Report No: 103/2021
PUBLIC REPORT

CABINET

27 July 2021

LLR SHARED HEALTH AND CARE RECORD - CHARTER

Report of the Strategic Director for Adult Services and Health

Strategic Aim:	Protecting the vulnerable Customer –focussed services	
Key Decision: No	Forward Plan Reference: FP/110621	
Exempt Information	No	
Cabinet Member(s) Responsible:	Cllr Alan Walters: Portfolio Holder for Health, Wellbeing and Adult Care	
Contact Officer(s):	John M Morley, Director of Adult Social Services	01572 758442 JNMorley@rutland.gov.uk
Ward Councillors	n/a	

DECISION RECOMMENDATIONS
That Cabinet: 1. Notes the beneficial development of a Shared Care Record (SCR) between health and adult social care. 2. Authorises the Director of Adult Services and Health, in discussion with the Portfolio Holder for Health, Wellbeing and Adult Care, to agree with the Integrated Care System (ICS) partners such changes to the Charter as are necessary to limit any unquantified risk to the Council's resources. 3. Approves the Director of Adult Services and Health, in discussion with the Portfolio holder for Health, Wellbeing and Adult Care, signing the charter on behalf of the Council subject to the changes referred to in recommendation 2.

1. PURPOSE OF THE REPORT

1.1 The purpose of this report is: (i) to update Cabinet on progress with the project to deliver integrated health and care services by implementing a Shared Care Record (SCR) for Leicester, Leicestershire and Rutland (LLR), and (ii) to approve a Collaborative Charter which confirms the participation of Rutland County Council as one of the partners in the project.

2 BACKGROUND TO THE SHARED HEALTH AND CARE RECORD AND MAIN CONSIDERATIONS

2.1 Through the NHS's Local Health and Care Record Exemplars (LHCREs) programme, Shared Care Records (SCR) across health and social care began to be implemented in selected regions of England in May 2019, with the intention to roll this out nationally in stages.

2.2 In November 2020, National Health Service England Improvement (NHSEI) published *Integrating care: Next steps to building strong and effective integrated care systems (ICS) across England*. It described the core purpose of an ICS as 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.

2.3 In November 2020, the Department of Health and Social Care stated that all ICS footprints will put in place a Shared Care Record (SCR). In March 2021, the Secretary of State stated that all local systems will have in place a basic shared record solution by September 2021. This has been reaffirmed by the recently published draft policy paper *Data Saves Lives: reshaping health and social care with data.*

2.4 The aim of the SCR is to enable the safe and secure sharing of an individual's health and care information as they move around different parts of the NHS and social care:

- saving time and money across the health and care system, including reducing information-seeking time, duplication and 'just in case' admission to hospital;
- improving the pace and quality of professional decision-making;
- improving care for individuals; and
- improving patient safety.

2.5 The SCR programme is driving infrastructure across England which will enable information to flow seamlessly between organisations so that, wherever someone lives or has travelled to in England, they will be able to receive fully informed health treatment and social care support.

3 RATIONALE AND IMPLICATIONS FOR THE COUNCIL

3.1 An SCR provides clinical and care staff directly involved in an individual's care with access to the most up to date information about them. It does this by sharing relevant information from the various health and social care systems holding that information. Records are kept strictly confidential and can only be accessed by the appropriate clinical and care staff.

3.2 The main benefit of a SCR, is that practitioners will have a single point of information about a person without having to sign onto multiple organisational systems or to seek information from other professionals by phone or email. This will streamline work processes, reduce bureaucracy, deliver more joined up care and improve care decisions.

3.3 The proposed solution for LLR builds on the existing case management and record keeping systems of constituent partners, rather than imposing investment in a single all-encompassing case management solution for all parties. Each partner will use their own native system, but be able to view information as required from other stakeholders' systems, either from within their own system or alongside it. This model aims to reduce overall costs and disruption to all parties and avoids locking partners into systems that could be more suitable for some than others.

3.4 The LLR project is being led by a central project team with organisational representation from across key stakeholders including primary, secondary, acute and social care.

4 DELIVERY IN PARTNERSHIP

4.1 The SCR project forms a key part of ICS activity and is to be funded from ICS Transformation or NHSX Digital Transformation funds.

4.2 The main stakeholders of the project are LLR Clinical Commissioning Groups, Leicestershire Partnership NHS Trust (LPT), University Hospitals Leicestershire (UHL), Derbyshire Health United, and the Rutland and Leicestershire County Councils and Leicester City Council.

4.3 More formal stakeholder commitment to engage in the project is now being sought. To facilitate this, a brief local Charter has been drafted for sign off by the stakeholders. UHL and LPT have already indicated their sign-up to the Charter. This is attached as an Appendix.

4.4 This local Charter outlines a minimal set of core principles as follows:

a) That LLR ICS is prepared to support the business case and bid made to NHSX to secure year 1 and potentially year 2 funding for this programme of work and make reasonable endeavours to ensure success of this bid, should LLR be required to provide additional commitment support for review purposes.
b) That within the bounds of legal compliance, appropriate information governance and security, and patient/citizen and clinical/practitioner safety, your organisation will commit to sharing the necessary information required to ensure that patient/citizen and clinical/practitioner benefits of an LLR SCR are maximised.
c) That without full financial support from NHSX in initial years and on a revenue basis, the running costs of the LLR SCR will have your organisation's support as an ICS funded system priority.
d) That your organisation (direct or by agreed representation) is prepared to contribute into any governance arrangements constituted in order to deliver the programme successfully.
e) That your organisation within the ICS, subject to discussion and agreement with the programme, will commit resources and prioritise (paid for by the programme where necessary or otherwise) to help deliver the programme successfully.

