Public Document Pack

# Sheffield Health and Wellbeing Board

**Sheffield City Council • Sheffield Clinical Commissioning Group**

## Thursday 28 October 2021 at 2.00 pm

## Town Hall, Sheffield City Council

**The Press and Public are Welcome to Attend**

**Membership**

# SHEFFIELD'S HEALTH AND WELLBEING BOARD

Sheffield City Council ● Sheffield Clinical Commissioning Group

Sheffield's Health and Wellbeing Board started to meet in shadow form in January 2012 and became a statutory group in April 2013. The Health and Social Care Act 2012 states that every local authority needs a Health and Wellbeing Board. It is a group of local GPs, local councillors, a representative of Sheffield citizens, and senior managers in the NHS and the local authority, all of whom seek to make local government and local health services better for local people. Its terms of reference sets out how it will operate.

Sheffield's Health and Wellbeing Board has a formal public meeting every three months as well as a range of public events held at least once a quarter.

Sheffield's Health and Wellbeing Board has a website which tells you more about what we do. http://www.sheffield.gov.uk/home/public-health/health-wellbeing-board

## PUBLIC ACCESS TO THE MEETING

A copy of the agenda and reports is available on the Council's website at www.sheffield.gov.uk. You can also see the reports to be discussed at the meeting if you call at the First Point Reception, Town Hall, Pinstone Street entrance. The Reception is open between 9.00 am and 5.00 pm, Monday to Thursday and between 9.00 am and 4.45 pm. on Friday. You may not be allowed to see some reports because they contain confidential information. These items are usually marked * on the agenda.

Meetings are normally open to the public but sometimes the Board may have to discuss an item in private. If this happens, you will be asked to leave. Any private items are normally left until last. If you would like to attend the meeting please report to the First Point Reception desk where you will be directed to the meeting room.

If you require any further information please contact Jason Dietsch on 0114 273 4117 or email jason.dietsch@sheffield.gov.uk

## FACILITIES

There are public toilets available, with wheelchair access, on the ground floor of the Town Hall. Induction loop facilities are available in meeting rooms.

# SHEFFIELD HEALTH AND WELLBEING BOARD AGENDA

Sheffield City Council ● Sheffield Clinical Commissioning Group

**28 OCTOBER 2021**

**Order of Business**

| | | |
|---|---|---|
| **1.** | **Apologies for Absence (5 mins)** | |
| **2.** | **Declarations of Interest (5 mins)**<br>Members to declare any interests they have in the business to be considered at the meeting. | (Pages 5 - 8) |
| **3.** | **Public Questions (10 mins)**<br>To receive any questions from members of the public. | |
| **4.** | **COVID-19 Update (20 mins)** | |
| **5.** | **ICS and Health and Wellbeing - Update and Role of the Board (30 mins)** | (Pages 9 - 64) |
| **6.** | **Better Care Fund (30 mins)** | (Pages 65 - 72) |
| **7.** | **Engagement and Health & Wellbeing (30 mins)** | (Pages 73 - 112) |
| **8.** | **Healthwatch Update (20 mins)** | |
| **9.** | **Minutes of the Previous Meeting (5 mins)** | (Pages 113 - 118) |
| **10.** | **Date and Time of Next Meeting (5 mins)**<br><br>**NOTE: The next meeting of Sheffield Health and Wellbeing Board will be held on Thursday 9 December 2021 at 2.00 pm** | |

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## ADVICE TO MEMBERS ON DECLARING INTERESTS AT MEETINGS

If you are present at a meeting of the Council, of its executive or any committee of the executive, or of any committee, sub-committee, joint committee, or joint sub-committee of the authority, and you have a **Disclosable Pecuniary Interest** (DPI) relating to any business that will be considered at the meeting, you must not:

- participate in any discussion of the business at the meeting, or if you become aware of your Disclosable Pecuniary Interest during the meeting, participate further in any discussion of the business, or
- participate in any vote or further vote taken on the matter at the meeting.

These prohibitions apply to any form of participation, including speaking as a member of the public.

You **must**:

- leave the room (in accordance with the Members' Code of Conduct)
- make a verbal declaration of the existence and nature of any DPI at any meeting at which you are present at which an item of business which affects or relates to the subject matter of that interest is under consideration, at or before the consideration of the item of business or as soon as the interest becomes apparent.
- declare it to the meeting and notify the Council's Monitoring Officer within 28 days, if the DPI is not already registered.

If you have any of the following pecuniary interests, they are your **disclosable pecuniary interests** under the new national rules. You have a pecuniary interest if you, or your spouse or civil partner, have a pecuniary interest.

- Any employment, office, trade, profession or vocation carried on for profit or gain, which you, or your spouse or civil partner undertakes.

- Any payment or provision of any other financial benefit (other than from your council or authority) made or provided within the relevant period* in respect of any expenses incurred by you in carrying out duties as a member, or towards your election expenses. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.

  *The relevant period is the 12 months ending on the day when you tell the Monitoring Officer about your disclosable pecuniary interests.

- Any contract which is made between you, or your spouse or your civil partner (or a body in which you, or your spouse or your civil partner, has a beneficial interest) and your council or authority –

  - under which goods or services are to be provided or works are to be executed; and
  - which has not been fully discharged.

- Any beneficial interest in land which you, or your spouse or your civil partner, have and which is within the area of your council or authority.

- Any licence (alone or jointly with others) which you, or your spouse or your civil partner, holds to occupy land in the area of your council or authority for a month or longer.

- Any tenancy where (to your knowledge) –
  - the landlord is your council or authority; and
  - the tenant is a body in which you, or your spouse or your civil partner, has a beneficial interest.

- Any beneficial interest which you, or your spouse or your civil partner has in securities of a body where -

  (a) that body (to your knowledge) has a place of business or land in the area of your council or authority; and

  (b) either -
    - the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body; or
    - if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which you, or your spouse or your civil partner, has a beneficial interest exceeds one hundredth of the total issued share capital of that class.

If you attend a meeting at which any item of business is to be considered and you are aware that you have a **personal interest** in the matter which does not amount to a DPI, you must make verbal declaration of the existence and nature of that interest at or before the consideration of the item of business or as soon as the interest becomes apparent. You should leave the room if your continued presence is incompatible with the 7 Principles of Public Life (selflessness; integrity; objectivity; accountability; openness; honesty; and leadership).

You have a personal interest where –

- a decision in relation to that business might reasonably be regarded as affecting the well-being or financial standing (including interests in land and easements over land) of you or a member of your family or a person or an organisation with whom you have a close association to a greater extent than it would affect the majority of the Council Tax payers, ratepayers or inhabitants of the ward or electoral area for which you have been elected or otherwise of the Authority's administrative area, or

- it relates to or is likely to affect any of the interests that are defined as DPIs but are in respect of a member of your family (other than a partner) or a person with whom you have a close association.

Guidance on declarations of interest, incorporating regulations published by the Government in relation to Disclosable Pecuniary Interests, has been circulated to you previously.

You should identify any potential interest you may have relating to business to be considered at the meeting. This will help you and anyone that you ask for advice to fully consider all the circumstances before deciding what action you should take.

In certain circumstances the Council may grant a **dispensation** to permit a Member to take part in the business of the Authority even if the member has a Disclosable Pecuniary Interest relating to that business.

To obtain a dispensation, you must write to the Monitoring Officer at least 48 hours before the meeting in question, explaining why a dispensation is sought and desirable, and specifying the period of time for which it is sought. The Monitoring Officer may consult with the Independent Person or the Council's Audit and Standards Committee in relation to a request for dispensation.

Further advice can be obtained from Gillian Duckworth, Director of Legal and Governance on 0114 2734018 or email gillian.duckworth@sheffield.gov.uk.

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# Integrated Care Systems: design framework

Version 1, June 2021

# Contents

# Introduction and summary

Everyone across the health and care system in England, in the NHS, local authorities and voluntary organisations, has made extraordinary efforts to manage the COVID-19 pandemic and deliver the vaccination programme while continuing to provide essential services.

We still face major operational challenges: tackling backlogs; meeting deferred demand, new care needs, changing public expectations; tackling longstanding health inequalities; enabling respite and recovery for those who have been at the frontline of our response; and re-adjusting to a post-pandemic financial regime. The intensity of the incident may have abated, but we are still managing exceptional pressure and uncertainty, with differential impacts across the country.

As we respond, Integrated Care Systems (ICSs) will play a critical role in aligning action between partners to achieve their shared purpose: to improve outcomes and tackle inequalities, to enhance productivity and make best use of resources and to strengthen local communities.

Throughout the pandemic our people told us time and time again that collaboration allowed faster decisions and better outcomes. Co-operation created resilience. Teamwork across organisations, sectors and professions enabled us to manage the pressures facing the NHS and our partners.

As we re-focus on the ambitions set out in the NHS Long Term Plan, it is imperative we maintain our commitment to collaborative action, along with the agility and pace in decision-making that has characterised our response to the pandemic.

We want to do everything we can to support this nationally and give you the best chance of making effective and enduring change for the people you serve.

This means seizing the opportunities presented by legislative reform to remove barriers to integrated care and create the conditions for local partnerships to thrive. And it means asking NHS leaders, working with partners in local government and beyond, to continue developing Integrated Care Systems during 2021/22, and preparing for new statutory arrangements from next year.

We know this is a significant ask. This document sets out the next steps. It builds on previous publications[1] to capture the headline ambitions for how we will expect NHS leaders and organisations to operate with their partners in ICSs from April 2022. It aims to support you as you continue to deliver against the core purpose of ICSs and put in place the practical steps to prepare for their new arrangements that we expect to be enabled by legislation in this Parliamentary session.

The ambition for ICSs is significant and the challenge for all leaders within systems is an exciting one. Successful systems will align action and maintain momentum during transition, with systems continuing to make progress in improving outcomes and supporting recovery while embedding new arrangements for strategic planning and collective accountability across partners. The collective leadership of ICSs and the organisations they include will bring teams with them on that journey and will command the confidence of NHS and other public sector leaders across their system as they deliver for their communities. The level of ambition and expectation is shared across all ICSs – and there will be consistent expectations set through the oversight framework, financial framework national standards and LTP commitment – with ICSs adjusting their arrangements to be most effective in their local context.

It is important that this next year of developing ICSs and implementing statutory changes, if approved by Parliament and once finalised, builds on progress to date and the great work that has already taken place across the country. Effective transition will see high performing systems taking their existing ways of working and creatively adapting these to the new statutory arrangements. It is an acceleration, in the current direction.

This document begins to describe future ambitions for:

- the **functions of the ICS Partnership** to align the ambitions, purpose and strategies of partners across each system[2]
- the **functions of the ICS NHS body**, including planning to meet population health needs, allocating resources, ensuring that services

[1] Integrating care: next steps to building strong and effective integrated care systems and Integration and innovation: working together to improve health and social care for all NHS Operational Planning and Contracting Guidance

[2] Guidance on the Partnership will be developed by DHSC with local government, NHS and other stakeholders. Expectations described here are based on the proposals set out in the Government's White Paper and initial discussions with local government partners.

are in place to deliver against ambitions, facilitating the transformation of services, co-ordinating and improving people and culture development, and overseeing delivery of improved outcomes for their population

- the **governance and management arrangements** that each ICS NHS body will need to establish to carry out those functions including the flexibility to operate in a way that reflects the local context through place-based partnerships and provider collaboratives
- the opportunity for **partner organisations** to work together as part of ICSs to agree and jointly deliver shared ambitions
- **key elements of good practice** that will be essential to the success of ICSs, including strong clinical and professional leadership, deep and embedded engagement with people and communities, and streamlined arrangements for maintaining accountability and oversight
- the key features of the **financial framework** that will underpin the future ambitions of systems, including the freedom and mechanisms to use resource flexibly to better meet identified needs and to manage financial resources at system level
- the roadmap to **implement new arrangements** for ICS NHS bodies by April 2022 to establish new organisations, appoint leadership teams to new statutory organisations and to ensure that people affected by change are offered a smooth transition that allows them to maintain focus on their critical role in supporting recovery from the pandemic.

**Further information or guidance, developed through engagement with systems and stakeholders, will be made available to support detailed planning. Where relevant, this will follow the presentation of proposed legislation to Parliament.**

We have heard a clear message from systems that they are looking for specificity about the consistent elements of how we will ask them to operate, alongside a high degree of flexibility to design their ways of working to best reflect local circumstances. This document aims to achieve both: to be clear and specific on the consistent requirements for systems and to define the parameters for the tailoring to local circumstances which is key to success. It goes beyond likely minimum statutory requirements and sets out the ambition from NHS England and NHS

Improvement[3] on what will be necessary for systems to be successful as they lead our recovery from the pandemic and the wider delivery of the Long Term Plan.

The Framework does not attempt to describe the full breadth of future ICS arrangements or role of all constituent partners but focuses on how we expect the NHS to contribute. For non-NHS organisations, we hope this document will provide helpful framing on how the NHS will be approaching the proposed establishment of ICS NHS bodies, and inform broader discussions on the creation of system-wide and place-based partnership arrangements.

From the outset, our ambition for ICSs has been co-developed with system leaders, people who use services and many other stakeholders. We will continue this approach as we develop guidance and implementation support, based on feedback and ongoing learning from what works best.

**The Framework is based on the objectives articulated in Integrating Care: next steps, which were reflected in the Government's White Paper.[4] But content referring to new statutory arrangements and duties, and/or which is dependent on the implementation of such arrangements and duties, is subject to legislation and its parliamentary process. Systems may make reasonable preparatory steps in advance of legislation but should not act as though the legislation is in place or inevitable.**

[3] In this document we use 'NHS England and NHS Improvement' when referring to the functions and activities of both NHS England and NHS Improvement prior to April 2022, and NHS England only from April 2022 (subject to legislation).

[4] This document uses the terminology of the White Paper (ICS Partnership and ICS NHS Body). The final legal terms to be adopted for the new statutory components of each ICS will be determined by the legislation.

## Context

In November 2020 NHS England and NHS Improvement published *Integrating care: Next steps to building strong and effective integrated care systems across England*. It described the core purpose of an ICS being to:

- **improve outcomes** in population health and healthcare
- **tackle inequalities** in outcomes, experience and access
- **enhance productivity** and value for money
- help the NHS support broader **social and economic development**.

It emphasised that the next phase of ICS development should be rooted in underlying principles of subsidiarity and collaboration. It described common features that every system is expected to have and develop, as the foundations for integrating care, with local flexibility in how best to design these to achieve consistent national standards and reduce inequalities, as:

- decisions taken closer to, and in consultation with, the communities they affect are likely to lead to better outcomes
- collaboration between partners, both within a place and at scale, is essential to address health inequalities, sustain joined-up, efficient and effective services and enhance productivity
- local flexibility, enabled by common digital capabilities and coordinated flows of data, will allow systems to identify the best way to improve the health and wellbeing of their populations.

Reflecting insight drawn from local systems, the document outlined the key components to enable ICSs to deliver their core purpose, including:

- **strong place-based partnerships** between the NHS, local councils and voluntary organisations, local residents, people who access service their carers and families, leading the detailed design and delivery of integrated services within specific localities (in many places, long-established local authority boundaries), incorporating a number of neighbourhoods
- **provider collaboratives**, bringing NHS providers together across one or more ICSs, working with clinical networks and alliances and other partners, to secure the benefits of working at scale.

In February 2021 NHS England and NHS Improvement made recommendations to Government to establish ICSs on a statutory basis, with strengthened provisions to ensure that local government could play a full part in ICS decision-making. These proposals were adopted in the Government's White Paper *Integration and Innovation: working together to improve health and social care for all*, and we expect legislation to be presented to Parliament shortly. This document is based on our expectations as to the content of that legislation, describing how new arrangements would look if the proposals were implemented, while recognising that the legislation is subject to Parliament's amendment and approval.

Subject to the passage of legislation, the statutory[5] ICS arrangements will comprise:

- an ICS Partnership, the broad alliance of organisations and representatives concerned with improving the care, health and wellbeing of the population, jointly convened by local authorities and the NHS
- an ICS NHS body, bringing the NHS together locally to improve population health and care.

This ICS Design Framework sets out in more detail how we expect NHS organisations to respond in the next phase of system development, including the anticipated establishment of statutory ICS NHS bodies from April 2022. It describes the 'core' arrangements we will expect to see in each system and those we expect local partners to determine in their local context; depending on their variation in scale, geography, population health need and maturity of system arrangements.

Its purpose is to provide some 'guide rails' for NHS organisations as they develop their plans - reflecting the best ways of serving communities and patients in their specific local context - to give them the best chance of delivering on the four core purposes, in the urgent context of COVID recovery.

[5] ICSs will comprise a much wider set of partnership arrangements supported by this statutory framework.

## The ICS Partnership

**Each ICS will have a Partnership at system level established by the NHS and local government as equal partners. The Partnership will operate as a forum[6] to bring partners – local government, NHS and others – together across the ICS area to align purpose and ambitions with plans to integrate care and improve health and wellbeing outcomes for their population.**

**The Partnership will facilitate joint action to improve health and care services and to influence the wider determinants of health and broader social and economic development. This joined-up, inclusive working is central to ensuring that ICS partners are targeting their collective action and resources at the areas which will have the greatest impact on outcomes and inequalities as we recover from the pandemic.**

We expect the ICS Partnership will have a specific responsibility to develop an 'integrated care strategy' for its whole population using best available evidence and data, covering health and social care (both children's and adult's social care), and addressing the wider determinants of health and wellbeing. This should be built bottom-up from local assessments of needs and assets identified at place level, based on Joint Strategic Needs Assessments. We expect these plans to be focused on improving health and care outcomes, reducing inequalities and addressing the consequences of the pandemic for communities. We expect each Partnership to champion inclusion and transparency and to challenge all partners to demonstrate progress in reducing inequalities and improving outcomes. It should support place- and neighbourhood-level engagement, ensuring the system is connected to the needs of every community it includes.

The Government has indicated that it does not intend to bring forward detailed or prescriptive legislation on how these Partnerships should operate. Rather the intention is to set a high-level legislative framework within which systems can develop the partnership arrangements that work best for them, based on the core principles of equal partnership across health and Local Government, subsidiarity, collaboration and flexibility.

[6] The ICS Partnership will be a committee, rather than a corporate body.

To support this process, formal guidance on ICS Partnerships will be developed jointly by the Department of Health and Social Care (DHSC), NHS England and NHS Improvement, and the Local Government Association (LGA), and consulted on ahead of implementation, including on the role and accountabilities of the chair of the Integrated Care Partnership. This document gives an overview of the type of information that we expect to be included in that guidance.

## Establishment and membership

The Partnership will be established locally and jointly by the relevant local authorities and the ICS NHS body, evolving from existing arrangements and with mutual agreement on its terms of reference, membership, ways of operating and administration. Appropriate arrangements will vary considerably, depending on the size and scale of each system.

Members must include local authorities that are responsible for social care services in the ICS area, as well as the local NHS (represented at least by the ICS NHS body). Beyond this, members may be from health and wellbeing boards, other statutory organisations, voluntary, community and social enterprise (VCSE) sector partners, social care providers and organisations with a relevant wider interest, such as employers, housing and education providers and the criminal justice system. They should draw on experience and expertise from across the wide range of partners working to improve health and care in their communities, including ensuring that the views and needs of patients, carers and the social care sector are built into their ways of working. The membership may change as the priorities of the partnership evolve.

To facilitate broad membership and stakeholder participation, Partnerships may use a range of sub-groups, networks and other methods to convene parties to agree and deliver the priorities set out in the shared strategy.

## Leadership and accountability

The ICS NHS body and local authorities will need to jointly select a Partnership chair and define their role, term of office and accountabilities.

Some systems will prefer the Partnership and ICS NHS body to have separate chairs. This may, for instance, provide greater scope for democratic representation. Others may select the appointed NHS ICS body chair as the chair for both the NHS

Board and the Partnership to help ensure co-ordination. This will be a matter for local determination.

We expect public health experts to play a significant role in these partnerships, specifically including local authority directors of public health and their teams who can support, inform and guide approaches to population health management and improvement.

Partnerships will need clear and transparent mechanisms for ensuring strategies are developed with people with lived experience of health and care services and communities, for example including patients, service users, unpaid carers and traditionally under-represented groups. These mechanisms should draw on best engagement practice; for example, by using citizens' panels and co-production approaches, including insights from place and neighbourhood engagement. Partnerships should build on the expertise, relationships and engagement forums that already exist across local areas, building priorities from the bottom up, to ensure the priorities in the strategy resonate with people across the ICS.

As a key forum for convening and influencing and engaging the public, the Partnership will need to be transparent with formal sessions held in public. Its work must be communicated to stakeholders in clear and inclusive language.

## Partnership principles

The ICS Partnership will play a key role in nurturing the culture and behaviours of a system. We invite systems to consider these 10 principles:

1. Come together under a distributed leadership model and commit to working together equally.
2. Use a collective model of decision-making that seeks to find consensus between system partners and make decisions based on unanimity as the norm, including working though difficult issues where appropriate.
3. Operate a collective model of accountability, where partners hold each other mutually accountable for their shared and individual organisational contributions to shared objectives.
4. Agree arrangements for transparency and local accountability, including meeting in public with minutes and papers available online.

5. Focus on improving outcomes for people, including improved health and wellbeing, supporting people to live more independent lives, and reduced health inequalities.
6. Champion co-production and inclusiveness throughout the ICS.
7. Support the triple aim (better health for everyone, better care for all and efficient use of NHS resources), the legal duties on statutory bodies to co-operate and the principle of subsidiarity (that decision-making should happen at the most local appropriate level).
8. Ensure place-based partnership arrangements are respected and supported, and have appropriate resource, capacity and autonomy to address community priorities, in line with the principle of subsidiarity.
9. Draw on the experience and expertise of professional, clinical, political and community leaders and promote strong clinical and professional system leadership.
10. Create a learning system, sharing evidence and insight across and beyond the ICS, crossing organisational and professional boundaries.

# The ICS NHS body

**ICS NHS bodies will be established as new organisations that bind partner organisations together in a new way with common purpose. They will lead integration within the NHS, bringing together all those involved in planning and providing NHS services to take a collaborative approach to agreeing and delivering ambitions for the health of their population. They will ensure that dynamic joint working arrangements, as demonstrated through the response to COVID-19, become the norm. They will establish shared strategic priorities within the NHS and provide seamless connections to wider partnership arrangements at a system level to tackle population health challenges and enhance services at the interface of health and social care.**

## Functions of the ICS NHS body

The ICS NHS body will be a statutory organisation responsible for specific functions that enable it to deliver against the four core purposes:

- **Developing a plan** to meet the health needs of the population within their area, having regard to the Partnership's strategy. This will include ensuring NHS services and performance are restored following the pandemic, in line with national operational planning requirements, and Long Term Plan commitments are met.
- **Allocating resources** to deliver the plan across the system, including determining what resources should be available to meet the needs of the population in each place and setting principles for how they should be allocated across services and providers (both revenue and capital). This will require striking the right balance between enabling local decision-making to meet specific needs and securing the benefits of standardisation and scale across larger footprints, especially for more specialist or acute services.
- **Establishing joint working arrangements** with partners that embed collaboration as the basis for delivery of joint priorities within the plan. The ICS NHS body may choose to commission jointly with local authorities, including the use of powers to make partnership arrangements under section 75 of the 2006 Act and supported through the integrated care strategy, across the whole system; this may happen at place where that is the relevant local authority footprint.

