NCF Listening Exercise on Integrated Care Systems with DHSC, NHSE and Social Care Providers

On Monday 9 May 2022, NCF coordinated a listening exercise with DHSC and NHSE, and our members, on models of engagement with Integrated Care Systems. Below we've summarised the content of the presentations and discussion. We will also circulate the slide packs that were used.

Aim of the session:

To achieve agreement to coproduce a model for engagement with the Social Care Provider sector and to think about where efforts are most profitably focused. A further aim is to influence the work NHSE and DHSC are doing in relation to engagement with the sector. Members will be enabled to share their thoughts and ideas for how engagement could work going forward and how NHSE and DHSC colleagues can support with addressing current barriers.

Speakers

We invited the following speakers to share their perspectives before entering a wider conversation with providers.

- **Anton Obholzer, Deputy Director, Integrated Care System Strategy and Policy, NHSE**
- **Frances Newell, Head of Partnership Development, System Transformation Team, NHSE**
- **Philippa Baker, Deputy Director of Legislation, Programme Team DHSC**
- **Rosa Napolitano, Executive Director of Business Development and Innovation , Look Ahead**
- **Oona Goldsworthy , Chief Executive, BrunelCare**
- **Leanne Blackwood, Financial Director, Sanctuary Care**
- **Tracey Bleakley, CEO Designate, Norfolk & Waverly ICB**
- **Cedi Frederick, Chair Designate, Kent and Medway ICB**

Frances Newell and Anton Obholzer – NHSE Engagement with Providers and Policy Outline

Our NHS colleagues provided an ICS policy brief as well as sharing their learning about engagement.

Anton gave an ICS policy update detailing the journey towards the current integrated care system model. The Legislative framework for the ICSs is contained in the Health and Care Act 2022. Anton then recapped the governance structure and different tiers of the ICSs. He focused particularly on the system level Integrated Care Board (ICB) and Integrated Care Partnership (ICP). The ICB is the statutory committee made up of representatives of the NHS & all top tier LAs in the footprint. The ICP is made up of wider system partners invited by the LA and NHS ICB. The ICP develops the ICS strategy on delivering better outcomes for local population and the ICB must have regard to the ICP strategy.

Anton outlined the Place-Based Partnerships at a LA level as the place where things get done and planned operationally.

Frances Newall then talked about their team's engagement with social care providers:

1. The creation of an ICS communications campaign toolkit for health and care staff to build knowledge of ICSs and their role
2. The creation of an explainer for social care providers about the ICS landscape. This is being co-produced with the Care Provider Alliance.
3. NHSE has commissioned the King's Fund to review the opportunities and challenges for social care providers' engagement in ICSs. This will lead to options for models for social care engagement.
4. The integration index – a new national service user and carer survey looking at experience of integrated care. The team is currently exploring involvement of the sector in development via NCF and wider CPA
5. Guidance is being created on clinical and care professional leadership in ICSs – this will give the sector the opportunity to get involved in leadership development at a system level.

The slides contain more examples and pieces of work such as VCSE alliances.

Philippa Baker – DHSC Engagement with Providers and Policy Outline

Philippa gave an outline of DHSC's work on developing the strategy and policy around Integrated Care Partnerships (ICPs) and their expectations for the partnerships. DHSC has five expectations for the ICPs:

1. They will be a core part of the ICSs driving the direction and priorities
2. They will be rooted in the needs of people, communities and places
3. They will create a space to develop and oversee population health strategies to improve health outcomes and experiences
4. They will support integrated approaches and subsidiarity
5. They will be open and inclusive in strategy development and leadership, involving communities and partners to utilise local data and insights

Philippa then outlined who is responsible for deciding membership of the ICP. This will be the ICB and the top tier LAs.

The Integrated Care Strategy that the ICP creates for the system should draw upon the Joint Strategic Needs Assessments produced by the Health and Wellbeing Boards in each LA area. This all feeds into a 5-year joint forward plan, which is developed with the ICB at system level.

DHSC is currently planning to write statutory guidance to help define the expectations of the integrated care strategy and better emphasise and explain the duties and powers relating to this strategy. This is due in July 2022 and will include guidance about engagement.

