February 2018

National Voices

Inquiry Submission

Health Select Committee: Inquiry on STPs

1. Summary of key points

1.1 NHS England now describes the key goal of STPs as being 'integration'. National Voices believes STPs have not yet had the time to influence integrated care. Those STPs where integration is strong will be those where pre-existing relationships and programmes developed by, for example, integration pioneers and vanguards, are strong.

1.2 In 2013, building on the integration duties in the 2012 Act, all the national system leaders signed a Shared Commitment to integrated care. It is not clear whether this remains a live, definitional and binding document and we would suggest that the committee establishes what definition of integration will govern STP/ICS development.

1.3 STP engagement with their voluntary and community sectors has been patchy. In the first year the VCSE sector felt excluded. Since then some selected voluntary organisations have been engaged, but often in tokenistic ways. Small to medium voluntary organisations have little access to STPs.

1.4 Some STPs have exemplary arrangements to share leadership with the VCSE sector, and/or to build patient and public representation. We suspect that most have no such formal arrangements.

1.5 STP plans need to be tested on the realism of their reliance on people to 'self-care' as a route to closing the sustainability gap.

1.6 STP plans need to be tested on their adequacy to meet the growing multimorbidity challenge, which would involve whole system care redesign rather than merely improving single disease pathways.

1.7 A significant barrier to the required 'population health' approach, and to integrating the care of individuals, is the lack of joined up, interoperable record systems. It is clear that there will be a new push to achieve these; but unclear where the investment money will come from.

2. About National Voices

2.1. National Voices is the coalition of charities that stands for people being in control of their health and care. Our executive team has had limited contact with some STPs since their inception. Member organisations are engaged with some STPs. We have consulted with members on our response to this inquiry.

2.2. Since the terms of reference for this inquiry were announced, NHS England's description of STPs has changed: it now focuses on integrated care. This includes renaming ACSs as Integrated Care Systems in the recently published NHS Planning Guidance. National Voices has significant experience in the quest for integrated care. Through our 'Narrative for person centred coordinated care', jointly with Think Local Act Personal, we provided the national definition of the goals of integration, at the heart of the 'Shared Commitment' of all system leading bodies in 2013[i]. We helped select the integration pioneer areas and worked with them for over two years.

2.3. National Voices has also supported the Five Year Forward View, focusing in particular on what it called the 'new relationship with people and communities'. We helped write Chapter 2 of that document; chaired the People and Communities Board (PCB) that explored how to achieve Chapter 2; and participated in relevant programme boards. The PCB provided STPs with 'Six Principles for Engaging People and Communities', which NHS England required them to adopt[ii].

2.4. National Voices intends, through incipient supplier frameworks, to offer its services to support STPs/ICSs.

2.5. In this submission we will answer only those Inquiry questions where we have relevant knowledge and expertise.

3. Effectiveness in joining up health and social care

3.1. Creating joined up care for people is a long term project. The experience of the integration pioneers and vanguards (and of previous pilots and schemes) suggests that it takes at least seven years, possibly up to ten, to create redesigned care at scale. While STPs may have brought leadership cohorts together, it is doubtful they have yet had any impact on redesigning care.

3.2. Those areas that became integration pioneers already had a significant hinterland of working towards integration, establishing the necessary relationships and trust. Many pioneers became 'rebadged' as vanguards. In addition there are some progressive CCGs that have worked extensively with local authority colleagues on integration, but on a footprint likely to be smaller than their STP. These are the (sometimes substantial) areas of the country that can demonstrate progress on integrated care over time. They have influenced their STPs, rather than vice versa.

3.3. Many other STPs are starting from much further back. Their pursuit of integration will still be at the early stage of forming relationships and creating paper plans, with an early focus on selected pathways of care.

3.4. We would suggest that the committee seeks to determine:

- 3.4.1. the extent to which STPs in general see their goal as integration, as opposed, for instance, to balancing the regional public services budget over the next five years;
- 3.4.2. whether the 2013 Shared Commitment remains the commitment of both national system leaders and the STPs;
- 3.4.3. and, if the answer to the latter is no, what definition of integration has replaced it.

4. Effectiveness of engaging parts of the system outside of the acute healthcare sector (including the public)

4.1. Chapter 2 of the Five Year Forward View emphasised the need to build new relationships with the Voluntary, Community and Social Enterprise (VCSE) sector. In the draft standard contract for Accountable Care Organisations, they are required to implement NICE Guideline 44 on

community engagement[iii]. The GP Forward View includes, as one of its ten action areas, establishing 'social prescribing' so that VCSE assets are developed to provide non-clinical support to people.

4.2. STPs were asked to have regard to the Six Principles formulated by the People and Communities Board. However, they were not required to bring their regional 'community sector(s)' into their shared leadership, and most have not done so. Thus in most areas the VCSE sector is not jointly involved in governance or shared planning.

