RESPONSE TO THE HEWITT REVIEW OF ICSs BY THE HEALTH DEVOLUTION COMMISSION

This is a submission by the Health Devolution Commission (the Commission) to the Hewitt Review of Integrated care Systems. Part 1 introduces the Commission, Part 2 explores issues associated with streamlining the current system of national targets, and Part 3 answers the specific questions in the call for evidence.

1 THE HEALTH DEVOLUTION COMMISSION

1.1 Who we are

The Health Devolution Commission is an independent cross-party and cross-sector body established in 2020 to champion and support the successful implementation of devolved and integrated health and social care services across England. Its Co-chairs are the Rt Hon Sir Norman Lamb and the Rt Hon Andy Burnham. Further details are available about the Commissioners, Partners and previous reports at www.healthdevolution.org.uk. The evidence in this submission is drawn largely from the contributions by system leaders at national and system-level during our roundtables during 2022.

1.2 Transformation through Integration and Devolution

The Commission has long believed that the lack of local integration between the NHS and social care, public health and other local government and public sector services, is a major barrier to improving people's health outcomes, improving the experience of care that people receive, reducing health inequalities and improving the public's health. As well as the economic and social costs to the health and prosperity of local communities, this lack of integration creates avoidable cost inefficiencies.

The Commission believes that the successful devolution and integration of health (physical and mental), social care and public health will enable frontline staff to better meet the needs of local people, families and communities; provide a better, seamless experience of care; improve the public health and economic wellbeing of local communities; help reduce health inequalities; and support the financial sustainability of local services.

1.3 Support for Integrated Care Systems

The Government's proposals for health and care integration in the White Paper 'Joining up care for people, places and populations' were largely welcomed by the Health Devolution Commission. It represents the paradigm shift called for by the Commission, among many others, to move the NHS towards a fundamentally new purpose and a genuinely new partnership with local government, the Voluntary Community and Social Enterprise sector, and the local communities that it serves.

In particular, the Commission supported the development of place-based shared outcomes to drive integration; joint leadership, accountability and finance; common digital and data systems; and integrated health and social care workforce planning. It also supported the view that integration is not just about delivering better person-centred care but also about improving the public's health and reducing health inequalities. We applauded, for example, the White Paper's call on people to 'think housing and community' when they develop their local partnerships and strategies.

The development of statutory Integrated Care Systems was very much welcomed by the Commission. Working with its partners - the LGA, the NHS Confederation, London Councils, BACP, Barnardo's, Mencap, GM Health and Social Care Partnership and WY Health and Care Partnership – the Commission is working directly to help make ICSs a success through collating, collaborating and sharing thought leadership and expert opinion on devolution and integration from a broad range of perspectives, providing examples of best practice and influencing Government and NHSE guidance.

2 *NATIONAL TARGETS AND LOCAL ACCOUNTABILITY*

2.1 The current system

The current system of national targets has grown up over time with successive Governments amending and adding to previous regimes creating a large and complex plethora of specific, detailed instructions and objectives that local commissioners and providers are expected and mandated to deliver. These national targets are laid out in a number of different policy documents including:

The NHS Constitution: The NHS constitution last updated in 2021 includes 7 principles, a list of NHS values and 7 rights that the public have. But it does not include any targets. These are in the Handbook to the NHS Constitution - last updated in January 2022 - and relate to specific pledges in the constitution, for example three of nineteen targets on waiting times are :

- a maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers
- a maximum 4-hour wait in A&E from arrival to admission, transfer or discharge
- 75% of people referred to the improving access to psychology therapies (IAPT) programme should begin treatment within 6 weeks of referral and 95% of people referred to the IAPT programme should begin treatment within 18 weeks of referral"

The NHS Mandate: The NHS Mandate for 2021/22 identifies 13 goal areas for the NHS (related to the NHS Long Term Plan), and the metrics to be used for each; but in some cases only gives a numerical target with no date for it be achieved (e.g., 50,000 more nurses working in the NHS) or no

target or date at all (e.g. number of people with a Learning Disability on the GP register receiving an annual health check).

NHSE Operational guidance 2022/23: The NHSE 2022/23 priorities and operational planning guidance sets out objectives for the NHS across 10 policy areas and within which there are some broad brush aspirations (e.g., accelerate the introduction of new roles, such as anaesthetic associates and first contact practitioners, and expanding advanced clinical practitioners) and some detailed targets (e.g., eliminate waits of over 104 weeks as a priority by July 2022 and maintain this position through 2022/23, except where patients choose to wait longer).

Ring-fenced Funding: Two examples of national targets linked to specific funding programmes are the 2022/23 £500m Hospital Discharge Fund and the Direct Enhanced Service funding to support the development of Primary Care Networks. These are funds allocated to local systems and both include targets to be achieved that are set nationally and for which local systems are accountable to the centre.

