Report of the Third Health Devolution Commission Roundtable
Integrated Workforce, Place-based and Neighbourhood Partnerships, and ICS Regulation
Held on 20th October 2022 by Zoom

CONTENTS

1. INTRODUCTION

This is a report of the third Health Devolution Commission roundtable chaired by Rt Hon Sir Norman Lamb and held on 20th October 2022. A list of attendees is given in Appendix 1. The background briefing paper for the roundtable is here along with a political and policy update. A recording of the proceedings can be found here. The roundtable included contributions and discussion with keynote speakers on three topics:

A Integrated workforce planning and development

- Jo Lenaghan, Director of Strategy, Health Education England
- Clenton Farquharson, Chair, TLAP
- Jenny Paton, Director of Strategy, Skills for Care

B Place-based and neighbourhood partnerships

- Cllr Tim Oliver, Chair, Surrey Integrated Care Partnership
- Dr Neil Modha, Co-chair North Place, Cambridgeshire and Peterborough ICS and contributor to 'Next Steps for Integrating Primary Care'

C The role of service and system regulators

- Scott Durairaj, Director of Integration, Inequalities and Improvement, Care Quality Commission
- Yvette Stanley, National Director for Regulation and Social Care, Ofsted

Political change

Soon after the roundtable there was a very significant level of change in the political landscape affecting the health and social care system including:

- A new Prime Minister, Rishi Sunak, MP
- Confirmation that the interim Chancellor, Jeremy Hunt MP (former SoS for HSC and former Chair of the HSC Select Committee), will continue in that role.
- A new ministerial team at DHSC including:
    - Steve Barclay, MP (Secretary of State)
    - Helen Whately MP (MoS),
    - Will Quince MP (MoS),
    - Maria Cauldfield MP (PUSS),
    - Neil O'Brien MP (PUSS), and
    - Lord Markham (PUSS).

Details of the specific responsibilities of each Minister have just been announced – please see https://www.gov.uk/government/organisations/department-of-health-and-social-care

2. FIFTEEN KEY CONCLUSIONS

The wide-ranging roundtable covered many themes and topics in some depth however fifteen key conclusions or messages emerged:

I. There is a big opportunity for ICSs to pursue integrated workforce planning and development for their health and social care workforce that treats social care as an equal partner to the NHS, in ways that reflect the values, diversity and strengths within the cultures of both sectors.

II. The health and social care workforce should shift from a transactional relationship to a relational relationship in which people who draw on health, social care and support are seen and treated as whole individuals.

III. The design principles that underpin the best social care – being person-centred, co-production, and support for self-directed care – should be hard-wired by ICSs into their integrated health and social care workforce recruitment and development strategies to 'make it real'.

IV. Investment in the health and social care workforce should be recognised for bringing a unique 'triple win' for each ICS - resulting in the delivery of better care services, supporting communities to be healthier and reducing demand pressures on the NHS.

V. ICSs must avoid short-term solutions to achieving their service targets (such as improving hospital discharges) that have wider unintended negative consequences for the social care workforce.

VI. Place-based partnerships must be a true partnership between the NHS, Local Government and the Third Sector (VCSE).

VII. The existing JSNAs, HWB Strategies and local health scrutiny committees provide a strong platform for establishing and monitoring priorities among place-based partnerships. The current NHS operating model appears to reflect a continuation of the top-down, silo approach that ICSs are designed to change. This needs to be replaced with a bottom-up approach that starts with the lived experience of local people.

VIII. Improving the population's heath and reducing health and wellbeing inequalities has to focus on the social determinants of health, 80% of which lie outside of clinical health care and require action by local government, the third sector and the business community as well as the NHS and wider Government policy.

IX. The development of Primary Care Networks (PCNs) as the foundation for broad-based Neighbourhood Partnerships provides the opportunity to work closely with local people and develop new ways of working with a diversity of local partners to improve health and social care services and address population health inequalities.

X. Neighbourhood anchor organisations formed from the co-location of services at the neighbourhood level gives added momentum to the provision of support to local people and communities to improve their health and wellbeing.