- **Establishing governance arrangements** to support collective accountability between partner organisations for whole-system delivery and performance, underpinned by the statutory and contractual accountabilities of individual organisations, to ensure the plan is implemented effectively within a system financial envelope set by NHS England and NHS Improvement.
- **Arranging for the provision of health services** in line with the allocated resources across the ICS through a range of activities including:

– Putting contracts and agreements in place to secure delivery of its plan by providers. These may be contracts and agreements with individual providers or lead providers within a place-based partnership or provider collaborative. They will reflect the resource allocations, priorities and specifications developed across the whole system and at place level. We expect contracts and agreements to be strategic, long-term and based on outcomes, with providers responsible for designing services and interventions to meet agreed system objectives.

– Convening and supporting providers (working both at scale and at place) to lead[7] major service transformation programmes to achieve agreed outcomes, including through joining-up health, care and wider support. In addition to ensuring that plans and contracts are designed to enable this, the ICS NHS body will facilitate partners in the health and care system to work together, combining their expertise and resources to deliver improvements, fostering and deploying research and innovations.

– Working with local authority and VCSE partners to put in place personalised care for people, including assessment and provision of continuing healthcare and funded nursing care, and agreeing personal health budgets and direct payments for care. This may be delegated to individual place partnerships and delivered through integrated teams working in neighbourhoods or across local places, further supporting the integration of planning and provision with adult social care and VCSE organisations.

- **Leading system implementation of the People Plan** by aligning partners across each ICS to develop and support the ‘one workforce’, including through closer collaboration across the health and care

[7] It is expected that the ICS NHS body will be able to delegate functions to statutory providers to enable this.

sector, and with local government, the voluntary and community sector and volunteers (See ‘People and culture’ section below).

- **Leading system-wide action on data and digital**: ICS NHS bodies will work with partners across the NHS and with local authorities to put in place smart digital and data foundations to connect health and care services and ultimately transform care to put the citizen at the centre of their care (see ‘Data and digital’ section below);
- Using joined-up data and digital capabilities to **understand local priorities, track delivery of plans, monitor and address variation and drive continuous improvemen**t in performance and outcomes.
- Working alongside councils to **invest in local community organisations and infrastructure** and, through joint working between health, social care and other partners including police, education, housing, safeguarding partnerships, employment and welfare services, **ensuring that the NHS plays a full part in social and economic development and environmental sustainability**.
- **Driving joint work on estates, procurement, supply chain and commercial strategies** to maximise value for money across the system and support these wider goals of development and sustainability
- **Planning for, responding to and leading recovery from incidents** (EPRR), to ensure NHS and partner organisations are joined up at times of greatest need, including taking on incident coordination responsibilities as delegated by NHS England and NHS Improvement.
- **Functions NHS England and NHS Improvement will be delegating** including commissioning of primary care and appropriate specialised services.

We expect that all clinical commissioning group (CCG) functions and duties will transfer to an ICS NHS body when they are established, along with all CCG assets and liabilities including their commissioning responsibilities and contracts.

Relevant statutory duties of CCGs regarding safeguarding, children in care and special educational needs and disabilities (SEND) will apply to ICS NHS bodies. We will clarify in guidance how these statutory duties will transition to ICS NHS bodies. ICSs should support joint working around responsibilities such as safeguarding through new and existing partnership arrangements; and health and

care strategies and governance should account for the needs of children and young people.

The board of the ICS NHS body will be responsible for ensuring that the body meets its statutory duties. We expect these duties will include supporting achievement of the triple aim, improving quality of services, reducing inequalities, ensuring public involvement, obtaining clinical and public health advice, promoting innovation and research, and other duties that may be defined in law.

We are reviewing our own operating model - including how our functions and activities will be carried out in future and how associated resources will be deployed -in the context of the expected creation of statutory ICS NHS bodies. We are committed to ensuring that the principle of subsidiarity is applied in considering our own functions, that resources are devolved accordingly, and that the creation of ICS NHS bodies does not lead to duplication or create additional bureaucracy within the NHS. We will co-design our new arrangements with the sector and our partners.

## People and culture

**Better care and outcomes will be achieved by people – local residents, service users, carers, professionals and leaders – working together in different ways. Successful ICSs will develop a culture that attracts people to work in and for their community and supports them to achieve their full potential.**

The NHS People Plan sets out the ambition of having 'more people, working differently, in a compassionate and inclusive culture'. Although individual employers remain the building blocks for delivering the People Plan, ICSs have an important role in leading and overseeing progress on this agenda – including strengthening collaboration among health and care partners – and have already developed their own local People Plans setting out how they will achieve this ambition in their area. These plans should be aligned with the ICS Partnership's Strategy as it is developed and be refreshed annually, taking account of national priorities.

From April 2022, ICS NHS bodies are expected to have specific responsibilities for delivering against the themes and actions set out in the NHS People Plan and the people priorities in operational planning guidance. ICS NHS bodies will play a critical role in shaping the approach to growing, developing, retaining and supporting the entire local health and care workforce. While the People Plan sets out specific objectives and responsibilities for NHS organisations, we expect ICS NHS bodies to adopt a 'one workforce' approach and develop shared principles and ambitions for people and culture with local authorities, the VCSE sector and other partners.

Those planning and delivering health and care services are employed by a range of different organisations (including the ICS NHS body in future). Each will have strategies for attracting, retaining and developing the people they need to deliver the services and functions they are responsible for. To deliver against the ICS's four core purposes and to make the local area a great place to work and live, the ICS NHS body – working with the ICS Partnership – will help bring these partners together to develop and support the 'one workforce' which contributes to providing care across the system. This includes supporting the expansion of primary care and integrated teams in the community and closer collaboration on workforce development across the health and care sector, and with local government, the third sector and volunteers.

The ICS NHS body will be expected to establish the appropriate people and workforce capability to discharge their responsibilities, including strong local leadership. In particular, the ICS NHS body will need to:

- have clear leadership and accountability for the organisation's role in delivering agreed local and national people priorities, with a named SRO with the appropriate expertise (registered people professional (CIPD accredited) or with equivalent experience)
- demonstrate how it is driving equality, diversity and inclusion. It should foster a culture of civility and respect, and develop a workforce and leadership that are representative of the population they serve.

To support local and national people priorities for the one workforce in the system, the ICS NHS body should work with organisations across the ICS to:

- Establish clear and effective governance arrangements for agreeing and delivering local strategic and operational people priorities. This will include ensuring there are clear lines of accountability and streamlined ways of working between individual organisations within the system, with other ICSs and with regional workforce teams
- Support the delivery of standardised, high-quality transactional HR services (eg payroll) across the ICS, supported by digital technology. These services should be delivered at the most effective level within the ICS footprint, based on the principle of subsidiarity, but proactively taking opportunities for collaboration and securing the benefits of delivering at scale. Local arrangements for delivering these services should be agreed by relevant employers across the system, facilitated by the NHS ICS Body, to support standardisation and remove duplication to allow for the reallocation resources to deliver on the strategic people agenda across the ICS
- Ensure action is taken to protect the health and wellbeing of people working within the ICS footprint, delivering the priorities set out in the 2021/22 planning guidance and in the People Promise, to improve the experience of working in the health and care system for all
- Establish leadership structures and processes (including leadership development, talent management and succession planning approaches) to drive the culture, behaviours and outcomes needed for

people working in the system and the local population, in line with the Leadership Compact[8]

- Undertake integrated and dynamic workforce, activity and finance planning based on population need, transformation of care models and changes in skills and ways of working – reflected in the system people plan and in the ICS Partnership's Strategy
- Plan the development – and where required, growth – of the one workforce to meet future need. This should include agreeing collaborative recruitment and retention approaches where relevant, planning local educational capacity and opportunities, and attracting local people into health and care employment and careers (including creating long-term volunteering opportunities)
- Develop new ways of working and delivering care that optimise staff skills, technology and wider innovation to meet population health needs and to create flexible and rewarding career pathways for those working in the system. This should be enabled by inclusive employment models, workforce sharing arrangements and passporting or accreditation systems
- Contribute to wider local social and economic growth and a vibrant local labour market, through collaboration with partner organisations, including the care home sector and education and skills providers.

To support ICS NHS bodies to discharge these responsibilities and deliver national and local people and workforce priorities, we will work with Health Education England to publish supplementary guidance and implementation support resources for ICSs on developing their strategic People capabilities, including a People operating model.

[8] The NHS Leadership Compact will set out the compassionate and inclusive behaviour we want all our leaders to show towards people. It will require every leader, at every level, to recognise, reflect and bring to life every day six core principles focused on: equality and diversity; continuous improvement; kindness, compassion and respect; trust; supporting people and celebrating success; and collaboration and partnership. The Compact will be published in due course.

## Governance and management arrangements

**Strong and effective governance and management arrangements are essential to enable ICSs to deliver their functions effectively. The pandemic has shown the success of partnership approaches that allow joined-up, agile and timely decision-making underpinned by common objectives. ICSs will build from this to establish robust governance and management arrangements that are flexibly designed to fit local circumstances and that bind partners together in collective endeavour.**

**This guidance provides an overview of our expectations for ICS governance and management arrangements. We will provide further resources throughout the year that share learning on the different approaches ICSs are developing.**

### The ICS NHS board

The statutory governance requirements for the NHS ICS body will be set out in legislation and NHS England and NHS Improvement will provide further guidance on the constitution of the board and process for this being agreed prior to establishment. This section provides an overview of our current expectations which will be developed, through engagement. As a new type of organisation, the governance arrangements for ICS NHS bodies will be different to those of existing commissioner and provider organisations in the NHS. They will need to reflect the different ways of working that will be required for ICS NHS bodies to effectively deliver their functions - as independent statutory NHS bodies, that bring together parties from across the NHS. The minimum requirements we set out are designed to provide a common framework for effective leadership and governance in this context.

The ICS NHS body will have a unitary board. The board will be responsible for ensuring the body plays its role in achieving the four purposes of the wider ICS and should be constituted in a way that ensures this focus on improving outcomes in population health and healthcare; tackling inequalities in outcomes, experience and access; enhancing productivity and value for money; and contributing to broader social and economic development.

All members of the ICS NHS board (referred to below as “the board”) will have shared corporate accountability for delivery of the functions and duties of the ICS

and the performance of the organisation. This includes ensuring that the interests of the public and people who use health and care services remain central to what the organisation does. The board will be the senior decision-making structure for the ICS NHS body.

The statutory minimum membership of the board of each ICS NHS body will be confirmed in legislation. To carry out its functions effectively we will expect every ICS NHS body to establish board roles above this minimum level, so in most cases they will include the following roles:

- Independent non-executives: chair plus a minimum of two other independent non-executive directors (as a minimum required to chair the audit and remuneration committees). These individuals will normally not hold positions or offices in other health and care organisations within the ICS footprint.
- Executive roles (employed by the body): chief executive (who will be the accountable officer for the funding allocated to the ICS NHS body), director of finance, director of nursing and medical director.
- Partner members: a minimum of three additional board members, including at least:
  - one member drawn from NHS trusts and foundation trusts who provide services within the ICS's area
  - one member drawn from the primary medical services (general practice) providers within the area of the ICS NHS body
  - one member drawn from the local authority, or authorities, with statutory social care responsibility whose area falls wholly or partly within the area of the ICS NHS body.

We expect all three partner members will be full members of the unitary board, bringing knowledge and a perspective from their sectors, but not acting as delegates of those sectors.

We expect the partner members from NHS trusts/foundation trusts and local authorities will often be the chief executive of their organisation or in a relevant executive-level local authority role.

The process of appointing the partner members, and the rules for qualification to be a member, will be set out in the constitution of the body.

The final composition of the board and the process of appointment of partner members will need to be consistent with any requirements set out in primary legislation and is therefore subject to Parliamentary process.

ICS NHS bodies will be able to supplement these minimum board positions as they develop their own ICS NHS body constitution, which will be subject to agreement with NHS England and NHS Improvement.

We expect all members of the board will be required to comply with the Nolan Principles of Public Life and meet the Fit & Proper Persons test, and boards must have clear governance and board level accountability for discharging the associated regulations.

Boards of ICS NHS bodies will need to be of an appropriate size to allow effective decision making to take place. Through a combination of their membership, and the ways in which members engage partners, the board and its committees should ensure they take into account the perspectives and expertise of all relevant partners. These should include all parts of the local health and care system across physical and mental health, primary care, community and acute services, patient and carer representatives, social care and public health, with directors of public health having an official role in the ICS NHS bodies and the Partnership.

It will be important that boards have strong leadership on issues that impact upon organisations and staff across the ICS, including the people agenda and digital transformation.

The ICS NHS body will be expected to promote open and transparent decision-making processes that facilitate finding consensus, drawing on agreed decision-making processes to manage areas of disagreement to ensure that the statutory duties of the ICS NHS body continue to be met. The board and its committees will have to make decisions transparently, holding meetings in public and publishing the papers.

NHS England and NHS Improvement will publish further guidance on the composition and operation of the board, including a draft model constitution. We will also provide guidance on the management of conflicting roles and interests,

ensuring partners can work together effectively and that the public can have confidence decisions are being made in their best interests as taxpayers and service users (see below for new provider selection regime).

## Committees and decision-making

All ICS NHS bodies will need to put arrangements in place to ensure they can effectively discharge their full range of duties and functions. This is likely to include arrangements for committees and groups to advise and feed into the board, and to exercise functions delegated by the board. Boards may be supported by an executive group including, for example, other professional and functional leads, to manage the day-to-day running of the organisation.

These arrangements should address the cross-cutting functional responsibilities of the body including finance and resources, people, quality, digital and data performance and oversight. They should enable full involvement of clinical and professional leaders, leaders of place-based partnerships and providers, including relevant provider collaboratives. We expect the ICS NHS body will have arrangements that bring all relevant partners together to participate in decision-making.

We expect that each board will be required to establish an audit committee and a remuneration committee. The board may establish other decision-making committees, in accordance with its scheme of delegation. The board may also establish advisory committees to advise it on discharging certain duties, such as public and patient engagement.

The legislation is expected to give ICS NHS bodies flexibility in how they establish and deploy such committees. In particular, they will have the power to:

- appoint individuals who are not board members or staff of the ICS NHS body to be members of any committee it has established
- establish joint committees with NHS Trusts/FTs to which they may delegate responsibilities (decision making) in accordance with those bodies' schemes of delegation.

As ICSs will have significant flexibility in how and where decisions and functions are undertaken, every ICS NHS body should maintain a 'functions and decision map' showing its arrangements with ICS partners to support good governance and

dialogue with internal and external stakeholders. This should include arrangements for any commissioning functions delegated or transferred by NHS England and NHS Improvement.

The boards of ICS NHS bodies, and their committees, should conduct their business in a way that builds consensus, and should seek to achieve consensus on decisions. They should foster constructive challenge, debate and the expression of different views, reflecting the scope of their remit and their constituencies. They should have agreed processes for resolving differences in the first instance, if consensus cannot be reached; for example, through referencing the principles and behaviours set out in the ICS NHS body's constitution and by assessing the decision for consistency with overarching objectives (including the triple aim) and plans already agreed. The chair may make decisions on behalf of the board where there is disagreement. Where necessary boards may draw on third party support such as peer review or mediation by NHS England and NHS Improvement.

The ICS NHS body's constitution may provide for a vote to be taken where consensus cannot be reached and to set out how the vote will be conducted (for example, the chair having the casting vote). However, voting should be considered a last resort rather than a routine mechanism for board decision-making.

## Place-based partnerships

Partnerships between organisations to collectively plan, deliver and monitor services within a locally defined 'place' have a long history. These place-based partnerships have typically been established by local agreement according to their context and this bottom-up approach has been an important enabler to meaningful collaboration. However, as part of the development of ICSs, we now expect that place-based partnerships are consistently recognised as key to the coordination and improvement of service planning and delivery, and as a forum to allow partners to collectively address wider determinants of health.

We have asked each system to define its place-based partnership arrangements, covering all parts of its geography, agreed collaboratively between the NHS, local government and other system partners working together in a particular locality or community.

There is no single way of defining place or determining a fixed set of responsibilities that a place-based partnership should hold. All systems should establish and

support place-based partnerships with configuration and catchment areas reflecting meaningful communities and geographies that local people recognise. In the smallest ICSs, the whole system may operate as a single place-based partnership. The arrangements for joint working at place should enable joined-up decision-making and delivery across the range of services meeting immediate care and support needs in those local places but should be designed flexibly to reflect what works in that area.

The ICS NHS body will want to agree with local partners the membership and form of governance that place-based partnerships adopt, building on or complementing existing local configurations and arrangements such as Health and Wellbeing Boards. At a minimum, these partnerships should involve primary care provider leadership, local authorities, including directors of public health, providers of acute, community and mental health services and representatives of people who access care and support.

The ICS NHS body will remain accountable for NHS resources deployed at place-level. Governance and leadership arrangements for place-based partnerships should support safe and effective delivery of the body's functions and responsibilities alongside wider functions of the partnership. Each ICS NHS body should clearly set out the role of place-based leaders within the governance arrangements for the body.

An NHS ICS body could establish any of the following place-based governance arrangements with local authorities and other partners, to jointly drive and oversee local integration:

- consultative forum, **informing** decisions by the ICS NHS body, local authorities and other partners
- committee of the ICS NHS body with delegated authority to take decisions about the use of ICS NHS body resources[9]
- joint committee of the ICS NHS body and one or more statutory provider(s), where the relevant statutory bodies delegate decision making on specific functions/services/populations to the joint committee in accordance with their schemes of delegation

[9] Contracts would be awarded and held, and payments made, by the ICS NHS body as the legal entity.

- individual directors of the ICS NHS body having delegated authority, which they may choose to exercise through a committee. This individual director could be a joint appointment with the local authority or with an NHS statutory provider and could also have delegated authority from those bodies
- lead provider managing resources and delivery at place-level under a contract with the ICS NHS body, having lead responsibility for delivering the agreed outcomes for the place.

Effective leadership at place level is critical to effective system working, but the specific approach is to be determined locally. The roles of place-based leaders will include convening the place-based partnership, representing the partnership in the wider structures and governance of the ICS and (potentially) taking on executive responsibility for functions delegated by the ICS NHS body CEO or relevant local authority.

## Supra-ICS arrangements

There are some functions where ICS NHS bodies will need to work together; for example, commissioning more specialised services, emergency ambulance services and other services where relatively small numbers of providers serve large populations, and when working with providers that span multiple ICSs or operate through clinical networks. In many areas, multiple providers and ICS NHS bodies will need to work together to develop a shared plan for cancer services, with existing Cancer Alliances[10] continuing to use their expertise to lead whole-system planning and delivery of cancer care on behalf of their constituent ICSs, as well as providing clinical leadership and advice on commissioning. Similarly, provider collaboratives, including those providing specialised mental health, learning disability and autism services, will span multiple ICS footprints where this is right for the clinical pathway for patients.

The governance arrangements to support this will need to be co-designed between the relevant providers, NHS ICS bodies clinical networks or alliances and, where relevant, NHS England and NHS Improvement regional teams. In smaller ICSs it will be particularly important to establish joint working arrangements at the appropriate scale for the task, joining up planning for services across a wider

[10] Service Development Funding for cancer will continue to be provided to Cancer Alliances to enable them to continue to deliver their existing functions on behalf of their constituent ICS(s).

footprint where that makes sense to establish provider collaboratives at the appropriate scale to support service transformation across wider clinical networks.

ICSs and ambulance providers, which typically provide services to a population across multiple ICSs, should agree their working relationships carefully to ensure that, where appropriate, there is a joined-up dialogue between ICSs and their relevant ambulance provider, avoiding unnecessary variation in practice or duplication of communication. Alongside this, ambulance providers should consider how they can play their role effectively as part of individual systems, provider collaboratives and place partnerships, for example supporting the implementation of an effective integrated urgent care offer.

## Quality governance

Quality is at the heart of all that we do. Each NHS organisation has individual responsibilities to ensure the delivery of high quality care. ICS NHS bodies will also have statutory duties to act with a view to securing continuous improvement in quality. We expect them to have arrangements for ensuring the fundamental standards of quality are delivered including to manage quality and safety risks and to address inequalities and variation; and to promote continual improvement in the quality of services, in a way that makes a real difference to the people using them.

ICSs are expected to build on existing quality oversight arrangements, with collaborative working across system partners, to maintain and improve the quality of care. ICS NHS bodies will need to resource quality governance arrangements appropriately, including leading System Quality Groups (previously Quality Surveillance Groups) and ensuring that clinical and care professional leads have capacity to participate in quality oversight and improvement. Operational support will also be provided through NHS England and NHS Improvement regional and national teams in line with National Quality Board's guidance, namely the refreshed *Shared Commitment to Quality* and the *Position Statement*. These key documents set out the core principles and consistent operational requirements for quality oversight that ICS NHS bodies are expected to embed during the transition period (2021/22) and beyond.

## The role of providers

Organisations providing health and care services are the frontline of each ICS. They will continue to lead the delivery and transformation of care and support, working alongside those who access their services and the wider communities they serve. As ICSs have developed, providers have increasingly embraced wider system leadership roles, working with partners to join up care pathways, embed population health management, reduce unwarranted variation and tackle heath inequalities.

The arrangements put in place by each ICS Partnership and ICS NHS body must harness the expertise, energy and ambition of the organisations directly responsible for delivering integrated care.

As constituent members of the ICS Partnership, the ICS NHS body and place-based partnerships, providers of NHS services will play a central role in establishing the priorities for change and improvement across their healthcare systems and delivering the solutions to achieving better outcomes.

We expect the contracts health service providers hold (NHS Standard, or national primary care[11] supplemented locally) to evolve to support longer term, outcomes-based agreements, with less transactional monitoring and greater dialogue on how shared objectives are achieved.

### Primary care in Integrated Care Systems

All primary care professionals have a fundamental role to play in ensuring that ICSs achieve their objectives. The success of efforts to integrate care will depend on primary care and other local leaders working together to deliver change across health and care systems.