4.5 For the reasons outlined in this report, Cabinet is asked to note the good intention in developing the charter and support the core principles of the charter. However, Principles c) and e) (above), do potentially provide for an unquantifiable commitment to resources which may lead to either financial risk, misinterpretation or discord between the Council and the ICS partnership. It is recommended therefore that the

Council should signal its intention to support the development of a SCR whilst seeking to clarify the commitment required to sign up to the charter. A central tenet to confirm is that signing the Charter does not commit the Council financially, and that requests for funding would need to pass through appropriate Council governance.

5 CONSULTATION

5.1 The project is a government obligation on national health and social care partners and, as such, consultation is not in scope at this stage.

6 FINANCIAL IMPLICATIONS

6.1 It is not anticipated that in cash terms this will have a direct call upon any single organisation to find money from existing allocations. Rather, the commitment being sought is that the project will remain a key priority of the ICS and potentially be top-sliced from their budget.

6.2 Implementation of the SCR is expected to cost c£5.7 million over a seven year period. The year one figure (2021-22) is £2.081m with a remaining £3.662m over the remaining six years (approximately £610k a year). It is likely that the 2021-22 figure will be supported by a £2.081m capital bid to NHSX, which will pay for the implementation phase, with Leicestershire Partnership NHS Trust hosting the money and the capital charges being a cost to the ICS.

6.3 There is confidence that monies will be available from a recent announcement from NHSX that a Unified Technology Fund will be available to the ICS to invest in SCRs. This was to be announced in June 2021, however it is unknown what a local allocation will be.

6.4 A £1.5m budgetary revenue figure has been set aside by the Clinical Commissioning Groups for this project as a contingency figure in case there is no funding from NHSX in 2021-22.

6.5 We do not believe there are any direct finance implications for RCC budgets, however we are in consultation with the CCG to gain further knowledge on the staffing resource ask.

7 LEGAL AND GOVERNANCE CONSIDERATIONS

7.1 The project will increase the sharing across organisations of sensitive personal data, in support of improved direct care. As part of its own assurance activities, the Council must ensure that the information sharing to be enabled is GDPR and Data Protection Act compliant.

7.2 LLR governance of the project is through the LLR Information Management and Technology (IM&T) Strategy Board.

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7.3 For Rutland, the project has been assessed as high risk, with the potential to reduce to medium risk when some unknowns are resolved. As such, significant decisions will be brought to both SMT and Cabinet and the project will be overseen by the corporate Programme Management Office (PMO).

8 DATA PROTECTION IMPLICATIONS

8.1 This project involves increased sharing of sensitive personal data in support of direct care. A Data Protection Impact Assessment (DPIA) is being completed at the level of the project.

9 EQUALITY IMPACT ASSESSMENT

9.1 An Equality and Human Rights Impact screening assessment will be undertaken in the early stages of the project. It is anticipated that this project would have a neutral to positive impact on communities with protected characteristics. For example, groups who are less able to explain their own health and care circumstances would be better served, including people living with learning disabilities or cognitive impairment, or whose primary language is not English.

10 COMMUNITY SAFETY IMPLICATIONS

10.1 There are no community safety implications of this project, except that it will help to improve care decisions for people in emergency situations.

11 HEALTH AND WELLBEING IMPLICATIONS

11.1 The SCR will have a positive impact on health and wellbeing. It will enhance the quality of direct health and social care services by enabling efficient access to the health and care information needed to support good quality decision-making.

12 CONCLUSION AND SUMMARY OF REASONS FOR THE RECOMMENDATIONS

12.1 The establishment of a Shared Care Record is a national requirement and forms an integral part of the medium-term objectives of the ICS. It will enable care and clinical staff access to real time health and care information across care providers and between different operational systems, leading to swifter and better informed care decisions for the benefit of all patients/service users.

12.2 The informal Charter attached as Appendix A seeks to commit the ICS to prioritising the development of the Shared Care Record, and as such requires support from a range of stakeholders. These include Rutland County Council, Leicestershire County Council and Leicester City Council.

12.3 It is important that the Council remains a committed stakeholder in order to represent the interests of adult social care in the project and to help shape the future approach to information sharing and collaboration.

12.4 However, the Council cannot make an open-ended commitment to provide resources which have not yet been quantified and which could present a risk to the authority's Medium Term Financial Plan position. As such, it is recommended that Cabinet agrees to support the Charter in principle, and asks the Director of Adults and Health to agree a suitable form of words with partners which limits the financial and strategic risk to the Council.

13 BACKGROUND PAPERS

13.1 Integrating care: Next steps to building strong and effective integrated care system across England
https://www.england.nhs.uk/publication/integrating-care-next-steps-to-building-strong-and-effective-integrated-care-systems-across-england/

13.2 Data Saves Lives: reshaping health and social care with data
https://www.gov.uk/government/publications/data-saves-lives-reshaping-health-and-social-care-with-data-draft

13.3 White Paper Integration and innovation: working together to improve health and social care for all
https://www.gov.uk/government/publications/working-together-to-improve-health-and-social-care-for-all/integration-and-innovation-working-together-to-improve-health-and-social-care-for-all-html-version

14 APPENDICES

14.1 APPENDIX A: Leicester, Leicestershire and Rutland Shared Care Record: A Charter for Collaborative Success

A Large Print or Braille Version of this Report is available upon request – Contact 01572 722577.