XI. As a result of devolving money and power down through systems, places and neighbourhoods, local people are better able to develop innovative ways of delivering better services, reducing health inequalities and improving population health in local communities.

XII. The CQC regards itself as a critical friend to ICSs that wants to ensure the voices of people are heard and properly represented and places a high priority on both reducing health inequalities among current service users and preventing future health inequalities. CQC knows what good looks like and three main themes of the its work in future will be leadership, integration, and service quality and safety.

XIII. Ofsted Inspection of council's Children's Services takes a whole system approach and is clear about what good looks in children's services. The 20% vacancy rate in children's services is a major contributory factor to the number of highly vulnerable children currently waiting for a secure care placement; and the mental health, self-harm and suicides among young people.

XIV. Ofsted and CQC are scheduled to launch a new area Special Educational Needs and Disability framework in early 2023 and it is vital that the voice of people with learning disabilities of all ages is properly heard within the NHS generally, and acute care to ensure they get the care and treatment they need.

XV. ICSs now have the health and wellbeing of children and young people within their scope and will, consequently, have a direct interest in both the quality of children's care services, the impact that schools have on children's health and wellbeing, and the enhanced role that Ofsted can play through its school inspections.

3. INTEGRATED WORKFORCE PLANNING AND DEVELOPMENT

3.1 Opportunities

Integrating service, financial and workforce planning

Integrated Care Systems provide an opportunity to integrate three fundamental planning processes – service planning, financial planning and workforce planning – that are currently undertaken as three separate processes.

Integrating health and social care workforce planning

The place-based level within ICSs provides the opportunity to undertake these processes in an integrated way across health and social care, and in ways that draw upon and support the wider labour market locally.

Workforce development as an investment for creating healthier communities

This wider approach to addressing the workforce challenges within an ICS should be seen as an **investment in people** not a **cost of people** as it brings direct benefits to local communities – improving the supply of labour to the health and care systems, and reducing demands upon that system in local communities with healthier populations.

3.2 Potential risks

Lack of honesty

If we fail to be honest about the evidence-base that shows the scale of the workforce challenge we risk not taking the action required at sufficient scale to resolve it. For example, the demographic changes of an ageing population affects both the supply of staff (as people retire) and the demand for care (as older people have higher care needs).

Short-termism

Reducing the focus on preventing ill-health in the short-term in order to cope with very high levels of demand for treatment will have medium to long term impacts on higher demands for care in future.

Competition between providers

The workforce shortages could lead to a retreat to silo thinking and behaviours with providers competing for staff within health services and between health and social care.

3.3 A person-centred and place-based workforce

Design principles

The design principles of person-centred, co-production and self-directed health and social care services should be hard-wired into workforce recruitment and development strategies. People who draw upon support and care to access services that enable them to lead the most meaningful life they can.

Relational approach

There needs to be a shift in the current and new members of the health and social care workforce (including GPs, hospital doctors, and nurses, not just Personal Assistants) from a transactional relationship to a relational relationship in which people who draw on health, social care and support are seen and treated as whole individuals.

Make it real

These principles need to be made real through:

- The use of 'I' and 'We' statements in workforce planning policies
- Having a shared language (e.g., 'people who draw on health, social care and support' rather than 'patients and service users')
- Recognising and trusting that people are experts in their own lives
- Not doing things 'to people' but 'with people'
- Recognising that individuals are the best integrators of their care
- Supporting autonomy and self-management of individuals (but not a free-for-all approach)
- Recognising and addressing inequalities in people's access to health and care services
- Engaging people individually and collectively at every level – the way a person's care is delivered, the way services are developed and run and the way the system works overall

3.4 The social care workforce

Equal partners

Fundamentally the social care workforce should be seen as an equal partner to the NHS workforce. They are often the source of answers to the current challenges facing the system as a whole - and not a cause of those problems. Crucially, social care services play a critical prevention role for the whole of the health and social care system in supporting people to live meaningful and productive lives.