Primary care should be represented and involved in decision-making at all levels of the ICS, including strategic decision-making forums at place and system level. It should be recognised that there is no single voice for primary care in the health and care system, and so ICSs should explore different and flexible ways for seeking primary care professional involvement in decision-making. In particular, primary care should have an important role in the development of shared plans at place and

[11] Primary care contracts will continue to be negotiated nationally

system, ensuring they represent the needs of their local populations at the neighbourhood level of the ICS, including with regards to health inequalities and inequality in access to services.

ICSs should explore approaches that enable plans to be built up from population needs at neighbourhood and place level, ensuring primary care professionals are involved throughout this process.

## The role of primary care networks

Primary care networks (PCNs), serving the patients of the constituent general practices, play a fundamental role improving health outcomes and joining up services. They have a close link to local communities, enabling them to identify priorities and address health inequalities. PCNs will develop integrated multi-disciplinary teams that include staff from community services and other NHS providers, local authorities and the voluntary, community and social enterprise (VCSE) sector to support effective care delivery. Joint working between PCNs and secondary care will be crucial to ensure effective patient care in and out of hospital.

PCNs in a place will want to consider how they could work together to drive improvement through peer support, lead on one another's behalf on place-based service transformation programmes and represent primary care in the place-based partnership. This work is in addition to their core function and will need to be resourced by the place-based partnership.

ICSs and place-based partnerships should also consider the support PCN clinical directors, as well as the wider primary care profession, may need to develop primary care and play their role in transforming community-based services. Place-based partnerships may also wish to consider how to leverage targeted operational support to their PCNs, for example with regard to data and analytics for population health management approaches, HR support or project management.

## Voluntary, community and social enterprise partners

The VCSE sector is a vital cornerstone of a progressive health and care system. ICSs should ensure their governance and decision-making arrangements support close working with the sector as a strategic partner in shaping, improving and delivering services and developing and delivering plans to tackle the wider determinants of health. VCSE partnership should be embedded as an essential part

of how the system operates at all levels. This will include involving the sector in governance structures and system workforce, population health management and service redesign work, leadership and organisational development plans.

We expect that by April 2022 Integrated Care Partnerships and the ICS NHS body will develop a formal agreement for engaging and embedding the VCSE sector in system level governance and decision-making arrangements, ideally by working through a VCSE alliance to reflect the diversity of the sector. These arrangements should build on the involvement of VCSE partners in relevant forums at place and neighbourhood level. A national development programme is in place to facilitate this in all areas.

## Independent sector providers

All providers, including independent providers to the NHS and local authorities, will need to be engaged with other relevant partners in the ICS, through existing or newly formed arrangements, to ensure care meets the needs of the population and is well co-ordinated.

## NHS trusts and foundation trusts

NHS trusts and foundation trusts will play a critical role in the transformation of services and outcomes within places and across and beyond systems.

As now, they will work alongside primary care, social care, public health and other colleagues in each of the places or localities they serve, to tailor their services to local needs and ensure they are integrated in local care pathways. They will also be more involved in collectively agreeing with partners how services and outcomes can be improved for that community, how resources should be used to achieve this and how they can best contribute to population health improvement as both service providers and as local ‘anchor institutions’. The most efficient and appropriate ways of doing this will vary for different types of providers and in different local contexts. ICS NHS bodies will need to work with providers that span multiple ICSs and cross ICS boundaries, including ambulance and community trusts, to agree arrangements that ensure they are fully engaged.

In future, we expect the ICS NHS body could ask NHS trusts and foundation trusts to take on what have been ‘commissioning’ functions for a certain population,

building on the model that NHS-led provider collaboratives for specialised mental health, learning disability and autism services have been developing.

The success of individual trusts and foundation trusts will increasingly be judged against their contribution to the objectives of the ICS, in addition to their existing duties to deliver safe and effective care. This will include delivering their agreed contribution to system financial balance, improving quality and outcomes and reducing unwarranted variation and inequalities across the system as a whole, in the context of the new 'triple aim' duty to promote better health for everyone, better care for all and efficient use of NHS resources.

## The new provider selection regime

NHS England and NHS Improvement has recommended that Parliament legislates to remove the current rules governing NHS procurement of healthcare services; and these are replaced by a new regime specifically created for the NHS.

This regime would give decision-makers greater discretion in how they decide to arrange services, with competition and tendering a tool to use where appropriate, rather than the default expectation. We want to make it straightforward for local organisations to continue with existing service provision where the arrangements are working well and there is no value in seeking an alternative provider. Where the system wants or needs to consider making changes to service provision, we want there to be a flexible, sensible, transparent and proportionate process for decision-making that allows shared responsibility to flow through it, rather than forcing the NHS into pointless tendering and competition.

The central requirement of the proposed new regime is that decisions about who provides NHS services must be made in a transparent way, in the best interests of patients, taxpayers and the population. The regime would need to be applied by NHS bodies (NHS England and NHS Improvement, ICS NHS bodies, NHS trusts and foundation trusts) and local authorities when making decisions about who provides healthcare services (the new regime will not apply to other local authority services).

The regime sets out the steps that decision-making bodies should take when seeking to justify continuing existing arrangements with an existing provider; how to select the most suitable provider when a service is new or changing substantially, but a competitive procurement is not appropriate; and how to run a competitive

procurement where this is considered appropriate. The regime sets out some key criteria decision-makers need to consider when arranging services, as well as requirements around transparency and scrutiny of decisions. Further details can be found at www.england.nhs.uk/publication/nhs-provider-selection-regime-consultation-on-proposals/

## Provider collaboratives

Provider collaboratives are partnership arrangements involving two or more trusts (foundation trusts or NHS trusts) working across multiple places to realise the benefits of mutual aid and working at scale. The response to COVID-19 has demonstrated both the need for and potential of this type of provider collaboration. During 2021/22 the dynamic management of capacity and resources, greater transparency and collective accountability seen during the pandemic must be continued and developed. Specifically, providers are expected to work together to agree and deliver plans to achieve inclusive service recovery, restoration and transformation across systems, and to ensure services are arranged in a way that is sustainable and in the best interests of the population.

From April 2022 trusts providing acute and/or mental health services are expected to be part of one or more provider collaboratives. Community trusts, ambulance trusts and non-NHS providers (eg community interest companies) should participate in provider collaboratives where this is beneficial for patients and makes sense for the providers and systems involved.[12]

The purpose of provider collaboratives is to better enable their members to work together to continuously improve quality, efficiency and outcomes, including proactively addressing unwarranted variation and inequalities in access and experience across different providers. They are expected to be important vehicles for trusts to collaboratively lead the transformation of services and the recovery from the pandemic, ensuring shared ownership of objectives and plans across all parties.

[12] Community trusts, ambulance trusts and other providers may need to maintain relationships with multiple provider collaboratives, and/or focus on relationships within place-based partnerships, in ways they should determine with partners.

Provider collaboratives will agree specific objectives with one or more ICS, to contribute to the delivery of that system's strategic priorities. The members of the collaborative will agree together how this contribution will be achieved.

Provider collaboratives will help facilitate the work of alliances and clinical networks, enabling specialty-level plans and decisions to be made and implemented in a more coordinated and systematic way in the context of whole system objectives. For example, Cancer Alliances already work with the providers in their local systems to lead a whole system approach to operational delivery and transformation, and in future Alliances will work with their relevant Provider Collaboratives.

It will be up to providers, working with partners, to decide on the specific model and best governance arrangements for their collaboratives.

ICS NHS bodies will contract with NHS trusts and foundation trusts for the delivery of services, using the NHS Standard Contract. For services delivered through collaborative arrangements, ICS NHS bodies could:

- contract with and pay providers within a collaborative individually. The providers would then agree as a provider collaborative how to use their respective resources to achieve their agreed shared objectives
- contract with and pay a lead provider acting on behalf of a provider collaborative (whole budget for in-scope services). The lead provider would agree sub-contracting and payment arrangements across the collaborative. The existing mental health provider collaboratives have been successfully based on lead provider arrangements.

The ICS NHS body and provider collaboratives should define their working relationship, including participation in committees via partner members and any supporting local arrangements, to facilitate the contribution of the provider collaborative to agreed ICS objectives.

Further guidance on provider collaboratives will be published in due course.

## Clinical and professional leadership

All ICSs should develop a model of distributed clinical and care professional leadership, and a culture which actively encourages and supports such leadership to thrive. This includes ensuring professional and clinical leaders have protected time and resource to carry out system roles, and are fully involved as key decision-makers, with a central role in setting and implementing ICS strategy.

These arrangements should support and enhance those of the organisations within the ICS footprint, which are responsible for the professional and clinical leadership of their people and services.

They should reflect the learning and experience gained from CCG clinical leadership, building out from this to reflect the rich diversity of clinical and care professions across the wider ICS partnership, including health, social care and the VCSE sectors, embedding an inclusive model of leadership at every level of the system.

Specific models for clinical and care professional leadership will be for ICSs to determine locally and we recognise that ICSs are at different stages of development in this regard. We will provide further resources describing the features of an effective model, informed by more than 2,000 clinical and care professionals and illustrating case studies from systems with more advanced approaches. These features include:

- effective structures and communication mechanisms to connect clinical and care professional leaders at each level of the system
- a culture which systematically embraces shared learning, supporting its clinical and care professional leaders to collaborate and innovate with a wide range of partners, including patients and local communities
- protected time, support and infrastructure for clinical and care professional leaders to carry out their system leadership roles
- clearly defined and visible support for clinical and care profession leaders, including support to develop the leadership skills required to work effectively across organisational and professional boundaries
- transparent approaches to identifying and recruiting leaders, which promote equity of opportunity and a professionally and demographically diverse talent pipeline which reflects that community it serves.

We will expect ICSs to use the resources to support self-assessment of their clinical and professional leadership model and implement mechanisms to measure their progress and performance. We encourage systems to consider how they could use a peer review approach to support their development in this area, buddying with other systems to undertake their assessment and develop subsequent plans.

For the NHS ICS body, the clinical roles on the Board, described in the 'Governance and management arrangements' section, are a minimum expectation, ensuring executive-level professional leadership of the organisation. Individuals in these roles are expected to ensure leaders from across clinical and care professions are involved and invested in the purpose and work of the ICS.

The ICS NHS board will be expected to sign off a model and improvement plan for clinical and care professional leadership that demonstrates how this will be achieved, and to ensure that the five guiding principles described above are reflected in its governance and leadership arrangements.

## Working with people and communities

The parties in an ICS, including those of the ICS Partnership, the NHS ICS body and place-based partnerships will be expected to agree how to listen consistently to, and collectively act on, the experience and aspirations of local people and communities. This includes supporting people to sustain and improve their health and wellbeing, as well as involving people and communities in developing plans and priorities, and continually improving services.

As part of the ICS-wide arrangements, we expect each ICS NHS body to build a range of engagement approaches into their activities at every level and to prioritise engaging with groups affected by inequalities. The solutions to reducing inequalities will often be found by engaging with communities through relational and strengths-based approaches drawing on the experience of local authority, VCSE and other partners with experience and expertise in this regard.

We expect that this will be supported by a legal duty for ICS NHS bodies to make arrangements to involve patients, unpaid carers and the public in planning and commissioning arrangements, and by the continuation of the existing NHS trust and foundation trust duties in relation to patient and public involvement, including the role of foundation trusts governors.

Working with a range of partners such as Healthwatch, the VCSE sector and experts by experience, the ICS NHS body should assess and where necessary strengthen public, patient and carers' voice at place and system levels. Places are an important component, as they typically cover the area and services with which most residents identify. We are working with ICSs, Healthwatch England and others to identify and disseminate some of the most effective place-based approaches, for example through place-level citizens' panel work.

Arrangements in a system or place should not just provide a mechanism for commentary on services but should be a source of genuine co-production and a key tool for supporting accountability and transparency of the system. Where decision-making affects communities, groups or specific services, these arrangements (including any formal consultation) should fully engage those affected, including populations, patients and carers across health and social care.

We have previously set out seven principles for how ICSs should work with people and communities. These are:

1. Use public engagement and insight to inform decision-making
2. Redesign models of care and tackle system priorities in partnership with staff, people who use care and support and unpaid carers
3. Work with Healthwatch and the voluntary, community and social enterprise sector as key transformation partners
4. Understand your community's experience and aspirations for health and care
5. Reach out to excluded groups, especially those affected by inequalities
6. Provide clear and accessible public information about vision, plans and progress to build understanding and trust
7. Use community development approaches that empower people and communities, making connections to social action.

Each ICS NHS body should use these principles as a basis for developing a system-wide strategy for engaging with people and communities, building on the existing relationships, good practice and networks across system partners.

As part of this strategy, the body should work with its partners across the ICS to develop arrangements for:

- ensuring the ICS Partnership and place-based partnerships have representation from local people and communities in priority setting and decision-making forums
- gathering intelligence about the experience and aspirations of people who use care and support, together with clear approaches to using these insights to inform decision making and quality governance.

More detailed information will be made available to systems in guidance on membership and governance of ICS NHS bodies and in the implementation support for how ICSs work with people and communities.

## Accountability and oversight

The ICS NHS body will be a statutory organisation. The members of its unitary board will have collective and corporate accountability for the performance of this organisation and will be responsible for ensuring its functions are discharged. NHS England and NHS Improvement through its regional teams, will agree the constitutions and plans of ICS NHS bodies and hold them to account for delivery through the chair and chief executive.

ICSs more broadly bring together NHS, local government and other partners, who each retain formal accountability for the statutory functions they are responsible for. Building on the relationships and ways of working they have developed to date, these partners will need to maintain a working principle of mutual accountability, where, irrespective of their formal accountability relationships, all partners consider themselves collectively accountable to the population and communities they serve, and to each other for their contribution the ICS's objectives.

Providers of NHS services will continue to be accountable:

- for quality, safety, use of resources and compliance with standards through the provider licence (or equivalent conditions in the case of NHS trusts) and CQC registration requirements
- for delivery of any services or functions commissioned from or delegated to them, including by an NHS ICS body, under the terms of an agreed contract and/or scheme of delegation.

Executives of provider organisations will remain accountable to their boards for the performance of functions for which their organisation is responsible. Where an executive of an NHS provider organisation sits on the board of an NHS ICS body, they will in their capacity as a member of that board also be accountable – collectively with other board members – for the performance of the ICS body and ensuring its functions are discharged. And when acting as an ICS body board member, they must act in the interests of the ICS body and the wider system, not those of their employing provider. NHS England and NHS Improvement will provide guidance to support ICS NHS bodies to manage conflicting roles and interests of board members.

## Approach to NHS oversight within ICSs

The oversight arrangements for 2022/23 will build on the final 2021/22 System Oversight Framework (SOF) reflecting the statutory status of ICS NHS bodies from April 2022. We expect these arrangements to confirm ICSs' formal role in oversight including:

- bringing system partners together to identify risks, issues and support needs and facilitate collective action to tackle performance challenges
- leading oversight and support of individual organisations and partnership arrangements within their system.

While ICS NHS bodies will, by default, lead local oversight and assurance, NHS England and NHS Improvement's future statutory regulatory responsibilities will be similar to its existing ones. This means that any formal regulatory action with providers will, when required, be taken by NHS England and NHS Improvement.

We will work with each ICS NHS body to ensure effective and proportionate oversight of organisations within the ICS area, with arrangements that reflect local delivery and governance arrangements and avoid duplication. In particular, where additional assurance or intervention is required, NHS England and NHS Improvement will work with the ICS partners to ensure such action is informed by the perspective of system stakeholders, and that any recovery plans agreed align with system objectives and plans.

NHS England and NHS Improvement and ICS NHS bodies may, over time, decide to take the role of provider collaboratives and place-based partnerships into account when determining how to address issues identified through system oversight. This may, for instance, include looking to these arrangements (and the partners involved) for support where poor performance is identified; or considering the effectiveness of collaborative working arrangements when considering whether systems/providers have an effective plan for improvement/recovery.

Systems will also benefit from existing local authority health overview and scrutiny committees reviewing and scrutinising their work. Scrutiny provides a mechanism for local democratic accountability through local government elected members. It enables valuable connections to be made between the experience and aspirations of residents and ICS governance, via the relationships that local councillors have with their constituents.

Accountability and transparency in ICSs will also be supported via:

- clearly agreed and articulated arrangements for how the system works with people and communities
- public meetings, published minutes, and regular and accessible updates on the ICSs' vision, plans and progress against priorities.

We are working with colleagues from the Care Quality Commission (CQC) and DHSC to agree the process and roles for reviewing and assessing systems. The aim is that this would complement the role of NHS England and NHS Improvement, avoiding duplication and overlap, and support the delivery of integrated care across system partners.

The proposed principles for NHS system oversight are:

- working with and through ICSs, wherever possible, to provide support and tackle problems
- a greater emphasis on local priorities and on system performance and quality of care outcomes alongside the contributions of individual organisations to system goals
- matching accountability for results with improvement support, as appropriate
- greater autonomy for ICSs and organisations with evidence of collective working and a track record of successful delivery of NHS priorities, including tackling inequality, health outcomes and access
- compassionate leadership behaviours that underpin all oversight interactions.

# Financial allocations and funding flows

Systems are currently funded under the COVID financial regime through a system funding envelope for each ICS, which includes system top-up and COVID fixed allocation arrangements. In due course, system funding allocations will move back towards the population-based distribution and funding quantum allocated as part of the Long Term Plan funding settlement, taking account of subsequent funding allocations and the outcome of the Spending Review.

## ICS allocations

NHS England and NHS Improvement will make financial allocations to each ICS NHS body for the performance of its functions. Decisions about spending will be devolved to ICS NHS bodies.

This will include the budgets for:

acute, community and mental health[13] services (currently CCG commissioned)

primary medical care (general practice) services (currently delegated to CCGs)

running cost allowances for the ICS NHS body.

This may also include the allocations for a range of functions currently held by NHS England and NHS Improvement, including:

- other primary care budgets
- relevant specialised commissioning services suitable for commissioning at ICS level (for example, excluding highly specialised services)
- the allocations for certain other directly commissioned services
- a significant proportion of nationally held transformation funding and service development funding
- the Financial Recovery Fund
- funding for digital and data services.

[13] Every ICS will be required to continue to meet the mental health investment standard and as such a minimum level of mental health funding remains ringfenced (ICSs are free to invest above this level).

Funding will continue to be linked to population need. Allocations will be based on longstanding principles of supporting equal opportunity of access for equal needs and contributing to the reduction of health inequalities. NHS England and NHS Improvement's approach will continue to be informed by the independent Advisory Committee on Resource Allocation (ACRA).[14] Allocations will be set in a way that avoids large swings in funding that would risk destabilising local health economies.

NHS England and NHS Improvement will allocate funding to ICSs, continuing to take into account both the need of their population ('the target allocation') and how quickly ICSs move towards their target allocations (known as pace-of-change). We would not make a centrally set allocation to 'place' within the ICS. Existing allocations tools can be adapted to support ICS NHS bodies in making decisions about how to deploy resource to places.

An open book relationship between providers of NHS services, supported by improved cost data (PLICS), will give further transparency for stakeholders that the NHS is meeting its commitment to deploy resource according to need and tackle inequalities.

Full capital allocations will be made to the ICS NHS body, based on:

- the outcome of the 2022/23 capital settlement for operational capital, building on the arrangements initially implemented in 2020/21
- capital budgets being a combination of system-level allocations (operational capital), nationally allocated funds (for large strategic projects) and other national programmes
- the methodology being kept under review to ensure available capital is best allocated against need. We hope future allocations can be set over a multi-year, subject to the outcome of the next Spending Review.

## Distribution of funds by the ICS NHS body

The ICS NHS body will agree how the allocation will be used to perform its functions, in line with health and care priorities set at a local level.

[14] An independent committee of academics, public health experts, GPs and NHS managers that makes recommendations on the preferred, relative, geographical distribution of resources for health services.

Money will flow from the ICS NHS body to providers largely through contracts[15] for services/outcomes, which may be managed by place-based partnerships or provider collaboratives.

The existing provider collaboratives for specialised mental health, learning disability and autism services have paved the way in taking on budgets through lead provider arrangements. In conjunction with ICS leaders, we will consider supporting provider collaboratives to take on further responsibility for use of resources to deliver population health outcomes.

The ICS NHS body will be able to commission jointly with local authorities under a section 75 joint commissioning arrangement, as CCGs can.

Spending will be part of a plan to deliver financial balance within a system's financial envelope, which would also be set by NHS England and NHS Improvement. This envelope covers expenditure across the whole system, including spending by NHS trusts/foundation trusts for services delivered for commissioners from outside the system.

Each ICS will have an agreed framework for collectively managing and distributing financial resources to address the greatest need and tackle inequalities in line with the NHS system plan, having regard to the strategies of the Partnership and the Health and Wellbeing Board/s. This is in line with the duty we expect to remain for the system to have regard for reducing health inequalities.

Financial rules will apply to ensure delivery of key national commitments, such as the Mental Health Investment Standard and the primary medical and community health services funding guarantee.

Based on these local priorities and national rules (including the National Tariff Payment System), the ICS NHS body will agree:

- priorities and outcomes to be achieved in plan against NHS budget (with clinical advice and with regard to ICS Partnership plan)
- the distribution of the NHS revenue allocation (both total financial value and service lines) to:

[15] The ICS NHS body will also be able to make grants to VCSE organisations and to NHS Trusts/FTs. In future, the ICS NHS body may wish to use its expected power to delegate its functions to statutory providers.

  - each place-based partnership as appropriate
  - each NHS provider (individually contracted or via a lead provider contract, including where operating as part of a provider collaborative)
  - contracts with other service providers
  - other collaboratives partnerships.
- A capital plan including how capital spend should be prioritised locally (developed through collective decision making across NHS providers, and with ability to co-ordinate with the estates and assets managed by local authorities).

The ICS NHS board and chief executive (AO) will be ultimately responsible for services under delegation arrangements with place-based partnerships or through lead provider contracts. They will need to put in place proportionate mechanisms to provide assurance on the spending of public money.

## Setting budgets for places

The ICS NHS body will have the freedom to set a delegated budget for place-based partnerships to support local financial decisions to spend ICS NHS resources. However, it must adopt the principle of equal access for equal need and the requirements to reduce health inequalities. The ICS NHS body should engage local authority partners on the ICS NHS resources for the NHS services to be commissioned at place and support transparency on the spending made at place level. It should explain any variation from previous CCG budgets and enable the shared planning or pooling of NHS and local authority budgets, including stated minimum NHS contributions to Better Care Fund arrangements.

Budget allocated to and managed within a place (under the agreed schemes of delegation) might include:

- primary medical care
- other primary care as delegated/transferred from NHS England and NHS Improvement – dental, pharmaceutical, ophthalmology services
- community services
- community mental health including IAPT
- community diagnostics
- intermediate care

- any services subject to Section 75 agreement with local authority
- any acute or secondary care services that is has been agreed should be commissioned at place-level.