DHSC also has a range of key findings regarding engagement with ICPs it will incorporate it in its approach going forward. Of those relevant to social care:

- Designate ICB leaders and LAs should be having active discussions about the role and running of their ICPS and reaching out to wider partners if they are not doing so already
- Each ICP should have published a single point of contact by the end of April 2022, so that local partners could get in touch and discuss how they might be involved. If this has not happened – email the DHSC team using the email address below

- ICPs should work with organisations representing social care providers to develop principles for their involvement in ICPs and ICBs
- DHSC will publish statutory guidance on the integrated care strategy in July 2022
- DHSC will include engagement expectations in its guidance on ICP strategies

If you have any feedback or suggestions for DHSC email: icp-policy@dhsc.gov.uk

Rosa Napolitano, Look Ahead – Case Study on Integration Work

Rosa outlined Look Ahead's proactive and successful work with local partners, particularly the NHS, to support over 6000 people per year who have learning disabilities or poor mental health, as well as working to reduce homelessness. Their experience of ICSs is based on individual contacts rather than formal governance arrangements. Trusted contacts and relationships were developed with people while the ICSs were in a shadow form. Through a series of small pilots, Look Ahead was able to build trust with and the confidence of system partners. This gave them a strong business case for their continued involvement and continued funding. In short:

- Big contribution on prevention, especially in supporting mental health agenda; trusts are less nervous with a move away from strict competition to a pilot & test approach to procurement
- BUT…. there is Long way to go to build that trust systematically – Look Ahead is hoping provider collaboratives will help

See this page on the NCF website for more information.

Oona Goldsworthy, Brunelcare – Case Study on Involvement with Place-Based Partnership

Oona, via the local care association, has a place on the place-based partnership for Bristol. She describes governance and system relationships as being at the forming, storming stage of change.

There has been a huge benefit being involved at locality level as that is where the change will happen and be operationalised while the ICB/ ICP will have to focus strategically on big budgets & Trust issues.

The place-based partnership has a Primary Care Network (GP) representative as well as representatives from the voluntary sector, ADASS and community health providers, alongside the LA. They have formed a working relationships and are currently building trust. This has allowed innovative models to be tried such as the Ageing Well programme – an opportunity to maximise the value of professionals going into people's homes and sharing information and learning between health, care and other partners. GPs, district nurses and home care workers are able to align what they do in a more joined-up way, improving the experience of care for the person. When the locality based work, works well, it begins to be noticed by the strategic system level – the ICB and ICP – and this allows change to happen. However, Oona flagged a number of things that policy makers and system leaders need to consider:

- How should social care providers be represented and accountable back to the sector at system level? The representative needs a clear mandate and must report back to the sector.
- There needs to be resource to allow for social care representation at both place and system level – all the other partners round the table are being funded to enable representation. Social care is not.
- There is no specific mechanism for the involvement of social care.

Leanne Blackwood – FD, Sanctuary Care

Leanne flagged that their experience, as a large provider, was not as positive as other contributors. As they have services across the country but no specific concentration in a particular ICS area, they are unable to find a seat at any ICS table to share their wealth of experience and knowledge. Local system leaders are prioritising those providers with a greater presence in their ICS area.

Tracey Bleakley, CEO Designate, Norfolk & Waveney ICB

Tracey gave an overview of the approach being taken in Norfolk and Waveney ICS. She stressed that she hasn't come from an NHS background (she came from Hospice UK) and understands the social care sector. She wants to see system leaders coming from the LA, social care and voluntary sector – not just the NHS. The system has been focusing on elective recovery and urgent & emergency care. An increasingly ageing population is using A&E more and so the question is, how can adult social care and NHS services work better together on both prevention and discharge. Working better with social care is instrumental.

She described the establishment of an ICS Executive Leaders meeting (EMT) – largely involving the LA voice – shortly after she became the CEO Designate to look at tactical approaches to issues in the ICS – including critical incidents in the NHS due to the pressure over the winter. She wants to see more social care involvement in this group. Social care is very fragmented in her ICS area, with lots of small providers. This is making it hard to engage social care. The issues being raised are all about the workforce crisis in social care. They have looked at workforce planning, sharing roles, skills passports, joint training and putting money into improving the hourly rate for social care.

Tracey pointed out that at some points, the number of people stuck in hospital was the same as the number of empty places in care homes, but that many care home places need workforce to operate the beds.