The risks of short-term solutions

Short-term thinking often dominates thinking and action to improve hospital discharges. For example, a longer-term, system-based approach that starts from the aim of helping people to lead the lives they want to lead, and recognises the strengths of the social care sector services will often lead to more sustainable solutions.

The NHS paying care workers more to deliver short-term discharge care can have a wider negative impact on the flow of staff from social care into the NHS. There needs to be national and local solutions by the NHS and Councils working together to improve the pay and conditions of the social care workforce as a whole to prevent these unintended consequences of short-term solutions.

Data-led workforce planning

Skills for Care has data and analysis of the social care workforce to support integrated workforce planning at regional and local levels. The drivers of the workforce challenges may be the same for the NHS and social care but the levers for change to resolve them are often very different as the nature of the workforce is different, for example:

- thousands of Personal Assistants (PAs) are engaged by people who draw upon care and support that are not to be found in the NHS
- the turnover of registered nurses in social care is around 44% compared to around 11% in the NHS running the risk of 'robbing Peter to pay Paul'.

Opportunities for integrated workforce planning

Integrated workforce planning requires the building of trust, relations, and positive engagement between health and social care at every level. HEE and SfC are working together on Framework 15, and on pilot joint programmes relating to better care co-ordination, trusted assessors and discharge co-ordination. Integrated workforce planning can be brought to life through social care and its emphasis on person-centred approaches rooted in the community and sense of place.

3.5 Discussion

In discussion, a number of key points were stressed:

- Supporting the local social care workforce (proper pay and conditions) is a crucial way of improving improving the community's health and economic wellbeing. It is a triple-win – better care services, healthier communities and reduced pressures on the NHS.

- Retreating into organisational silos is often a reaction when times are tough and this must be avoided if the challenges ahead are to be tackled successfully.

- We must encourage system leaders and mangers to adopt 'best behaviours' through observing and giving feedback to people, good facilitation of cross-sector discussions, and focusing on retention to reinforce the competence in the system.

- KPIs are major drivers in the system and we should ensure that 'Human Indicators' are included as KPIs.

- It is not known how many vacant posts in the system are filled by Agency staff although the 'capacity tracker' is a useful workforce planning tool. The churn in the social care workforce and the use of Agency staff can be very disruptive and expensive for service providers to manage.

4. PLACE-BASED PARTNERSHIPS

4.1 True Partnerships

Place-based partnerships must be a true partnership between the NHS, Local Government and the Third Sector (VCSE). The ICB and the ICP are different bodies with distinct and different roles, and it is important that the right service is organised and delivered at the right level getting as close as possible to the community and local people – patients, care users and residents. There must be a focus on prevention and early intervention to ensure the system is financially sustainable and improves people's lives.

4.2 Data analysis and joint planning

The Joint Strategic Needs Assessment (JSNA) of 'place' provides the information about deprivation and health inequalities at the level of place and is the platform on which the local Health and Wellbeing Strategies are built to improve physical health, improve mental health and prevent ill-health in the population.

4.3 Social determinants of health

20% of the determinants of health can be addressed through clinical interventions by acute or community health services in the NHS. 30% are caused by people's behaviour (eating, drinking, exercise) and can be addressed by public health interventions; and 50% can be addressed by Local (and National) Government in different ways through policies and action relating to housing, green spaces, community facilities and so on. Improving the population's heath and reducing health and wellbeing inequalities has therefore to focus on those social determinants of health outside of clinical health care and involve local government, the third sector and the business community as well as the NHS and wider Government.

4.4 Organisational footprints

The local boundaries/footprints for joint working between the different partners will vary between areas and be determined by those partners. In Surrey for example they are not the borough/parish boundaries, nor the OPCN boundaries but are based on the 27 towns within Surrey that everyone knows and identifies with as the places in which they live.

4.5 Financial drivers for partnership

Money can help to drive partnership ways of working at the level of place, and the Better Care Fund provides one such source that helps people to get agreement on planning and delivering place-based, person-centred services.