## Financial and regulatory mechanisms to support collaboration

ICS NHS bodies will have a duty to co-operate with other NHS bodies, including NHS trusts and foundation trusts, and local authorities. They also have a duty to promote integration. These duties, combined with the new triple aim duty, should be a key driver for ensuring NHS ICS partners work together to meet the four purposes of the ICS with the resources available.

Collaboration in the NHS has accelerated in recent years and this is already supported by a wide range of enablers to ensure a shared investment in system objectives and plans.

Enablers already established, or expected to be established, through NHS England and NHS Improvement's system-by-default approach include:

- Setting system financial envelopes, which describe the funding available to spend in an ICS, including CCG allocations and national sustainability funding. These budgets will be based on population need and will support systems to work together to free up resources, which can be spent elsewhere in the system
- Proposals to establish an aligned payment and incentive (API) approach, in which fixed payments are set for an agreed level of planned activity; variable payments would also be agreed for activity above or below these plans. This should give the ICS NSH body, NHS trusts and foundation trusts greater certainty over payments and the agreed level of activity these payments will cover
- Inclusion of a System Collaboration and Financial Management Agreement in the NHS standard contract, which is a collaborative document aimed to ensuring NHS system partners work together to deliver shared financial objectives. The ICB, NHS trusts and foundation trusts will agree in advance ways of working and the risk management approach to dealing with unplanned pressures

- Change in oversight focus in the System Oversight Framework (SOF) which works with and through the system to tackle problems with an emphasis on system performance and greater autonomy for organisations with evidence of effective joint working.
- Guidance to be issued on provider governance to support providers to work collaboratively as part of ICSs to deliver system objectives. This will include an updated Code of Governance for NHS provider trusts, updated guidance on the duties of foundation trust governors, and updated memorandums for accounting officers of foundation trusts and NHS trusts. New guidance will be issued under the NHS Provider Licence that good governance for NHS providers includes a requirement to collaborate.

In addition to these policy developments, further enablers to support system collaboration are expected from the proposed legislation and policy, including:

- A common duty for ICS NHS bodies, NHS trusts and foundation trusts in relation to the triple aim, which requires them to have regard to the wider effect of their decisions in each of the three strands of the triple aim improving population health, quality of care and the use of resources
- Imposition of duties on the ICS NHS body to act with a view to ensuring system financial balance and to meet other financial requirement and objectives set by NHS England and NHS Improvement. This would also apply to NHS trusts and foundation trusts. This should mean that ICS NHS bodies, NHS trusts and foundation trusts have shared investment in the delivery of system financial balance and strong reason to collaborate to agree a system plan for meeting this; supported by a review of the NHS provider licence
- Powers to ensure organisational capital spending is in line with system capital plans. A review of the NHS provider licence in light of the new legislation and policy developments and specifically to support providers to work effectively as part of ICSs to deliver system objectives.

**Services currently commissioned by NHS England and NHS Improvement**

The legislation will enable the direct commissioning functions of NHS England and NHS Improvement to be jointly commissioned, delegated or transferred at an appropriate time to ICS NHS bodies.

NHS England and NHS Improvement is considering how it might shift some of its direct commissioning functions to ICS NHS bodies. Subject to discussions with systems and our Regions and further work on HR, our intention is to enable ICS NHS bodies to take on responsibility as soon as they are ready to do so after the enactment of legislation.

Commissioning of primary medical services is currently delegated to CCGs and will transition immediately into ICS NHS bodies when they are established. ICS NHS bodies might also take on primary dental services, general ophthalmic and pharmaceutical services commissioning.

Further work is taking place at national and regional levels to explore how the commissioning model for specialised services could evolve , in line with the safeguards and four principles set out in *Integrating Care: Next steps to building strong and effective integrated care systems across England*.

NHS England and NHS Improvement has a range of other direct commissioning functions including health and justice, armed forces and aspects of public health. Engagement with ICSs will continue to establish how they could take on greater responsibility for these services in future.

## Data and digital standards and requirements

The standards and requirements for digital and data will be centred around the What Good Looks Like framework, which will set out a common vision to support ICS leaders to accelerate digital and data transformation in their systems with partner organisations. Based on consultation with a wide range of NHS and care stakeholders, the framework identifies seven success measures and will be published in the first quarter of 21/22.

We expect digital and data experts to have a pivotal role in ICSs, supporting transformation and ensuring health and care partners provide a modern operating environment to support their workforce, citizens and populations.

From April 2022, systems will need to have smart digital and data foundations in place. The way that these capabilities are developed and delivered will vary from system to system. Systems will locally determine the right way to develop these capabilities and to ensure they are available at system and place level, and across provider collaboratives.

Specifically, ICS NHS bodies are expected to:

- Have a renewed digital and data transformation plan that is embedded within the ICS NHS body plan and details the roadmap to achieve ‘What Good Looks Like’; and enables a cross system approach to transformation, so that changes to models of care and service redesign involve digital and data experts working with partners from all relevant sectors.
- Have clear accountability for digital and data, with a named SRO with the appropriate expertise, (registered professional or with equivalent experience), underpinned by governance arrangements that have clear oversight and responsibility for digital and data standards and requirements for the ICS and enabling partner organisation programmes and services.
- Invest in levelling-up and consolidation of infrastructure, linked to the future ICS reference target architecture and data model, adopting a simplified cloud-first infrastructure that provides agility and frictionless cross-site working experience for the workforce.

- Implement a shared care record, that allows information to follow the patient and flow across the ICS to ensure that clinical and care decisions are made with the fullest of information.
- Ensure adherence by constituent partners to standards and processes that allow for interoperability across the ICS, and alignment to forthcoming national guidance.
- Enable a single co-ordinated offer of digital channels for citizens across the system and roll out remote monitoring technologies to help citizens manage their care at home.
- Cultivate a cross-system intelligence function to support operational and strategic conversations, as well as building platforms to enable better clinical decisions. This will require ICSs to have linked data, accessible by a shared analytical resource that can work on cross-system priorities.
- Agree a plan for embedding population health management capabilities and ensuring these are supported by the necessary data and digital infrastructure, such as linked data and digital interventions. Online PHM support can also be found at https://future.nhs.uk/populationhealth/grouphome and here Population Health Management - e-Learning for Healthcare (e-lfh.org.uk).

Arrangements should be co-ordinated across the NHS and local government, as well as between NHS organisations.

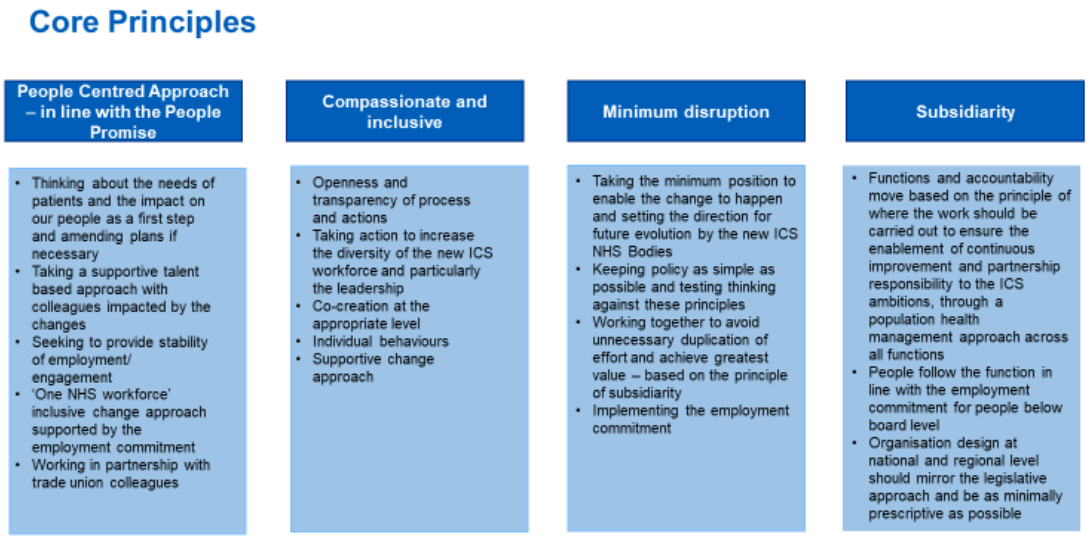
## Managing the transition to statutory ICSs

We will work in partnership with systems, individual organisations affected, trade unions, voluntary organisations and central and local government to ensure the opportunities for improved outcomes for populations and improvements for our people are realised. We aim to create an environment that enables this change to take place with minimum uncertainty and employment stability for all colleagues who are involved.

The change and transition approach is guided by our Employment Commitment and a set of core principles designed to inform the thinking and actions of all colleagues throughout the process, acknowledging the wide variation in circumstances across systems.

> **The Employment Commitment**
>
> *"NHS people within the wider health and care system (below board level) affected directly by these legislative changes, including CCGs, NHS England and NHS Improvement and NHS providers, will receive an employment commitment to continuity of terms and conditions (even if not required by law) to enable all affected colleagues to be treated in a similar way despite a variety of contractual relationships. This commitment is designed to provide stability and remove uncertainty during this transition."*

The Employment Commitment is designed to minimise uncertainty and provide employment stability for people who will transfer directly from their employment or engagement directly into the statutory ICS NHS body. During the transition period the Employment Commitment asks affected organisations not to carry out significant internal organisational change and not to displace people. The commitment does not apply to those people in senior/board level roles who are likely to be affected by the new ICS Board structure and will have to go through organisational change as part of the abolition and establishment process.




Accountability for managing the change process will be with the current ICS and CCG leadership, with increasing involvement of the new leaders (eg chair, chief executive and others at board level) who may be appointed on a shadow or designate basis, pending the legislation.

Each ICS should make initial arrangements to manage the transition and ensure that there is capacity in place ready for implementation of the new ICS body. Plans should be agreed with regional NHS England and NHS Improvement teams.

Each ICS should ensure that planning adequately addresses the implications of organisational development implications as operations evolve from the current into the future configuration. This should be explicitly based in the local context.

It is important to note that any plans are subject to the passage of the legislation. Systems cannot pre-empt the decision of Parliament on whether to approve a bill or how it is to be amended. While plans can be made, systems should not take decisions or enter into arrangements which presume any legislation is already in place or that it is inevitable it will become law, before the Parliamentary process has been completed.

The overarching aim is to ensure and enable:

- the safe transfer of functions into the ICS NHS body (ie existing statutory functions that are to be exercised by the ICS NHS body) and prepare for the ICS body to take on new functions as appropriate
- the smooth transition of our people (ie legally compliant, with minimum disruption).

The indicative outputs expected in every ICS over the course of the transition period in 2021/22 are set out below. This is subject to legislation and other factors (including pending decisions on ICS boundaries in some areas).

| | |
|---|---|
| By end Q1<br>Preparation | • Update System Development Plans (SDPs) against the key implementation requirements (functions, leadership, capabilities and governance) and identify key support requirements.<br>• Develop plans in preparation for managing organisational and people transition, taking into account the anticipated process and timetable, and any potential changes to ICS boundaries and the need to transform functions to support recovery and delivery across the ICS. |
| By end Q2<br>Implementation | • Ensure people currently in ICS Chair, ICS lead or AO roles are well supported and consulted with appropriately.<br>• Carry out the agreed national recruitment and selection processes for the ICS NHS body chair and chief executive, in accordance with guidance on competencies and job descriptions issued by NHS England and NHS Improvement. This will reflect the expected new accountabilities and responsibilities of ICS NHS bodies.<br>• Confirm appointments to ICS Chair and chief executive. Subject to the progress of the Bill and after the second reading these roles will be confirmed as designate roles.<br>• Draft proposed **new** ICS NHS body MoU arrangements for **2022/23**, including ICS operating model and governance arrangements, in line with the NHS England and NHS Improvement model constitution and guidance.<br>• Plan for CCG teams to only operate at sub-ICS level where the SDP confirms that the ICS plans to establish a significant place-based function at that footprint.<br>• Begin due diligence planning. |
| By end Q3<br>Implementation | • Ensure people in impacted roles are well supported and consulted with appropriately. |

| | |
|---|---|
| | • Carry out the recruitment and selection processes for designate finance director, medical director, director of nursing and other board level role in the NHS ICS body, using local filling of posts processes.<br>• Confirm designate appointments to ICS NHS body finance director, medical director and director of nursing roles and other board and senior level roles.<br>• ICS NHS bodies and ICS Partnerships to be ready to operate in shadow form.<br>• Engagement on local ICS Constitution and governance arrangements for ICS NHS body and ICS Partnership. |
| By end Q4<br>Transition | • Ensure people in affected roles are consulted and supported.<br>• Continue the recruitment and selection processes for all other designate ICS NHS body senior roles, including place-level leaders and non-executive roles, using local filling of posts processes.<br>• Confirm designate appointments to any remaining senior ICS roles (in line with our relevant guidance) so that as much of the ICS NHS executive board and other senior leadership is ready (subject to formal decisions on appointments after the legislation is in place/in force).<br>• Complete due diligence and preparations for staff and property (assets and liabilities, including contracts) transfers from CCGs and other NHS staff transfers to new ICS NHS body in line with our guidance.<br>• Commence engagement and consultation on the transfer with trade unions.<br>• Complete preparations to shift our direct commissioning functions to ICS NHS body, where this is agreed from 1 April 2022.<br>• Ensure that revised digital, data and financial systems are in place ready for ‘go live’.<br>• Submit the ICS NHS body constitution for approval and agree the 2022/23 ICS MoU with NHS England and NHS Improvement, setting out key elements of how the new ICS NHS body and ICS Partnership will operate in the future, in accordance with guidance to be issued by NHS England and NHS Improvement. |

NHS England and NHS Improvement is working with a range of stakeholder groups, including a newly formed ICS Transition Partnership Group, which is a sub-group of the national Social Partnership Forum, to make available a range of resources and guidance to support the transition. The following document will be published in support of this:

- Employment Commitment Guidance – which builds on the commitment made in the FAQs published on 11 February 2021 and sets out what 'board level' means in this context. This also sets out the national support and senior level support that is available for colleagues affected by these changes.

After the legislation is introduced, we will publish further resources and guidance to support people transition planning and implementation.

## Conclusion

As we move into the next phase of system development, we must capture and build on the spirit and practice of partnership now embedded across the NHS local councils, the VCSE sector and beyond. We continue to face an unprecedented challenge as a health and care system, but ICSs offer a clear way forward.

Strengthening local partnerships through ICSs is one of the most important and exciting missions in the public sector today.  We would like to thank colleagues in every part of every system for your continued efforts to pursue it. This is an opportunity to deliver better care and population health; to ensure services treat us all as individuals and respond to our increasingly complex health and care needs. It is also an opportunity to work in partnership with local residents in new ways, removing even more of the traditional barriers to joined-up, personalised care and support.

Building on the achievements of system leaders over several years, the further ‘transformation by necessity’ prompted by the pandemic provides a platform for ongoing improvement of relationships, services and outcomes. Working together through ICSs will allow us to seize these opportunities, ensure our health and care systems are fit for the future and that we achieve world class health outcomes for our whole population.

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This publication can be made available in a number of other formats on request.



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# HEALTH AND WELLBEING BOARD PAPER
# FORMAL PUBLIC MEETING

**Report of:** Sandie Buchan, Director of Commissioning Development (CCG) **and** Alexis Chappell, Director of Adult Health & Social Care (SCC)

**Date:** 28 October 2021

**Subject:** Sheffield's Better Care Fund Plan 2021-22

**Author of Report:** Jennie Milner, Deputy Director of Planning and Commissioning

**Summary:**

The Better Care Fund (BCF) is a programme spanning both the NHS and Local Government that seeks to join-up health and care services; empowering people to manage their own health and wellbeing and to live independently in their communities for as long as possible.

Central Government have published a Policy Framework for the implementation of the Better Care Fund (BCF) in 2021-22.

Local areas were not required to submit BCF plans in 2020-21, given the exceptional pressures on systems due to the COVID-19 pandemic, but were required to agree use of the mandatory funding streams locally, to pool these into a joint agreement under section 75 of the NHS Act 2006 and to provide an end of year report, which was reported to the Health & Wellbeing Board (H&WB) on 24 June 2021.

The focus will be on continuity in 2021-22, while enabling areas to agree plans for integrated care that support recovery from the pandemic and build on the closer working many systems developed to respond to it.

For 2021-22, BCF plans will consist of:

- a narrative plan
- a completed BCF planning template, including:
  - planned expenditure from BCF sources;
  - confirmation that national conditions of the fund are met, as well as specific conditions attached to individual funding streams
  - ambitions and plans for performance against BCF national metrics – any additional contributions to BCF section 75 agreements.

The purpose of this paper is to inform the Health and Wellbeing Board of the requirements of the planning guidance and draft plan. Provide more detailed information on two new metrics in the 2021 planning guidance and request delegation of approval for the final submission to the Co-Chairs.

---

**Questions for the Health and Wellbeing Board:**

1. Is the Board comfortable they understand the planning guidance requirements and new metrics included within the better care fund, and for the Joint Commissioning Committee to continue to monitor progress on behalf of Health and Wellbeing Board?

2. Is the Board happy to delegate approval of the narrative plan and submission to the Co-Chairs due to the tight timescales of submission?

**Recommendations for the Health and Wellbeing Board:**

The Health and Wellbeing Board is asked to:

1. Delegate approval to the Co-Chairs for approval of the final submission.

**Background Papers:**

NHS England Better Care Fund Planning Requirements
B0898-300921-Better-Care-Fund-Planning-Requirements.pdf (england.nhs.uk)

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**Which of the ambitions in the Health & Wellbeing Strategy does this help to deliver?**

- **Starting Well**
  - Every child achieves a level of development in their early years for the best start in life
  - Every child and young person has a successful transition to independence

- **Living Well**
  - Everyone has access to a home that supports their health

- **Ageing Well**
  - Everyone has equitable access to care and support shaped around them
  - Everyone has the level of meaningful social contact that they want
  - Everyone lives the end of their life with dignity in the place of their choice

**Who has contributed to this paper?**

Both the CCG and Local Authority have contributed to the production of this document via the Executive Teams, Work-stream Leads and Executive Management Group. Partnership groups have been established and are now embedded within the Accountable Care Partnership.

## SHEFFIELD'S BETTER CARE FUND (BCF) PLAN 2021-22

### 1.0 SUMMARY

1.1 The purpose of this paper is to inform the Health and Wellbeing Board of the requirements of the planning guidance and draft plan.

1.2 The paper provides information on two new metrics in the 2021 planning guidance and requests delegation of approval for the final submission to the Co-Chairs of the Board.

1.3 The paper confirms the minimum confirms the minimum BCF contribution and update on the potential additional funding, subject to final budget confirmations

### 2.0 HOW DOES THIS IMPACT ON HEALTH INEQUALITIES IN SHEFFIELD?

Our shared aspiration is to improve health outcomes and inequalities for Sheffield people. The benefits for Sheffield people continue to include:

- More seamless, integrated care and prevention services, improving patient experience and reducing handovers;
- A more holistic approach to health and wellbeing;
- Care and support provided for patients at home, enabling people to remain independent for as long as possible;
- A single approach to long term care that focusses on maintaining independence and providing cost effective care, not assessing to determine who pays;
- Better health of those most at risk of health crises requiring hospital admission, eg; through care planning, better management of long term conditions and reduction of clinical and social risk factors such as loneliness and isolation;
- Reduced admissions to hospital and care homes;
- An improvement in patient outcomes and an increase in positive patient experiences of care;
- Better use of financial resources for the CCG and Council.

### 3.0 OUTLINE

3.1 Central Government have published a Policy Framework for the implementation of the Better Care Fund (BCF) in 2021-22.

3.2 Local areas were not required to submit BCF plans in 2020-21, given the exceptional pressures on systems due to the COVID-19 pandemic, but were required to agree use of the mandatory funding streams locally, to pool these into a joint agreement under section 75 of the NHS Act 2006 and to provide an end of year report, which was report to the Health & Wellbeing Board (H&WB) on 24 June 2021.

3.3 The focus will be on continuity in 2021-22, while enabling areas to agree plans for integrated care that support recovery from the pandemic and build on the closer working many systems developed to respond to it.

3.4 For 2021-22, BCF plans will consist of:

- a narrative plan;
- a completed BCF planning template, including:

- planned expenditure from BCF sources;
- confirmation that national conditions of the fund are met, as well as specific conditions attached to individual funding streams
- ambitions and plans for performance against BCF national metrics – any additional contributions to BCF section 75 agreements.

3.5 A narrative plan is required which will include details around finance outlining minimum and additional contributions, key performance indicators (KPI's) including baseline, targets and narrative around the delivery of the KPI's.

3.6 A number of deadlines are required to be met as follows:

- Approval by regional Better Care Fund Team by 19 October for feedback by 2 November 2021;
- Approval by Health & Wellbeing Board or delegated to Chairs;
- Approval by Chief Executive of Sheffield City Council and the CCG Accountable Officer;
- Submitted by 17 November 2021;
- Approval letters issued in January 2022;
- Section 75 signed and in place by 31 January 2022.

3.5 The narrative plan includes involvement of stakeholders in the BCF plans, an executive summary which outlines the priorities for 2021-22 and any key changes since the previous BCF plan, governance around how the plan is implemented via Executive Management Group (EMG), EMG Working Party with oversight from the Joint Commissioning Committee (JCC).

3.7 The narrative plan will also detail:

- the overall approach to integration with regard to integrated person-centred health, how social care and housing services is embedded, joint priorities, approaches to joint collaborative commissioning, overarching approach to supporting people to remain independent at home, including strengths-based approaches and person-centred care;
- How BCF funded services are supporting our approach to integration – changes to services we are commissioning through the BCF;
- Supporting discharge - our approach to improving outcomes for people being discharged from hospital?
- How BCF funded activity supporting safe, timely and effective discharge;
- Disabled facilities grant and wider services –our approach to bringing together health, care and housing services to support people to remain at home through adaptations and other activity to meet the housing needs of older and disabled people.

3.8 The BCF includes 5 measures as detailed below:

- **Avoidable admissions** – unplanned hospitalisation for chronic ambulatory care sensitive conditions;
- **Length of Stay** – percentage of patients, residents in the HWB who have been an inpatient in an acute hospital for 14 or 21 days or more;
- **Discharge to normal place of residence** – percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence.

- **Residential admissions** – Long term support needs of older people (Age 65 and over) met by admission to residential and nursing care homes per 100,000 population;
- **Reablement** – Proportion of older people (65 and over) who are still at home 91 days after discharge from hospital into reablement/rehabilitation services.

