

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

Submission from Hospice UK

8 January 2020

### 1. Do you agree that giving ICSs a statutory footing from 2022, alongside other legislative proposals, provides the right foundation for the NHS over the next decade?

- 1.1. We support NHS England and NHS Improvement's proposals to place ICSs on a statutory footing. We recognise that mandating ICSs' responsibilities will enable system working with greater impetus and clarity.
- 1.2. We support the direction of travel away from market mechanisms which have acted as a barrier to integration, towards more collaborative working across the health and care system centred on citizens, patients, and service users.
- 1.3. We believe that statutory footing will ensure greater transparency and accountability to the public, especially given how much public money is proposed to be routed through ICSs.

However, key questions and concerns must be addressed:

- 1.4. The ICS as proposed in this document is primarily an NHS body, with local government and optional voluntary sector representation. As a result, it risks not fully integrating the whole health and social care system, to the ultimate detriment of citizens, patients, and service users.
- 1.5. The proposals broadly describe collaborative commissioning between NHS bodies and joint committees of commissioners and providers. It does not account for the commissioning of independent, non-NHS healthcare provision, such as the palliative and end of life care and bereavement services provided by charitable hospices. It risks excluding the valuable perspectives from those independently providing essential care, such as unpaid carers.
- 1.6. It also does not acknowledge the position of local authorities as commissioners of social care or the integral role that social care plays in managing population health. For example, social care plays a significant role in supporting people with palliative care needs or those at the end of life. Without this support people are unable to remain home, get out of hospital, or live as well as possible before death. It can include physical care such as washing and dressing and advance care planning, which allows patients to plan their future care and medical treatment, while they have the capacity to do so.
- 1.7. An absence of cross-sector commissioning and provision will be a barrier to improved outcomes. It is imperative that social care and the independent, non-NHS provision of

health and social care services factor into these proposals, or we risk further entrenching the disparities in provision between health and social care.

- 1.8. The optional status of voluntary sector representation at board-level, as well as the proposals' lack of acknowledgement of voluntary sector health and care providers, risks further compounding these disparities leading to poor outcomes. It is imperative that the voluntary sector's inclusion is made mandatory.
- 1.9. For example, charitable hospices are providers of essential clinical care, as well as being independent charities. They are an integral part of the palliative and end of life care sector, delivering specialist palliative and bereavement care to 225,000 people and their families each year across the UK.
- 1.10. Hospices have played and continue to play a vital role in supporting and relieving pressures on the NHS in its response to COVID-19, providing support to patients and their families and carers in the community alongside offering expert support to care home staff and residents as they have sought to control the virus. During Q1 of 2020-21, hospices in England provided a total of 1.3 million inpatient and hospice at home contacts, and 9.3 million community contacts. Data suggests that this rate of activity has remained consistent beyond Q1. NHS England estimates that hospices cared for over 170,000 people during Q1, including both COVID-19 and non-COVID-19 patients.
- 1.11. The proposals risk taking a one-dimensional view of the voluntary sector, focusing on the sector's role in supporting and reflecting public voice. The sector is diverse and multi-faceted, with different organisations playing different roles and championing different causes. This includes as sector infrastructure bodies, providers of care, and reflecting the public voice, with many organisations fulfilling a mix of these three key functions.
- 1.12. The voluntary sector also works primarily at the neighbourhood or place levels (through relationships with CCGs, or within local communities), with limited infrastructure to coalesce at the system (ICS) level.
- 1.13. It is important that the expertise of the voluntary sector is represented at board-level within ICSs and informs its governance and strategic decision-making. One way to achieve this might be to guarantee the inclusion at board-level voluntary sector organisations that meet each of the three key roles – infrastructure, provider, and voice.
- 1.14. What's more, it is unclear how the financial allocations will work across health and social care boundaries.
- 1.15. The exact nature of the powers that ICSs will have over constituent organisations and that provider collaboratives will have over members also remains unclear.
- 1.16. In light of Public Health England's dissolution, how would these proposed changes align with the operating model for public health, which is being developed separately?
- 2. Do you agree that option 2 offers a model that provides greater incentive for collaboration alongside clarity of accountability across systems, to Parliament and most importantly, to patients?**
- 2.1. Of the two options outlined, we agree that Option 2 is a clearer model that avoids messy accountability lines; a single corporate body across NHS organisations should be

effective in increasing collaboration between NHS organisations in an area, with the ability to plan strategically deploy resources.