4.6 Bottom-up

There is a need for greater clarity around the role of local government health scrutiny committees and the role of local Health and Wellbeing Boards. And membership of the ICBs may need to be reviewed to check it has the right skillset mix to deliver its wider remit.

The ICB needs to make arrangements of analysis and accountability of what is happening at the level of place to deliver population health improvement, but the latest NHS operating model does not mention ICPs that have this as their core task. This is a major gap and appears to reflect a continuation of the top-down, silo approach of the NHS that ICSs are designed to change. This needs to be replaced with bottom-up approach that starts with the lived experience of local people.

4.7 Innovation

Examples of local innovation include the development of a joint training academy between the NHS and Local Government to support children's services. This is helping to address the reality that the social care workforce is still not seen as equally valued members of staff that are given proper recognition for the role they play in people's lives.

5. NEIGHBOURHOOD PARTNERSHIPS

5.1 Opportunity

The development of Primary Care Networks as the foundation for broad-based neighbourhood partnerships covering populations of 30-50k provides the opportunity to work closely with local people and develop new ways of working with local partners to improve health and social care services and address population health inequalities.

The additional roles such as social prescribing and health and wellbeing coaches in these neighbourhood partnerships can be filled by local people from deprived and challenged communities and given support and training to carry out these roles.

5.2 Flexibility

Each ICS has the flexibility to design the place and neighbourhood boundaries/populations to suit their local circumstances. In one area, the two larger place-based partnerships within which the neighbourhood partnerships sit, match the catchment areas of the two main hospitals locally. These place partnerships provide a key role in supporting the neighbourhood partnerships and the engagement of local organisations and community groups in their work.

5.3 Neighbourhood Anchors

One approach being undertaken is to co-locate services at the neighbourhood level to form the basis of neighbourhood anchor organisations that support local people and communities in improving local health and wellbeing. This has led to much innovation in neighbourhoods to address the particular needs of local communities and target populations for example in different areas, the health and wellbeing of the Polish community, the Core20PLUS5 group, frequent visitors to GP practices with undiagnosed mental health needs, and the health needs of sex workers and their clients with a high-risk of ill-health.

5.4 Innovation

The local GP federation has also actively supported this approach working across the neighbourhood partnerships to pro-actively identify people at risk of disease or health conditions that can't get out of their homes and are visited by a health professional instead for blood tests, flu jabs etc. The AMBO project is another example of innovation in which people who would otherwise go to A&E and experience very long waiting time are visited to support them at home and prevent an unnecessary visit or admission.

5.5 VCSE Sector

The VCSE sector is key to successful neighbourhood partnerships through supporting the delivery of social prescriptions. However, resources need to be found to fund these organisations to deliver that prescription.

5.6 Discussion

In discussion, a number of key points were stressed:

- There are examples in Norway of new ways of working between relatives, GPs and the ambulance service to support people in their own homes and reduce the pressure on acute care and unnecessary hospital admissions.

- Cuts to services generally for people with learning disabilities are a concern and it is vital that people with a learning disability have a voice and are properly heard if they go into hospital rather than having people saying things for them. The Oliver McGowan training is a vital tool to ensure health and care staff get this right.

- The easiest way to think about the different footprints for ICS, place-based partnerships and neighbourhood partnerships (30-50k) is through population size that is then related to what local people identify with as their locality.

- Continuity of care for people is essential but primary care is now a blend of different people that can best deliver this to suit the needs of the individual.

- Neighbourhood partnerships with co-location of multiple services delivered in multiple languages by multiple organisations to suit the local community is a major step forward.

6. REGULATORS OF ICS SYSTEMS AND SERVICES

6.1 CQC

A critical friend to ICSs

The Care Quality Commission (CQC) sees itself as a critical friend of ICSs and will need to develop new ways of influencing those systems; it also works closely with NHSE as a regulatory partner in fulfilling its role as the independent inspector and regulator of the system.

Prevention

The CQC is concerned with the prevention of health inequalities in future but this can't be done in a vacuum from the prevalence of current health inequalities leading to people losing their lives today.