3.9 The NHS Covid-19 block funding regime has remained in place into 2021/22. The financial year has been split into H1 (April-September) and H2 (October-March) with allocations given for H1 but with the budgets still not clear for the H2 period. H2 guidance has only lately been received and planning work is still being completed to understand the increased efficiency requirement within NHS budgets in the second half of 2021/22. Until the details are known the reporting position is assuming nil impact of this change. It should also be noted that NHS budgets are usually phased to allow for seasonal variances (e.g. winter pressures) which is not possible under the current working arrangements meaning the forecast pressure will not be felt equally throughout the year.

3.10 The Council budgets in 2020/21 were set at the end of 2020 when the full year outturn was not yet available. The increase in the underlying recurrent costs of care packages caused by the changes in practice during the Covid-19 pandemic and the increasing complexity of care required was not fully evident. The funding requirement and subsequent required savings targets were not available to build into the position. At the time of the budgets being set the availability and amounts of on-going central funding were not known and therefore could not be taken into account.

3.11 The 2021/22 budgets include £79m of funding which must be included within the better care fund and £341m of funding which has been included by local decision.

| Running Balances | Budget |
|---|---|
| DFG | £5,652,504 |
| Minimum CCG Contribution | £44,998,236 |
| iBCF | £28,428,597 |
| Additional LA Contribution | £108,920,366 |
| Additional CCG Contribution | £231,777,008 |
| **Total** | £419,776,711 |

**4.0 The Joint Commissioning Intentions can be seen in Appendix A and include the following priorities for 2021/22:**

- We will continue to respond to the COVID-19 pandemic;
- We will reduce health and social care inequalities across Sheffield;
- We will focus on improving access to and availability of health and care services;
- We will ensure all children across Sheffield have the best possible start in life;
- We will improve the support and treatment for your mental health and wellbeing;
- We will make sure if you need health and social care support then this is personalised to your needs.

## 5.0 How will we measure success?

5.1 Supporting people to manage their long-term conditions effective to prevent hospital admissions. Primary care, social care and community services working together to support people with long term conditions can reduce the need for hospital admission. Position during 20/21 and 21/22 has significantly deteriorated due to the need to focus capacity and workforce upon Covid management, provision of rehabilitation and same day care, rather than on prevention and ongoing management. Currently 648 had an unplanned hospitalisation for chronic ambulatory sensitive conditions in 20-21 it is expected this will return to 1,052 in 2122.

5.2 Reducing the number of people in hospital over 14 and 21 days. Ensuring people are able to be discharged from hospital within 14 and before 21 days is an indicator of better overall health outcomes. Currently 25% are in hospital after 14 and 20% are in hospital after 21 days. Recognising the pressure to ensure people are discharged back to place of residence and avoid readmissions results in delays in discharge, we are working together to improve the length of time in hospital and still maintain our success in the other areas.

5.3 Discharge to ordinary place of residence. Currently 83% are discharged back to their ordinary place of residence.

5.4 Admission to permanent residential care. Sheffield currently supports more people than expected in the community. It was expected 816 people would be admitted to permanent residential care last year, only 588 were admitted to permanent residential care.

5.5 Reablement – preventing admission within 90 days of discharge. Currently 81% of people remain at home 90 days after discharge.

## 6.0 QUESTIONS FOR THE BOARD

6.1 Is the Board comfortable they understand the planning guidance requirements and new metrics included within the better care fund, and for the Joint Commissioning Committee to continue to monitor progress on behalf of HWB;

6.2 Is the Board happy to delegate approval of the narrative plan and submission to the Co-Chairs due to the tight timescales of submission?

## 7.0 RECOMMENDATIONS

7.1 The Health and Wellbeing Board is recommended to:

Delegate approval to the Co-Chairs for approval of the final submission.

# Joint Commissioning Intentions for 2021/22

- **Communities/Voluntary Sector**

  Tackling health inequalities within primary care and your community;
  Improve access to healthcare and health outcomes for people experiencing homelessness, vulnerable migrants, sex workers, traveller groups and ex-offenders;
  Establish a Sheffield Alcohol Liaison Service for individuals who repeatedly present at the Northern General Hospital with alcohol related conditions and support needs.

- **Ongoing Care**

  Work with partners to adopt and develop a personalised approach to re-establish long term condition monitoring and reviews to recover control and management of conditions to pre-COVID levels;
  Recommission the Individual Placement Support employment service and Working Win.

- **Children & Families**

  Design a new model of local children and young peoples' health and care services.
  Review and improve existing services that help children who have experienced adverse events (ACEs);
  Put in place enhanced SEND (Special Educational Needs and Disabilities) support provision in line with the Sheffield Inclusion Strategy;
  Improve the linkage between children's and adults' services.

- **Mental Health & Learning Disability**

  Establish an all age eating disorder service;
  Improve access to 24/7 crisis services for children, young people and adults; and extend the mental health liaison service;
  Improve access to mental health support for children and young people focusing on early intervention, prevention, support into schools and access into CAMHS (Child and Adolescent Mental Health Services);
  To improve and enhance the out of hours crisis care for people with learning disability as part of the national "Building the Right Support model" and aligning to the Crisis Transformation Programme;
  Improve the physical health of people with mental health, learning disability, autism and dementia;
  To deliver the 13 recommendations outlined within the Dementia Strategy aimed at improving a range of pathways to support for this population and their families;
  Implement city wide roll out of Mental Health Primary and Community Care new model of neighbourhood support.

- **Frailty**

  Further development of a city wide intermediate care offer to sustain the reduced delayed transfers of care position;
  Development of discharge home to assess service to enable assessment at home of any ongoing support needs.

NIHR | School for Public Health Research

# Sheffield Health and Wellbeing Board and Public Engagement

FINAL report
July 2021

# Summary

## Implications and questions to consider

1. **Leadership:** Who is leading and driving public engagement as a means to address inequalities in power, control and voice as a determinant of health across the city?

There is an opportunity for the Health and Wellbeing Board (HWBB) to occupy this strategic leadership role and to drive institutional changes in public engagement within Boards and organisations across the city.

2. **Coordination and joining-up:** How joined-up are spaces for engagement across the city, and how are insights shared and used proactively within decision-making across city partners?

There seems to be an opportunity for the HWBB to take on the role of a listening body and central point of coordination across decision-making relating to inequality, health and wellbeing; and to consider if or how partnerships and joined-up public engagement can be extended at a community-level.

3. **Inclusion:** How inclusive are different spaces for people with differing social and economic perspectives, and how inclusive are they for those who already experience forms of disadvantage and exclusion?

Any engagement strategy going forward needs to consider unequal access to resources, capabilities and respect for individuals and groups across the city; including how, for example, people have been or can be excluded from participating due to age, race, ethnicity, gender, sexuality, disability, class, or a combination of these factors.

4. **Depth of participation:** How do different spaces offer opportunities for meaningful and ongoing engagement within communities for individuals or groups (as opposed to more transactional forms of 'consultation')?

The COVID-19 pandemic has provided an opportunity to learn from, re-commit to and re-examine public engagement to inform the Health and Well-being Board's Strategy going forward. Also, an opportunity to consider ways to create safe spaces for challenging and potentially uncomfortable conversations about inequalities.

Strategic ambition on inequality requires confronting issues of power and voice, and building capabilities, relationships and trust with people. It necessitates taking a long-term approach to:

- Identifying and addressing discrimination and deficits of respect, trust and feeling unheard
- Confronting socio-economic, class-based, gender, racial, ethnic and other inequities
- Tackling disability inclusion
- Confronting issues of power and control, stigma, identity and belonging

5. **Prioritisation and resourcing:** How are resources (people, time, skills, funding) prioritised and strategically coordinated towards engagement across the city?

There seems to be an opportunity for HWBB members to have a leadership role in recognising, and considering how to adequately resource long-term approaches to public engagement that enable and develop individual's and group's capabilities to influence. This includes consideration of the role and sustainable resourcing of the VCS as valued partners in this process.

6. **Governance and accountability:** How are city partners 'held to account' for engaging people in ways that could address inequalities and other determinants of health and wellbeing outcomes across the city?

HWBB members could explore opportunities to establish clear commitments, transparent processes and mechanisms to ensure organisations and leaders are formally accountable for public engagement and for addressing inequalities in power, control and voice as a determinant of health across the city.

# Learning from examples of good practice

The following elements seem central in the examples of successful engagement identified in Sheffield:

**People who are connectors:** Good practice examples identified involved people or organisations who were connectors and could facilitate conversations and dialogue, and/or bring people together (i.e. residents, VCS, statutory partners). This role was, for example, carried out by trusted people within VCS organisations, within the Council, universities or parts of the NHS.

**Formal and informal spaces for participation:** Good practice examples all involved both formal meetings and informal spaces for participation (e.g. phoning people, informal chats, with food). Facilitation within these spaces helped promote more inclusive forms of dialogue and reshape power dynamics; creating space for listening, demonstrating respect and forms of talking that people could be comfortable with.

**Collective learning:** Each good practice example created opportunities for those involved - residents, statutory organisations, VCS - to listen, share knowledge and learn together, through dialogue and discussion, and sometimes in creative ways.

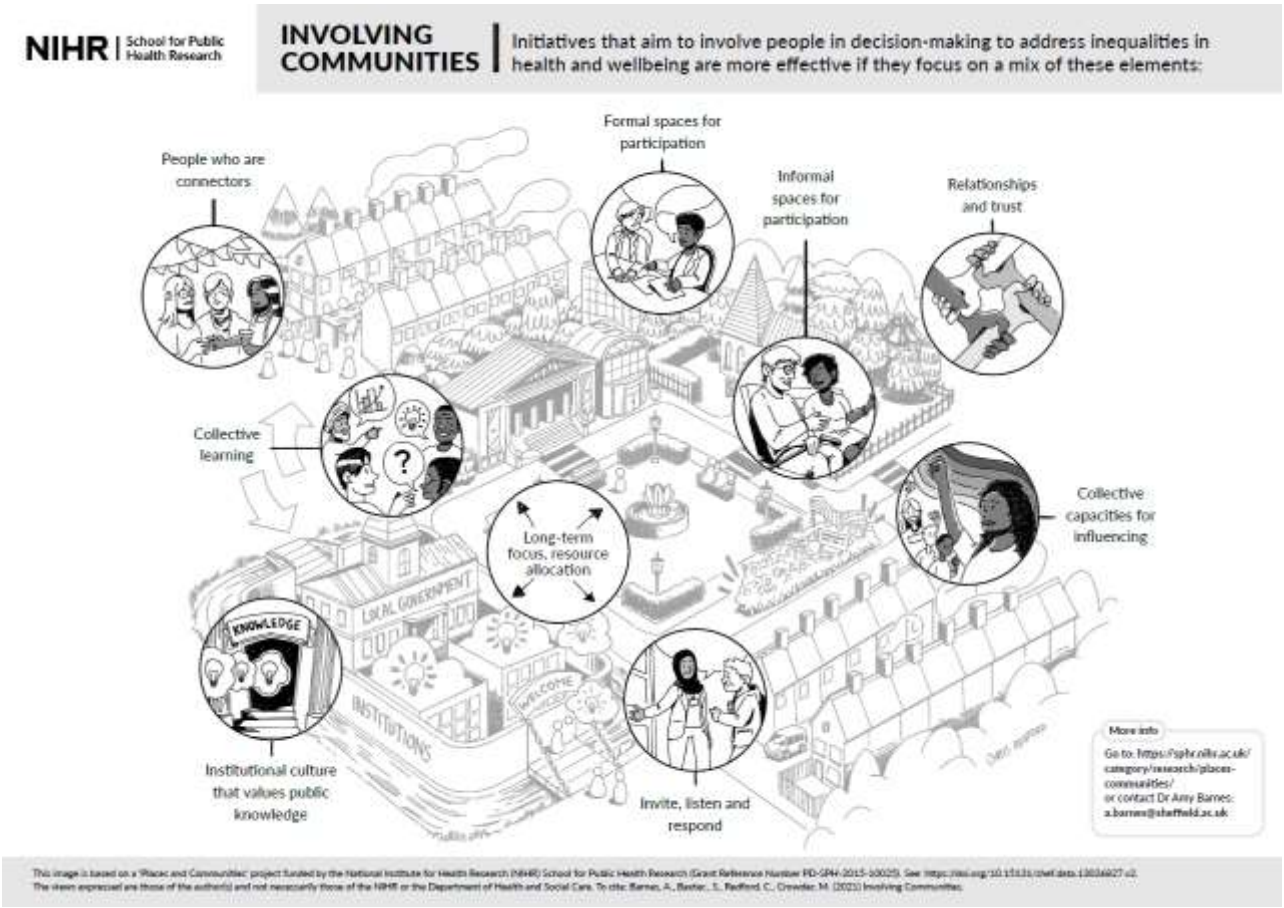

**Institutional culture that values public knowledge:** All examples were formally-supported by an individual or team within the Council, VCS, universities and/or parts of the NHS who valued the contribution of public knowledge and who were resourced and 'authorised' by more senior leaders to engage with people in the city and/or other partners in 'messy' and collaborative ways; and therefore had some form of internal 'route to influence'.

**Invite, listen and respond**: Examples involved dialogue, conversations and 'feeding back', which sometimes helped reshape relationships, existing power-dynamics, or build trust.

**Relationships and trust**: Strengthening relationships and trust were central processes within each example of good engagement and creating routes to influence within decision-making.

**Collective capacities for influencing**: Examples brought people together, building the individual and/or group capacities needed for influencing (e.g. knowledge and skills, confidence, relationships, mutual support).


**Long-term focus, resource allocation:** All examples had access to specific funding and involved people who were able to commit time and energy specifically for engaging people and relationship-building. In some cases, COVID-19 appears to have led to renewed resource commitments (perhaps due to the greater visibility and political recognition of inequalities within the city), though sustainability is an issue.



# Why was the work needed?

Sheffield's Health and Wellbeing Board (HWBB) has recognised the value of public engagement in order to better understand and work towards its strategic aims of reducing health inequalities and improving healthy life expectancy for everyone. A number of engagement exercises have taken place during the lifespan of the Board. A paper on engagement went to the Board recently for discussion and led to a Working Group being established to draw up a suggested engagement plan for the Board. Discussions regarding public engagement frequently refer to the potential for building on existing engagement work, with a perception that this could be better used. The Board is at a point of taking stock of its activity on public engagement, current learning and future direction.

We have worked to identify examples of existing engagement activity and to map these against the ambitions of the current Sheffield Joint Health and Wellbeing Strategy 2019-2024. This strategy takes a life course approach to consider upstream factors, structures and conditions that influence and shape everybody's opportunities for a healthy life, throughout life. It sets out a series of 9 strategic ambitions relating to Starting Well, Living Well, and Ageing Well in order to improve life chances and reduce inequalities in the city.

## What are the questions that needed answering?

- What engagement work has the HWBB carried out in recent years?
- How does this engagement work map against the 9 ambitions of the current health and wellbeing strategy?
- Are there gaps in engagement for particular ambitions and/or for particular demographic groups?
- Are there examples of good practice in the city where engagement has made an impact within the Board or the work of partners of the Board?
- Are there areas where engagement has failed to make an impact, if so why?

## What did we do?

We carried out 16 interviews (22 people in total took part) with people who live in Sheffield and people from statutory organisations, the voluntary sector and community groups who have some knowledge of the HWBB, other Partnerships or engagement in local policy-making in Sheffield. The research was carried out between December 2020 and May 2021. The interviews were informed by an analysis of documents relating to the HWBB and public engagement in the city, and a prior systematic review of the research literature carried out by the research team (Baxter et al., 2020).

## What did we find out?

The HWBB has supported **three main types** of invited public engagement in the city in the last five years:

1. Large, one-off and often service-focused public events

2. Smaller scale, usually one-off activities in diverse public settings – these have invited public discussion on wider determinants of health and involved some targeted conversations with specific groups locally
3. Creating space for public discussion within planned HWBB work and meetings

Prior to 2017, the HWBB focused on supporting large, **one-off public engagement** spaces that have tended to focus on health or social care services. As one interviewee described them: "*big set piece service-focused engagement events, standard town-hall kind of thing*" *(Int: 9_27-04-2021).*

More recently, the HWBB has supported **more diverse, smaller-scale spaces for engagement.** These have also been short-lived but more oriented towards understanding wider determinants of health and wellbeing for people in the city. These smaller-scale public engagement spaces have largely been facilitated by Healthwatch who were commissioned in 2018 (through a short contract and with limited resource, c. £10,000) to engage people in the city to understand what they thought about the HWBB Strategy and what creates health (see Healthwatch, 2019). This engagement involved using existing **events** and **relationships with community partners** to set up conversations with many different people at, for example, Sheffield by the Sea, stalls on the Peace Gardens and Fargate, and some established forums and social groups in the city (e.g. at Burton Street, Firvale Community Hub, men's group at SOAR).

The HWBB has also tried to **create space for public discussion** within their meetings; for example, providing opportunities for people to ask questions and bring their experiences into discussions at Board level (e.g. in developing the dementia strategy in the city). Following the release of the HWBB Strategy in 2019, the HWBB had planned to extend this type of space for public engagement: creating opportunities for people with differing social and economic experiences to discuss and potentially challenge the nine ambitions of the HWBB Strategy.

As one interviewee explained, the idea was to **co-produce an engagement process** which gathered data and people's views and also created space within the Board to collectively learn and build a picture of how each of the 9 ambitions looked across the city:

> *"…bringing some of the people involved in that into the Board conversations and giving them the authority and permission to contribute and say 'what you are talking about here is not how I recognise it from my perspective', and that really strong role in, showing that voice of the city matters in these conversations: it's not just these leaders that are going to shape it."* (Int:9_27-04-2021)

Some interviewees shared their disappointment that this process had not happened so far, partly due to COVID-19, and hoped the HWBB would **recommit** to **engage the public in meaningful ways** in future and **resource it** appropriately (Int:9_27-04-2021 Int:6_19-04-2021; Int:8_23-04-2021).

## How engagement maps to Health and Wellbeing Strategy ambitions

To some extent, it is unclear how the spaces for public engagement described above map to the 9 ambitions of the Joint Health and Wellbeing Strategy 2019-2024 and its 'life course' approach. A number of interviewees indicated that development of the

HWBB strategy itself **had not been informed by much public engagement** and that when efforts were made to do so (for example via Equality Hubs) it had almost been "*signed off, so it was more of an informational thing*" (Int:8_23-04-2021). Two interviewees explained how the **time, funding** and **human resources** for developing the strategy were very limited, and thus there had been extremely limited capacity to advance it in an engaged way.

Interviewees explained that the subsequent spaces for public engagement that Healthwatch were commissioned to create were opportunities to broaden public conversations about wider determinants of health, to find out what people thought key issues were in the city and therefore provide a test of how people felt about their lives and **whether people's experiences actually fitted with the 9 strategic ambitions**. Three interviewees described how some insights **did not fit well** with the ambitions, thus exposing potential gaps that the Board could investigate. A number of interviewees talked about **gaps between the HWBB Strategy and public concerns** on the issue of travel and transport.

For example, while the Strategy frames travel as a strategic ambition ('everyone can safely walk or cycle in their local area regardless of age or ability'), people engaged by Healthwatch tended instead to emphasise the importance of public transport: buses and where they went, the accessibility of the city centre particularly for people with disabilities, and difficulties in accessing taxis to get around (see Healthwatch, 2019). A potential gap was also identified in relation to perspectives on food (Healthwatch, 2019). Interviewees further mentioned that the Strategy separates out ambitions into "**the life course"**, but that this **did not reflect the way people frame everyday discussions** about determinants of their health and wellbeing: because of this it was quite difficult to separate out issues and topics raised by the public in relation to the 9 strategic ambitions (Healthwatch, 2019).

## Other spaces for public engagement and the ambitions

We identified many **other spaces for public engagement** across the city within the last 5 years which potentially map to the ambitions of the HWBB Strategy. It has not been possible within the limits of this research to produce an exhaustive list of these spaces, but examples are included in Appendix 1. This shows a breadth of spaces for public engagement that map to the Board's strategic ambitions. Many are spaces in which the public are **'invited-in' by formal organisations** in the city (e.g. strategic Partnerships, Council, parts of the NHS, police). It is important to note that **spaces can also however be initiated by residents** or community groups in order to try and influence decision-making, and these are an important part of 'civic life' and local governance within the city (e.g. resident-led campaigns, local actions to make changes within neighbourhoods, or to change local services).

All interviewees mentioned examples of these **wider forms of public engagement** when talking about the HWBB, health, wellbeing and inequalities. While the breadth of spaces was understood as reflecting a **general level of commitment and willingness** across city partners to engage with people living in the city, and of people wanting to be involved in and have a sense of control where they live, a number of **questions were raised** in the research (see Box 1). These topics are explored in the sections below: we explain what the research found about gaps, good practice and areas where public engagement in the HWBB, or more generally in city decision-making, could have more impact.

Box 1. Six key questions raised about public engagement to address inequalities, health and wellbeing

1. **Leadership:** Who is leading and driving public engagement as a means to address inequalities in power, control and voice as a determinant of health across the city?
2. **Coordination and joining-up:** How joined-up are spaces for engagement across the city, and how are insights shared and used proactively within decision-making across city partners?
3. **Inclusion:** How inclusive are different spaces for people with differing social and economic perspectives, and how inclusive are they for those who already experience forms of disadvantage and exclusion?
4. **Depth of participation:** How do different spaces offer opportunities for meaningful and ongoing engagement within communities for individuals or groups (as opposed to more transactional forms of 'consultation')?
5. **Prioritisation and resourcing:** How are resources (people, time, skills, funding) prioritised and strategically coordinated towards engagement across the city?
6. **Governance and accountability:** How are city partners 'held to account' for engaging people in ways that could address inequalities and other determinants of health and wellbeing outcomes across the city?