There is also a piece of organisational and commissioning culture work, to improve the understanding of each other. Colleagues in the voluntary and adult social care sector need security of income through contracts that are longer to have a more stable income. Place leaders must come from adult social care, from voluntary sector, and those using services. They are undertaking a lot of co-design with carers.

Cedi Frederick, Chair Designate, Kent and Medway ICB

Cedi focused on the need to build trust between the NHS and adult social care. The NHS must recognise that it is often impenetrable and must become open and willing to be held to account. However, social care must make it clear what the return on investment it wants from representation and involvement in ICSs. What do providers need and want from the new systems? Funding? Workforce planning? That question needs to be answered clearly to system leaders.

Wider Discussion Themes

The ensuing discussion and questions can be grouped into the following themes:

Models of Engagement & Representation of social care providers

The bulk of questions, comments and discussions centred on how social care providers should engage in their ICSs and how any representation should be structured.

There were quite a number of calls for formal representation for adult social care in ICSs at both place and system level, mandated by any statutory guidance written. Current interim guidance doesn't (particularly the provider collaborative guidance) really give social care much of a role beyond meeting NHS needs.

There were a number of suggestions about how representation might be achieved:

- Use the Care Association structure as a basis for representation at Place and possibly System level. In areas where there isn't a strong Care Association, attendees suggested the use of funding to strengthen them or to create an alternative representative organisation
- The need for ICBs & ICPs need an 'open door' policy for ASC providers.
- At place level, there needs to be a clear single point of accountability to approach if providers do not feel engaged – there needs to be named contacts in each area
- System leaders need to be pushed to proactively engage social care providers – currently far too many providers feel ignored or are not having any communication from their ICSs
- The need for regional and national engagement with social care – particularly for large, geographically spread providers
- Not-for-profit providers might be able to access representation through the VCSE alliances. Some providers on the call have done just this. However, there is uncertainty about whether this is the appropriate forum to talk about social care.
- Some providers suggested a model based around the VCSE alliance model for social care
- Engagement needs to be resourced – VCSEs and NHS staff are resourced to take part in the governance of ICSs, social care providers are not.
- Communication from ICBs and ICPs needs to be clear and reach the entire system
- Local Authorities are not the same as social care providers – you can't substitute one for the other
- We also need to ensure we involve those social care organisations that don't quite fit the usual mould of health and care or even VCSE – those organisations working with homeless people or addiction, housing and rehabilitation support.

Changing the Narrative

Conversation around Cedi's comments highlighted that the NHS is currently struggling to prevent people entering hospital and to get them discharged into the community again but social care plays a part in solving this. Social care needs to be more upfront about what it can do.

This discussion stressed that social care is also so much more than this – it is a service that enables people to live their best lives, in the communities they want to be, despite their circumstances. We need to shift the narrative. If we are to rise to Cedi's challenge – what can social care bring and what does it want from involvement – we need to stress the contribution social care makes to population wellbeing and health outcomes independently of the NHS. One provider felt that ICB Chairs see social care as a means to an end in achieving their priorities in clinical terms. What we really need are social care providers in all their diversity to be represented – and not just those contracted with the LA.

One provider called for a clearly articulated shared agenda for action which outlines what both the NHS and social care bring to the table.

Others stressed the need to approach this with a relational and transformational point of view rather than transactional and insisting on formal governance positions.

Coproduction & use of language

A number of questions and comments centred on how people who access social care services can be engaged with ICSs. It was pointed out that the language being used is not conductive to this – 'patient' is often used but is an inaccurate description of many people in the system.

It also became clear in the discussions that there is no clear mechanism for the representation of the voice of those accessing social care services. This is not Healthwatch's remit, and no detail, other than the ICB has a duty to consult people with lived experience, is in the Act. It is similarly unclear how unpaid carers engage.

Budgets

Finally, there were a few comments and questions about budgets in the new systems. The Integration White Paper talks about a desire to more closely align (but not pool) LA and NHS budgets around common goals – such as adult social care. A number of providers raised the question about the organisational and political barriers to this alignment. LAs have their own budgets which are set by locally elected politicians, while the NHS ICSs are having their budget set by NHSE. What can ICS leaders do to ensure that commissioning is more joined-up for adult social care?