2.2 Streamlining

There is clearly a large and at times confusing array of what may be called generically 'national targets' across a range of policy and operational guidance documents that include rights, objectives, values, pledges, metrics. The total number of targets probably runs into many hundreds, and can cover very different aspects of health care services including inputs (e.g., the workforce), outputs (e.g., waiting times) and outcomes (e.g., cancer treatment success rates).

There is, without doubt, a de facto case for streamlining and rationalising the current system of national targets as part of the process of determining which targets might be devolved to ICSs for local determination and accountability.

The Hewitt review of how to improve local accountability and autonomy within the NHS should lead to a joint (local and national) comprehensive review of the whole system of national targets to rationalise, streamline and simplify the system to make it fit for purpose as part of a more devolved approach to responsibility and accountability by ICSs for the current targets.

A streamlined and more devolved system of national and local targets should include the appropriate number and nature of national targets for the new, wider goals of the NHS namely, contributing to local social and economic development, and reducing local health inequalities in local populations. The detailed nature of these new aims, roles and obligations of the NHS will vary hugely between and within the 42 different integrated care systems depending on local needs and circumstances so flexibility for local determination within a national framework of expectations.

A streamlined system should also seek to create greater certainty over longer-term funding by converting 'recurring non-recurrent funding' into recurrent funding, and reducing the number of short-term ring-fenced funding pots/programmes with prescribed outputs (e.g., The Hospital Discharge Fund), which can hold back innovation and undermine efficiency.

2.3 Fewer national targets – more local priorities and decisions

The Commission believes that a streamlined system of fewer national targets (mutually agreed between the centre and systems), that focuses on the outcomes that ICSs are expected to achieve, combined with flexibility for each ICS to determine on **how best** to achieve them, and local targets that have a similar level of priority, provides the right framework for a successful integrated health and care system with a broader set of aims. ICB and ICP strategic planning can then take place within an enabling national framework that avoids a restrictive and prescriptive approach.

Distinguishing between national outcomes that fulfil the NHS Mandate and Constitution, and locally determined ways of working designed to address local needs and circumstances in partnership with key stakeholders, is the key that unlocks the challenge of ensuring the right combination of both vertical and horizontal accountability within Integrated Care Systems. The Commission believes the centre should focus on 'why' and 'what' systems should achieve, not 'how', and assess them on outcomes based on ICSs' four core purposes. Guidance on this should be co-produced between systems and the centre agreed via a Memorandum of Understanding.

There is potential for creating a limited number of time-limited national targets on specific health challenges. At present this might be to ensure that the needs of underserved groups who experience most health inequalities are given priority in every area and could include giving a voice to and improving the health of children and adults with learning disabilities, and improving outcomes for young adults with severe mental ill-health. Such targets should be established when the evidence suggests that national leadership is needed in the short term to help ensure a fair and inclusive approach is developed across the country.

2.4 Public and Political Expectations

Any change to the current system will need to recognise that national health targets have come to embody the public's expectation that the NHS is a national service that seeks to provide health care fairly and equally well wherever they live and whatever their circumstances. However, the Commission believes there are only a relatively limited number of core performance areas of high concern to the public such as waiting times at A&E or delays in diagnosis for serious health conditions such as cancer; and that there is considerable scope for streamlining the current system of targets in ways that maintain the confidence of the public and giving greater flexibility to local decision making about how to achieve them.

National health targets are a political as well as a policy issue so, discussion of options for improving their role as an NHS performance management tool is often conflated with a political analysis. Bluntly, there is a concern that having fewer national targets might let the Government of the day 'off the hook' by reducing the scope of opposition parties of the day to raise concerns about Government support and leadership of the NHS.

It is important that this concern, alongside public expectations of the NHS, is properly understood and taken into account when undertaking the streamlining of national targets; and when making choices about the number and nature of those targets that are better set locally with local accountability.

3 RESPONSES TO THE HEWITT REVIEW THEMES AND QUESTIONS

THEME 1 EMPOWERING LOCAL LEADERS

"As the system moves towards new ways of working, we are keen to explore how we can empower local leaders within ICSs."

Question 1

Please share examples from the health and care system, where local leaders and organisations have created transformational change to improve people's lives. (250 word limit) This can include the way services have been provided or how organisations work with residents and can be from a neighbourhood, place or system level.

