item of review meetings and providers are asked to provide case studies celebrating success and showing how complaints, if applicable, are resolved.

Safeguarding of Children and Adults at Risk Implications

58. Safeguarding is a standing item on contract review meeting agendas and providers are expected to report any areas of concern allowing the Authority to ensure children and adults at risk are safe.

Implications for Service Users

59. The management and quality monitoring of contracts are mechanisms by which commissioners secure assurance about the safety and quality of services using the public health grant for service users.

RECOMMENDATION

60. The Adult Social Care and Public Health Committee considers whether there are any further actions it requires arising from the information in this report.

Jonathan Gribbin
Director of Public Health

For any enquiries about this report please contact:
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Constitutional Comments (AK 07/01/2021)

61. The recommendation falls within the delegation to Adult Social Care and Public Health Committee under its terms of reference.

Finance Comments (DG 05/01/2021)

62. There are no direct financial implications arising from this report.

Background Papers and Published Documents

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

63. None

Electoral Division(s) and Member(s) Affected

64. All

Nottinghamshire County Council

Nottinghamshire County Public Health Services Performance Report

Quarter 2 2020/21

Service Name	Indicator or Quality Standard	Annual plan 2020/21	2020/21 Q1	202021 Q2	Actual YTD
NHS Health Checks	No. of eligible patients who have been offered health checks	34,000	149	3,077	3,226
	No. of patients offered who have received health checks	23,800	103	766	869
Integrated Sexual Health Services	**Total number of filled appointments**				
	Sherwood Forest Hospital NHS Trust	23,381	2,496	4,518	7,014
	Nottingham University Hospital NHS Trust	15,819	2,213	3,507	5,720
	Doncaster and Bassetlaw Hospitals NHS Trust	8,130	1,684	2,086	3,770
	Total	**47,330**	**6,393**	**10,111**	**16,504**
	Quality Standard 60 % of new service users accepting a HIV test				
	Sherwood Forest Hospital NHS Trust	>60%	12%	20%	20%
	Nottingham University Hospital NHS Trust	>60%	18%	33%	33%
	Doncaster and Bassetlaw Hospitals NHS Trust	>60%	2%	14%	14%
	Quality Standard At least 75% of 15-24 year olds in contact with the service accepting a chlamydia test				
	Sherwood Forest Hospital NHS Trust	>75%	35%	48%	48%
	Nottingham University Hospital NHS Trust	>75%	63%	65%	65%
	Doncaster and Bassetlaw Hospitals NHS Trust	>75%	66%	67%	67%
	Quality Standard 30% of women aged 16-24 receiving contraception accepting LARC				
	Sherwood Forest Hospital NHS Trust	>30%	46%	52%	52%
	Nottingham University Hospital NHS Trust	>30%	60%	60%	60%
	Doncaster and Bassetlaw Hospitals NHS Trust	>30%	40%	42%	42%
Young Peoples Sexual Health Service - C Card	Number of individuals aged 13-25 registered onto the scheme	1,400	14	45	59
	Number of individual young people aged 13-25 who return to use the scheme (at least once)	2,000	16	61	77
All Age Substance Misuse Service	Total numbers in Treatment Adult and Children	-	2,983	3,126	3,085
	Number of successful completions (YP and Adults and Parents)	-	318	292	610
	Number of unplanned exists (Adults, YP and parents)	-	164	271	435
Integrated Wellbeing Service	Smoking Cessation: Number of clients quit at 4 weeks following quit date	3,000	388	479	867
	Smoking Cessation: % of clients quit at 4 weeks following quit date	-	57%	62%	60%
	Adult Weight Management : The number of all adults (excluding pregnant women) who 'start' go onto to lose 5% weight loss compared with their initial weight	1,400	9	18	27
	Adult Weight Management: The % of all adults (excluding pregnant women) who 'start' go onto to lose 5% weight loss compared with their initial weight	-	16%	7%	12%
	Childrens Weight Management: The number of children and young people (4-15) who have maintained or reduced their BMI z score at completion of an intervention at 6 months	720	2	0	2
	Childrens Weight Management: The % of children and young people (4-15) who have maintained or reduced their BMI z score at completion of an intervention at 6 months	-	100%	0%	50%
	Alcohol: The number of people who have reduced their AUDIT C score post intervention compared to pre-intervention	3,100	75	165	240
Illicit Tobacco Services	Number of inspections	-	0	6	6
Domestic Abuse Services	Number of eligible referrals who have engaged and accepted support	-	896	538	1,434
	Children of survivors	-	520	222	742
	Number of training events delivered (specialists courses, seminars, briefings, conferences)	-	0	15	15
Healthy Families	Percentage of New Birth Visits (NBVs) completed within 14 days	91%	91%	95%	95%
	Percentage of 6-8 week reviews completed	87%	88%	92%	92%
	Percentage of 12 month development reviews completed by the time the child turned 15 months	86%	93%	89%	91%
	Percentage of 2-2½ year reviews completed using ASQ-3 (Ages and Stages Questionnaire)	90%	99%	99%	99%
Oral Health Promotion Services	Number of frontline staff (CHILD RELATED) trained to deliver oral health brief advice	200	14	63	77
	Number of frontline staff (ADULT RELATED) trained to deliver oral health brief advice	200	4	3	7
Homelessness	Hostel Accommodation Number exited in a planned way	-	21	60	81
	Hostel Accommodation % exited in a planned way	>80%	75%	87%	84%
	Move on Accommodation Number exited in a planned way	-	14	38	52
	Move on Accommodation % exited in a planned way	>80%	82%	100%	95%