People's voice

CQC is developing the way it works to ensure the voices of people are heard and properly represented and this includes the NHSE System Oversight Framework and the CQC Single Assessment Framework which must be meaningful to people and make a difference to people.

Health inequalities

Reducing health inequalities is a key focus and we must not forget that 75% of the people who died 18 months ago serving people during the Covid pandemic were from Black, Asian and other ethnic groups. And that a similar disparity of deaths as evident among similar groups in the community. For people who experience health inequalities it is not a one-off experience of a bad service but can scar people for life.

What good looks like

The CQC is clear about what good looks like and examines three main themes:

- Leadership (diverse culture, compassionate, inclusive leaders, governance and assurance)
- Integration (people not falling through any gaps between community, mental health and acute services for particular groups such as people with learning disabilities)
- Service quality and safety (quality statements including local super output area level analyses).

The diversity and morale of the workforce is key in leading to a better experience of care for patients. Next step is to go live in 2023 with this new approach (assuming it is agreed with the SoS for HSC) building on the pilots underway.

6.2. Ofsted

Children's services

Ofsted Inspection of Local Authority Children's Services (ILACS) takes a whole system approach and has been in place since January 2018, and includes:

- Self-evaluations and annual engagement meetings
- Short (good and outstanding) and standard (RI and re-inspection of inadequate) judgement inspection 3 yearly
- In between inspections – focused visits – usually 2 HMI for 2 days looking at part of the service or a cohort of children – no grading on the 4-point scale

Ofsted also evaluate the effectiveness of leaders in leading and contributing to multi-agency working that leads to effective social work practice.

What good looks like

The ingredients for 'good' are described by Ofsted as:

- A visible, stable, ambitious, child centred leadership team for children's services driven by the continuous improvement of practice for the benefit of children and families
- Values-based practice models systemic, child-centred, relationship-based, strengths based etc implemented well including regular frequent supervision and practice development
- A direct line of sight to and a shared understanding of the risk the frontline is managing and the impact that will have on volumes of activity at all levels of risk and need
- Coherent structures and manageable caseloads which enable impactful relationship-based direct work and oversight which supports the frontline make good and timely decisions for children and families
- Good back-office support for frontline practice from CPD, HR, IT, policy and performance, facilities management amongst others
- Strong mutually challenging local safeguarding partnerships who understand each other's thresholds, who learn and quality assure practice, working together well strategically and operationally and ambitious corporate parenting boards

Joint targeted area inspections (JTAIs)

Ofsted are also partners in joint targeted area inspections. Two types of JTAI are carried out by Ofsted, CQC and HMICFRS:

- A JTAI of the multi-agency response to identification of initial need and risk (the 'front door')
- A JTAI of the experience of cohorts of children. For example, those at risk of exploitation or domestic abuse ('thematic' JTAIs)

All JTAIs focus on the multi-agency response in the local area and all provide line-of-sight to the effectiveness of MASAs and the local safeguarding partnership

Special Educational Needs and Disabilities (SEND)

- Ofsted and CQC are scheduled to launch a new area SEND framework in early 2023.
- The new inspection framework will be a continuous cycle of inspections and focus on the impact of local area partnerships and their commissioning arrangements for children and young people with SEND.
- Changes to the framework include:
    - Introducing a continuous cycle of inspections to encourage better long-term strategic planning by the local area
    - Moving to a system including full inspections, monitoring inspections and engagement conversations
    - Evaluating against a clearly defined concept of an effective SEND system
    - Three distinct outcomes and inspection reports that set out recommendations and where responsibility for improvement lies
    - Evaluating local authorities use and commissioning of alternative provision (AP)
    - The inclusion of social care in the inspection team to better evaluate multi-agency working

Priorities

It is a major concern that at the current time there are 60-90 highly vulnerable children waiting for a secure placement for their care.

Workforce

There is currently a 20% vacancy rate in the childcare workforce, and workforce planning needs to cover all client age-groups not just the adult care workforce.

There is often a lack of NHS presence in many children's care services, and we see significant pressures on health visitors staffing, and NHS CAMHS services that have huge impact on the health and wellbeing of children.