Commission response

Children in the Room: The Commission heard about a joint initiative between Barnardo's and Frimley ICS on engaging with children and young people (CYP) at the level of system, place and neighbourhood including two major initiatives: 'Solar' - an integrated local mental health offer at place, and 'LINKS' - a social prescribing offer in neighbourhoods for CYP. Key actions that ICSs should take are to:

- Start with a vision from the perspective of CYP
- Develop a clear set of principles for what it means to embed CYP's voice in decision-making and programme development
- Define how system, place and neighbourhoods are meaningful to CYP, how they need to interact and how strategic plans need to respond
- Give equal priority to the twin challenges of health creation and service integration and optimisation
- Determine priority shared outcomes for CYP, and what this means for all partners

Suggestions for measures of success in delivering priority shared outcomes are levels of:

- School readiness
- Childhood obesity
- Young people reporting low mood and/or anxiety
- School attendance
- Young people not in education, employment or training
- Crisis interventions, or unplanned care e.g. asthma, diabetes, A&E attendances

The design principles for an ICS children and young people's policy framework could include:

- Comprehensive in scope (health, social care, education and family life)
- Reflect the life-course of children and young people (pre-conception to 25 years)
- Identify specific components to be addressed, and collective action of all partners
- Clear measures for assessing success and outcomes
- Equal weighting of health creation and service integration elements

Question 2: Helpful policies

Do you have examples where policy frameworks, policies and support mechanisms have enabled local leaders and, in particular, ICSs to achieve their goals? (250 word limit). This can include local, regional or national examples.

Commission Response

National Policy: The Government has made a fundamental legal shift from competition to collaboration as the organising principle of the health and social care system. It has supported the implementation of this principle through the creation of an entirely new sub-national 3-tier partnership delivery structure of Integrated Care Systems, place-based boards and neighbourhood primary care networks. And it has spelled out helpfully the four broad shared aims this new delivery structure is designed to achieve, namely to:

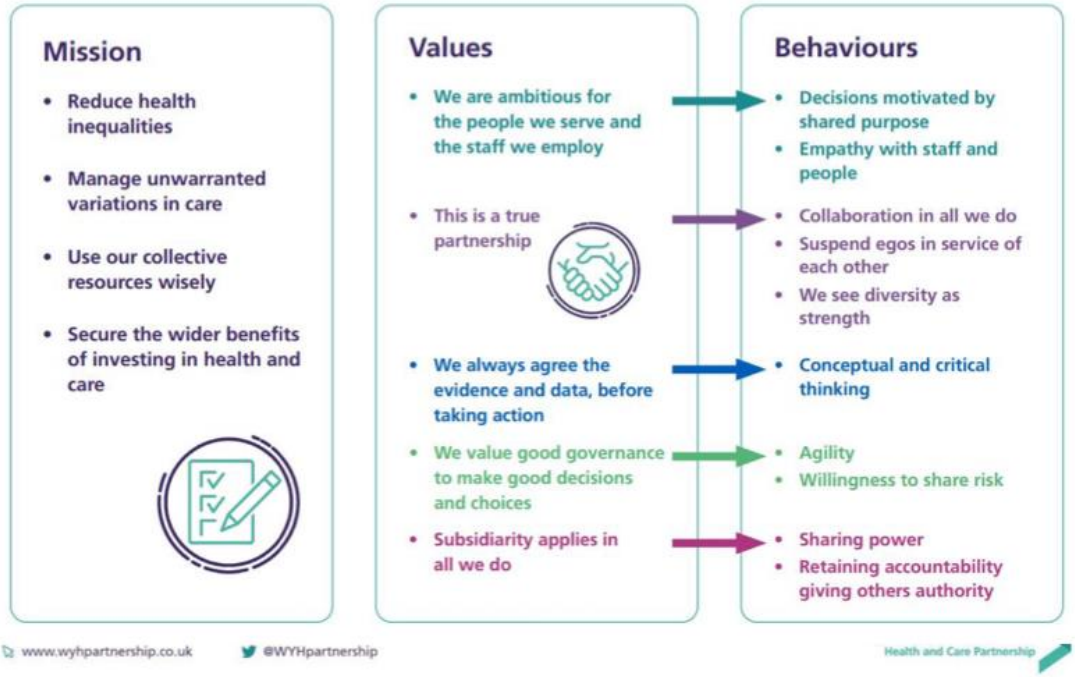
- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- help the NHS support broader social and economic development