Nottinghamshire County Council

Report to Adult Social Care and Public Health Committee

8 February 2021

Agenda Item: 8

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

BETTER CARE FUND DEMENTIA PROJECT – PROJECT SUPPORT POST

Purpose of the Report

1. To seek approval for the establishment of a 0.8 FTE Public Health Support Officer post, band B for 12 months, funded by Better Care Fund (BCF) Reserves. The purpose of the role will be to develop a standardised format and improve the uptake of advance care plans by people living with dementia across Nottinghamshire. The outcome of which will be to embed this process across the health and social care system.

Information

2. Dementia and compassionate end of life care are part of the Nottinghamshire Health and Wellbeing strategy. Advance care planning (ACP) allows people to record their wishes about future health, care and life choices before their mental capacity is lost. In dementia, where mental capacity loss is inevitable, ACP has the potential to facilitate a person-centred approach to care.

3. Nationally evidence shows that uptake of ACP by people living with dementia is poor and this is reflected in local data – with less than 20% uptake across the Nottinghamshire Integrated Care System, ICS, (31/07/19, GP systems data provided by Greater Notts CCG Intelligence Team).

4. ACP can help to improve quality of life and outcomes for people living with dementia. Evidence shows:

   a) With ACP people with dementia are more likely to receive optimal End of Life (EOL) Care and have better access to Specialist Palliative Care (SPC)[1]

   b) Inappropriate hospitalisation is less likely with ACP, helping to avoid the consequences of inappropriate admissions, which may include:

      i. Unplanned admissions increase mortality risk in patients with dementia compared to those without[1].

[1] Sampson EL, Leurent B, Blanchard MR, Jones L, King M. Survival of people with de-mentia after unplanned acute hospital admission: a prospective cohort study. Int J Geri-atr Psychiatry. 2013 Oct; 28(10):1015–22

ii. Around 42% of unplanned admissions to an acute hospital of people over 70 have dementia and 25% of hospital beds are occupied by people living with dementia who are over 65[2].

c) Reduction in repeated admissions can reduce the likelihood of a person with dementia crossing a 'Line of Dependency' enabling them to remain in their own home for longer and reduce their need for residential care[3].

d) Relatives can find proxy decision-making easier where there is an ACP.[4]

5. Local engagement with people living with dementia and their carers/supporters in 2019 identified that there is a lack of awareness about ACP. However, there is an acknowledgement of the need for increased communication and awareness of its benefits as a standardised approach and means to share ACP across the system involved in the care of people living with dementia.

6. In January 2020 BCF reserves funding of £45,000 for 12 months was awarded to Public Health to support the Nottinghamshire County Dementia Declaration Action Plan and the work of the Nottingham and Nottinghamshire (ICS) Dementia Steering Group (NNDSG). This is to support a project to:

   a) Develop multi-agency standardised Advance Care Plan (ACP) – documentation that can be used in paper and, when systems allow, digital formats to meet the needs of all users.

   b) Specify the functionality required from digital information systems for ACP. This will require user involvement to co-produce material and linking with the Connected Nottinghamshire Programme to explore potential digital options. This would ideally enable ACP to incorporate into current systems' developments for use across all partners involved in the care of people living with dementia.

   c) Promote and raise awareness of the importance of ACP in people with dementia and those involved in their care, to help to increase uptake of ACP at an early stage post-diagnosis.

   d) Map the dementia pathway as experienced by people living with dementia and benchmark current experience against best practice to identify opportunities for better integrated care and to make recommendations to CCG commissioners.

   e) Review the role of dementia support worker/s to make recommendations to system partners.

