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Integrating care: Next steps to building strong and effective integrated care systems

National Voices response to the NHS England consultation

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1. Introduction

National Voices welcomes the opportunity to give our views on the NHS England and Improvement (NHSEI) consultation on proposals for Integrated Care Systems. National Voices is the leading coalition of health and social care charities in England. We have more than 160 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.

We have discussed our response with a small number of members and other sector stakeholders; the timing of the consultation over the Christmas period made it impossible to engage more formally and fully with our membership. Members have also pointed out that many had to reduce the size of their policy teams in response to the loss of community fundraised income, and in order to protect their 'frontline'. **We are reassured that NHSEI have signalled that they will seek further input from us** and our members once they have heard from all respondents and as they aim to contextualise their legislative proposals with more concerted efforts to support partnership working.

2. National Voices main considerations and proposals

National Voices is fully supportive of the overall policy aim to drive forward a more place-based, coordinated and integrated design and delivery of health and care services and functions. Our vision is of all organisations with a stake in the health of their communities working together, and working with communities and people themselves to realise better, more equitable and relevant health and wellbeing outcomes for everyone. Removing obstacles to this way of working is important. Supporting organisational, system and community leaders with new ways of working is even more crucial, since these changes often go against the grain of NHS management and organisational culture.

Legislation might be necessary, but is nowhere near sufficient, for the cultural changes the system needs to integrate care for people. Some partners inside the NHS have expressed a belief that there are legislative obstacles to better collaboration and coordination which are worth removing. All the people inside and outside the formal health system we managed to speak to are clear that the most important changes are about behaviour, relationships and culture, which

remain largely untouched by legislative change. It would be helpful if future proposals for legislation were more explicitly contextualised with a commitment to provide sustained support and challenge to systems as they mature into true partnerships.

We are therefore somewhat sceptical about the impact structural and legislative changes have on the way the NHS actually works, and in particular how citizens, communities and patients actually experience NHS care. We were supportive of the consensus statement to which we contributed in September 2019, which included legislative changes, because it also emphasised the need for accountability of the NHS to communities and citizens, and it included a commitment to widen the goal of collaborations to work towards not just health, but also wellbeing outcomes, which are often more appropriate to non-NHS stakeholders.

We understand that the consultation on next steps is now focused on the exact nature of legislative changes, but we are disappointed that the document is largely silent on the need to ensure substantial, consistent and meaningful input of communities, citizens and their organisations in the governance, design and delivery of health and care services and functions. Whilst the document speaks of collaboration *in the interest of* patients and communities it does not speak of collaboration *with* communities, citizens and patients. Many years of experience have shown that where interests and voices are not represented at the table, they will not shape the outcomes of any decision-making processes.

Overall, provisions for meaningful co-production with communities - whether they are defined locally (residents of a patch) or by interest (people living with a certain health condition) - need to be substantially strengthened, both in the legislative proposals and in plans and funding for supportive activity to build meaningful partnerships. We need to move beyond engagement and insight (important though they are) and move towards governance and leadership that is explicitly shared with those people who need health and care to deliver better, more equitable value and outcomes.

We are concerned that the move to systems, as understood by the NHS, risks leaving behind existing engagement mechanisms and leaves communities and their organisations stranded where their footprints and relationships are not reflected in the size and structures of 'systems'. On the whole, VCSE organisations large and small, national and local, do not organise themselves into patches the NHS now defines as *systems*. If the system level is expected to be where most important design decisions are made, this risks leaving behind communities and their organisations, unless clear provisions are made that:

- Systems have a statutory duty to engage with communities, citizens and their organisations (NHS trusts, CCGs and NHSEI explicitly have such duties)
- Systems are required to include VCSE organisations and community representatives in their governance structures
- Systems are required to devolve back down decisions and funding to places wherever possible, including offering consistent and sustained support and challenge for VCSE and community engagement

- Communities and their organisations, large and small, condition specific and place based, including Healthwatch, are supported (which includes being funded) to enable them to engage with system level decision making.