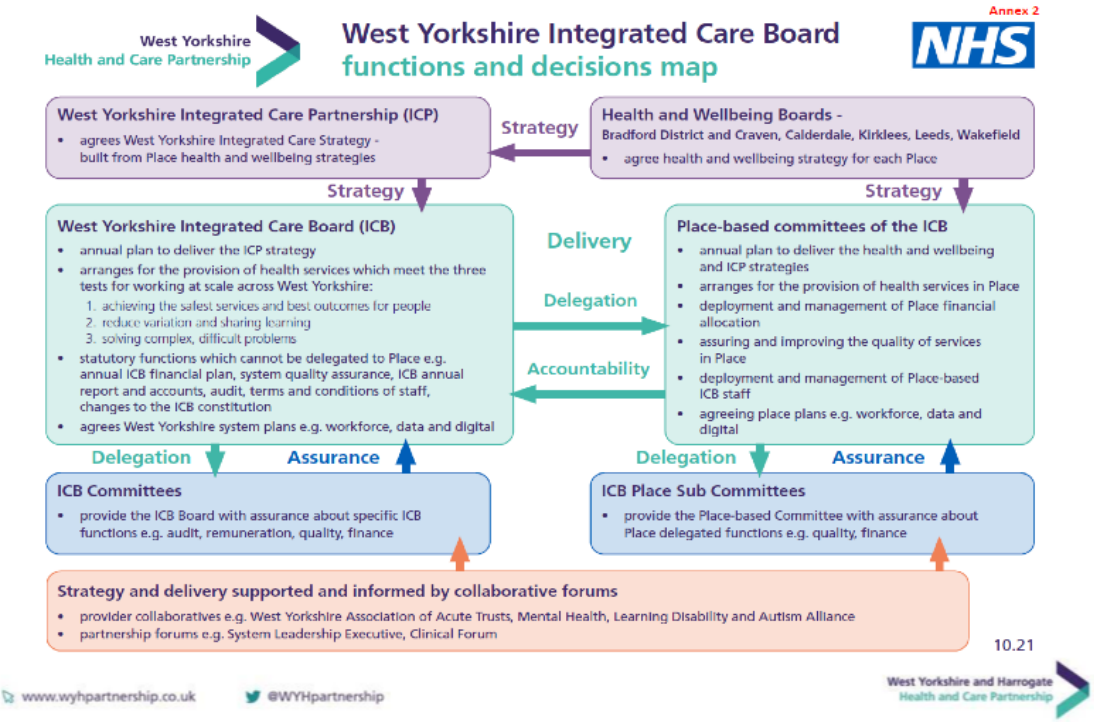
The Commission believes that this structural reform now needs to bed down and that there should be no further substantial restructuring of the health and care landscape for a number of years.

System-level Policy: In West Yorkshire this national policy required a change in culture that meant having:

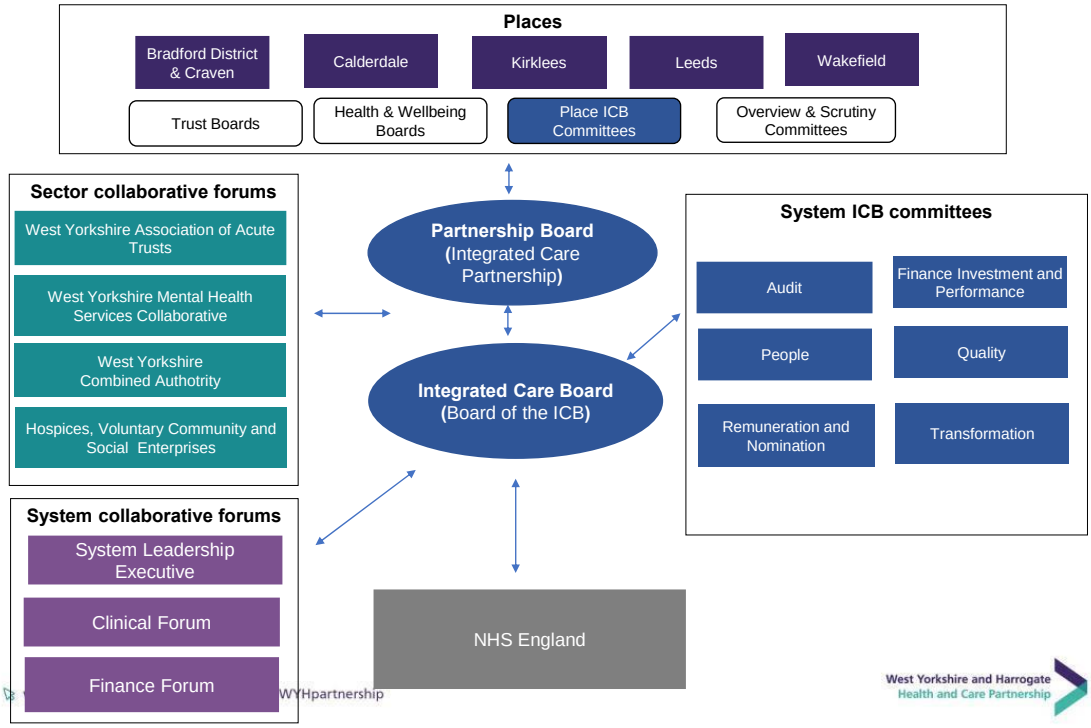
- a performance development culture that encompasses:
    - operational performance
    - quality and outcomes
    - service transformation
    - finance
- a single framework, covering individual places, and the ICS as a whole
- a focus on making judgements about a whole place, while understanding the positions of individual organisations
- an element of peer review and mutual accountability
- improvement-focused intervention, support and capacity building.

Three examples from West Yorkshire ICS are given below that illustrate their mission, values and behaviours, their functions and decisions map, and their governance and accountability arrangements to support and enable this change are given below.