7. The majority of the funding will be used to recruit a 0.8 FTE Band B Public Health Support Officer to provide additional capacity to co-ordinate the delivery of the project. The actual time frames will be confirmed once the project support officer is in place.

8. It is anticipated that the post will sit within the Public Health establishment, specifically the Public Mental Health and Wellbeing Team and be line managed by the Public Health and Commissioning Manager lead for dementia.

9. The recruitment and project has been paused during the pandemic to enable Public Health resources to focus on the response to the Coronavirus Pandemic agendas. Assuming a

[2] Alzheimer's uk, Dementia Statistics Hub
[3] Dementia timeline (Dr Aamer Ali, NUH, May 2019)
[4] My future wishes: Advance Care Planning (ACP) for people with dementia in all settings, NHSE

reduction in the ongoing impact of the pandemic, it is anticipated that the recruitment to the post will now start in April 2021.

Other Options Considered

10. The option to not recruit to this Public Health post would mean a continued lack of capacity to take forward the BCF funded project.

Reason/s for Recommendation/s

11. The recommendations relating to the establishment of the Public Health post are made to enable the County Council to support the delivery of the objectives of the Nottinghamshire County Dementia Declaration Action Plan and the Nottingham and Nottinghamshire (ICS) Dementia Steering Group (NNDSG) to improve the quality of life and outcomes for people living with dementia in Nottinghamshire.

Statutory and Policy Implications

12. This report has been compiled after consideration of implications in respect of crime and disorder, data protection and information governance, finance, human resources, human rights, the NHS Constitution (public health services), the public-sector equality duty, safeguarding of children and adults at risk, service users, smarter working, sustainability and the environment and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Financial Implications

13. The table below shows the proposed breakdown of the BCF reserves funding which is primarily to fund the project support post.

	FTE Salary with on costs	**0.8 FTE**	**Remaining from 45K**
Top of Hay band B	£47,679	£38,143	£6,857

14. The remaining c£6,850 will enable engagement and co-production work to take place across the ICS footprint and if required some graphic design input in the development and promotion of a standardised Advance Care Plan. Engagement and and promotion will be adapted to incorporate virtual methods where necessary.

Human Resources Implications

15. The human resource implications are outlined in paragraphs 7, 8, 9, 10, 11, 13 and 14. The proposal to establish and recruit to the post has been shared, for information purposes, with the relevant recognised trade unions.

RECOMMENDATION/S

That Committee:

1) gives approval for the establishment of the following temporary Public Health post:

Post Title	FTE	Grade/ Band	End date	Cost per annum	Funding Source
Public Health Support Officer	0.8	B	12 months from recruitment	£38,143	BCF reserves

Jonathan Gribbin
Director of Public Health

For any enquiries about this report please contact:
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Constitutional Comments (EP 23/08/2019)

16. The recommendation falls within the remit of the Adult Social Care and Public Health Committee by virtue of its terms of reference.

Financial Comments (DG 07/01/2021)

17. The establishment of one 0.8 WTE Public Health Support Officer post, band B for 12 months (£38,143), and engagement and co-production work (£6,857) will be funded by Better Care Fund (BCF) Reserves (£45,000)

HR Comments (WI 07/01/2021)

18. Recruitment to the post will be undertaken in line with the Authority's recruitment procedures and the successful candidate will be appointed on a fixed term contract for the duration described in the report

Background Papers and Published Documents

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

Record of BCF reserves funded projects approval:

Item 8 Review of the Better Care Fund Programme and Use of BCF Reserve for Short-Term Transformation Projects
Health and Wellbeing Board meeting 24.07.2020
Minutes of HWB meeting 24.07.2020

Electoral Division(s) and Member(s) Affected
All.