4.3. Early surveys of the voluntary and community sector in the first year of STP formation suggested very few organisations had been asked to engage.

4.4. Subsequently, as plans have crystallised, more VCSE organisations have been brought into lower level planning groups. Anecdotal evidence suggests that STPS usually target those organisations they know about, which tend to be the larger 'household name' charities. Few have developed pathways for small to medium organisations, who constitute the majority of the sector, to engage.

4.5. In many cases this replicates the lack of knowledge and expertise of local health commissioners, the majority of whom are not skilled at 'shaping the market' of VCSE assets. Data gathered by National Voices and Social Enterprise UK found that only 13% of CCGs can clearly show that they are actively committed to pursuing 'social value' in their procurement and commissioning decisions[iv]. Without having a well-developed local approach to commissioning for social value there is a weak foundation of VCSE engagement to build upon at a more regional STP level.

4.6. Those of our members who have been invited to sit on STP working groups have informed us that their involvement from the start felt tokenistic and nominal. Voluntary sector representatives informed us that their role often appears to be about signing off decisions once they have already been made, rather than shaping or informing the process.

4.7. Additionally some members and patient representatives told us about how if they are given the chance to be included in making decisions, operational factors dissuaded them from taking part in a meaningful way. We were provided with examples of where meetings were held in inconvenient or expensive locations without providing travel expenses; that meetings were not adapted so that a lay member could understand

what was being discussed; and that participants felt pressured not to contribute or express their opinions.

4.8. There are some examples of better practice. West Midlands appears to have a genuine partnership with its VCSE sector in pursuing devolution. Leeds (an integration pioneer) has a strong commitment to inclusion and shared leadership. Other STPs, such as North West London, have models of public and patient involvement grown during previous integration programmes. Greater Manchester, although it originally neglected the VCSE sector, now has a Memorandum of Understanding[v], bespoke VCSE funding for transformation, and significant engagement in high level planning boards.

4.9. Despite the warm words of the Five Year Forward View, the health sector has not recognised that the VCSE sector has been significantly depleted by austerity, including the loss of local government funding for its local umbrella and 'infrastructure' bodies, such as councils for voluntary service. Most truly local voluntary organisations do not have the capacity to engage in policy-level or planning relationships with health bodies.

5. The Progress Dashboard

5.1. Most of the indicators in the dashboard other than the 'leadership' judgements are based on existing validated data collections and in that sense are 'reliable'. In the short term, any changes in these indicators will be the result of actions by providers and commissioners working within the Planning Guidance objectives, rather than the STP itself.

5.2. If the goal of STPs/ICSs is to integrate care, National Voices would prefer to see indicators of the achievement of person centred coordinated care used to judge their performance. Unfortunately the challenge of designing these has consistently been ducked by government since the 2012 Act and 2013 Shared Commitment. Of the system leading bodies, the Care Quality Commission has been most advanced in developing ways to assess integration across providers, and there is scope to build on this role.

6. Credibility, realism, gaps in STP plans

6.1. National Voices' main concerns here are: a) fantastical reliance on the notion of 'self-care' as an answer to the sustainability gap, and b) failure

to understand the extent of the multimorbidities challenge and its implications for care design.

6.2. Most if not all STP plans make reference to greater reliance on people to 'self-care'. Few of these plans define what this might mean, or evidence an understanding of what is required to achieve it.

6.3. 'Self-care' can be narrowly interpreted as people looking after than own trivial symptoms or time-limited conditions, and not presenting at services. This is the focus, for example, of the DH-sponsored annual Self Care Week. There is an assumption that with better public information and more sense of personal responsibility, demand for appointments could be reduced. While National Voices has sympathy with this desire, we note that: it conflicts with other messages that encourage people to present themselves earlier with symptoms in pursuit of earlier disease diagnosis; it has little impact at times of major stress such as during the recent winter/flu pressures; and its impact is reduced by NHS protocols which positively steer people into urgent and emergency care when they ask for advice (eg through NHS 111).

6.4. A wider interpretation of 'self-care' relates to people taking greater control over all aspects of their health and health status. This usually relates to people with existing conditions. National Voices prefers to call this 'self-management' (on which there is an extensive literature and evidence), as it includes both direct care of one's own symptoms, and wider management goals such as improved diet and exercise.

6.5. Self-management, to be successful, requires support both from the professionals and services one encounters and from other sources such as peers and the community. As such it must be 'designed in' to mainstream care; frontline professionals need to be trained to work in a different way; and there has to be investment in sources of support such as education courses for self-management, health coaching, and peer support programmes. A full evidence base for these approaches was provided to NHS England through the Realising the Value programme in which National Voices was a partner[vi]; and subsequently the approaches have been included as requirements in the draft standard contract for ACOs.