Mission
Reduce health inequalities
Manage unwarranted variations in care
Use our collective resources wisely
Secure the wider benefits of investing in health and care
Values
We are ambitious for the people we serve and the staff we employ
This is a true partnership
We always agree the evidence and data, before taking action
We value good governance to make good decisions and choices
Subsidiarity applies in all we do
Behaviours
Decisions motivated by shared purpose
Empathy with staff and people
Collaboration in all we do
Suspend egos in service of each other
We see diversity as strength
Conceptual and critical thinking
Agility
Willingness to share risk
Sharing power
Retaining accountability giving others authority
www.wyhpartnership.co.uk
@WYHpartnership
Health and Care Partnership


West Yorkshire Health and Care Partnership
West Yorkshire Integrated Care Board functions and decisions map
Annex 2
NHS
West Yorkshire Integrated Care Partnership (ICP)
agrees West Yorkshire Integrated Care Strategy - built from Place health and wellbeing strategies
Strategy
Health and Wellbeing Boards - Bradford District and Craven, Calderdale, Kirklees, Leeds, Wakefield
agree health and wellbeing strategy for each Place
Strategy
Strategy
West Yorkshire Integrated Care Board (ICB)
annual plan to deliver the ICP strategy
arranges for the provision of health services which meet the three tests for working at scale across West Yorkshire:
1. achieving the safest services and best outcomes for people
2. reduce variation and sharing learning
3. solving complex, difficult problems
statutory functions which cannot be delegated to Place e.g. annual ICB financial plan, system quality assurance, ICB annual report and accounts, audit, terms and conditions of staff, changes to the ICB constitution
agrees West Yorkshire system plans e.g. workforce, data and digital
Delivery
Delegation
Accountability
Place-based committees of the ICB
annual plan to deliver the health and wellbeing and ICP strategies
arranges for the provision of health services in Place
deployment and management of Place financial allocation
assuring and improving the quality of services in Place
deployment and management of Place-based ICB staff
agreeing place plans e.g. workforce, data and digital
Delegation
Assurance
Delegation
Assurance
ICB Committees
provide the ICB Board with assurance about specific ICB functions e.g. audit, remuneration, quality, finance
ICB Place Sub Committees
provide the Place-based Committee with assurance about Place delegated functions e.g. quality, finance
Strategy and delivery supported and informed by collaborative forums
provider collaboratives e.g. West Yorkshire Association of Acute Trusts, Mental Health, Learning Disability and Autism Alliance
partnership forums e.g. System Leadership Executive, Clinical Forum
10.21
www.wyhpartnership.co.uk
@WYHpartnership
West Yorkshire and Harrogate Health and Care Partnership

Governance and accountability



Question 3: Unhelpful policies

Do you have examples where policy frameworks, policies, and support mechanisms that made it difficult for local leaders and, in particular, ICSs to achieve their goals? (250 word limit). This can include local, regional or national examples.

Commission Response

Fortress mentality: Experience suggests that, in the current climate, positive and concerted action will be required to avoid the return of a fortress mentality at every level. To that end, Government should:

- Set out fewer, more focused, national targets - ICSs should not be viewed as, nor treated as, a new layer for top-down performance management by NHSE: the new accountability framework must map to all four aims of ICSs.
- Increase funding for social care services which are at breaking point and be clear that health and social care services are an 'investable proposition' that are critical for wider economic and social development - integration is not a goal in itself but the way to deliver better NHS, social care and public health services
- Respect local autonomy and let local health and local government leaders lead – devolution is not a goal in itself but a necessity in order to deliver genuine integration
- Actively support the development of place-based and neighbourhood partnerships – subsidiarity is the defining principle here.
- Actively acknowledge the key role of VCSE partners in delivering the ICS mission

- Produce a comprehensive and funded workforce strategy that addresses the profound staffing challenges in both social care and the NHS
- Ensure that wider policies affecting the social and economic determinants of health support rather than undermine action on the ground to improve the health of the population
- Commit to close and meaningful engagement with the public on self-management and personalisation

Question 4: Innovation and pace

What do you think would be needed for ICSs and the organisations and partnerships within them to increase innovation and go further and faster in pursuing their goals? (250 word limit)

Commission Response

Adopt a 'health in all policies' approach: The Commission heard from Professor Marmot about the importance of all public, private and third sector bodies adopting a 'health in all policies' approach including housing, the workplace, the community and the environment. This is key to improving the health of the population rather than focussing only on improving the performance of health and care systems. This approach is now underway at local, city, region, national and supra-national levels within the UK and in other countries. National Government policy must be an exemplar of this approach and show leadership to reinforce and not undermine local efforts.

Identify the economic development impact in all health policies: The Commission heard about the importance of the NHS identifying the social and economic value of its presence and footprint in local communities. The Shelford group of large hospital trusts described their role as anchor institutions in local communities including co-located staff and joint apprenticeships, pooling assets through civic and commercial partnerships, partnership working on housing and transport, and using capital to change lives.

Understand the crucial link between work and health: The Commission heard about the Greater Manchester Independent Prosperity Review that explored the relationship between health and productivity that most labour productivity models ignore. The impact of losing a job on people's health is now widely recognised – the longer people are out of work the more their health, particularly mental health deteriorates. The productivity gap between the north and the rest of the UK average could be reduced by 30% if participation in the workforce was raised by addressing ill-health.