# Gaps and issues

## Clarity of the HWBB's role and purpose

Many interviewees spoke about the role and purpose of the HWWB and how they felt the Board and its members were genuinely **interested in hearing from the public** and **connecting with better dialogue into communities**. Interviewees questioned however, whether the Board's role and purpose affected efforts to do so in practice. While the HWBB brings together "*high-level, powerful people*" from key organisations across public health, and health and social care, a number of interviewees questioned the **purpose** and **power of the Board *collectively*** (Int:6_19-04-2021, Int:8_23-04-2021, Int:9_27-04-2021, Int:1_22-04-2021). Specifically, some questioned the **relative balance** in the Board's role, and collective power and ownership, in promoting action to address wider determinants of health *vis a vis* commissioning of health and social care services and were uncertain about what the Board actively worked on *together.* People spoke about how this undermined public engagement. As one person explained:

> *"There's a slight existential crisis about what the Board can and can't do. So on the one hand they are very high level ...they should be able to make stuff happen, but obviously they are each there as a representative of their own individual organisation, but what is their purpose and power collectively as a Board... So consequently if you are doing engagement… the kind of ownership of that and where it sits to drive change, it just, doesn't really seem very clear. So what the purpose of any of their engagement is, is hard to pin down, because it is quite hard to pin down the purpose of the Board"* (Int:6_19-04-2021)

A lack of clarity in relation to what the Board does means that it is **difficult to have meaningful discussion** with groups in the city and risks "*putting people off*" (Int:6_19-04-2021, Int:8_23-04-2021). Some interviewees spoke about how this lack of role clarity also meant the Board was perhaps sometimes unclear about the **topics it should be listening and responding to**, and about **how to use** public insights to take action or influence decision-making *together:* if an individual or group raised an issue with the HWBB, it was not always clear how the Board could or should act on that together, report back to each other and **be held to account.**

One story recounted was of a Sheffield resident raising an issue with the Board about the rerouting of bus services going to the Northern General Hospital. Rather than **'**taking this issue on'**,** the interviewee discussed the Board's ***"lack of willingness to even engage** in it*", despite transport, in their view, being a fundamental determinant of public health and the potential impacts on equitable access to healthcare (Int:6_19-04-2021). Interviewees spoke also about how they felt the Board had not been sure how to collectively respond to "*inconvenient truths*" in Healthwatch's public engagement work about possible gaps in the Board's strategic ambitions to address inequality and other health and wellbeing outcomes (Int:6_19-04-2021, Int:8_23-04-2021, Int:10_10-05-2021).

A number of interviewees indicated that getting action on issues raised through public engagement tended to **depend on individual Board members** 'taking these back' to their own organisations: HWBB members were not currently held formally **accountable** (individually or collectively) for responding to public engagement *within* the Board (Int:1_22-04-2021, Int:5_29-04-2021; Int:6_19-04-2021, Int:8_23-04-2021, Int:9_27-04-2021).

## National directives and reforms compound role uncertainty

Importantly, interviewees emphasised that these above issues were partly related to **national statutory directives** and **ongoing reforms** in health and social care. The Board's statutory history is in this field and the Board has a specified role in promoting **integration** across health and social care commissioning. The HWBB has been transitioning to have a greater **strategic focus** on wider determinants of public health and inequality, which is taking time, and achieving a balance in practice is challenging (Int: 8_23-04-2021; Int: 9_27-04-2021). This has been compounded by the relatively constant national changes within health and social care, including recent reforms and legislative proposals on integrated care systems (Int:1_22-04-2021; Int:8_23-04-2021; Int:9_27-04-2021):

> "[the Board is] *in a massive state of flux. I don't think it really knows where it sits in the new system that is being created... It would be great if it ended up being a central point of coordination, to be a listening body* " (Int:8_23-04-2021)

## How to have conversations about strategic issues, determinants of health and inequalities?

Challenges for public engagement due to issues with the HWBB's role and purpose were felt to be compounded by more general issues associated with engaging people on ***strategic*** **health and wellbeing topics** and **wider determinants of health and inequalities**. A number of interviewees highlighted perceived difficulties in speaking with people from a public health or determinants perspective, and contrasted this with

more typical narratives and discussions around service delivery. As one interviewee noted, during some of the public engagement work relating to the HWBB strategy they felt that it had been **"*a tricky space*"** to engage people and difficult "*to keep the conversations from getting dragged on to specific issues with services*" (Int:9_27-04-2021). This may have been because some of the people and established groups who were engaged were motivated to take part "*because they want to talk about issues with particular services they have identified*" (Int:9_27-04-2021). It may also be because **'talking about services'** is the more dominant and 'typical' way for people to be engaged in conversations by key organisations in the city (i.e. the Council, NHS organisations).

Some interviewees reflected that "*people tend to think about their GP or, you know, their housing association or whatever*" (Int:8_23-04-2021) or about the places and **everyday experiences** in their lives. Separating issues out, for example, as in the HWBB strategy using a life course approach, **does not match the way that people tend to discuss things**, although: "*...the wider determinants are always part of the conversatio*n" (Int:2_27-04-2021; Int:6_19-04-2021; Int:9_27-04-2021). This highlights the need to **think carefully about the language used** in conversations, and the way in which people are engaged in the work of the HWBB.

Linked to this challenge was a perception that the strategic work of the HWBB - and indeed other city partnerships - could be perceived as "*nebulous*" and "*not relatable*" (Int: 6_19-04-2021). Strategic aspirations are not easy to "*get your head round and pitch to members of the public*" (Int:9_27-04-2021). As one interviewee put it:

> *"...your communities won't understand what the purpose of that partnership is and even when you explain it, it is somewhere up here and local people in communities, it doesn't mean anything to their lives ...don't go and talk to them about infrastructure and housing, don't talk to them about the economy because that means nothing. Talk to them about their experience of the economy, have they got a job, what kind of job, what's good, what's not good*" (Int:10_10-05-2021)

At the same time, a number of interviewees reflected on their experiences of working in particular areas and communities in Sheffield, noting that conversations relating to wider determinants and inequalities (e.g. having a good job, education for your kids, being disrespected, feeling stigmatized, not listened to) may **not always be easy or comfortable conversations** to have.

Yet addressing the HWBB's strategic ambition on inequalities means confronting these issues and engaging with people to:

- Identify and address discrimination and deficits of respect, trust and feeling unheard
- Confront socio-economic, class-based, gender, racial, ethnic and other inequities
- Tackle disability inclusion
- Confront issues of power and control, stigma, identity and belonging.

**Power dynamics** can be a very real barrier to some people's participation and ability to discuss issues where they live and/or inequitable experiences of services. As one resident we spoke to commented:

> *"People are worried that if they say anything, even if you say it's anonymous, they are really terrified that if they complain that they're going to lose the service…. They say 'well, other people aren't complaining, what are you complaining about?'" (Int:15_18-05.21).*

This means that it can be important for engagement to involve the **creation of safe spaces** that enable inclusive forms of participation; and promote **recognition, listening** and **learning** about how and why some people and groups in the city are underserved and experience exclusion, and about how different social and economic inequities shape people's lives, their health and wellbeing (Int:12_11-05-2021). In this way, terms like public engagement and 'co-production' were described as requiring "*more honesty*" and greater consideration from the HWBB and its partner members, of what they **really mean in practice** (Int:10_10-05-2021; Int:11_10-05-2021). As one interviewee reflected, the only way you can change things is by being honest about the experiences people are having and that is very much about **enabling relationships**: *"If you've got a relationship, you can have those conversations" (Int:11_10-05-2021).*

## Enabling and developing people's capabilities to engage and influence, and the role of the VCS

On this topic of enabling forms of engagement, interviewees highlighted the importance of **building individual and/or group capabilities** to engage and influence locally in order to address inequalities and improve health and wellbeing, whether within the scope of the HWBB or more broadly in the city. This means, for example, building trust, improving individual or a group's confidence to participate, strengthening relationships, developing knowledge about who and how decisions are made, developing skills in listening, questioning and more.

Interviewees spoke about how building capabilities could address inequities that exist in how and whether different people across the city can engage due to **unequal access to resources, capabilities** and **respect,** and how this could lead to processes of exclusion for, for example, people who were **younger, had disabilities,** were from **minority ethnic backgrounds,** and/or **working-class backgrounds**. As one interviewee indicated:

> *"I really do think that that voice is being lost in the city… so I think that there is something about class, about working class communities being marginalised" (Int:13_29_04_2021)*

During the interviews it was emphasised how **facilitation** was often important in supporting people to take part effectively in decision-making, with the voluntary and community sector (VCS) having a particularly important role in enabling and developing people's **individual or collective capabilities** to exert an influence. VCS organisations were described as "*having the connections*" - particularly with individuals or groups in the city who experience forms of social and/or economic exclusion. People spoke about how the **VCS has often built trusted relationships** slowly, over a long-time, which enables discussion and engagement. In this way, the VCS was perceived as being able to facilitate trusted 'routes in' for statutory organisations and, for example, for the HWBB to engage with different people.

At the same time, the VCS can **support community development** and civic action that can lead to influence within decision-making; for example, **facilitating residents** to campaign about local issues to improve where they live: "*We didn't do it. We just gave them a room to meet in, the resources, they needed paper and a printer. Off you go, do it*" (Int:13_29-04-21). This could result in **tensions** with other organisations or local Councillors, but be central to residents developing their capabilities to exert an influence together:

> "*They were absolutely furious because we'd actually enabled that to happen…[but] hang on, this is an issue that local people are not happy about, you need to listen*" (Int:13_29_04_2021).

A number of interviewees questioned the extent to which the role of the VCS in supporting public engagement was **recognised, valued** or **adequately resourced** across partner organisations in the HWBB and suggested that this is something the HWBB might consider and seek to address. There were suggestions that this could be changing however, given recognition of the essential linking and coordinating role played by the VCS during the COVID-19 pandemic (Int:12_11-05-21).

Resourcing of the VCS, particularly VCS organisations working with or representing individuals or groups in the city who are younger, have disabilities, are LGBT+, and/or are from minority ethnic backgrounds was emphasised as critical in building the knowledge, confidence, trust and sustainable relationships that enable influence within decision-making. **Resourcing** is not only needed at a practical level (i.e. funding people's time, core infrastructure) but also demonstrates that engagement is **valued** and that the knowledge and experiences of people who take part are **respected** (Int:2_29-04-2021; Int:12_11-05-2021). Interviewees emphasised that **austerity** and the recent **COVID-19 pandemic** had **undermined VCS infrastructures**, risking and limiting the capacity to enable people across the city in these kinds of ways (see also the later section on resourcing).

Some interviewees spoke about the limitations of approaches where engagement is just '**commissioned-out**' to the VCS or in which individuals or groups are only **'invited in'** to attend a meeting, as this does not build trust, relationships or **'**close the feedback loop', which is important if are people **to know if they had an influence** or **'made a difference'.** As different people who live in the city commented:

> *"We're often told that we make good points and they were very glad we attended a meeting, but evidence of any change in policy or the decision-making minds of the decision-makers is very difficult to spot" (Int:15_18-05.21)*

> *"Services come … they either don't listen and we never then hear anything, or they listen but we never then find out what happened with what we'd said" (Int:16_19-05.21).*

This issue with 'closing the loop' was also recognised by those who worked in city organisations:

> "*It's not something you can just do now and then, 'oh I've got that answer' and go away, which I think we do quite a lot, and you go away and you never hear from them again*" (Int:10_10-05-21).

With attending formal meetings in particular, it was highlighted that **power dynamics** between 'professionals' and the public could shape whether public knowledge was valued or not, and could lead people to feel "*patronised, excluded and not get anything out of it*" (Int:5_29-04-21). As one of our public participants commented:

> *"They are patronising. 'Oh I know about that, I don't need you to tell me'" (Int:15_18-05.21).*

It was recommended that spaces for engagement in decision-making should be diversified and **driven down to a local-level,** to the grassroots: engagement needs to be **taken out to people,** to community venues, places or spaces where different people feel comfortable and **made part of people's 'everyday'** (Int:6_19-04-21): "*rather than requiring people to come stand up in a Council Chamber, which is for some people an intimidating thing to do*" (Int:7_8-12-21).

The importance of developing people's capabilities to engage and adopting inclusive approaches to engagement was illustrated by the experiences of some of the members of the public we spoke to. For some people, reliance on fixed events and meetings can present a barrier to engagement. Without attention to how particular spaces work for different people or flexible, creative approaches that fit with the needs and circumstances of those facing most disadvantage, people who are already 'seldom heard' may be further excluded:

> *"if you've got someone who is disabled in the family, the chances of getting there is very remote" (Int:15_18-05.21).*

> *"… and you couldn't really say anything. There were that many people at the meeting it was impossible to actually contribute anything" (Int:16_19-05.21).*

Emphasising this point, for those who are able to attend, the way in which meetings and events are managed can make it difficult to contribute and feel heard:

> *"I felt like every time we tried to contribute we just got spoke over or ignored by the people who were running it" (Int:16_19-05.21).*

The importance of supporting the development of an individual's or group's confidence and other capabilities to engage on issues important to them was also highlighted by the people we spoke to who live in the city (as was the impact that **not** being listened to and respected can have on people's willingness to engage); for example:

> *"[there are people I know who] have some sort of experience at school of mental health services, or ableism at school, or homophobia in the street. And quite a lot of people I know are too scared to talk up about it because when they have for whatever reason, no-one's listened to them. So I take very much a stand point of 'I'm not afraid to talk about it so I'm going to keep talking about it until someone starts to listen', because they can't do it themselves and I can. And at one point I couldn't do it either so other people had to do it when I couldn't" (Int:16_19-05-21)*

## Institutional culture, skills for and practices of public engagement

Interviewees questioned the extent to which an approach to public engagement that recognises the importance of 'enabling and developing people's capabilities' was embedded in the institutional culture, skill sets and practices of the HWBB and some of its partners. Many examples of 'good practice' across the city were discussed, with interviewees highlighting how and why particular initiatives had worked well, in the sense that they had strengthened capabilities and created 'routes to influence' (see later section of 'good practices' below). This suggests **depth of knowledge** and **experience** within city partners and residents themselves in terms of enabling forms of engagement.

Yet almost all interviewees spoke about a **dominant tendency** by many of the main partners of the HWBB (e.g. Council, CCG, NHS Trusts, universities) towards **'consultation':** a **"*transactional and top heavy*"** (Int:6_19-04-2021) approach to engaging residents that is more about 'telling', seeking approval or authorisation for plans, with limited space for people, particularly those who have lived experience of marginalisation, to engage collectively, to drive the agenda or "*to have ongoing dialogue*" (Int:6_19-04-2021). As members of the public who we spoke to commented:

> *"[this is] a big failing of all the major institutions in the city and I think that is one that impacts quite significantly on people's feeling and emotion about being part of the solution, because they are not, they are being given the solution" (Int:7_8-12-2021)*
>
> *"They'll do a consultation but unfortunately consultations are a complete waste of time … because they'll already have made their minds up. They're only having a consultation because legally they've got to" (Int:15_18-05-21)*
>
> *"They basically want to do what they want to do and make it look as though they're not doing and hope people don't notice". (Int:15_18-05-21)*
>
> *"Sometimes they'd come and you could tell they weren't listening to a word we were saying to them. And then they'd go and we'd either hear no follow-up from it, or the follow-up we'd hear would be 'oh, they stuck to their original plan before they even spoke to us" (Int:16_19-05-21)*

Importantly, a number of interviewees emphasised that they were not necessarily questioning the intentions or agenda of city partners, noting that there was often a common aim of "*improving the lives of citizens of Sheffield*" (Int:13_29_04_2021). However, interviewees positioned consultation as different to 'deeper', enabling forms of engagement, which focus on dialogue, developing people, strengthening relationships, learning together and involving residents more directly in decision-making (Int:12_11-05-2021; Int:13_29_04_2021; Int:6_19-04-2021). This alternative approach can result in new or altered understandings of issues and strengths, and lead people to have more direct forms of influence within decision-making, and to feel more empowered and in control.

As interviewees, including people who live in the city that we spoke to, explained, the issue is that consultations happen **too late in decision-making,** and the questions and language within the consultative process can be **overly directive** prompting perceptions of 'already knowing' which is disempowering, or of being meaningless, so

that **people cannot see how proposals, strategies or ambitions would affect their lives** (Int:7_8-12-2021; Int:11_10-05-2021; Int:13_29_04_2021). It may also undermine decision-making by limiting the solutions brought into consideration, when people living in or trying to access services in the city may have valuable contributions to make:

> *"We were given various options to consider, but we couldn't go beyond those options" (Int:15_18-05.21)*

Some interviewees explained how they felt that the **institutional culture** of the Council, for example, lead to the dominance of a 'consultation' approach to engagement, due to prevailing political ideas about who has the legitimacy to make decisions - a situation compounded by limits to local powers and deep austerity-driven funding cuts (see later sections):

> *"There is a lot of, a lot of talk around empowerment and engagement. The reality is, I still think the Council, because its politicians who determine this, is still on the spectrum towards the control side… they want to look after people, but how they do it is very paternalistic. They want to look after their citizens because people have elected them to represent their views. So they see themselves as having that democratic legitimacy. You can question this depending on how many people actually go out and vote… The amount of money that the Council have actually got control over is very limited… they've lost control of housing… of the transport system. So what power they've got I think they hang on to and it is very hard for them to even consider giving up any more than they have already lost" (Int:13_29_04_2021)*

Most interviewees contrasted how deeper, more enabling examples of public engagement tended to **happen in "*pockets*"** across the main partners of the HWBB (e.g. commissioning or engagement teams within the Council, CCG, NHS Trusts, universities), and were often **led by committed people working 'lower-down'**, rather than perhaps by senior or political leaders in the city. Some interviewees, including those members of the public who we spoke to, questioned the extent to which people's lived experiences were valued in senior-level decision-making, and highlighted trust issues that were partly a result of this: *"I think that there is a **huge trust issue***" (Int:8_23-04-2021). Some also questioned whether staff in city organisations or political leaders always had the skills, knowledge or resources to support participation or perhaps even felt "*scared of getting it wrong*" (Int: 6_19-04-2021). As one person explained:

> "*That in itself is a barrier and a blocker. If you don't understand how to do it then you're not going to do it"* (Int:5_29-04-2021).

In this way, deeper, enabling approaches to engagement were **not felt to be uniformly valued** or **embedded** in the **skills**, **knowledge** or **'everyday' working practices** of senior leaders in the city, their organisations (i.e. the Council, NHS Trusts, CCG, Universities), or in the practices of the HWBB and other strategic boards, although that was felt to be changing:

> *"Part of the problem is that it's not culturally embedded. It's not embedded in the processes of how they work, and how they develop these Boards, and how they develop these strategies… It's not on the agenda as a standing item, it's not*

> *reviewed, it's not considered and it's not integral… Tells you all you need to know… It should be the golden thread that runs through all of it" (Int:5_29-04-2021)*

> *"[public engagement] its not embedded in the Council certainly, uniformly, across the organisation, as 'what everybody does'... that is changing though" (Int:8_23-04-2021)*

This issue could be compounded by **personnel changes** within organisations (e.g. commissioning, locality, engagement or partnership teams), on the HWBB or on other strategic boards in the city. Interviewees gave examples of when progress in gaining commitment to and integration of public engagement in strategic activities or commissioning processes was undone when personnel moved on (Int:5_29-04-2021; Int:15_18-05.21). The need for **cultural change and training** so that people felt it was 'everyone's business' to engage was highlighted. As one person explained in relation to engaging younger people in particular:

> *"I think that every single person who has anything to do with a young person, in mental health services, physical health service, schools, social care, needs to be participation-trained and trained in how to talk to YP, if there is training in that" (Int:16_19-05-21).*

In relation to the HWBB specifically, interviewees discussed ways to ensure there was more **diverse** and **inclusive representation** on the HWBB, which better reflected the perspectives and backgrounds of people in Sheffield. A number of people reflected on how the existing routines and practices of Board meetings could also exclude. Meetings were already affected by **power dynamics** and relationships between different partners and it was indicated that **'expected' ways of talking** and language within this formal space could marginalise: "*there is power in language*" (Int:13_29-04-2021).

Interviewees described, for example, how the use of professional language can lead to power imbalances or how ***"language of criticism"*** could lead to "*defensiveness*" (Int:11_10-05-2021; Int:13_29-04-2021). It was suggested that it would be useful to **undo the belief** that the only way to do things is through very formal **structured meetings** (Int:5_29-04-2021; Int:12_11-05-2021): this was perceived as "*never going to work to engage young people"* (Int:5_29-04-2021).

## Senior leadership and commitments to drive change across the city

Interviewees emphasised the importance of senior-organisational and political **leadership** and **'buy-in'** to drive institutional changes within the HWBB and within its member organisations, and for leaders to also **resource and 'authorise' people** to try and support participation without fear of reprisals from 'getting it wrong', despite it being ***"so hard to get right"*** *(*Int:*6_19-04-2021):*

> *"Until you've got very senior leadership buy-in for this… it doesn't really happen. It happens very ad hoc or very patchily and is done on a shoestring budget" (Int:8_23-04-2021)*

> *"To make it work all over, you've got to have it from the top" (Int:15_18-05.21).*

Some highlighted that working in this way would mean that senior leaders across health and wellbeing, including political leaders in the city, would need to accept and be ready to engage in this more **open, messy** and potentially **challenging** way (Int:9_27-04-2021; Int:11_10-05-2021; Int:2_29-04-2021).

Some felt the Council could be **moving in the right direction,** with the incoming Chief Executive, for example, emphasising the importance of collaborating across city partners and more deeply connecting within communities, and with potential opportunities to engage better with residents through the Local Area Committees that are to be set up, if these do not become too Council-led: "*There is a strong steer from senior leadership now… to develop better dialogue*" (Int:8_23-04-2021; Int:9_27-04-2021; Int:10_10-05-2021). It was emphasised however, that this type of change (and indeed the new Local Area Committees in the city) needed ideally to focus on giving residents more decision-making power and to **involve *all* key health and wellbeing partners** in the city (e.g. Council, CCG, NHS Trusts, universities, voluntary and community groups, police, transport):

> *"Wouldn't it be great if you could have the city partnerships replicated at a community-level and even if… you'd got limited staff resources, you would have other resources coming in from those organisations that can then be used around the community engagement work" (Int: 13_29_04_2021)*

A number of interviewees indicated that they would like to see HWBB members explicitly **commit to drive institutional changes** within the Board and also in their own organisations: to be 'change-makers' that are **held formally accountable** within the HWBB for **embedding public engagement 'in the everyday'** work of their organisations across Sheffield. For example, within the Board itself, that might involve having a standing item and time for dialogue on this topic in meetings (Int:2_29-04-2021; Int:5_29-04-2021; Int:8_23-04-2021). In other words, some spoke about the HWBB finding ways to **lead and drive public engagement together** across the city. As one interviewee put it simply:

> *"I don't think the city has a strategic approach to engagement… we've no longer got a city approach to engaging communities, and actually I think that is what we need" (Int:13_29_04_2021)*

One interviewee suggested that to achieve this all senior leaders on the HWBB needed to have **mechanisms for listening to voices of "*real people*"** to ensure that they always have "*that voice on [their] shoulder*" in senior-level discussion and meetings about places, neighbourhoods and commissioning, as well as mechanisms to ensure that they are aware of the engagement work and approaches of their respective organisations, which could sometimes 'get lost' within each individual organisation (Int:2_29-04-21).