- 2.2. However, questions remain regarding the role of non-NHS partners, such as local government, social care, and the voluntary sector, within this structure, in which the ICS would be a statutory NHS body accountable for NHS finances.
- 2.3. The critical role of social care, the voluntary sector, and the views of citizens, patients, and service users must be reflected with parity of esteem within this structure with mandatory membership. This could be achieved by making mandatory the inclusion of a collective or assembly of voluntary sector organisations that reflect the sector's three key functions: infrastructure, provider, and voice, as detailed in our response to Question 1.
- 2.4. What's more, while Option 2's structure should improve access to health and care services, this is not tantamount to addressing health inequalities, the wider determinants of health, or improving population health.
3. **Do you agree that, other than mandatory participation of NHS bodies and Local Authorities, membership should be sufficiently permissive to allow systems to shape their own governance arrangements to best suit their populations needs?**
  - 3.1. While we acknowledge that it would be impossible to create a definitive mandatory membership list that would apply equally in all areas, we are concerned by the conspicuous omission of any mandatory citizen, patient, or service-user involvement on the ICS board. There appears to be little concrete commitment to a person-centred and co-productive approach.
  - 3.2. Given the proposals' recognition of the importance of meaningful co-production (2.36; 2.38) and stated ambition to "*put the citizen at the heart of their own care*" (2.51), we would expect to see the mandatory inclusion of citizen, patient, or service-user voice at board-level.
  - 3.3. With the emphasis that the proposals place on the role of digital and data, adopting a meaningfully co-productive approach will undoubtedly help tackle issues that would otherwise lead to poor outcomes, such as digital exclusion and digital poverty.
  - 3.4. Beyond the mandatory inclusion of voluntary sector organisations that can amplify these important voices at board-level, a potential solution would be to make it a legal requirement for ICSs to involve Health and Wellbeing Boards (HWBs). Not only would this ensure local accountability through existing democratic structures, ICSs would also benefit from the established links that HWBs have with their local communities.
  - 3.5. It would otherwise be difficult to see how the voices and priorities of citizens, service users, and patients will be captured and meaningfully reflected in the governance and decision-making of ICSs as a priority.
  - 3.6. We are also concerned to see that the voluntary sector is not included in the proposed mandatory membership. Charitable organisations often sit at the heart of their communities, providing essential services that meet otherwise unmet needs. They hold valuable data and insights regarding the local populations that they serve, which will pertain to their health outcomes and the wider determinants of health.

- 3.7. The proposals underline the importance of collaboration between providers. It is disappointing that the collaboration listed between providers in 1.9 is exclusive to healthcare, with no mention of social care or the voluntary sector. Providers come in many different forms and from different sectors – what is desperately needed is cross-sector collaboration. Ultimately, proposals should ensure parity of esteem for social care and voluntary sector providers.
- 3.8. For example, the proposals have a stated ambition to break down siloes between providers and deliver frictionless care. Palliative and end of life care is an exemplar of a multiagency system, involving: the NHS, social care, the voluntary sector (notably, charitable hospices, communities, families, and carers). A prime example is the Leeds Palliative Care Network which includes representation from charitable hospices, acute hospital trusts, community providers, the local authority, commissioners, and a wider range of voluntary sector organisations. Key successes of the group include ensuring palliative is a core component of the Leeds plan for health and care, supporting the development of the Leeds Care Record (a single city-wide joined-up digital care record) and driving standardisation and consistency (for example, in advanced care planning and education). Collaboration, knowledge and data sharing, and acknowledgement that each of these organisations provide unique value is key to this success.
- 3.9. It is important that proposed ICS structures meaningfully capitalise on the expertise and exemplary practice of providers beyond the NHS.
- 4. Do you agree, subject to appropriate safeguards and where appropriate, that services currently commissioned by NHSE should be either transferred or delegated to ICS bodies?**
- 4.1. We agree that this is a prudent approach to take and appreciate the balance between commissioning specialised services at scale while acknowledging the massive variation in ICS population.
- 4.2. For example, it would make little sense to plan paediatric palliative care provision at place level, given the comparatively low numbers accessing these services on such a local basis.
- 4.3. However, NHS England and NHS Improvement must clarify the benefits they envisage of delegating the commissioning of primary care, including GP services, to ICS-level, and detail how they plan to mitigate the real risk of compounding unnecessary and undesirable local variation in service provision by doing so.

### For further information

If you have any questions or would like further information, please do not hesitate to contact us at [policy@hospiceuk.org](mailto:policy@hospiceuk.org)