Develop a new devolved model of community-based care for children and adults with learning disabilities/autism or mental health needs that is less institutionalised, more transparent to family members and much closer to home.

Question 5: Supportive frameworks

What policy frameworks, regulations or support mechanisms do you think could best support the active involvement of partners in integrated care systems? (250 word limit) Examples of partners include adult social care providers, children's social care services and voluntary, community and social enterprise (VCSE) organisations. This can include local, regional or national suggestions.

Commission response

Children and Young People: ICSs should develop a children and young people's policy framework based on a common set of design principles and containing clear indicators of success. The children's landscape is complex and ICSs and place-based partnerships must fully engage with schools and education to achieve their health and care goals for children. This must be supported at a national level by new cross-departmental leadership between DfE and clearly value the benefit for children and young people of accessing informal support in the community as well statutory services.

Equality and Quality: The goal of equality as well as quality should be embedded in ICS and organisational codes of governance, and clear evidence shown that institutional resources are being shifted upstream towards prevention.

Mental Health Recovery Plan: ICSs have a critical role to play in improving people's mental health, improving the services they rely on, reducing health inequalities and improving access to mental health services for marginalised groups in need. ICSs should be committed to parity of esteem between physical and mental health services and funding. Making improvements to primary care mental health services should be a priority for ICSs, maximising the impact that the existing Improving Access to Psychological Therapies (IAPT) services can have for their diverse local populations and augmenting this with additional mental health services and with providers from the VCSE sector. ICSs should develop a fully funded post-covid mental health recovery plan for their area supported by a robust workforce development strategy.

Learning Disabilities Action Plan: ICSs should develop a learning disability action plan that includes ensuring there is a voice for people with learning disabilities at every level of the ICS; driving up the numbers on the Learning Disability Register that is a passport to other services and benefits; exceeding the national target for Annual Health Checks; and ensuring GPs provide a Health Action Plan for all people with learning disabilities.

THEME 2 NATIONAL TARGETS AND ACCOUNTABILITY

Question 1: Recommendations

What recommendations would you give national bodies setting national targets or priorities in identifying which issues to include and which to leave to local or system level decision-making?

Commission Response

The Commission believes that to be effective and successful, integrated care systems require an entirely new approach to the balance between local and national accountability and autonomy within and between the health and social care system at every level.

It requires a concomitant shift from an accountability system based on hierarchy and instruction from above, to mutual accountability based on local networks, collaboration and partnerships within a national framework.

Specifically, the legislation for transformation of the health and care system means that Integrated Care Boards should not, as before, 'look up' for instruction and permission to move. But rather, to 'look out' and fully and formally collaborate with organisations which are locally democratically accountable. In effect ICBs, like their place-based boards, must now perceive themselves as being primarily accountable to the geography of their system and no longer accountable only to the bigger NHS region (and through them nationally to NHSEI and the DHSC) in which they happen to sit.

This new balance between 'vertical' and 'horizontal' accountability requires the NHS and local partners to develop a new culture of partnership working and mutual accountability for shared outcomes; new collaborative processes and structures; and a new transparency in the way decisions are made. These are already apparent in some systems and the move must be supported by changes in the way NHS England and national agencies work.

Vertical/national accountability in the transformed system is still, of course, required in some form (which we discuss in our introduction) but crucially is now only one element in a system of governance that must have an appropriate balance of multiple accountabilities. If not, then nothing will have fundamentally changed and the new legal purpose and structures of the reformed health and social care system will be fatally undermined.

Question 2

What mechanisms outside of national targets could be used to support performance improvement? (250 word limit). Examples could include peer support, peer review, shared learning and the publication of data at a local level. Please provide any examples of existing successful or unsuccessful mechanisms.

Commission Response

Accountability through performance targets: the nature of (a reduced number of) national performance targets should shift to give more emphasis on national quality standards delivered through local decision-making on how they are met. The role of the centre should shift to that of supporting local systems to set local performance targets and priorities that are coproduced with communities and clearly reflect the needs and circumstances of their populations and services and deliver national quality standards.

Accountability through financial controls: design principles for financial flows within ICSs that reflect a collaborative approach were identified by the Commission and could be applied to NHSE's relationship to ICSs. These include rigorously removing financial disincentives to achieving shared outcomes; maximising flexibility in spending (but protecting long-term prevention investment); and ensuring full budgetary transparency.

Accountability through pooled budgets: within ICSs, aligning and/or pooling NHS and social care budgets at the level of place-based boards, and reflecting a 'fair and appropriate' contribution by the NHS and local government, offers opportunities to accelerate the integration of services. For each pooled budget, there should be clear accountability for the management of funds and the delivery of services within the place.