## Prioritisation and resourcing and engagement in a context of austerity

Importantly, interviewees highlighted that driving institutional changes in the ways suggested above will mean **addressing gaps in** the **prioritisation** and **resourcing** of public engagement across HWBB partners, which will likely be challenging due to continued local repercussions from deep **cuts to local resources** from national austerity policies. On this issue, interviewees described how lack of recognition and

organisational commitments (as mentioned above) meant that public engagement was often not prioritised or resourced appropriately within the HWBB, or more broadly across health and wellbeing partners in the city. It was emphasised that enabling and empowering forms of engagement are often: resource-intensive, require considerable time and funding (e.g. for people's time, to cover infrastructure, activities) and need a long-term approach to support respectful dialogue and challenging conversations:

> *"There's something about recognising it takes time. One of the big things at strategic level is that timescales and turnaround are always really short. They also don't recognise that actually there is a need for some resource to enable that to happen, in terms of whether they're doing it themselves or whether they're asking other people to [help]" (Int:11_10-05-2021)*

Time and funding were emphasised as particularly important to reach and build **trust and relationships** with those individuals or groups in the city who are most at a disadvantage, so as to address the inequities already experienced and ensure people are at a point where they feel able and respected to engage (Int:10_10-05-2021).

Yet because **engagement was not felt to be uniformly valued** or **recognised** across organisational partners of the HWBB, nor seen as 'what everyone does', interviewees felt that it was often left to particular people or to engagement teams, which tended to be *"very small" and "very much struggling to find the internal resource to do decent engagement that feeds up into decision-making within an individual organisation" (Int:8_23-04-2021).*

In this way, resources allocated to public engagement were described as **ad hoc** and **funding-led**, rather than built strategically into budgets. Where engagement did take place it was often due to pots of funding unexpectedly being made available or fought for, rather than as part of a planned approach that was integral to *"the way business is done*" (Int:6_19-04-2021; Int:12_11-05-2021; Int:11_10-05-2021). For example, it was highlighted that the HWBB does **not have a dedicated budget** to underpin a long-term strategic approach to engagement and interviewees noted that putting in place a budget to resource the recent Healthwatch engagement work for the Strategy was driven primarily by one partner with funding drawn from existing budgets: *"rather than the Board saying yes we agree that this is something really important to invest in it [collectively]"* (Int:8_23-04-2021). Engagement also tended to happen in relation to specific commissioning decisions or service redesigns, rather than as part of a coherent organisational or joined-up city-wide strategy.

It was indicated that **austerity-driven cuts** had compounded these prioritisation and resourcing issues. On the one hand, it was suggested that a failure to prioritise public engagement had led the Council to make cuts locally in engagement in order to weather extremely challenging austerity budgets, whereas it was perceived that engagementmay have been 'protected' in other local authorities:

> *"...I do think that it has affected engagement. And I think that the resources for the Council to do that engagement were stripped out because it is not statutory, so they've had to make decisions about 'do I put money into social care or do I carry on doing engagement work?' and the engagement work suffered because it does need resourcing…that said it is a matter of priorities and choices… whether it is passive choice or not, it is still a choice" (Int:9_27-04-2021)*

At the same time, there was general agreement that the **capacity of the VCS** has been eroded as a result of austerity and lack of investment, with few organisations having core resources or posts specifically for community engagement and development (Int:8_23-04-2021; Int:5_29-04-2021; Int:12_11-05-2021):

> *"What I've seen over the last 3 or 4 years though is other voluntary organisations… going 'actually we need some community engagement workers' " (Int:13_29_04_2021)*

Others spoke about how **reduced capacity within the VCS** has limited the extent to which VCS organisations could engage with Boards and 'get involved in the conversations': attending Board meetings, identifying opportunities to influence decisions, engaging with services and commissioners all takes a significant amount of VCS staff time that is rarely funded, and if VCS organisations lack the capacity to get involved this means it is difficult to facilitate the involvement of individuals and groups that they work with (Int: 5_29-04-2021). It was indicated that there had been some funding available for engagement activities for some VCS organisations during COVID-19, often coming from regional or national sources (Int:3_28-04-2021). In the VCS it has often been small pots of funding from a variety of sources, but again, **ad hoc** and **fragmented**, and the sheer number of different pots of funding can stretch the financial management capacity of small VCS organisations (Int:11_10-05-2021; Int:12_11-05-2021)

In terms of Healthwatch's role locally, one interviewee reflected on how they felt the small budget allocated to Healthwatch by the Department of Health for engaging the public in their statutory role was *"ludicrous"* when compared to the scale of the health and social care system (Int:13_29-04-2021).

# Examples of engagement with routes to influence

Despite the challenges noted above, it is important to highlight that many examples of good public engagement within the city were identified during the research that focused on addressing inequalities, health or wellbeing, whilst also creating some **routes to influence** within decision-making (see illustrative examples below). A rapid analysis of the examples identified suggests that, while these were not without challenges (e.g. power dynamics, issues of trust and resourcing), many had 'common' features that reflect the findings of a recent systematic review completed by the research team on this topic (see Figure 1; Baxter et al., 2020).

The 'good practice' examples were, for example, supported by staff within the Council, VCS, universities and/or NHS who **valued the contribution of public knowledge** and who were **resourced** and **'authorised'** by more senior leaders to engage with residents and/or other partners in more 'messy' and collaborative ways. The examples also appeared to involve a mix of elements that, *together*, supported a process of engagement and routes to influence. They involved: creating both **formal and informal spaces** for people to participate - **equitably and safely**; developing opportunities to **share knowledge** (sometimes in creative ways); collectively **learning together**; and ensuring **dialogue**, **conversations** and **'feeding back'**, which sometimes helped reshape relationships, existing power-dynamics, or build trust.

## Examples of good practice in engagement

Example 1.

**Understanding inequitable impacts of COVID-19**
There has been recent dialogue and action taken to address inequitable impacts of COVID-19 on black and other minority ethnic groups in Sheffield. The process created formal and informal spaces for participation: bringing together VCS organisations working in the city (e.g. Faithstar, SADACCA, Fir Vale Community Hub, Pakistani Muslim Centre), and with statutory organisations. It has involved a process of learning together about issues of racial inequity, trust, respect, resourcing, influence and more. This ongoing process may be creating new capacities within the VCS, routes to listen, learn and respond to people living in the city, and with signs of improvements in trust as well as capacities to influence within the roll-out of the city's COVID-19 vaccination programme, which may be impacting on vaccine access and uptake.

Example 2.

**State of Sheffield Summit engagement with residents**
The Sheffield City Partnership committed to work alongside community facilitators to connect and engage residents in different local and informal spaces (e.g. group of men from Norfolk Park, young people and youth workers from Upperthorpe and Netherthorpe) about how Sheffield works for different people. Creative methods to engage were used to promote conversations that recognised what is good, people's capabilities, as well as what could be improved. This process influenced the inclusiveness of discussions across residents and senior leaders within the more formal 'State of Sheffield' Summit 2019, contributing to strategic understandings of how the city could better work for everyone (further work has been limited by COVID-19).

Example 3.

**Co-development within service transformation**
An ethos of co-development in the approach taken in one health service area has been supported by early investment in a communications plan to ensure shared understandings. Parent/carer involvement in regular task and finish group meetings ensures assumptions are challenged by the voice of lived experience. The dual strategic and operational role of the group puts 'real live problems' into the conversation and provides a channel for addressing issues and problems raised by parents/carers; this in turn supports constructive conversations. Early cautiousness/nervousness within the organization about engaging in open, transparent discussions between service staff and parents/carers has rapidly been overcome by recognised benefits for effective decision-making: "*once you start doing it, it's just natural*".

# Learning from examples of good practice

The following elements seem central in the examples of successful engagement identified in Sheffield:

**People who are connectors:** Good practice examples identified involved people or organisations who were connectors and could facilitate conversations and dialogue, and/or bring people together (i.e. residents, VCS, statutory partners). This role was, for example, carried out by trusted people within VCS organisations, within the Council, universities or parts of the NHS.

**Formal and informal spaces for participation:** Good practice examples all involved both formal meetings and informal spaces for participation (e.g. phoning people, informal chats, with food). Facilitation within these spaces helped promote more inclusive forms of dialogue and reshape power dynamics; creating space for listening, demonstrating respect and forms of talking that people could be comfortable with.

**Collective learning:** Each good practice example created opportunities for those involved - residents, statutory organisations, VCS - to listen, share knowledge and learn together, through dialogue and discussion, and sometimes in creative ways.


**Institutional culture that values public knowledge:** All examples were formally-supported by an individual or team within the Council, VCS, universities and/or parts of the NHS who valued the contribution of public knowledge and who were resourced and 'authorised' by more senior leaders to engage with people in the city and/or other partners in 'messy' and collaborative ways; and therefore had some form of internal 'route to influence'.

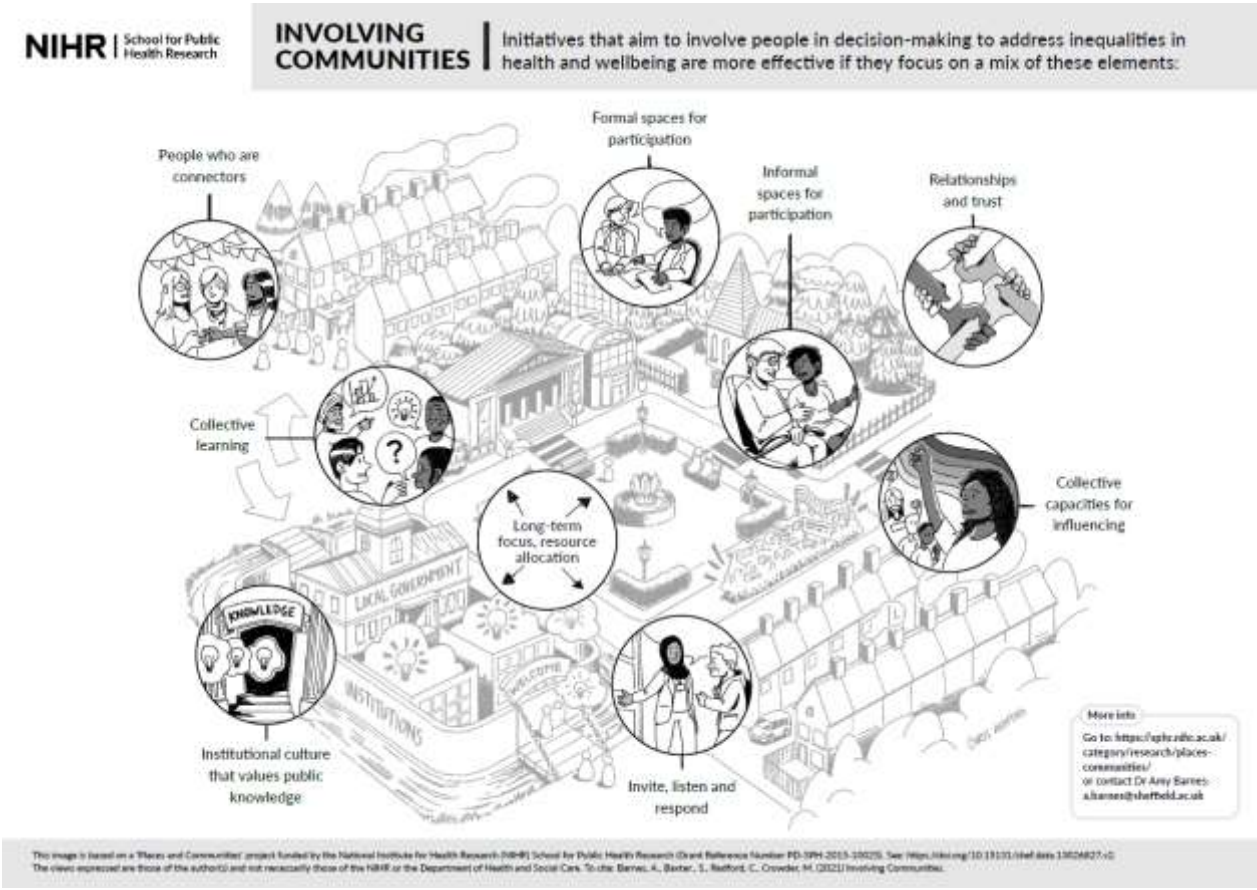
**Invite, listen and respond**: Examples involved dialogue, conversations and 'feeding back', which sometimes helped reshape relationships, existing power-dynamics, or build trust.

**Relationships and trust**: Strengthening relationships and trust were central processes within each example of good engagement and creating routes to influence within decision-making.

**Collective capacities for influencing**: Examples brought people together, building the individual and/or group capacities needed for influencing (e.g. knowledge, confidence, relationships, mutual support).


**Long-term focus, resource allocation:** All examples had access to specific funding and involved people able to commit time and energy specifically for engaging people and relationship-building. COVID-19 has led to some renewed resource commitments (perhaps due to greater visibility and political recognition of inequalities within the city), though sustainability is an issue.

Figure 1. Key elements of more effective initiatives to involve people in decision-making



# Implications and questions to consider

1. **Leadership:** Who is leading and driving public engagement as a means to address inequalities in power, control and voice as a determinant of health across the city?

There is an opportunity for the Health and Wellbeing Board (HWBB) to occupy this strategic leadership role and to drive institutional changes in public engagement within Boards and organisations across the city.

2. **Coordination and joining-up:** How joined-up are spaces for engagement across the city, and how are insights shared and used proactively within decision-making across city partners?

There seems to be an opportunity for the HWBB to take on the role of a listening body and central point of coordination across decision-making relating to inequality, health and wellbeing; and to consider if or how partnerships and joined-up public engagement can be extended at a community-level.

3. **Inclusion:** How inclusive are different spaces for people with differing social and economic perspectives, and how inclusive are they for those who already experience forms of disadvantage and exclusion?

Any engagement strategy going forward needs to consider unequal access to resources, capabilities and respect for individuals and groups across the city; including how, for example, people have been or can be excluded from participating due to age, race, ethnicity, gender, sexuality, disability, class, or a combination of these factors.

4. **Depth of participation:** How do different spaces offer opportunities for meaningful and ongoing engagement within communities for individuals or groups (as opposed to more transactional forms of 'consultation')?

The COVID-19 pandemic has provided an opportunity to learn from, re-commit to and re-examine public engagement to inform the Health and Well-being Board's Strategy going forward. Also, an opportunity to consider ways to create safe spaces for challenging and potentially uncomfortable conversations about inequalities.

Strategic ambition on inequality requires confronting issues of power and voice, and building capabilities, relationships and trust with people. It necessitates taking a long-term approach to:

- Identifying and addressing discrimination and deficits of respect, trust and feeling unheard
- Confronting socio-economic, class-based, gender, racial, ethnic and other inequities
- Tackling disability inclusion
- Confronting issues of power and control, stigma, identity and belonging

5. **Prioritisation and resourcing:** How are resources (people, time, skills, funding) prioritised and strategically coordinated towards engagement across the city?

There seems to be an opportunity for HWBB members to have a leadership role in recognising, and considering how to adequately resource long-term approaches to public engagement that enable and develop individual's and group's capabilities to influence. This includes consideration of the role and sustainable resourcing of the VCS as valued partners in this process.

6. **Governance and accountability:** How are city partners 'held to account' for engaging people in ways that could address inequalities and other determinants of health and wellbeing outcomes across the city?

HWBB members could explore opportunities to establish clear commitments, transparent processes and mechanisms to ensure organisations and leaders are formally accountable for public engagement and for addressing inequalities in power, control and voice as a determinant of health across the city.

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# Appendix 1. Mapping of engagement activities to HWBB strategic ambitions

| Details of engagment activity | | Potential relationships of engagement to HWBB ambitions | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Date(s)** | **Type of engagement / brief description** | **Start well: Early years/best start** | **Start well: Education/access local school** | **Start well: Transition to adulthood** | **Live well: Access to healthy home** | **Live well: Good quality work / sufficient resources** | **Live well: Transport/safety** | **Age well: Equitable access to care and support/personalised** | **Age well: Meaningful social contact** | **Age well: End of life with dignity/ choices** |
| 2020-21 | COVID-19 Hub Network - Embedded involvement via Covid-19 hub network: Covid-19 hub network formed of 19 geographically-focused community hubs, and 17 specialist hubs. The start of the hub network was in place at the start of lockdown. Linked to emerging informal and neighbourhood groups. | | | | | | | X | X | |
| Jan-June 2019 | Sheffield City Partnership - Partnership Framework for an Inclusive and Sustainable Economy community engagement. Process/series of events and conversations, workshops using community facilitators: Starting at the launch event of the Partnership Framework for an Inclusive and Sustainable Economy, we will build a shared plan with stakeholders and communities to deliver these seven actions and identify priorities ( to meet Commitment Working together to build a Sheffield that works for everyone. To deliver this, we will focus on: • Working better together to drive change • Leading by example • Involving and including people in the city). New approach was taken to the State of Sheffield 2019 - using local events working with communities to fill gaps and develop responses and solutions together, focusing on people's real experience of Sheffield's economy by talking to more people about what an inclusive economy would look like for them. Conversations were collected then presented at large event / reflection on key messages. There was a co-produced discussion tool and briefing pack – shaped by community facilitators and 130 people at the event. | | X | | X | X | X | X | | |
| 2019 | Big City Conversation - Talking to people in every part of the city about the issues that matter to them. How Sheffielders: − Want get involved in their local community and local issues; − Want to influence decision making - Survey, pop up conversations, organised discussions | X | X | X | X | X | X | X | X | |
| ? | Transport strategy engagement - Online consultation 'citizen space' and on-street surveys: 75% responded via "Citizen Space" site and 25% via on-street surveys (commissioned to get a 'more representative' sample in terms of age and ethnicity, reach people who do not usually engage with consultations). We will develop cycling proposals with local communities to serve not only the city's transport needs, but also the aspirations and needs of the city's people, including its disadvantaged communities. - will help understand where best to provide for cycling that that works for local people, meets objectives and is not unduly led by existing interests and so better supports congestion relief, | | | | | | X | | | |

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| | accessibility and health outcomes. | | | | | | | | | |
| Nov 2016, March 2018, March 2019 | Engaging young people via the Every Child Matters/Our Voice Matters survey and Our Voice Matters Debate. The theme of young people having a 'voice' that is heard by the local authority and schools is part of the work of the Participation Team. In November 2016 - The Great Sheffield Youth Debate for secondary school students in the Town Hall. In March 2018 - The Young People's Debate for primary and secondary schools in the Town Hall. In March 2019, a third debate - marrying it up to the survey (i.e. Our Voice Matters Debate) - listening to young people, via anonymous surveys, opportunity to share views with other young people, Elected Members. | X | X | X | | | | | | |
| 2018 | Gleadless Valley masterplan engagement - Place-based survey and meetings and design for change workshops, events, exhibitions. e.g. residents' survey about what like, don't like about living in Gleadless Valley; design for change workshops to develop options for improving Gleadless Valley. Sharing back options relating to housing, community facilities, parking, open space, play facilities at public exhibition events in October – asked to state if they supported, were neutral or did not support each option. | X | | | X | X | X | | X | |
| 2015 | Parkwood Springs Master plan engagement - Community workshop?<br>It is essential that the community is engaged in all the ways Parkwood Springs could change over the next 10 years, and engagement with local groups carried out in preparation of this Plan has been invaluable. In preparation for this Masterplan a community workshop in May 2015 provided an opportunity to discuss the general character of Parkwood Springs and allow a vision to emerge. | | | | | | X | | | |
| 2014 - Ongoing | Equalities Hubs - now Equalities Partnership<br>Sheffield's six 'equality hubs' were set up in 2014 to give a voice to particular groups of people in the city. | X | X | X | X | X | X | X | X | X |
| Ongoing | Local governance mechanisms – seven Local Area Partnerships, now new Local Area Committees? Bodies to join together more locally and seek to engage with people in their neighbourhoods. e.g. has been past focused engagement in communities around integration and social cohesion. | | | | | | X | | | |
| Ongoing (various) | Children's Health and Wellbeing Transformation Board - various engagement activities | X | X | X | | | | | | |
| 2015-2018? | Tackling Poverty - Strategy Partnership Reference Group was set up to oversee engagement, including with children, young people, families, individuals. | X | X | X | | | | | | |
| Ongoing (various) | Approaches to engagement on Council budget: - different approaches to engagement on the budget in recent years, including large scale public events in the Town Hall and neighbourhood-based events for citizens to discuss budget decisions with Cabinet Members and senior officers. Population survey on budget themes and issues using Citizenspace consultation. Engagement and consultation with citizens and service users on specific proposals – services and teams consult service users on specific proposals relating to a particular service. | X | X | X | X | X | X | X | X | |

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| Ongoing (various) | Various engagement activities by South Yorkshire Police (SYP): Both police and the Police and Crime Commissioner engage extensively, both independently and jointly, to understand the public's priorities. This enables their views to become an integral part of the decision making process, which is vital to increasing public trust and confidence in policing. Throughout the year the engagement that takes place provides a dialogue between the OPCC, the Force and the public and stakeholders to create and manage sustained and effective opportunities for the public to learn about, question and shape policing priorities and activities, and ultimately to participate in community safety as an active partner. The PCC has a duty to ensure that South Yorkshire Police is effectively engaging with communities via its Local Policing Teams and other means. | | | | X | | X | | | |
| Ongoing (various) | Citizen space consultations (various) Examples include: - application by the Broomhill, Broomfield, Endcliffe, Summerfield & Tapton (BBEST) Neighbourhood Forum to renew the designation of the forum for a further 5 years as required by the Neighbourhood Planning (General) Regulations 2012 (as amended). - proposals for new play facilities in Colley Park. - feedback on our draft Equality Objectives for 2019-23. – on proposals for introducing Selective Licensing of private rented properties. - Lower Manor Community Survey - the survey asked a number of questions that relate to local services, including how satisfied they are with these services, and provided some space for additional information about their neighbourhood and what can be done to make it an even better place to live. | X | | X | X | | X | X | X | |

NIHR | School for Public Health Research

**For more information, please contact Dr Amy Barnes a.barnes@sheffield.ac.uk**

Produced by Dr Amy Barnes, Mary Crowder, Dr Sue Baxter, School of Health and related Research (ScHARR), University of Sheffield, May 2021.

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# HEALTH AND WELLBEING BOARD PAPER

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| **Report of:** | **The Engagement Working Group** |
| **Date:** | **June 24th 2021** |
| **Subject:** | Health and Wellbeing Board: Future Engagement |
| **Author of Report:** | Rosie May |


**Summary:**

The Health and Wellbeing Board has a responsibility to engage with the public in the development and implementation of its strategy to improve the health and wellbeing of the citizens of Sheffield. A number of engagement approaches have been used in the past, and there are a number of options available for future engagement depending on what the Board wants to understand, how much it can resource this and what people can influence. Following a meeting in December 2020 an Engagement Working Group was established to identify how the Board can better connect to the communities it serves.