Schools

The main drivers in schools are the curriculum and learning outcomes but Ofsted do inspect some health elements in areas such as the PHSE curriculum, safeguarding of children, healthy relationships in schools and healthy diets. A project in Greater Manchester is looking at how to measure wellbeing in schools.

Parents

Parents play a critical role in a child's health and education and their involvement in changes to improve the health and wellbeing of children and young people must be recognised and understood.

Joined up working

For babies and for teenagers there is a need to create joined up thinking about their health and wellbeing needs and how to meet them. There is a real need to better understand how to create a 'community of common interest' that includes schools at a place-based level to promote the health and wellbeing of children and young people.

6.3 Discussion

- Mental health and suicides among young people are a major concern. An example in West Sussex showed the importance of a wide range of agencies working together to address a 'suicide cluster' that led to park organisations cutting down low hanging tree branches as a prevention measure.

- ICSs should focus on the most complex cases of children and young people self-harming and committing suicide to learn the lessons about what needs to change and how organisations should work netter together.
- ICSs now have the health and wellbeing of children and young people within their scope and will, consequently, have a direct interest in both the quality of children's care services, the impact that schools have on children's health and wellbeing, and the role that Ofsted can plays through school inspections.

APPENDIX: ATTENDEES

HEALTH DEVOLUTION	***SPEAKERS AND COMMISSIONERS (FULL OR ADVISORY)***
Rt Hon Norman Lamb	Co-chair, HDC
Jo Lenaghan	Director of Strategy, Health Education England
Clenton Farquharson	Chair, TLAP, Former Minister of State for Care Services (& author of background briefing)
Jenny Paton	Director of Strategy, Skills for Care
Cllr Tim Oliver	Chair, Surrey Integrated Care Partnership
Dr Neil Modha	Co-chair, North Place, Cambridgeshire and Peterborough ICS
Scott Durairaj	Director of Integration, Inequalities and Improvement, Care Quality Commission
Yvette Stanley	National Director, Regulation and Social Care, Ofsted
Dr Linda Patterson	Former Medical Director of CHI and Vice President of RCP; currently Chair of the Bradford Care Trust Association & Commissioner
Nadra Ahmed	Executive Chair, National Care Association & Commissioner
Phil Hope	Former Minister of State for Care Services (& author of background briefing)
Peter Hay	Commissioner
Ciara Lawrence	Mencap (Advisory Commissioner)
Alyson Morley	LGA (Advisory Commissioner)
Rukshana Kapasi	Barnardo's (Advisory Commissioner)

OTHERS	*ORGANISATION*
Becky Rice	Barnardo's
Dan Scorer	Mencap
Hazel Buchanan	Nottingham and Nottinghamshire ICB
Rachel Skingle	DHSC
William Palmer	Nuffield
Billy Palmer	Nuffield
Rhys McKenzie	Managers in Partnership
Amanda Williams	CQC
Nigel Thompson	CQC
Camilla de Bernhardt Lane	Centre for Governance and Scrutiny
Nicola Skinner	HEE
Andy Gill	HEE
Kelly Sarsfield	RCGP
Jonathan Blay	RCGP
Matthew Smith-Lilley	British Association for Counselling and Psychotherapy (BACP)
Andrew Cato	IC24 /Social Enterprise UK
Joan Skeggs	Regional Head of Integrated Care System Development, East of England
Cheryl Davenport	East of England LGA
Paul Clarke	Skills for Care
Guy Collis	UNISON
Brynnen Ririe	Chartered Society of Physiotherapy
Leo Ewbank	NHS Providers
Sarah Harrison	PAD, Wes Streeting MP
Ann McGauran	MJ
Louis O'Halloran	DevoConnect
Steve Barwick	HDC Secretariat

The partners of the Health Devolution Commission are NHS Confederation, Local Government Association, London Councils, British Association for Counselling and Psychotherapy, Greater Manchester Health & Social Care Partnership, West Yorkshire Health and Care Partnership, Mencap and Barnardo's.