Accountability through public engagement and transparency: ICSs will need to be open and accountable to the people who draw on NHS and social care services including children, young people, vulnerable groups, those with a learning disability and those requiring support with their mental health. ICSs should also ensure they are working in a spirit of parity of esteem with voluntary and community sector partners, and a charter detailing how this will take place in practice should be agreed.

Accountability through local democratic structures: in addition to the political accountability to the Secretary of State for Health – and the accountability to CQC and Ofsted and health and social care services users - there is a need for local political and democratic accountability. It is important that the public within an ICS area know 'where the buck stops' and who is responsible locally if, for example, there is a critical error or particularly successful outcome in the delivery and planning of services.

THEME 3 DATA AND TRANSPARENCY

We recognise that key to reaching greater local control and accountability is the transparent use of data, both at a local and national level.

Question 1: innovation in data/digital

Do you have any examples, at a neighbourhood, place or system level, of innovative uses of data or digital services? (250 word limit). Please refer to examples that improve outcomes for populations and the quality, safety, transparency or experience of services for people; or that increase the productivity and efficiency of services.

Commission response

Learning disability and health: The Commission heard that a very effective way of improving health services and outcomes for people with a learning disability would be to drive up the numbers who are on the Learning Disability Register as this is their passport to a range of other services and benefits.

In addition, an analysis of the local LeDeR (formerly called Learning from Deaths Review) data on the experience of people with a learning disability and autistic people, should be used to improve care, reduce health inequalities and prevent premature mortality of people with a learning disability and autistic people by reviewing information about the health and social care support people received, and draw up an appropriate action plan to improve the health of people with a learning disability and reduce health inequalities.

Children and Young People: The Commission heard that effective data sharing is still not in place within the NHS, between the NHS and children's care services, and between health and social care and the education/school system. The ICSs, who now have children and young people within their scope, provide a new opportunity to put this right and ensure that a child-centred approach to data collection across all the key agencies is put in place.

Developing the right data*:* The Commission heard that the use of evidenced-based decision making is key to decision making but that developing that evidence base should reflect a number of elements:

- Having robust population health and clinical data
- Having sufficient granularity of data for particular population groups or particular localities/pockets within a place experiencing high health inequalities
- Drawing on professional knowledge and insights about populations, localities, and interventions is essential
- Recognising the value of real-time data for decision making
- Ensuring data collection is done at a cost proportionate to the benefits the data analysis provides
- Having all partners signed up to the evidence-base development process and the evidence that emerges.

Question 2: Data collection

How could the collection of data from ICSs, including ICBs and partner organisations, such as trusts, be streamlined and what collections and standards should be set nationally? (250 word limit)

Commission response

Interoperability: The Commission's work did not include a deep-dive analysis of how data is best collected. However, the key issue of the interoperability of different digital systems used by different organisations was identified as a critical success factor in, for example, developing shared care records for individuals; and in combining the local authority public health data with the NHS population health management data to create a single version of 'the truth in the data' that all partners could draw upon. The centre should engage ICBs, local government and VCSEs to define appropriate data interoperability standards.

Question 3: standards

What standards and support should be provided by national bodies to support effective data use and digital services? (250 word limit)

Commission response

Capacity and capability: The Voluntary, Community and Social Enterprise (VCSE) sector are key partners in integrated, person-centred, and place-based services who are often able to reach and engage with underserved communities and groups at most risk of experiencing health inequalities. The value of their contribution however, can often be limited by their lack of digital capacity and capability to access and contribute to individual shared care records, use digital approaches to service management (e.g., rostering) or delivery (e.g., service user support). Support is needed for the VCSE sector to enable it to play a full part in digital ways of working by the NHS and local government.

Digital standards not prescribed systems: There are already a range of digital systems and ways of working being delivered at ICSs, place-based partnerships and neighbourhood levels by a range of statutory and VCSE sector providers. Providing standards and support on interoperability for these systems would be of value whilst imposing prescribed should be avoided at all costs.

THEME 4 SYSTEM OVERSIGHT

ICSs are continuing to develop, and DHSC, NHS England and the Care Quality Commission (CQC) are still in the process of developing their working relationships with them. We recognise that there is significant variation in maturity, capability and performance between different systems and partner organisations, including trusts. This will require an appropriate balance between autonomy, support, regulation and intervention. We are keen to explore whether there are any principles we can identify to help set that balance.

Commission Response

The Commission was established in 2020 to champion and support the successful implementation of devolved and integrated health and social care services across England. The Commission's 2022 final report concluded that integrated care systems are the only long-term solution to creating a financially sustainable and successful NHS and social care system; improving the population's health and reducing health inequalities.

Moreover, it concluded that Integration within the NHS, and between the NHS, social care and wider public services, can only be achieved if there is devolution of resources and power to local organisations working collaboratively and with mutual accountability in the shared geographies of ICSs, place-based partnerships and neighbourhood networks. The 'Local' in local government requires robust development of the 'Local' in the NHS if genuine collaboration, partnership working and mutual accountability is to be achieved.