6.6. Most STP plans evidence little recognition of the need for self-management support; the retraining of the workforce; the need for basic care redesign such as establishing proactive care planning; or the need to invest in support.

6.7. These considerations are linked to the multimorbidities challenge. NICE Guideline 56 on managing multimorbidities clearly emphasises that for people with several long term conditions, the single disease protocols and pathways that dominate healthcare are inappropriate[vii]. Instead, people need 'tailored care' (which we would describe as person centred care) based on helping the individual identify their key goals and wrapping support around them. In short it requires a fundamental redesign of care towards a chronic care model; whereas most STPs remain focused on single pathway redesign.

6.8. The significance of this is that multimorbidities are not confined to a small segment of 'the most complex' cases, as many healthcare organisations believe. There is increasing evidence that multimorbidities are 'the norm' in that most people with one condition also have others; and that they span the age distribution, rather than being only among the very old. People with multiple long term conditions already account for a significant amount of healthcare spend and usage; but recent research from Newcastle University's Institute for Age and Ageing suggests there will be a further 'massive expansion' in the next 17 years[viii]. In short, people with multiple conditions will increasingly be the 'core users' of healthcare, and mainstream care will require whole system redesign. Few STPs are considering or preparing for this reality.

6.9. NHS England and NHS Improvement have now released revised NHS planning and contracting guidance for 2017-2019. We are disappointed to see that the new funds available as a result of the November Budget will not be used to build infrastructure or reform practice in a noticeable way. There also appears to be no new initiative which will enable a radical shift to siting more care closer to home, in order to underpin better support for self-management, holistic care for people with multiple conditions, and coordinated care that wraps around the individual.

6.10. As such the burden appears to be on STPs to go beyond the Shared Planning Guidance in order to innovate within existing financial constraints. While we hope that STPs will take advantage of the efforts of the integration pioneers and vanguards to disseminate their learning, without a complementary allocation of budget and time to implement new initiatives, National Voices remains concerned that any potential efforts to truly reform practice will be pushed aside.

7. Barriers to implementation

7.1. National Voices would like to note one particular barrier to the achievement of STP/ICS goals: the lack of joined up record systems.

7.2. STPs are required to take a 'population health' approach. This must be underpinned by excellent data on the population, its health needs and its usage of care and support services. This data is difficult to extract from multiple, siloed record systems held by a range of providers.

7.3. Equally, at the level of the individual, coordinated (integrated) care is not possible if their health goals, plans and interactions with services are not recorded in a single record accessible at all key points of their contact with professionals and services.

7.4. We expect there to be a significant new emphasis on achieving this essential underpinning for population health and integrated care in the next two years. A framework for the supply of support to STPs/ICSs includes several 'Lots' relating to creating joined up, interoperable record systems. These are also fundamental to the digital strategies of the NHS, and likewise to the Industrial and Life Sciences strategies, which aim to integrate patient data so as to provide a research base for innovation.

7.5. In this respect National Voices notes that there appears to be no new money for this work in the Planning Guidance; and questions how STP areas are expected to finance it.

Contact

National Voices thanks the Health Committee for the opportunity to submit our thoughts on this inquiry. We would like to offer our continued engagement on this issue and hope to be able to work together to ensure STPs and ACSs can be a vehicle for delivering the principles of high quality coordinated care

Please contact National Voices' Policy Director, Don Redding, if any further clarification is required on the contents of this submission. His email is don.redding@nationalvoices.org.uk.

[i] Integrated Care: Our Shared Commitment, DH, 2013

[ii] Six Principles for engaging People and Communities: putting them into practice, National Voices, 2016
[iii] Community engagement: improving health and wellbeing and reducing health inequalities, NG44, NICE, 2016
[iv] Healthy Commissioning, National Voices and Social Enterprise UK, 2017
[v] MEMORANDUM OF UNDERSTANDING between The Greater Manchester Health and Social Care Partnership And The Voluntary, Community and Social Enterprise Sector in Greater Manchester, signed January 2017, available at https://www.gmcvo.org.uk/system/files/gm_vcse_mou_agreed_27.01.17.pdf
[vi] Realising the Value: Ten actions to put people and communities at the heart of health and wellbeing, Nesta, 2016; and other associated reports and resources via https://www.nesta.org.uk/realising-value-programme-reports-tools-and-resources
[vii] Multimorbidity: clinical assessment and management, NG56, NICE, 2017
[viii] Projections of multi-morbidity in the older population in England to 2035: estimates from the Population Ageing and Care Simulation (PACSim) model. Andrew Kingston, Louise Robinson, Heather Booth, Martin Knapp, Carol Jagger for the MODEM project. Age and Ageing. doi: 10.1093/ageing/afx201