Nottinghamshire County Council

Report to Adult Social Care and Public Health Committee

8 February 2021

Agenda Item: 9

REPORT OF SERVICE DIRECTOR, CUSTOMERS, GOVERNANCE AND EMPLOYEES

WORK PROGRAMME

Purpose of the Report

1. To consider the Committee's work programme.

Information

2. The County Council requires each committee to maintain a work programme. The work programme will assist the management of the committee's agenda, the scheduling of the committee's business and forward planning. The work programme will be updated and reviewed at each pre-agenda meeting and committee meeting. Any member of the committee is able to suggest items for possible inclusion.

3. The attached work programme has been drafted in consultation with the Chair and Vice-Chairs and includes items which can be anticipated at the present time. Other items will be added to the programme as they are identified. The meeting dates and agenda items are subject to review in light of the ongoing COVID-19 period.

4. As part of the transparency introduced by the revised committee arrangements in 2012, committees are expected to review day to day operational decisions made by officers using their delegated powers. It is anticipated that the committee will wish to commission periodic reports on such decisions. The committee is therefore requested to identify activities on which it would like to receive reports for inclusion in the work programme.

Other Options Considered

5. None

Reason/s for Recommendation/s

6. To assist the committee in preparing its work programme.

Statutory and Policy Implications

7. This report has been compiled after consideration of implications in respect of crime and disorder, data protection and information governance finance, human resources, human

rights, the NHS Constitution (public health services), the public sector equality duty, safeguarding of children and adults at risk, service users, smarter working, sustainability and the environment and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

RECOMMENDATION/S

That the committee considers whether any amendments are required to the work programme.

Marjorie Toward
Service Director, Customers, Governance & Employees

For any enquiries about this report please contact: Jo Toomey – jo.toomey@nottscc.gov.uk.

Constitutional Comments (HD)

8. The Committee has authority to consider the matters set out in this report by virtue of its terms of reference.

Financial Comments (NS)

9. There are no direct financial implications arising from the contents of this report. Any future reports to Committee on operational activities and officer working groups, will contain relevant financial information and comments.

Background Papers and Published Documents

- None

Electoral Division(s) and Member(s) Affected

- All

ADULT SOCIAL CARE AND PUBLIC HEALTH COMMITTEE – WORK PROGRAMME 2020-21

Report Title	Brief Summary of Agenda Item	Lead Officer	Report Author
29 March 2021			
Market management position statement	Report on current market position, contract suspensions and auditing activity, and future priorities for supporting the care market.	Corporate Director, Adult Social Care and Health	Gemma Shelton
Performance and financial position update	To update the Committee on the department's current financial situation and current performance across services.	Corporate Director, Adult Social Care and Health	Louise Hemment/Matt Garrard/Kath Sargent
Strengths-based programme	To provide an update on the implementation of strengths-based working across ASC&H.	Corporate Director, Adult Social Care and Health	Mary Read
Older Adults Care Homes contracts and assessment beds		Corporate Director, Adult Social Care and Health	Martyn Harris
Carers Strategy		Service Director, Community Services (Living Well and Provider Services)	Dan Godley
Hospital Discharge & Rapid Response Services		Corporate Director, Adult Social Care and Health	Jane Cashmore
Suicide Prevention funding (wave 4)		Jonathan Gribbin	Lucy Jones
14 June 2021			
Public Health Services Performance and Quality Report for Funded Contracts (Quarter 3)	Regular performance report on services funded with ring fenced Public Health Grant (quarterly)	Consultant in Public Health	Nathalie Birkett
Performance and financial position update	To update the Committee on the department's current financial situation and current performance across services.	Corporate Director, Adult Social Care and Health	Louise Hemment/Matt Garrard/Kath Sargent
Review of workforce	To update the Committee on progress with	Service Director, Living Well/	Sue Batty/Ainsley

Report Title	Brief Summary of Agenda Item	Lead Officer	Report Author
restructure in Adult Social Care	the new workforce model implemented in Sept 2020.	Service Director, Ageing Well	MacDonnell
Day Opportunities Strategy	To present the proposed Strategy for approval to consult.	Service Director, Strategic Commissioning and Integration	Mercy-Lett Charnock
Developing Short Breaks services and support for carers in Nottinghamshire		Service Director, Community Services (Living Well and Provider Services)	Dan Godley
Market management position statement	Report on current market position, contract suspensions and auditing activity, and future priorities for supporting the care market.	Corporate Director, Adult Social Care and Health	Gemma Shelton
12 July 2021			