

March 2021

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National Voices' submission to  
the Health and Social Care  
Select Committee White Paper,  
'Integration and innovation:  
working together to improve  
health and social care for all'

# Introduction

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National Voices is the leading coalition of health and social care charities in England. We have more than 170 members covering a diverse range of health conditions and communities, connecting us with the experiences of millions of people. We work together to strengthen the voice of patients, service users, carers, their families, and the voluntary organisations that work for them. Our mission is to democratise and humanise health and care.

We have worked with a substantial number of our members on a shared position since legislative plans have been announced and are grateful for the opportunity to contribute our insight and perspective to the Committee's deliberations.

## Our overall position on the White Paper

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We supported the 2019 consensus statement and are broadly supportive of the direction of travel outlined in the White Paper. Clearly it is good for people and communities if all providers, planners and stakeholders with a responsibility for health and wellbeing are challenged and supported to collaborate with each other in a place.

However, we have a number of concerns to raise around where we think provisions need to be strengthened:

1. A clearer duty to collaborate with people, communities and their organisations – increasing accountability, transparency and engagement.
2. A duty to coproduce with the people who need health and care to work better, particularly those often not served well by existing models – building outwards from lived experience and tackling the inverse care law.
3. The need to progress social care reform – without which integration will be meaningless for most people who have substantial health needs (because they will have social care needs too).
4. A stronger focus on improving health, not just health services, and a clearer connection to the Government's ambition to increase healthy life expectancy by five years.

# 1. A clear duty to collaborate with communities and their organisations

While the White Paper states the ambition that reform will lead to better engagement and closer partnership working, its provisions are curiously silent on how this will be achieved. In our view, it is paramount that community governance, partnership and engagement are at the core of the reform agenda, otherwise many other policy goals won't be achieved, including:

- A move to more community based, preventative and holistic models of care.
- A thorough grounding of health and care services in the health and wellbeing needs and ambitions of people.
- A person and community centred perspective on integration (otherwise you integrate in ways that fail to place people at the centre).
- A reduction in health inequity and exclusion.
- A more asset-based perspective on how health and wellbeing are generated and supported – taking into account the role of neighbours, families, volunteers, charities, community led initiatives and institutions.

We set out our concerns in [this HSJ comment piece](#). The duty to engage needs to be reflected at ICS level, for both the NHS body and the Partnership Board, at place and at neighbourhood level.

“The right locus to understand how to convince a particular community on your patch to attend a vaccine centre is probably the **neighbourhood**. The primary care network needs to have a relationship with a primary school's PTA or a ward councillor's community charity, to find a credible way of bridging into communities at risk of exclusion. The **place** is the right place to commission, to define need, to plan for it, in partnership with your local, place based, community specific or infrastructure charities.

The ICS is where this work needs to be challenged and supported. Where communities, their organisations, and patients or service users can ask questions about quality, and equality and about the need for a more strategic understanding of how the ecosystem of statutory and voluntary provision, of formal and informal insight, of NHS data sets and community feedback actually is working. And particularly how it is working for people and communities at the wrong end of the inverse care law.”

VCSE engagement for the 'system' footprint requires particular attention since the VCSE, both large and small, is not organised into these footprints. This means that engagement needs to be supported, both to provide

challenge and support from and for place level partnership working, and to plug the VCSE and the communities they work with into the planning and commissioning functions at system level.

- All ICSs should be obliged to design and report on mechanisms that enable engagement at system level.
- They should also be obliged to set up and run a VCSE investment fund (some progressive ICSs have started on this course), which places at least some of the contribution the VCSE makes to health and wellbeing on a more sustainable footing.
- Finally, ICSs should be obliged to at least once per year interrogate and report on the health and nature of 'their' VCSE, reviewing its financial and organisational resilience, its reach and impact and identifying underserved issues or communities which can then be addressed through targeted investment.

## 2. Coproduction

Listening to people and communities who need health and care to work much better will unlock many of the ambitions the White Paper pursues: integration, innovation, collaboration happen naturally where people's needs and ambitions are placed at the centre of plans and services.

Particular care is needed to reach out to people who are at the wrong end of the inverse care law, and less likely to be well served by existing models.

Coproduction needs to start with a place based strategic assessment of what health needs and ambitions characterise people in a place. Such a plan and its underlying coproduction should be signed off by the local authority, the NHS and a community organisation such as Healthwatch.

Where competitive procurement is scaled back (which we broadly welcome), it is particularly important that the views and experiences of people who need services (including those who are not currently engaged, but have unmet needs) are front of centre of decisions to change or redesign services, or to continue unchanged.

Much of the existing engagement duties focus on service reconfiguration or tenders – this will play a smaller role going forward, but it needs to be replaced with ongoing, as well as bespoke listening and engagement so

that commissioners and providers have a clear sense of the quality of or gaps in the services they run.