The Commission concluded that, to be effective, ICSs are best built around eight design principles:

- Genuine parity of esteem within the NHS between physical and mental health services
- Genuine equality between the NHS and local government services at every level in the new structures
- Shared responsibility for improving public health and reducing population health inequalities
- A strong voice in the system at every level for people who draw upon care and support
- Meaningful partnerships with the voluntary, community and social enterprise sector
- Effective place-based partnerships and neighbourhood networks as the engine rooms for delivery
- An integrated approach to the planning and development of the health and social care workforce
- Freedom and flexibility for partners to agree and act upon locally determined priorities

Question 1: Performance monitoring

What do think are the most important things for NHS England, the CQC and DHSC to monitor, to allow them to identify performance or capability issues and variation within an ICS that require support? (250 word limit)

Commission Response

Ofsted: ICSs now have the health and wellbeing of children and young people within their scope and will, consequently, have a direct interest in the quality of children's care services, the impact that schools have on children's health and wellbeing, and the enhanced role that Ofsted can play through its school inspections. The absence of a reference to Ofsted in this question is an indicator of the shift in thinking required nationally about the scope of ICSs and their relationship to education providers – schools, colleges and universities – if they are to achieve their goal of improving the health (particularly mental health) and wellbeing of children and young people.

National partnerships: There should be a partnership approach within Government between DHSC and DfE, between CQC and Ofsted, and between and national health and local government bodies in regard to education and children's social care that adopts a family-centred, place-based approach to improving the health and wellbeing of children and young people. This would be a major boost to aligning and supporting ICSs and local partnerships in developing local integrated policies and services.

Underserved groups: The Commission has sought to highlight the health and wellbeing needs of groups with high health inequalities and that are often overlooked or underserved such as people of all ages with learning disabilities and autism, and young people with mental health needs. Whilst local partners should have the freedom and flexibility to identify local health inequality priorities and develop ways of meeting them, it would be helpful to monitor nationally local performance on numbers of people on the Learning Disability register, and waiting times for young people accessing mental health services. And, if the evidence supports the need for more national leadership on these inequalities, to set national targets for a limited time period to ensure fairness across the country.

Question 2: support, regulation and intervention

What type of support, regulation and intervention do you think would be most appropriate for ICSs or other organisations that are experiencing performance or capability issues? (250 word limit)

Commission response

Workforce shortages: Organisations experience performance or capability issues for different reasons and the Commission believes that one key factor is not having sufficient staff to deliver the service. The Commission heard for example that the 20% vacancy rate in children's services is a major contributory factor to the number of highly vulnerable children currently waiting for a secure care placement; and the mental health, self-harm and suicides among young people. Developing and delivering a workforce strategy for NHS and social care services for people of all ages would be the single most effective way that the Government could support ICSs. A good start would be to co-produce a Social Care People Plan as proposed by the Future Social Care Coalition.

Ofsted: A specific step that would support ICSs to achieve their goals for children would be to ensure that Ofsted plays an active role, through its inspections, to ensure that local education providers are working in partnership with the new integrated care structures; and develop shared health and wellbeing goals for children and young people in primary, secondary and tertiary education settings.

CQC: It will be important that the CQC's method of operating and the understanding of its inspection teams really reflect a systems approach in which partners in an ICS work in collaboration and partnership, and not be viewed as just a collective of NHS provider trusts in which CQC aggregate provider performance to arrive at an assessment of ICS performance.

Joint approach: The Commission would caution against simplistic ratings by Ofsted or CQC of complex systems, which would offer little value and potentially give false reassurance. A joint approach by Ofsted and CQC developed in partnership with local system leaders to support the ICSs as they mature would be of much greater value. The regulatory oversight provided by NHSE should focus on ICSs delivering their four statutory duties.

THEME ADDITIONAL EVIDENCE

Question 1: additional evidence

Is there any additional evidence you would like the review to consider? (250 word limit.)

Commission response

The Commission has identified the following as potential risks to the success of ICSs in 2023 and beyond:

- A retreat into silo thinking and command-and control behaviour by the Government and NHS institutions as demand pressures and funding reductions have an impact on services
- A narrow focus by Government and national/local system leaders on treatment and clinical care - particularly acute care - at the expense of implementing strategies for public health, prevention and early intervention
- A drop in the priority given by Government and system leaders to reducing health inequalities for both those already in need of health and social care support, and the population as a whole
- Government failing to increase funding for social care services that are already at breaking point
- Government and system leaders reducing social care to a problem of patient discharge from hospital and ignoring the far wider social care reform agenda and the value of social care as a service in its own right not just its potential to benefit the NHS.
- ICSs becoming "talking shops" rather than doing shops – a place to articulate good intentions rather than a place where things get done and get better

Finally the Commission calls for the Government to undertake a full, 13 week statutory consultation – and ideally a nationwide debate – on what it is minded to conclude/take forward after the Hewitt Review has reported.