**Recommendations for the Health and Wellbeing Board:**

- **Previous engagement:** Make better use of existing engagement pathways, previous engagement carried out by the Board and by individual partners. Endorse the ScHARR report and commit to acting on its observations.
- **Coordination:** Board to act as coordination and information sharing centre for health and wellbeing engagement in the city: JSNA website to be adapted to host open access qualitative engagement data and reports
- **Standards**: Board to endorse revised Healthwatch engagement standards when completed
- **Planning and accountability**: The plan for the year ahead Health and Wellbeing Board meetings to be published. Partners to plan engagement together ahead of time. All papers/presentations at Board must include information about engagement on that subject.
- **Impact:** Implement a system to monitor/scrutinise impacts of engagement on Board decisions/community capacity/health outcomes. Commit to feeding back to participants in engagement projects about how what they have said is making a difference.

- **Finance:** All Partners to commit to agreeing an annual budget for engagement by the September public meeting.
- **Engagement Plan 2024:** Engagement working group to draw up three-year engagement plan which addresses points raised by SchARR. This plan will inform the next Joint Health and Wellbeing Strategy. This plan should take an action learning approach to engagement: identifying themes and what works in an iterative process over the three years. As part of this investigate new digital platforms for engagement in conjunction with LACS/SCC
- **Engagement 2021-2024**: findings should be fed back to the Board on a regular basis and if necessary, the current strategy adapted to reflect their findings.

**Context: Engagement Working group Update May 2021**

The working group has been meeting regularly since January 2021 to find a way forward for future engagement for the Health and Wellbeing Board. The group has discussed a number of issues including previous engagement undertaken by the Board, how partners carry out their own engagement in these areas, the scope of HWBB engagement and what people can change, the standards to be used in engagement and issues or sharing and effectively using information from engagement projects. ScHARR (The School of Health and Related Research at Sheffield University ) has also completed its evaluation of what has worked in previous health and wellbeing engagement in the city, and where the Board can improve. Its findings are below. A number of options for trialling different forms, methods and stages of engagement for the Board have been explored including investigating what the Board has directly control over, what needs to be delivered by partners, what people who engage with the Board can reasonably expect to influence and whether or not the current strategy is included in the remit of any consultation and engagement.

Following a number of referrals back to full Board to refine the steer, as well as discussion within the working group, the group feels that it has enough understanding of the full picture to be able to draft up a comprehensive engagement plan for the next Joint Health & Wellbeing Strategy if given a defined budget to work with. It is important to begin engagement for this now to ensure that as many different voices as possible are included in the design of the next plan, that we are able to build up long lasting relationships, and that we can take a reflective approach to engagement which allows us to work with communities to understand engagement processes that work best for them. The engagement group will be able to produce a draft plan by the next public meeting and start engagement from September if these recommendations are endorsed.

**Key questions and findings from** ScHARR **report:**

**1. Leadership**: Who is leading and driving public engagement as a means to address inequalities in power, control and voice as a determinant of health across the city? There is an opportunity for the Health and Wellbeing Board (HWBB) to occupy this strategic leadership role and to drive institutional changes in public engagement within Boards and organisations across the city.

**2. Coordination and joining-up**: How joined-up are spaces for engagement across the city, and how are insights shared and used proactively within decision-making across city partners? There seems to be an

opportunity for the HWBB to take on the role of a listening body and central point of coordination across decision-making relating to inequality, health and wellbeing; and to consider if or how partnerships and joined-up public engagement can be extended at a community-level.

**3. Inclusion:** How inclusive are different spaces for people with differing social and economic perspectives, and how inclusive are they for those who already experience forms of disadvantage and exclusion? Any engagement strategy going forward needs to consider unequal access to resources, capabilities and respect for individuals and groups across the city; including how, for example, people have been or can be excluded from participating due to age, race, ethnicity, gender, sexuality, disability, class, or a combination of these factors.

**4. Depth of participation**: How do different spaces offer opportunities for meaningful and ongoing engagement within communities for individuals or groups (as opposed to more transactional forms of 'consultation')? The COVID-19 pandemic has provided an opportunity to learn from, re-commit to and re-examine public engagement to inform the Health and Well-being Board's Strategy going forward. Also, an opportunity to consider ways to create safe spaces for challenging and potentially uncomfortable conversations about inequalities. Strategic ambition on inequality requires confronting issues of power and voice, and building capabilities, relationships and trust with people. It necessitates taking a longterm approach to:

- Identifying and addressing discrimination and deficits of respect, trust and feeling unheard
- Confronting socio-economic, class-based, gender, racial, ethnic and other inequities
- Tackling disability inclusion
- Confronting issues of power and control, stigma, identity and belonging

**5. Prioritisation and resourcing:** How are resources (people, time, skills, funding) prioritised and strategically coordinated towards engagement across the city? There seems to be an opportunity for HWBB members to have a leadership role in recognising, and considering how to adequately resource long-term approaches to public engagement that enable and develop individual's and group's capabilities to influence. This includes consideration of the role and sustainable resourcing of the VCS as valued partners in this process.

**6. Governance and accountability:** How are city partners 'held to account' for engaging people in ways that could address inequalities and other determinants of health and wellbeing outcomes across the city? HWBB members could explore opportunities to establish clear commitments, transparent processes and mechanisms to ensure organisations and leaders are formally accountable for public engagement and for addressing inequalities in power, control and voice as a determinant of health across the city.

ScHARR **report May 2021**

**Background Papers:**

Appendix 1: ScHARR report on health engagement (May 2021)

**Which of the ambitions in the Health & Wellbeing Strategy does this help to deliver?**

All of them: the strategy cannot be fully realised without meaningful public engagement

**Who has contributed to this paper?**

The HWBB Engagement Working Group comprising:

- Judy Robinson and Lucy Davies, Healthwatch
- Adele Robinson; Head of Equalities and Engagement, Sheffield City Council
- Alaina Briggs, Equalities and engagement officer SCC
- Dan Spicer Policy and Partnerships Manager, SCC
- Jane Ginniver Deputy Director ACP
- Helen Mulholland CCG
- Amy Barnes, Mary Crowder and Sue Baxter, ScHARR

# HEALTH AND WELLBEING BOARD PAPER

# FORMAL PUBLIC MEETING

| | |
|---|---|
| **Report of:** | *Rosie May* |
| **Date:** | 28th October 2021 |
| **Subject:** | Engagement and Health & Wellbeing |
| **Author of Report:** | Rosie May |


**Summary:**

The Health and Wellbeing Board has a responsibility to engage with the public in the development and implementation of its strategy to improve the health and wellbeing of the citizens of Sheffield. Following a meeting in December 2020 an Engagement Working Group was established to identify how the Board can better connect to the communities it serves. The group has met a number of times in the last 9 months, each time working towards a better understanding of a number of issues and defining the scope of the engagement for the next Health and Wellbeing Strategy. This paper focuses on the financial and organisational practicalities of the future engagement work.


**Questions for the Health and Wellbeing Board:**

- How can partners pool resources and funding to cover the costs of a part time post to coordinate engagement over the next three years and extra funding for Healthwatch to work with the VCS?

**Recommendations for the Health and Wellbeing Board:**

- Identify approx. £20k per annum over three years to fund a part-time post (based on a Grade 7 Council post working three days a week) to draw up a three-year Engagement Plan and monitor and evaluate its success, as well as acting as a coordination point for health and wellbeing engagement across the city.

- Commit to funding Healthwatch £20k per annum over three years to build on existing engagement work with a particular focus on working with the voluntary and community sector to bring a range of diverse voices and experiences to the Board on a regular basis
- Commit to working together to agree shared health and wellbeing engagement standards for the city
- Commit to the Engagement Working group to continue as a steering group for the work of the coordinator and the engagement plan

**Background Papers:**

*ScHaRR report*

*Previous Engagement Update*

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**Which of the ambitions in the Health & Wellbeing Strategy does this help to deliver?**

This contributes to work against all of the ambitions in the Strategy.

**Who has contributed to this paper?**

*The Engagement Working Group:*

- Judy Robinson and Lucy Davies, Healthwatch
- Adele Robinson; Head of Equalities and Engagement, Sheffield City Council
- Alaina Briggs, Equalities and engagement officer SCC
- Dan Spicer Policy and Partnerships Manager, SCC
- Jane Ginniver Deputy Director ACP
- Helen Mulholland CCG
- Amy Barnes, Mary Crowder and Sue Baxter, ScHARR
- Helen Steers, VAS

## Report of the Engagement Working Group

### 1.0 SUMMARY

1.1 The Health and Wellbeing Board has a responsibility to engage with the public in the development and implementation of its strategy to improve the health and wellbeing of the citizens of Sheffield. Following a meeting in December 2020 an Engagement Working Group was established to identify how the Board can better connect to the communities it serves. The group has met a number of times in the last 9 months, each time working towards a better understanding of:

- what works and what doesn't in terms of previous engagement,
- which groups have been included and excluded from decision making,
- what exactly the Board should be engaging with its communities on,
- how this can make a real impact on health inequalities in Sheffield,
- the standards of engagement we should be working to and
- how the Board and working group practically go about carrying out this work.

1.2 This paper focuses predominantly on the latter point.

### 2.0 KEY MESSAGES FROM THE WORKING GROUP

2.1 **HWBB needs to engage MORE and BETTER:** We know HWBB needs to connect better with its communities: to listen to what the city and its diverse communities need, to raise its profile so people can make it work better for them, and to ensure that it prioritises the right collective action at the right time for Sheffield's citizens, in order to make a real impact in reducing health inequalities. We are particularly aware that the Board is not engaging as well as it could with certain marginalised groups, and also that it is not making the best use it can of existing engagement initiatives across the city.

2.2 **The Engagement Working Group has met regularly since last year:** The Board set up a working group made up of representatives of many of Sheffield's institutions including the voluntary sector to explore collectively how we might be able to better collaborate on engaging with the public. It has spent time defining good engagement, reviewing past engagement (in partnership with ScHARR at Sheffield University) and establishing what exactly the Board needs to engage with the public about.

2.3 **We need to draw up a three year-engagement plan for the next HWBB strategy:** Following a number of papers to the Board to hone the scope of the work it was agreed that the Working Group needed to plan and cost out a three-year action learning focused engagement plan to work with as many different communities across the city over a sustained period of time in order to better understand the different health and wellbeing priorities and also different approaches to health messaging of different

communities of interest. The work would also evaluate the best engagement methods for diverse communities and make recommendations to the board about future approaches.

2.4 **We know what good engagement looks like:** There is a great deal of health and wellbeing engagement expertise in Sheffield's institutions, statutory partners and the voluntary and community sector. Often however it has done in a piecemeal and uncoordinated manner, with different bodies repeatedly consulting with the same groups about the same issues and not sharing information. Whilst this is partly due to statutory engagement requirements for different partners, findings could be better shared across partners and with the Board, and collaborative solutions found instead of partners working in isolation. This would lead to better solutions, more capacity and less strain on communities. It would be useful if engagement standards could be agreed on by all major Board partners.

2.5 **We need capacity to co-ordinate existing and planned engagement:** A key aspect of the three-year engagement plan would be to better coordinate and collaborate on existing and planned engagement plans and share intelligence for the benefit of the city as a whole. We do not need to carry out However there is not the resource in the working group to do this (especially with key staff members leaving and changes in the healthcare landscape). A part-time engagement officer (circa £20k: at a Council equivalent of a Band 7 post) based in one of the major institutions in the city is needed to coordinate this work, navigate the larger organisations, hold them to account for actions and report back to the Board and, crucially, those most affected by health inequalities (and the city at large) on what has been achieved.

2.6 **We need capacity to deliver embedded, long-term, sustainable engagement:** Better co-ordination is not the only answer. For the Board to properly engage it needs long-term, community-embedded dedicated health engagement resource with expertise in working with as many of Sheffield's diverse communities as possible. A particular focus should be on accessing the voices and experiences (and building the capacity for self-advocacy) of those who the Board does not, at present, fully represent. This needs to be two way: better sharing of information and feedback on action to communities as well as listening to and working with communities on the future plan. This should be equal to or more than the funding allocated to the engagement officer post (£20k+ per annum for VCS engagement work). The funding is increased from previous years to encourage more sustained work with marginalised communities, in order to build a meaningful reciprocal relationship with the Board and its members. This could be funding pooled for existing organisational engagement resource or an extra contribution from partners.

## 3.0 QUESTIONS FOR THE BOARD

- How can partners pool resources and funding to cover the costs of a part time post to coordinate engagement over the next three years and extra funding for Healthwatch to work with the VCS?

## 4.0 RECOMMENDATIONS

4.1 The Board are recommended to:

- Identify approx. £20k per annum over three years to fund a part-time post (based on a Grade 7 Council post working three days a week) to draw up a three-year engagement plan and monitor and evaluate its success, as well as acting as a coordination point for health and wellbeing engagement across the city
- Commit to funding Healthwatch £20k per annum over three years to build on existing engagement work with a particularly focus on working with the VCS to bring a range of diverse voices and experiences to the Board on a regular basis
- Commit to working together to agree shared health and wellbeing engagement standards for the city
- Commit to the Engagement Working group to continue as a steering group for the work of the coordinator and the engagement plan

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**SHEFFIELD CITY COUNCIL**

# Sheffield Health and Wellbeing Board

## Meeting held 25 March 2021

**PRESENT:** Councillor George Lindars-Hammond (SCC) (Chair)
Terry Hudsen (GP Governing Body Chair, Sheffield CCG) (Co-Chair)
Simon Verrall (South Yorkshire Police)
Councillor Jackie Drayton (SCC)
Kate Josephs (Chief Executive, SCC)
Eleanor Rutter (Consultant in Public Health, SCC and Representative of Greg Fell [Director of Public Health, SCC])
John Macilwraith (SCC)
Brian Hughes (CCG)
Judy Robinson (Chair of Healthwatch)
Mike Potts (Health and Social Care Trust)
Alexis Chappell (SCC)
Rosie May (Development Officer, SCC)
Dan Spicer (Strategy and Partnerships Manager, SCC)
David Warwicker (SCC)

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## 1. APOLOGIES FOR ABSENCE

1.1 Apologies for absence were received from Alison Knowles (NHS England), Mick Crofts (SCC), Greg Fell (Director of Public Health, SCC), Helen Steers (VAS), Dr David Hughes (Sheffield Teaching Hospitals NHS Foundation Trust), Zac McMurray (Sheffield CCG), Councillor Paul Wood (SCC), Dr Mike Hunter (Sheffield Health and Social Care NHS Foundation Trust), John Doyle (Director of Strategy and Commissioning, SCC) and Lesley Smith (Sheffield CCG).

## 2. DECLARATIONS OF INTEREST

2.1 There were no declarations of interest made.

## 3. PUBLIC QUESTIONS

3.1 There were no questions from members of the public.

## 4. BETTER CARE FUND UPDATE

4.1 Jennie Milner provided a verbal update on the Better Care Fund and stated she would share a brief document to the public domain following this meeting. She shared information around the budget for 2020-2021.

4.2 Jennie confirmed the budget had been allocated and stated she believed the money received would be used. The actual Better Care Fund required a minimum contribution from the CCG to the Local Authority to support their schemes. Jennie

confirmed that the CCG's contribution was in excess of the minimum required. She presented the final values for this year as follows:

- Disabled Facilities Grant - £5,108,320 (Income and expenditure is identical)
- Minimum CCG Contribution - £42,820,993 (Income and expenditure is identical)
- Integrated Better Care Fund - £28,428,597 (Income and expenditure is identical)
- Additional Local Authority Contribution - £97,451,154 (Income and expenditure is identical)

Additional CCG Contribution - £223,624,476 (Income and expenditure is identical).

4.3 Jennie stated that there would be a June summary of the proposed expenditure and actual expenditure for this financial year. She said that the excess contribution demonstrated the commitment to health in Sheffield. She added that the Bettercare Fund was on track to stay within budget.

4.4 The Chair thanked Jennie for the update.

## 5. HEALTHWATCH UPDATE

5.1 Judy Robinson gave a verbal update on the work of Healthwatch. Judy stated these updates tended to focus on problematic areas; however, there had been a lot of good feedback received – particularly around the Covid-19 vaccination programme.

5.2 Judy said there were a number of issues with communication. The first was that people were struggling to contact GPs and were getting stuck in referral loops.

5.3 The second example was dentistry, which Judy said was an ongoing issue. She stated people were struggling because of the guidelines which stated that people did not need to be registered with dentists, which can lead people to not have urgent dental care. She said that there was a lack of clear information and clarity around what urgent dental care is which needed to be improved.

5.4 Finally, Judy said there were issues with access to services for deaf people. There were growing numbers of individuals who were deaf and communication needed to be improved to this group of people.

5.5 Judy said that there was a report from Healthwatch to the March meeting of the Healthier Communities and Adult Social Care Scrutiny Committee which focused on the disproportionate effect of COVID-19 on people with disabilities, particularly those with learning disabilities. She stated that communication was a key issue within the report, alongside the poor experience of disabled people in hospitals. She referred to a couple who were profoundly deaf, and one of them passed away in hospital recently. She said there had been poor communication around this.

5.6 Judy added there was a significant amount of fear for disabled people for life after COVID-19. There was a need to understand people's concerns and to take these into account. She talked through the report further, mentioning a change in health care visits, a reduction in service choices and communication which is often poorest to those who need it most. Judy said that considerations of health inequality did not include disabilities enough. Judy said she would share these reports with attendees, The Chair offered to share these on her behalf and encouraged attendees to sign up to Healthwatch updates.

5.7 Councillor Jackie Drayton thanked Judy Robinson for the report. Councillor Drayton stated that the report and its recommendations would be going to the Outbreak Control Board (the COVID-19 Prevention and Management Board) in two weeks. Councillor Drayton added that the report had been discussed in the Council's regular meeting and that the Council was considering what more they could do in response to the recommendations. Councillor Drayton said she attended the Learning Disability Partnership Board, during which she heard about the lived experience of those with disabilities alongside the charities and organisations that work with those who have disabilities.

5.8 Councillor Drayton said that there were a number of people with disabilities concerned around Do Not Resuscitate letters being sent by GPs, although not necessarily in Sheffield. Councillor Drayton said that the Council were reassuring the public that this would not happen.

5.9 Brian Hughes (CCG) thanked Judy for the reports and for sharing the lived experiences of those with disabilities. He stated he would use those reports to inform the work of the CCG.

5.10 Brian Hughes stated that Sheffield participated in a review of Do Not Resuscitate letters. He said that this needed to be followed up on locally, but that Sheffield is exemplar.

5.11 Brian Hughes spoke about the profoundly deaf couple mentioned by Ms Robinson. He said that their experience was relayed to the CCG's governing body in public session last month. The appropriateness of communication was being taken out into the CCG's providers to pause, reflect and act appropriately.

5.12 Mike Potts (Health and Social Care Trust) said that Rebecca Walls, a Clinical Nurse Specialist had been commissioned by four of the CCG boards across South Yorkshire to highlight the issues of deaf people and had attended the Health and Social Care January board meeting. Mike Potts said this was an important learning opportunity which informed attendees of ways to improve the experiences of deaf people.

5.13 Judy Robinson stated that Healthwatch had been sharing the experiences of those who suffer from poor services for a number of years and that she was glad to hear Councillor Drayton talk about embedding the report's recommendations.

5.14 The Chair hoped by the next Healthwatch update the Council would be further down the road in terms of embedding processes.

## 6. STATEMENT OF INTENT

6.1 Terry Hudsen (Co-Chair) stated the Health and Wellbeing Board had brought back the item as they recognised the importance of the voluntary and community sectors play in the city.

6.2 Terry said that Board had spent a good deal of time reflecting on the demands COVID-19 had placed on Sheffield. He said that the Rapid Health Impact Assessments received in late 2020 demonstrate that the voluntary and community sectors are essential to tackling health inequality. Conversations around this paper began in October 2020 and were focused on Ambition 8 of the Health and Wellbeing Strategy which stated that everybody had a level of meaningful social contact that they want. Terry said it became clear that organisations from the voluntary and community sector were one of the most important partners across all 9 of the ambitions within the Health and Wellbeing Strategy. The issue of how the Board worked with the voluntary and community sector was raised at last month's strategy meeting and that the Health and Wellbeing Board along with Sheffield as a city was working to enhance their relationship with these groups.

6.3 Terry provided an overview of the key questions and issues raised as follows:

- The Board was asked to recognise and honour the centrality of leadership that the voluntary and community sector plays in Sheffield;
- The Board was asked to recognise that the voluntary and community sector did not just exist as a provider of something but as a vital source of lived experience;
- The Board was asked to recognise the current threats and challenges that voluntary and community organisations were facing to their short-term stability and longer-term viability;
- The Board was asked to examine the barriers which existed in Local Authority and health commissioning which needed to be removed in order to enable the voluntary and community sector to better connect with other parts of the system;
- The Board was asked to ensure that any plan to support the voluntary and community sector was based on mutual trust, openness and an enhanced two-way sharing of information.

Terry said that at the end of this meeting the Health and Wellbeing Board agreed a Statement of Intent to renew their relationship with the voluntary and community sector.

6.4 Terry referred attendees to the appendix of the report of the Statement of Intent, to be shared with partners within the city. Terry said the paper's recommendations were as follows:

- That the Health and Wellbeing Board endorses this Statement of Intent and publish this on the website;
- That the Health and Wellbeing Board agree and review this statement annually;

- That the Health and Wellbeing Board work to produce a short-term action plan owned by the board, reporting back on the process of these actions annually.

6.5 Judy Robinson stated that some of the existing voluntary and community groups might be struggling within the next 12 months due to COVID-19. She mentioned emergency funding for these organisations in the short-term. Terry responded to this and said there were a set of actions within the paper to address the issues and that these would be brought to a future Health and Wellbeing Board for approval. Brian Hughes echoed these comments.

6.6 John Macilwraith (SCC) stated that the City Council had resurrected its strategic partnership with the voluntary and community sector and Councillor Paul Wood had been in attendance at the inaugural meeting.

6.7 Terry Hudsen thanked everybody who contributed to the Statement of Intent. Terry asked that Board Members endorse the statement. Terry said that this statement will be confirmed in a letter sent to partners.

6.8 **AGREED** that the Statement of Intent had be endorsed.

## 7. UPDATE ON ENGAGEMENT WORKING GROUP

7.1 The Chair stated that work was ongoing and it was intended that an update on the Engagement Working Group be given in June 2021.

## 8. MINUTES OF THE PREVIOUS MEETING

8.1 **AGREED** that the minutes of the meeting held on the 10th December 2020 to be approved as a correct record.

## 9. DATE AND TIME OF NEXT MEETING

9.1 The next meeting of Sheffield Health and Wellbeing Board would be held on Thursday 24th June 2021 at 3pm.

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