Particularly around rarer conditions (which collectively amount to a substantial proportion of both ill health and services), communities and their organisations aren't always strong enough locally to influence and drive up the quality of provision. It is therefore important that even with the new ICS structures, there remains a role for national influencing by groups who advocate for the less common conditions, and that nationally agreed standards and improvement programmes filter through consistently and coherently into local practice.

### **3. Integrating health, care and a wider support network**

Once again, we are making plans for integrating health and care without sorting out, or even spelling out plans for reforming, social care. This against a backdrop of local authority finances entering an ever more precarious state. Who or what will the NHS integrate with, if social care is allowed to fall into further disrepair and public health budgets are cut in real terms yet again?

People with substantial health needs will more often than not have care needs too, and people in receipt of social care are likely to have health needs – even the distinction between the two doesn't make sense to real people living real lives.

The other distinction that does not make sense from a lived experience perspective, and in our view actively harms people, is the distinction between mental and physical health which permeates the health system and also gets in the way of good integration of services around people who often live with both mental and physical health needs. Having physical health conditions puts you at much greater risk of developing mental health problems; people with severe and enduring mental ill health are far more likely to also have a poor physical health status, and as a consequence often die prematurely from preventable illness.

We need both a short-term package of investment to shore up social care provision, and a credible and costed plan for long term reform – reform that enables people to live in the place we call home, with the people and things

that we love, in communities where we look out for each other, doing things that matter to us.

We urge the Committee to challenge the Government to stop announcing imminent plans on social care and to share the decisions that are being made and the information they are based on.

## 4. Health beyond healthcare

Ultimately, health and care services can only be sustainable, if people are supported to live well and to improve their health and wellbeing. This requires us to organise how we build houses, run companies, create environments and neighbourhoods with a view to their ability to both create or undermine health.

The White Paper contains little or no detail on how any of this will be achieved. This is particularly disappointing in light of the welcome and ambitious commitment from the Government to add five years of healthy life expectancy to people's lives. This expansion of healthy lives can only be achieved by tackling the stark and unacceptable inequalities that blight the wellbeing and health of communities. For instance, in the most deprived areas infant mortality and suicide rates are double that of least deprived<sup>1</sup>, and males living in the most deprived areas of England can expect to live 18.9 years less in 'good' health compared with those in the least deprived<sup>2</sup>.

The centrality of community and its infrastructure, and the hideous effects of ongoing inequality, have both been amply demonstrated during the Covid pandemic.

Community resilience and wellbeing depends on local authorities being able to invest in the health creating nature of places. It also requires a thriving and connected infrastructure of VCSE organisations large and small that can step up in a crisis, but also provide ongoing support for people's wellbeing. This goes way beyond the VCSE in health (advice services, youth charities, social activities, volunteering etc).

- We need to see much clearer commitments to strengthening a health and wellbeing and health inequality perspective across all areas of

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<sup>1</sup> [Health Inequalities Dashboard: statistical commentary, March 2021 - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/statistical-data-sets/health-inequalities-dashboards)

<sup>2</sup> [Health state life expectancies by national deprivation deciles, England - Office for National Statistics \(ons.gov.uk\)](https://www.ons.gov.uk/peoplepopulationandcommunity/healthandlife/articles/health-state-life-expectancies-by-national-deprivation-deciles-england/2019-03-28)

local and national policy and spending – the White Paper is an opportunity to make this real.

- We need the Government to develop and publish plans for how we will make progress against the healthy life expectancy target it has committed to.
- We call, together with the Inequalities in Health Alliance,
  - for a cross-government strategy to reduce health inequalities;
  - Government to commence use of the socio-economic duty, section 1 of the Equality Act 2010, which would ensure vulnerable people be considered in every policy decision they make;
  - and the adoption of a 'child health in all policies' approach to policy-making.
- We also believe that a much stronger link needs to be made between social infrastructure and the levelling up agenda: locally determined investment in the things that connect and support people will enhance the productivity and resilience of places and communities that are too often left behind.

## Conclusion

In conclusion, whilst we are broadly supportive of much of the stated intent of the White Paper, we hope that the Committee will probe how some of the stated intentions of the reforms will be achieved in practice.

We and our members urge the Committee to call on the Government to include in the Bill a clear and strong commitment to engage with people and communities, and then to detail how this will be achieved in accompanying guidance.

There is a real risk that the distraction of legislative reform and subsequent NHS reorganisations means we will not be able to maintain the strong focus on recovery, access, and quality we need to enable people to recover from the impact of the pandemic. This distraction can only be justified if the outcome is a more democratic, person centred and inclusive health and care system.

## National Voices

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