Most VCSE organisations have no formal or financial ties to the statutory commissioning system, be that NHS or local authority run. Those VCSE organisations that do, mostly connect with decision makers at place level, either through local authorities or CCGs. This is the level at which meaningful accountability can be achieved. Many people know who runs their local authority; many organisations know who they need to connect with in a CCG. We don't believe citizens and communities understand or are sighted of decision making at system level, given systems are often very large and are at times defined by the NHS as administrative units that aren't reflected in geography, history or community. This automatically leads to a deficit of accountability, because people do not understand and cannot see who makes decisions how, and therefore cannot influence those decisions.

To balance or mitigate some of these risks, there is an **opportunity** to use the proposed statutory nature of ICSs to enhance engagement processes at the level of the ICS *and* at place. Too often, statutory consultation is only considered as a legal hoop that needs to be jumped through with minimal effort to reach seldom heard voices or to explore alternatives, priorities and the wider experiences of communities. So we need to take this opportunity to:

- Refresh the existing consultation processes on major service change, by pushing for considered and deep engagement with communities, especially those most at risk of health inequalities
- Make explicit that ICSs like all statutory NHS bodies have a duty to engage with communities and the VCSE sector, as well as Healthwatches, with a particular focus on seldom-heard voices
- Require that ICSs conduct their business in public and publish all meeting minutes and papers
- Mandate VCSE and community representation in ICS governance structures at all levels – we think, ideally, this should include an infrastructure organisation, a provider organisation and a voice organisation, as well as a Healthwatch, in order to do justice to dimensions of community activity.

This also offers the opportunity for ICSs to create an environment where places and communities can flourish, through strengthening links between statutory services and the VCSE sector. ICSs, as part of their business intelligence and population health management functions, should be required to work with places and the VCSE sector to:

- Define the priority outcomes communities want to achieve for their health and wellbeing, particularly those who carry a substantial burden of ill health
- Understand the nature, strengths and weaknesses, of their local VCSE sector, its funding situation, staffing structures, volunteer base and reach
- Interrogate whether commissioning and procurement processes at system and place level support the sustainability and collaborative leadership of the sector

- Identify gaps in community sector provision and tackle the inverse care law that can manifest in VCSE activity and assets by strategically supporting activity that addresses disadvantage and unmet need
- Ensure commissioning and procurement maximises social value
- Develop and deliver strategic plans that support places and the local VCSE organisations to grow their effectiveness and reach and address the inverse care law.

All legislative change creates a distraction. It means hard-working system colleagues focus on new structures, new jobs, and different processes. The health and care system during 2021 is struggling with the most serious challenge in its entire history – how to cope with a surge in COVID-19 infections, the roll-out of mass vaccinations, and the staggering levels of unmet need now prevalent in our communities, on formal waiting lists and way beyond them. Health and care services are not meeting the needs of many people already, and too often leave behind those people and communities with the most substantial burdens of ill health who are also struggling with poverty, discrimination and racism.

It is our view that the distraction of legislative change at this current moment can only be justified if it is very explicitly focused on delivering more community-based and community-led, person-centred, equitable and enabling health and care.

3. Legislative proposals

Enshrining ICS in legislation, and their membership (Q1, 2 and 3)

In our view, ICSs cannot both be at the same time a statutory corporate NHS body, and a true and equal partnership with non-NHS bodies. Our NHS colleagues explained clearly and convincingly to us that NHS organisations in a system (both commissioners and providers) need to be brought together in order to deal with unhelpful competition, inefficiencies and obstacles to better service integration. In our view, it is therefore probably advantageous to enable this 'NHS internal' integration. Our hope would be that the NHS would therefore also become easier to partner-up with, easier to hold to account and easier to engage with (in fact, whether VCSE organisations or other external partners report that the NHS is in fact now easier to work with, should be used as a benchmark for whether any legislative change has been a success).

But we also think there is a need for creating powerful partnerships that local authorities with their various functions can be members of – and not just through social care: this needs to include public health, housing, children's services, education, and so on.

We also hold that the VCSE and community representatives need to be formal partners in the ICS partnership (as per our arguments above).

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020 3176 0738
info@nationalvoices.org.uk

www.nationalvoices.org.uk
@NVTweeting

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